Integration of Population, Health and Environment (PHE) Approach for improved Reproductive Health (RH)/Family Planning (FP) and Livelihood: The Case of PHE implementation sites in Ethiopia

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Abstract

1. Background

The socio-economic and reproductive health situation in Ethiopia has improved in the past couple of years. The recent stride in the use of FP in the country has got international recognition with a doubling of users within five years. Despite the remarkable achievements made, the country still has many mothers dying from preventable and curable maternal complications unbalanced population growth complicated by local and international migration high unemployment rate of young people, climate change and land degradation posing significant negative effects on the development of the country.

Given the complex problems in the country where large population size, low agricultural productivity and limited basic health care access are the major problems, it is mandatory and timely to ensure the well being of the community and the environment in a harmonized manner. In this regard, multi sectoral integrated Population Health and Environment (PHE) approach is key to address developmental challenges through joint action of all relevant stakeholders. According to a number of reports across the world, the PHE approach has demonstrated its effectiveness in reducing unmet need for family planning in rural communities, empowering women and increasing the participation of men and the youth in family planning and health in general.

1. Program Intervention

Making use of the project funds obtained from the David & Lucile Packard Foundation, PHE Ethiopia Consortium implemented a project titled "Strengthen & Scale up RH/FP intervention through multi sectoral PHE integrated approach" since 2014 in two districts. This abstract highlight the major outcomes and learning's of this intervention and the implications for future initiatives. Major interventions includes establishment of multi sectoral taskforce, innovative community distribution through PHE providers, engaged in biological and biophysical soil and water conservation and livelihood diversification and income improvement.

1. Methodology

The findings for this article are obtained from the final-term evaluation of the project, which was conducted by an independent consultant

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The data collection tools employed for the evaluation include :survey of households through structured questionnaires, review of the project documents and other relevant secondary data sources, focus group discussions (FGD), and interview of key informants . As the beneficiary size was 179 households in the targeted two districts, Metu 79 and Hurumu 100, about 27% of the sample size (numbering 50 HH) have been taken, out of the total 50 respondents, 40 (80%) were women while the remaining 10 (20%) were men. The sample HHs were randomly selected using the list of beneficiaries in the respective village as a sampling frame. FGDs were conducted in four villages of the two districts. A total of 20 project beneficiaries (25% female) involved in the discussions. Key Informant Interview (KII) was made with 22 beneficiaries and relevant local sectoral stakeholders who have important role and participated in project implementation. The primary quantitative data collected through the household survey were organized and analyzed using SPSS and Excel programs.

2. Results

As a result of the project intervention, the contraceptive acceptance rate of the Metu and Hurumu districts increased from 58, and 69 percent in 2014 to 76and 91 percent in 2017 respectively. Institutional delivery at health centers has also shown remarkable progress from 22, and 16 percent in 2014 to 42, and 29 percent in 2017 for Metu and Hurumu districts respectively. In addition, more than 105 women were organized in four credits and saving associations and 86 percent of women improved their livelihood through alternative income generation activities. The introduction of fuel saving stoves resulted in a reduction in the time spent in fire wood collection by women by 71.4 percent and mitigated the health impacts of indoor air pollution.

To improve FP accessibility for the rural community, the project recruited rural shop owners to be *PHE providers*. These shop owners were intensively trained by the HEW Health Extension Workers on the provision of short term FP services (condoms and pills). These PHE providers have been found to complement the HEWs and are becoming the primary source of FP services when HEWs are not available. As a result of this strategy, one PHE provider has been able to support on average 10-20 short term FP users per month, which has contributed to reducing the unwanted pregnancy of the district from 12% to 2.5%. In addition, evidence shows that youths who are not comfortable going to the health post use PHE providers as an alternative source of contraceptives.

3. Program Implications

The four major lessons from the project are:

1. PHE integrated approach is effective for achieving FP and fertility outcomes: It enhances women's FP and fertility knowledge, attitude and practice and fosters knowledge to have lower desire for more children.

2. PHE approach empowers women: the approach focused on the vulnerable groups particularly poor rural women. The improvements in income of the women have shifted from short acting to long acting FP methods.

3. PHE integrated approach is an effective strategy for improving the multifaceted problems of the rural community, for livelihood diversification and income improvement.

4. PHE multi sectoral integrated approach is more effective and efficient to address local development problems through a multi-disciplinary approach focusing on health (RH/FP, hygiene and sanitation) and natural resource management.