Assessment Report on Partners Opinions, Feedbacks, and recommendations on Ipas-Ethiopia Project Implementation

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Abbreviations and Acronyms

CAC: Comprehensive Abortion Care

CC: Comprehensive contraceptives

CSOs: Civil Society Organizations

EPI: Expanded Program on Immunization

LARC: long-acting reversible contraception

MISP: Minimum Initial Service Package

MHPSS: Mental Health and Psychosocial Support

MOH: Ministry of Health

MPDSR: Maternal and Perinatal Death Surveillance and Response

NGOs: Non-Government Organizations

PAC: Post Abortion Care

PNC: Post Natal Care

PPH: Post-Partum Hemorrhage

RHBs: Regional Health Bureaus

RH: Reproductive Health

SPHMMC: Saint Paul's Hospital Millennium Medical College

SPSS: Statistical Package for Social Sciences

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Executive summary

Background: Ipas is a non-profit making, nongovernmental organization that works around the world including Ethiopia to increase women's ability to exercise their sexual and reproductive rights, especially the right to safe abortion and contraception. In more than 20 countries in Africa, Asia, and Latin America, Ipas works in partnership with diverse stakeholders to carry out different interventions. Ipas is planning to re-envision its strategies and needed opinions and feedbacks from its partners.

Objective: The main objective of this research is to gather feedbacks/opinions from key actors of the abortion and contraception ecosystem and use them to inform Ipas's strategic planning exercise.

Methods: An exploratory study was conducted from December 5th to 20th of 2021. A total of 18 participants were selected purposively and interviewed about Ipas's contribution to CAC & CC programs and their experience and perspective about the organizations. Government participants were selected from federal (Ministry of Health), regional health bureaus (Amhara, Oromia, and SNNP), and zonal health departments (West Gojam, East Shoa, and Gurage). Other partners include NGOs (Endanger Health, MSIE, DKT, FAGE, PSI, CHAI), consortiums, (CORHA), professional associations (EMWA, ESOG), and donors (Packard Foundation). All interviews transcribed and translated digitally to export into qualitative data software (Opencode). The qualitative data were analyzed with reiterations; first by reading and rereading the full transcripts, second becoming familiar with the data and finally by performing thematic coding and analysis to identify the main themes and concepts.

Result: A total of 18 study participants were included for the current qualitative study. All the organizations included considered Ipas as their strategic partner and listed out the following key points.

- **Contribution of Ipas in training and infrastructure support to expand CAC and CC**: Ipas has provided basic and TOT trainings to health care workers, especially for gynecologists, general practitioners, emergency surgeons, health officers, nurses, midwives, and health extension workers. Almost all the study participants from government facilities ~~were~~ mentioned that Ipas has tremendous role in preparation of

training documents, provision of CAC and CC full package equipment, renovation of health facilities and building separate rooms for CAC and CC at different Ipas project areas of the country. In collaboration with ESOG, VCAT training has also been provided to police officers, community, and religious leaders. The finding also indicated that all the current study settings received financial support from Ipas, but it was not in cash.

- **Contributions in abortion related policy and law:** Partners identified that Ipas is one of the major contributors in the development of the Technical and Procedural Guideline for Safe Abortion Care Services in Ethiopia (2006) which was revised in 2014. In addition to its role in the development and revision, Ipas has had high impact in enforcing the implementation of the abortion law through evidence-based advocacy. Ipas had also coordinated partners for development and implementation of the abortion law.

  It is also noted that Ipas has significantly contributed to the development and distribution of CAC, CC, and SRH related training guidelines, policies, and manuals.
- **Contribution on community awareness and attitude transformation:** Ipas produced and distributed different communication materials like print media (e.g., leaflets, posters), developed and broadcasted spot messages through TV and radio to create community awareness on CAC, CC, and SRH issues and services. It has also worked with civil society organizations to create community awareness and attitude transformation on CAC and CC. Besides, Ipas was involved in CAC ad CC service quality assurance activities at the community level.
- **Best practices and lessons learned from partnerships with government and NGOs/CSOs/professional societies**: The following major activities/initiatives were listed as best practices: Policy development and implementation, Expansion of CAC & CC services and scale up of postpartum family planning, Advocacy to respond to the anti-choice movements, Introduction of medical abortion and promotion and advocacy towards long-acting and permanent contraceptive options, CAC Mentorship program, Developing Second trimester abortion training package, Promoting Inter-facility referral linkage, and Integration of CAC & CC training in the pre-service training/curriculum. Additional best practices include valuable role on concerted action to reduce the impact of GAG rule to get fund for the expansion of SRH services, Changing health care professionals' attitude towards safe abortion care, social norms, and policies in favor of safe abortion care, Strong

coordination and facilitation during advocacy, knowledge sharing, and guideline development.

- **SWOT analysis of Ipas's stewardship program design and implementation**:
  - **Strengths**: commitment for the expansion and quality of CAC & CC services, experience on renovation work, strong monitoring and evaluation approaches, commitment to resource mobilization, good experience sharing culture, experience in organizing different advocacy events on CAC/CC, experience in improving SRH knowledge and reducing abortion stigma, focused and mission-driven nature for safe abortion, experienced in working collaboratively, and has technical expertise on women health care and rights especially on reproductive health are the strengths of Ipas mentioned by ~~the~~ partners.
  - **Weaknesses**: Limited engagement with health extension workers, poor engagement of the private sectors, weak effort to capacitate local agencies (non-governmental institutions), absence of exit strategy to sustain abortion and FP services, limited geographic scope, and limited staffing at project areas (one person for 2 zones)
  - **Opportunities**: Presence of MISP (Minimum Initial Service Package) that is focusing on SRHR during humanitarian situations, availability of MoH's 5-year strategic plan, incorporation of SRH rights into the broader/comprehensive women empowerment framework, need for SRHR services in humanitarian settings secondary to manmade or natural disasters, presence of policies and strategies focusing on SRHR, the presence of RMNCH self-care guide, and the use of digital technologies to facilitate learning and knowledge sharing.
  - **Threats**: Low acceptance of abortion services by some policy makers, poor health professionals' attitude/providers' resistance, cultural and religious taboos for abortion and contraception, poor awareness, attitude and misconceptions in the community on CAC & CC, shift in the global funding landscape from SRH services, the ever-increasing anti-abortion movement in the country, and the COVID-19 pandemic.
- **Expectations from Ipas during the current conflict and COVID-19 pandemic**:
  - Support SRHR services including SGBV care in conflict affected areas.

- Support the recovery and reconstruction of the destructed health institutions
- Support SRHR preparedness and response through procurement, preposition, and distribution of SRHR kits during disasters and in humanitarian settings.

- **Partners recommendations for future program strategy and design improvement**: Below are key recommendations made to Ipas:
  - Give special attention and emphasis for CAC and CC services tailored for youths between 10 and 24 years.
  - Support the enhancement of community abortion service seeking behavior
  - Work with health extension workers and women development armies
  - Provide training and technical assistance to CBOs until they can run their programs by themselves.
  - Strengthen partnership with more local (registered in Ethiopia) agencies like professional associations and CSOs.
  - Give attention to pastoralist areas and regions with low CAC and CC performance
  - Engage on male involvement interventions especially on CC service.
  - Expand capacity building activities for newly introduced technologies on CAC and CC.
  - Provide Structured on-job training (SOJT) for health care providers on CAC and CC.
  - The training program should be integrated with the SRH curriculum and provide training to health professionals at higher education level. This could include supporting skill labs with CAC and CC equipment.
  - Work on other RMNCH issues/essential services that are most demanding, such as PPH, skilled delivery, enhancing facility-based delivery, ANC, postnatal care, and MPDSR.
  - Strengthen public private partnership (PPP) and support private sectors to provide quality CAC & CC Services.
  - Combat stigma and provider resistance on abortion
  - Support interventions implemented through CBOs to strengthen SRHR education and prevent SGBV, unwanted pregnancy and unsafe abortion and their consequences, and to strengthen referral linkage to service points.

- **Conclusion**: Ipas has been providing commendable CAC & CC services to the target communities in selected regions in Ethiopia. All stakeholders identified Ipas as a strategic partner and expected it to continue the support it has been providing- further push its effort in advocacy and policy works, expand CAC & CC services and community interventions. On the other hand, Ipas has limited geographic scope, poor engagement of local partners, no engagement of the private sector, and weak involvement of health extension workers.
- **Recommendation:** It is recommended that Ipas needs to broaden its geographic scope (more regions, pastoral areas), sectoral scope (private sector, other professional associations, CBOs, and CSOs), target group (younger age group and males), service scope (humanitarian settings, disaster management, MHPSS, MPDSR, other RMNCH care, SRHR and SGBV care), and community engagement (health extension workers, women development army).

Contents

1. Introduction

1.1 Background

Ipas is a non-profit making, nongovernmental organization that works around the world including Ethiopia to increase women's ability to exercise their sexual and reproductive rights, especially the right to safe abortion care and contraceptive services. It seeks to eliminate unsafe abortion and the resulting deaths and injuries and to expand women's access to comprehensive abortion care and contraceptive services. Further, it strives to foster a legal, policy and social environment supportive of women's rights to make their own sexual and reproductive health decisions freely and safely (1).

In more than 20 countries in Africa, Asia, and Latin America, Ipas works in partnership with diverse stakeholders to carry out different activities. These includes clinical provider training, country-level advocacy for progressive abortion law, policies, and technical guidelines, community outreach to enhance women and girls' level of knowledge, skills, and social support to exercise their reproductive rights. Further, it makes easily accessible of the global manufacturing and distribution of high-quality manual vacuum aspiration instruments (2).

After Ethiopia's abortion law was revised in 2005, after the issuance of the "Technical and Procedural Guideline for Safe Abortion Care in Ethiopia" in 2006, the government implemented programs to train health-care providers, equip facilities and expand the services they offer and integrate abortion care into the broader reproductive health services. These efforts have resulted in significant improvements in women's ability to access safe abortion care. However, abortion continues to happen outside health facilities, often under unsafe conditions. Working closely with the Ministry of Health (MoH) and other partners, Ipas Ethiopia has become a national leader in establishing safe abortion services and creating reproductive health networks that connect women with care. Since 2010, when a study of abortion complications in Ethiopia showed a high percentage of deaths from unsafe abortion among women in the second trimester of pregnancy, Ipas Ethiopia has also worked with the MoH to introduce medical abortion services for women at or after 13 weeks pregnancy into all major regions of the country (3).

Stakeholders both at the community level and within the health system greatly influence community and societal norms about CAC and CC as well as women's knowledge and social support to access these services. At the community level, Ipas has worked with community-based

organizations, including some that are focused on youth attending universities, to reach women and adolescents with information on reproductive health (RH) services and referrals, and to shift attitudes on stigmatized issues such as abortion. Ipas has also supported the government's efforts to improve community awareness and support for CAC and CC services and change societal norms around these essential services. Ipas has built the capacity of healthcare workers to implement several strategies to provide information on the prevention of unwanted pregnancy and unsafe abortion, as well as counseling women, girls, boys, and men on CC with a focus on long-acting reversible contraception (LARC) and permanent contraceptive methods. HEWs also provide short-acting contraceptive methods and Implanon and refer women who need other contraceptive methods and abortion care services to health facilities that are providing these services. These strategies have led to the uptake of contraceptive methods and have ensured women have access to the contraceptive method of their choice and CAC services.

1.2 Statement of the Problem

Ipas has worked regionally in different African countries for more than 15 years in partnership with a diverse group of organizations and advocates for women's health and rights to support development and dissemination of progressive policies and laws on safe abortion (1). It has developed and maintained a strong partnership with governments and other various NGOs/CSOs to expand access and availability of comprehensive abortion care and family planning services.

In Ethiopia, it has a collaboration with the MoH, Regional Health Bureaus (RHBs), Zonal Health Departments, Woreda Health Offices, and health facilities to establish, scale up, and strengthen high-quality abortion care and contraceptive services. This comprehensive health system work has focused on:

- Establishing and equipping training centers
- Training and supporting service providers in women-centered CAC and CC
- Ensuring health facilities' management staff and infrastructure are fully supportive of services
- Strengthening commodity supply forecasting, procurement, and distribution protocols
- Monitoring service provision and addressing challenges as they arise (4).

To instill greater commitment and ownership of CAC and CC programming at all levels, Ipas has closely collaborated with the maternal health departments of the RHBs to fully engage them during

planning, program implementation, and monitoring and evaluation. Through these efforts, Ipas has learned that a key strategy to improving program performance is regional and national review meetings during which data on services and facility supervision provided the basis for targeting additional support or adjusting strategies.

Strengthening local partners' capacity improves project outcomes and sustainability. Several partner organizations (although Ipas has limited or no engagement with the private sector and professional associations working on health programs other than SRH) reported having directly benefitted from technical support provided by Ipas specifically noted increased skill in project management and report writing, in addition to improved knowledge about comprehensive abortion care. This helped them able to integrate these enhanced skills and knowledge into their ongoing projects, increasing benefits to the communities they serve even after Ipas partnerships end (5).

Globally, Ipas conducted 1,351 clinical activities (clinical trainings, orientations, or training of trainers) and engaged 17,071 participants. Through these activities, it trained or oriented 5,176 health workers to provide comprehensive abortion care (CAC), post abortion care (PAC), and/or contraception. Besides, 624,633 abortions were provided to women in the 5,384 intervention sites where Ipas trained health providers, provided technical assistance, and/or supported infrastructure upgrades internationally. Furthermore, 76% (476,043) of all women who received abortion care at Ipas intervention sites received modern contraceptive methods before discharge. Globally, l 1,533,857 clients (women and men) received modern method of contraception as a part of Ipas-supported stand-alone contraception programs in Bangladesh, Ethiopia, Ghana, India, Kenya, Nicaragua, Nigeria, and Zambia (2). Ipas program supports also include provision of necessary supplies for health facilities; supporting university students who serve as peer educators on sexual and reproductive health; and educates communities on how and where to access contraception and safe abortion (3).

Although its performance reviews showed that Ipas-Ethiopia has been contributing a lot, objective feedback from its key stakeholders and partners would help get a better insight in its future engagement. Ipas will take lessons (best practices or gaps) to inform its strategic plan and get guidance on its way forward. Therefore, the current study was aimed to collect partners'/stakeholders' opinion and feedback on the role and impact of Ipas and its projects.

1.3 Justification and Significance of the Assessment

The need for objective partners' feedback/opinion is widely recognized by Ipas, both on grounds of accountability and learning. Best practices and lessons learned are important inputs for continued program planning and implementation, while also being a vital component in creating robust and meaningful partnerships with the government and NGOs/CSOs. Best practice and lesson learned documentation is vital for improving the effectiveness of program implementation and ensuring that the hard-won lessons are institutionalized. Besides, with the current humanitarian crises in Ethiopia, stakeholders/partners feedback/opinions will indicate where the next new set of actions are required in the field.

Partner feedback mechanism could also provide 'unique and invaluable sources of information to be used for better project management and outcomes' (6). They can help identify and address mistakes or shortcomings, improving the quality of the program or project (7, 8). These changes and the uptake of other suggestions from beneficiaries may lead to increased effectiveness and efficiency (9, 10, 11). For example, targeting can be improved through identification of inclusion and exclusion errors (12 9), and any factors inhibiting affected populations' access to the program or project can be minimized (9). Stakeholder feedback mechanisms can also be useful for informing management of issues faced and support needed in the field (9), which can also lead to improved effectiveness. Getting people's feedback through different approaches has proved valuable to projects, as they've been able to make small but significant improvements to strengthen implementation and, ultimately, the impact of the activities. (8, 9).

1.4 Purpose of the Study

This assessment aims to collect partners' feedbacks/opinions on the Ipas implementation strategies and approaches to expand and improve access, utilization, and quality of sexual and reproductive health services and use them as an input for future strategic approaches and program designs/interventions.

2. Objectives

2.1 General objective

- To gather feedbacks/opinions from key actors of the abortion/contraception ecosystem and use them to inform moving forward best practices.

2.2 Specific objectives

- To assess Ipas's contribution to the expansion of CAC & CC services from the perspective of key partners
- To assess best practices and lessons learned from partnerships with government and NGOs/CSOs/professional societies.
- Explore the strength and weakness of Ipas's stewardship of program design and implementation from the point of view of strategic partners.
- To document the effectiveness of Ipas's coordination and facilitation role during the execution of activities conducted in collaboration with partners.
- Utilize results of the assessment to inform Ipas's future program strategy and design and further strengthen the abortion/contraception ecosystem in the country.

3. Methods

3.1 Study Area

The study was conducted at the federal, regional, and zonal level by engaging selected key stakeholders of Ipas Ethiopia including MoH, RHBs, ZHOs, WHOs, partner organizations, donors, CSOs and professional societies such as ESOG and EMWA.

3.2 Study Design and Period

Qualitative research with an exploratory study design was used. The study was conducted from 5th to 20th of December 2021.

3.3 Study Populations

Representatives of MoH, RHBs, ZHOs, WHOs, partner organizations, donors, CSOs and professional societies such as ESOG and EMWA assigned by the respective organization were the study populations.

3.4 Inclusion Criteria

- ✓ Organizations who are working at Ipas supported administration systems
- ✓ Organizations with strategic partnership, working in collaboration or interacted with Ipas
- ✓ Individuals from partner organizations who have a leadership or technical role in SRHR

3.5 Sample Size Determination and Sampling Technique

Organizations and respondent individuals were purposely selected based on the inclusion criteria from a list of partners provided by Ipas. A total of 18 participants were selected and interviewed about Ipas's contribution to CAC & CC programs and their experience and perspective with the organizations. This includes a total of 8 participants from government facilities, 5 from NGOs, 2 form professional associations, 1 from a consortium of CSOs and 2 from funders (Annex A).

3.6 Data Collection

Key Informant Interview (KII) tool was developed by Alephtav which was reviewed and approved by Ipas. Primary data was collected through KII by experienced and trained data collectors from Alephtav. Data was collected either through in-person interviews, phone interviews, or virtual meetings. All interviews were recorded.

3.7 Data Processing and Analysis

All interviews transcribed and translated digitally to export into qualitative data software (Opencode). The qualitative data were analyzed with reiterations; first by reading and rereading

the full transcripts, second becoming familiar with the data and finally by performing thematic coding and analysis to identify the main themes and concepts.

3.8 Ethical Considerations and Procedures

Ethical clearance was obtained from SPHMMC Institutional Review Board. Support letters were prepared by Ipas and Alephtav to each organization to get permission to do the research. Appointments were made with the respective key informants to explain the details of the research where verbal consent was sought to carry out and record the interviews. Participants from all organizations were informed, and permission was obtained before data collection occurs. In order to protect the confidentiality, the information was used only for the current research project.

4. Result

4.1 Socio-demographic Characteristics of the Study Participants

A total of 18 study participants from 17 partners were included for the current qualitative study and 88.9% of them were males. Around 44% of the participants were from government institutions (MoH, RHBs, ZHOs). Majority (72.2%) of the participants were SRH leaders while 27.8 were SRH officers (Annex B).

4.2 Results on Ipas's contribution to the Expansion of CAC & CC Services

Ipas's partnership history with the participant organizations ranged from about 4 years to over 20 years (Annex C). All the participants had described that their organization/sector has strong partnership with Ipas. Some organizations described the level of partnership they have had with Ipas as "Sister organization" and "Strategic partner".

Representative from MoH describe the level of partnership with Ipas as follow; "***Ipas has been a key partner in implementing SRH related activities and we have platforms to jointly plan and execute activities***".

The partnership Ipas had with different organizations includes capacity building, supply chain, facility renovation, service provision, coordination, evidence generation and knowledge transfer, technical guidelines and training manual development, social behavioral change, policy and advocacy, finance, and quality assurance.

- **Capacity building**: It provided basic, TOT, and refreshment trainings for health care providers such as nurses, midwives, health officers, doctors, gynecologist, pharmacists

(MOH, ESOG, ARHB, CHAI, etc.). Furthermore, it provided VACT training to police officers, community members, and religious leaders. Ipas had also given program coordinators training to program managers (MOH, ESOG).

- **Supply chain**: It has been delivering CAC and CC essential equipment and supplies to health facilities including health posts (MOH, ARHB, CHAI, ESOG, etc.).
- **Facility renovation**: It renovates health facilities through building separate rooms for CAC, CC and for youth friendly services (ARHB, SNNPR health bureau, ESOG, etc). A participant from zonal health department said that "***Ipas has established an adolescent-specific reproductive health service center as a pilot program in Meki to facilitate abortion care***".
- **Service provision:** Ipas has long been a key partner in supporting CAC & CC including postpartum family planning (MOH, ARHB, CHAI, EH etc.).
  As one of the respondents from MoH put it "***MoH's report suggested that around 50% of health facilities provide CAC service in Ethiopia and almost 100% provide CC. For this achievement, Ipas's contribution is very high especially on expanding postpartum family planning services***".
- **Evidence generation and knowledge transfer**: Ipas implemented various research projects to support SRH program with current evidence. It conducted two comprehensive national studies to measure magnitudes of abortion. Ipas shared the findings of special studies and provided scientific updates on SRH related issues (CORHA, EH, FGAE, etc).
- **Technical guidelines and training manual development**: Ipas supports the development of technical and procedural guidelines, training manuals and communication strategy manuals regarding CAC, FP, and other SRH services (MOH, CHAI, CORHA, EH EMwA, etc). One respondent said that "***Ipas is one of the contributors in the revision of the Ethiopian 2005 abortion law and family planning training manual***".
- **Coordination and facilitation**: Ipas actively participated and contributed a lot to the realization of several activities of the SRH TWGs.
- **Social behavioral change**: Ipas improved community awareness about abortion and LARC through community-based interventions and, preparing and distributing

leaflets, posters, spot messages through TV and radio (CHAI, EMwA, FGAE, EH). One respondent said that "***All health care workers such as gynecologist, midwives, and health extension workers and communities especially mothers benefited with information regarding CAC & CC***".

- **Policy and Advocacy works**: Ipas works on evidence-based advocacy to realize the current abortion law, which had previously allowed the procedure only to save the life of a woman or protect her physical health, get safe induced abortion procedure more acceptance by the high-level policy makers & community at large (MoH, CORHA, EMwA, EH, PSI etc.). One participant mentioned that "***It has a great contribution in advocating for the realization of the current abortion law we are using in Ethiopia".***
- **Financial support**: Ipas provides financial support for SRH programs, development of guidelines and manuals and renovation of health facilities (MOH, CORHA). One of the respondents described the financial support as follow; "***IPAS provided financial support to our association ranging from 50,000 to 100,000 ETB during events***".
- **Quality Assurance**: It regularly assess the quality of abortion and FP services in public health facilities and private clinics and implemented remedial interventions (EMwA, EH, etc)

In general, all partners acknowledged that Ipas is a major partner who has been striving to expand CAC and CC in different regions of the country. Almost all the participants acknowledged that Ipas's support was vital, and Ipas has played a key role in achieving their goal.

The participants from EMwA said that "***We achieved 100% of our project goals through the support given from Ipas. We reached different beneficiaries like Adolescents, youth girls, and women in reproductive age groups***".

On the other hand, a participant from MoH said that "***during the fiscal year of 2013 E.C around 70,000 CAC and 1.6 million CC services has been given at national level. This means 54% of the CAC and CC related plan of MoH is achieved. Ipas has made a valuable contribution to this achievement.***" Another respondent also said "***Besides, Ipas has played a critical role to the reduction of maternal mortality caused by unsafe abortion, from 32% to 11%."***

4.3 Findings on best practices and lessons learned from partnerships with government and NGOs/CSOs/professional societies

The research tried to identify best practices from Ipas's project implementation and engagement with partners. The following are best practices identified by the study participants.

- **Abortion law and its implementation**: Ipas has strongly engaged in the advocacy and effective implementation of the abortion policy in Ethiopia. Ipas's role in the advocacy, implementation, and evaluation of abortion law outcomes was commendable.
- **Expanding CAC and postpartum family planning services:** Ipas's interventions benefited reproductive age groups especially those who had unplanned pregnancy. It has helped to shape professionals' attitude towards providing CAC services. CHAI has since adapted this best practice and have been working on postpartum family planning. Ipas has introduced CAC services including second trimester abortion in several health facilities, develop guidelines and manuals, facilitate coordination and collaboration among stakeholders working in similar area & changing of policies. Ipas supports the mentorship of health facilities and professionals. Evaluation of the mentorship program revealed that it improved the effectiveness of inter-facility referral linkage with respect to CAC and reducing abortion related complication.

  This resulted in improved engagement of professionals to avail abortion care services. It has also improved post-partum long-acting family planning service from 0% to 4% at national level. Expanding CAC and CC services to the lower tiers of health facilities, which before were restricted to hospitals had also happened due to Ipas's effort. Capacity building and awareness raising activities were pretty much solely done by Ipas. Ipas expanded comprehensive abortion care and family planning services in remote areas by building separate rooms.
- **Advocacy to respond to the anti-choice movements**: Ipas's engagement in the advocacy was a contributing factor for the sustenance of CAC service delivery. This is thought to be one of the factors that has resulted in the decline of maternal mortality due to unsafe abortion practices from about 40% to around 15% (according to the opinion from FGAE representative).

- **Introduction of medical abortion and promotion and advocacy towards long acting and permanent contraceptive options**: The introduction of medical abortion which was initiated by EH and Ipas (*according to the respondent from EH*) has really eased service utility by clients as well as quality care provision. Ipas was engaged in the advocacy and promotion of these services. The 10-year project assessment report of EH, showed that the percentage of women using different types of contraceptive methods has risen by over 12%. The best lessons drawn were regarding the changes in value, attitude, social norms, and policies in favor of safe abortion care.
- **Second trimester abortion training package**: The training package was developed in 2020 and improved access to abortion service for women of reproductive age group during second trimester. Development partners, universities, MoH, professional associations, donors and regional health bureaus were key stakeholders involved in development process. This initiative resulted in increased number of trained health workers which improved availability of second trimester abortion services in public hospitals.
- **Inter-facility referral linkage**: Ipas helped the establishment of linking health centers with health posts and health centers with hospitals. This initiative has played a big role in reaching the target population and providing quality services.
- **Integration of CAC & CC training in the curriculum**: Ipas has worked with stakeholders to integrate globally applied tools and approaches such as CAC training with CC, cascading VCAT workshops, and revising the preservice training curriculum.

4.4 SWOT analysis of Ipas's stewardship of program design and implementation

The study tried to identify the strengths, weakness, opportunities, and treats of Ipas's stewardship program design. The findings are presented as follows (Table 1).

Table 1: SWOT analysis of Ipas's stewardship program from the perspective of its partner

Strength	**Weakness**
• Its commitment on expansion and quality of CAC & CC services • Its experience on health facility renovation work • The excellence in abortion evidence generation. • Its eagerness to share national and international experiences on CAC & CC • Its potential in creating new initiatives • Its experience to organize different advocacy events on CAC • Its focused and mission-driven organization for safe abortion • Its experience to work collaboratively • The experience on synthesizing guidelines, manuals, and clinical updates.	• Limited engagement with health extension worker. • There is a tendency to apply international experiences with little analysis/ consideration of the local context. • Weak consideration of the target's population religion and culture while expanding CAC and CC services. • Poor collaboration and partnership with the private sectors. • weak effort to support, strengthen, and work with nongovernmental organizations (Professional Associations, CSOs) • Absence of exit strategy. • Limited effort to ensure sustainability of CAC service, particularly safe abortion • Limited geographic coverage • Limited staffing at lower level of project implementation areas
Opportunities	**Threats**
• Presence of MISP (Minimum Initial Service Package) that is focusing on SRHR during humanitarian situations • Availability of MoH's 5-year SRH strategic plan	• Less commitment and ownership of CAC service at all levels of the health system, from MOH to facilities.

• Incorporation of reproductive health rights into the broader/comprehensive women empowerment framework • Urgent need for SRHR services in humanitarian settings due to internal conflict. • Presence of policies and strategies focusing on SRHR • Ipas's long years of international and local experiences. • Presence of partnership with key stakeholders in the area and coordination platforms such as TWG	• Abortion stigma at all levels of the health system and within community members. • Lack of awareness and misconceptions about SRH issues and consequences in the community. • Politicizing FP and abortion programs; provider resistance to provide abortion services and LARC. • Shift in the global funding landscape away from supporting SRH programs. • The ever-increasing anti-abortion movement in the country • The COVID-19 pandemic

4.5 Effectiveness of Ipas's coordination and facilitation role during the execution of activities

The current study revealed that Ipas had better level of coordination with the government and partners while executing its projects. A respondent from one zonal health department said that "***they have good coordination system from head office to woreda level***".

According to the respondents' observations, Ipas has used different coordination platforms which includes TWGs, performance review forums, plan harmonization and joint planning workshops, creating coalition, joint supportive supervisions, and assigning program coordinators at project implementation areas.

The study participants mentioned that Ipas assumed different roles in the various coordination platforms such as advisory, supervisory, and/or leadership. Besides, Ipas has played important roles in identifying program problems, provision/proposal solutions on SRH /CAC & FP related problems, evaluation of the progress of various interventions, and continuous and close follow-up

of CAC and CC programs. Ipas has also acted as an advocate of SRH services, introduction of newer contraceptive and safe abortion methods, and revision of guidelines using the coordination platforms. Ipas has also experience in coordinating and facilitating some of the coordination meetings with government and partners.

4.6 Partners recommendations for future strategy and program design

4.6.1 Recommendations to improve CAC and CC programs

- **Expansion of target population and service providers**: Ipas shall give special attention and emphasis for CAC and CC services tailored for youths between 10 and 24 years of age. Ipas Should also work target males in SRH interventions especially on CC service.

- **Expansion of target service providers**: Ipas should work more on health workers and program managers through value clarification and attitude transformation especially on abortion and FP. It should also work with health extension workers and women development armies to make CAC and CC services more accessible to the community.

- **Expansion of geographic scope**: Ipas must continue to expand CAC and CC related clinical Services in rural and hard to reach areas. It should also focus on regions which had low CAC and CC performance. Ipas should consider working in pastoralist areas where CAC and CC services are not easily accessible.
- **Service integration and expansion**: Partners emphasized the importance of integrating the CC service with the other programs to increase the service uptake and expand its scope beyond its current mission and strategic framework. Ipas should continue to map, evaluate, and introduce new technologies, innovations, systems, and services that are being used elsewhere.
- **Enhanced training**: Ipas should continue to provide in-service trainings since a lot of health professionals are deployed without the necessary abortion and FP procedure skills. Ipas shall continue its effort to improve pre-service training programs through integrating CAC and CC with curricula and provision of training to health professionals at higher education level. Ipas should also continue supporting more higher education institutions through establishment of skill labs. Ipas shall continue its support to the MoH, RHBs, and health facilities by providing Structured On-Job Training (SOJT) on CAC & CC.

- **Expansion and improved partnership**: Ipas need to enhance its partnership with the government and other partners to meet SRHR needs of the community and enhance the level of effort in combating abortion stigma and provider resistance. It should also expand its support to the private sector through public private partnership (PPP) to provide quality CAC & CC services. It should also strengthen its partnership with local professional associations and societies other than ESOG and EMWA to reach more community groups. Ipas should also partner with CBOs and support them to become self-sufficient by providing CAC and CC training and technical assistance.

4.6.2 Recommendations related to the current conflict and COVID-19 pandemic future emergencies

Partners were asked whether Ipas has any role in expanding its CAC and CC services/SRHR services for those affected by disaster such as the ongoing conflict and the COVID-19 pandemic. The study has also explored whether Ipas is able to/should expand its programs to humanitarian situations since SRHR services among victims of conflicts or disasters such as internally displaced people (IDPs) has been given less attention. Hence, below are the major suggestions provided to Ipas by partners and the government regarding expansion of CAC and CC services during humanitarian situations and emergencies.

- **Support the recovery and reconstruction of the destructed health institutions**
  - Recovery and rehabilitation support through availing equipment, training of professionals, renovation and furnishing of rooms.
  - Provide training on MISP to health workers and align the CAC & CC program in conflict affected areas.
  - Support the restoration of health facilities by coordinating local and international organizations that are working on CAC and CC/SRHR.
  - Support provision of essential SRH equipment's and supplies to affected regions to reinitiate CAC and CC services.
  - Assess the impact of internal conflicts and pandemics on SRHR to strategically support long-term recovery and rehabilitation.

- **Prevention of SGBV and unwanted pregnancy and managing their consequences**
  - Provide mental health and psychosocial support (MHPSS) to GBV survivors in conflict affected areas and IDP sites
  - Support the establishment of MHPSS provision sites in IDPs and conflict affected regions
  - Provide/initiate CAC and CC services in IDP sites
  - Provide MHPSS training for health professional
  - Conduct assessments to understand the magnitude of rape, GBV, and unwanted pregnancies in conflict affected areas and generate project ideas for fund raising.
  - Support the establishment of mobile teams which could be composed of midwives, health extension worker, psychologist, and social worker. The mobile teams will provide screening, MHPSS, and referral linkage for rape/GBV survivors.
  - Recruit and deploy mental health professional who can provide counseling and psychosocial support to GBV survivors.
- **Disaster prevention and management to sustain SRH services in humanitarian setting**
  - Continue providing training for health professionals on CAC, CC, basic SRHR.
  - Support SRHR preparedness and response through procurement, preposition, and distribution of SRHR kits during disasters.
  - Continue creating awareness among community members on SRH issues, risk communication and community engagement to enhance SRHR service seeking behavior.
  - Mobilize resources for SRHR intervention for humanitarian situations and minimize the risks associated with SRH and SGBV.
  - Include SRHR in humanitarian settings into Ipas's strategic plan.

Respondents echoed the above recommendations and the need for Ipas to engage in SRH and GBV related care in humanitarian settings. Below are some examples.

A respondent from a zonal health bureau said that "***Through anecdotal evidence, we have observed an increased number of unwanted pregnancies and abortion cases due to the internal conflict and COVID pandemic. We require timely CAC & CC interventions from Ipas during this difficult time, Ipas should support with CAC & CC service provisions and mobilize community awareness and mitigate SRH risks in humanitarian settings***".

On the other hand, a respondent from MoH said "***the minimum initial service package (MISP) is expected to be started within 24 hours of after a conflict happened. However, because of lack of no readiness from MoH and its partners, most of the time the services are not started on time. Therefore, we recommend Ipas to support on preparedness and readiness of implementation of MISP during crises***".

Another participant also said that "***We advocate the introduction and promotion of self-administered methods/products for both CAC and FP in cases where health facilities and healthcare professionals are not ~~be~~ available during emergencies***".

5. Discussion

This study revealed that Ipas is the pioneers in the implementation of safe abortion care in Ethiopia. As per the partners' opinion, in addition to CAC, it has been one of the major organizations in the country engaged in expanding access to family planning services. Provision of Safe abortion services contributed to the reduction of maternal death and morbidity by significantly reducing complications of unsafe abortion which was the major cause of maternal death in Ethiopia.

According to the WHO report, 6 out of 10 of all unintended pregnancies end in an induced abortion and around 45% of all abortions are unsafe, of which 97% take place in developing countries (13). Safe induced abortion in health facilities is increasing from time to time. For instance, in 2014 it was 53%, nearly double the proportion in 2008 (27%). In 2014, around 66% of the abortion cares were provided by private or NGO facilities (14).

In this study, almost all the participants described that Ipas has significant contribution in increasing access to CAC and CC services and in improving SRH knowledge and attitude among community members through implementation of various interventions. This includes training, supplies, equipment, renovation, and awareness creation. This can be exemplified by the comment of different respondents:

"***The contraceptive prevalence rate increases from 10 % to 45% in Oromia region through the support of Ipas and other partners***". (Participant from Oromia Regional Health Bureau)

"***We achieved 100 % of our project goals through the support of Ipas. We reached increased number of Adolescents and young girls and women in reproductive age groups***" (participant from professional association).

"***Ipas has been working on community access interventions to improve SRH knowledge and attitude of the community at large and women of reproductive age in particular. This has changed health seeking behavior of women and resulted in a decline of maternal mortality from abortion related complications from 31% to less than 10%***". (Respondent from zonal health department)

Ipas build the capacity of abortion service providers with the information, training and supplies they need including personal protective equipment to safely offer abortion and contraceptive care during COVID-19 (15). The finding also showed that Ipas has been providing different supplies for health sectors specifically CAC and CC related equipment and supplies, including gown, speculum, gallipot, gloves, and family planning kits and abortion drugs and instrument. In collaboration with other NGOs, it introduced recent technologies in the area of safe abortion. Ipas contributed to integrate CAC & CC into the pre-service training curriculum, which is essential for sustaining CAC & CC services. Ipas has also provided trainings for instructors/ lecturers on the revised curriculum. This includes expanding women's ability to access abortion without having to visit a health center, by building telehealth solutions and supporting women to self-manage abortion with pills (15).

In addition, the current study finding showed that Ipas advocated for improved access of CAC and CC services for women and young girls. In 2005, the revised Ethiopian penal code changed the abortion law and Ipas was one of the key players in the process through evidence-based advocacy.

Ipas has also engaged in awareness creation using different approaches. The community access intervention aimed to ensure women and young girls have the power and right to make their own reproductive health choices. However, participants have also raised that its services are limited to specific areas of the country. Therefore, in countries like Ethiopia, where people's culture and religious devotion remains high, it should come up with a strategy that considers the norms, religion, and cultures of the community towards modern-contraceptives and abortion cares (16).

In addition, participants pinpointed that Ipas gives less attention to private health sectors and didn't support and capacitate local agencies (professional associations and CBOs) as needed. This would have negative consequence in the sustainability of the CAC and CC services. The private health sectors have been owning and managing a wide range of health facilities and offering diverse

health services including abortion and FP services (17). So, if Ipas also considers such sectors it could help to improve accessibility and quality of SRH services and reach more beneficiaries.

6. Limitations of the study

The study didn't include as many SRH partners (NGOs, CSOs, private sector, professional associations, CBOs, academic institutions, and donors) as possible to due to limitation in resources and short research period. The study didn't also include the community, an important stakeholder on CAC and CC.

7. Conclusion

In general, the current study finding showed that Ipas has provided commendable CAC and CC services and information to the target communities in Ethiopia.

Its contribution to CAC and CC has been reflected by several best practices that includes the CAC technical and procedural guideline development and implementation, contributing nationally indorsed CAC training manual, training and mentorship program, introducing postpartum family planning, advocacy to scan and respond to anti-choice movements, introduction of medical abortion and promotion and advocacy towards long-acting and permanent contraceptive options, social marketing program for family planning, developing second trimester abortion training package, inter-facility referral linkage, and integration of CAC & CC training in the pre-service training/curriculum.

On the other hand, the current study also found out that Ipas gave less attention to the private sector and professional associations working in areas other than SRH, CSOs, or CBOs, has limited geographic scope, operates in limited population segments, has less engagement with health extension workers and women development army, and has limited programmatic scope in the field of RMNCH although this is done to avoid duplication with other partners. This study has also showed that Ipas is not engaged in CAC and CC services during humanitarian situations and disasters.

Stakeholders also identified that there is a lack of sustainability and exit strategy from Ipas which is coupled with weak ownership and commitment of the government for comprehensive abortion care.

8. Recommendation

Respondents recommended Ipas to continue the good work of supporting CAC & CC services with wider geographic coverage and reaching out marginalized/rural areas by adding new regions, new communities such as pastoralists, new population groups such as males and the youth.

To enhance its impact, Ipas should strongly consider partnering with the private health sector, professional associations, CSOs, and CBOs to further expand advocacy works and improve the quality of services. Ipas should include the health extension workers and women development armies as they are the closest to the community.

Due to the increasing deterioration of professionals' attitude towards CAC, Ipas should work more on value clarification and attitude transformation on health workers, program coordinators, and leaders. Ipas should also broaden its program reaches by engaging in the current and future humanitarian situations or disasters. Besides, it should also consider engaging in other RMNCH programs such as management of MPDSR, GBV, SRHR, MHPSS, PPH, ANC, and PNC.

Ipas should also work with all relevant stakeholder to ensure government ownership and commitment while developing sustainability and exit strategies in its new strategic documents. In general, Ipas has amassed several best practices which shall be documented separately to facilitate service expansion and institutionalization.

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Annexes

Annex-I: Information form

My name is _____ the data collector for the research project which is conducted by Alephtav Consultancy and Trading PLC on the research project entitled "***Collect partners opinions and feedbacks to take lessons from past implementation to inform best practices moving forward***". This information form is prepared for staffs from partners of Ipas

Name of the principal organization; Alephtav Consultancy and Trading PLC

Name of the principal investigator; Dr. Beyene Moges

This information form is prepared to explain about the study that you are being asked to join. Please listen carefully and ask any questions about the study before you agree to join. You may ask a question at any time after joining the study.

Procedure: - staffs from the partner institutions/organization are purposively selected based their roles and knowledge in partnership with Ipas. You do not need to mentioned your name during the interview and all your response and the result obtained will be kept confidentially.

Risk/discomfort: - by participating in this research project there is no risk or discomfort that it will happen on you except may feel that it has some discomfort especially on wasting time about 45-60 minutes.

Benefits: you may not be directly benefited but the information that you are going to give will help to Ipas to evaluate its previous performance and to take influential recommendations.

Incentives/payment for participating: there is no incentive or payment to be gained by taking part in this research.

Will the information that is obtained from you be kept confidential?

We will do all that we can to protect your confidentiality. No names will be collected and you will remain anonymous. We will not share any information that could identify you and no published data will be linked back to you.

Do I have a choice to be in the study?

Yes. If you choose to be in the study you can stop being in it at any time and for any reason. There will be no consequences to you if you do not choose to participate in the study.

Annex-II: Consent Form

I have been given all the information about the study and I have understood the information given. I have a right to withdraw from the study at any time.

Would you participate in responding to questions in this questionnaire?

Yes No.

Signature of the study participant _____

If No acknowledge the respondent and proceed to the next respondent

Name and signature of interviewer who sought consent----------

Annex III: Interview guides for representatives from partners of Ipas

Section 1: Introduction

Ask about participant's role and institution/organization background.

1. Name of organization: _____
2. Type of organization: _____
3. Gender: _____
4. Position: Could you tell me about your current position and role in this institution/organization and for how long you have been working with this position?

Section 2: To assess level of partnership and contribution of Ipas in the expansion of CAC & CC (Objective 1)

5. How do you describe the partnership between your institution and Ipas? Probe: how long has this partnership existed? What was the nature of the partnership?
6. How do you describe the contribution of Ipas in the provision and expansion of Comprehensive Abortion Care & Contraception services? Probe for each of the following.
    a. With respect to providing clinical services like CAC, CC?
    b. With respect to providing training to staffs. Could you list the professions who are benefited from the training (Probe: Drs, HOs, nurses, health extension workers, midwives)
    c. With respect to provision of equipment.
    d. With respect to building infrastructures.
    e. With respect to providing of community services.
    f. Engagement in health system development, like developing and distributions of polices, guidelines, plans, manuals.
    g. With respect to creating awareness about Comprehensive Abortion Care & Contraception services. (Probe: what approaches does it used? Like leaflets, TV, SMS, audio etc)
    h. With respect to support in finance. (Probe: for what purpose does the money allocated, could you mention the amount of the money, frequency of support)

7. Could you mention or list the target population who are benefited from the partnership and support of Ipas? How high was the level of Ipas contribution in improving CAC and CC needs of these target population?
8. As per your opinion to what extent have you achieved your aim/goal through partnership with Ipas?

Section 3: best practices and lessons learned from partnerships (Objective 2)

9. Can you identify best practices your institution acquired or experienced through the partnership with Ipas? why is that intervention/activities considered as a best practice? (Select one among the listed best practices and prob the following questions)
    a. what was the problem that needed to addressed?
    b. Which population was affected?
    c. How did the problem impact on the population?
    d. which objectives were achieved?
    e. what were the main activities carried out?
    f. when and where the activities carried out?
    g. who were the key implementers and collaborators and what was the role of Ipas?
    h. what were the resource implication?
    i. What was the concert results achieved with regard to outputs and outcomes?
    j. Was an assessment of the best carried out? if yes – what was the result?
10. What best lessons does the institution has learnt from the partnership?
    a. what worked really well? what facilitated these?
    b. what did not work? and why did not work?
11. How have the results benefited the target population?
12. What recommendations can be made from the best practices and lesson learnt?

Section 4; Strength, weakness, challenges and opportunities related questions of Ipas with the perspective of partners (Objective 3)

13. According to your opinion and observation, could you explain the strong part of Ipas? (prob; like on training, CAC and CC clinical services, community services etc)? what were the enablers?

14. According to your opinion and observation, what are the weakness of Ipas? prob; like on training, CAC and CC clinical services, community services etc)? what were the limiting factors?
15. Could you mention the opportunities which can help to enhance and sustaining of partnership with Ipas? (prob; like policies, strategies, plans, etc)
16. What could be the major challenges/threats that can affect the partnership with Ipas? (probe; like policies, strategies, plans, conflicts, disasters, etc etc)

Section 5; effectiveness of coordination and facilitation (Objective 4)

17. How do you see the effectiveness of Ipas's coordination role during the execution of activities conducted in collaboration with your institution?
    a) What coordination platforms or mechanisms were used by Ipas? (prob: TWG, joint planning, plan harmonization, joint performance reviews, etc)
    b) What was its main role in coordination of the activity/ies?
    c) Was the coordination effective? (prob; if yes what approach was used; if no what hides its effectiveness?)
    d) Do you have any advice or suggestion that would help to improve the coordination effort of Ipas?
18. How do you see the effectiveness of Ipas's facilitation role during the execution of activities conducted in collaboration with your institution?

Section 6; recommendation for future improvement

19. What can you recommend to Ipas which it has to be continue as a support and to be improve?
    a) In integration of CAC and CC
    b) In working with CBOs (probe; in train of community through CBOs, service linkage in between CBOs and government institutions and other respective institutions)
    c) In field related activities
    d) Expansion of training on CAC and CC
    e) Supplies and equipment regarding CAC, CC or other RH services
    f) Renovation and furnishing of institutions/organization-beyond RH service
20. In the context of the current country situations such as conflict and ongoing pandemic (COVID-19) what do you expect from Ipas in the future?
    a) On expansion of CAC and CC for displaced peoples due to conflict

b) On the destructed health institutions
c) On prevention and managing of rape, GBV, and unwanted pregnancy and their consequences (probe; for displaced communities, for the general populations)
d) On psychological disturbance or stress (probe; what management approach, on creation of linkages, etc) such as mental health and psychosocial support (MHPSS)
e) On future disaster prevention and management in terms of SRH in humanitarian setting?

21. Based on the observation, experiences and partnership you had during your encounter with Ipsa, what areas of expansions you would like to recommend to Ipas?

Annex A: list of targeted study settings and their categories/partnership

Partnership	**Name of organization**	**Sample Size**	**Selected organizations/Department**	**Sampling technique**	**Data collection approach**
Government institutions	MoH	2	RNMCH	Purposive	KII in-person and virtual
	RHB	3	Oromia, Amhara, and SNNP	Purposive	KII with phone
	Zonal HOs	3	West Gojam (Amhara), East Shewa (Oromia), Gurage (SNNP)	Purposive	KII with phone
NGOs	Marie Stops, EH, FGA, DKT, PSI, CHAI, Pathfinder	5	Marie Stops, EH, FGA, DKT, PSI, CHAI, PSI	SRS (lottery method)	KII in person
RH partner	Professional associations (ESOG and EMWA)	2	ESOG and EMWA	Purposive	KII in person
	~~CSOs or~~ Consortiums	1	CORHA	Purposive	KII in person
Donors	Packard foundation, Netherland Embassy	2	Packard Foundation	SRS (lottery method)	KII in person
Total		**18**			

Annex B: Demographic characteristics of the study participants for IPAS partners feedback assessment, Ethiopia, 2021

S. N	Gender	Name of the organization	Type of organization	Position of the participant
1	Female	Federal Ministry of Health	Government	National Maternal Health Coordinator
2	Female	Federal Ministry of Health	Government	Maternal Health Program Officer
3	Male	Amhara regional health bureau	Government	Maternal and Youth Health Officer
4	Male	Oromia health bureau	Government	Reproductive Health Officer
5	Male	SNNPR health bureau	Government	Reproductive Health Officer
6	Male	East Shoa Zone Health Office	Government	Director for SRH Services
7	Male	Gurage Zone Health Department	Government	Director for SRH Services
8	Male	West Gojam Zone Health Office	Government	Maternal and Child Health Services Officer
9	Male	CHAI	NGO	RMNCH Senior Program Manager
10	Male	CORHA	CSO	Executive Director
11	Male	EMWA	Professional Association	Monitoring, Evaluation, Research and Learning Coordinator
12	Male	ESOG	Professional Association	Project Coordinator
13	Male	DKT Ethiopia	NGO	National Key Account Manager for DKT
14	Male	Engender Health	NDO	Country Representative for Engender Health
15	Male	Family Guidance Association of Ethiopia	NGO	Coordinator for Monitoring, Evaluation and Knowledge Management Department

16	Male	MSIE	NGO	Director of Clinical Quality & Provider Development
17	Male	PSI	NGO	SRH Deputy Director
18	Male	Packard Foundation	Donor	Reproductive Program Coordinator and Advisor for Ethiopia & Rwanda

Annex C: Length of Ipas's partnership with different organization, Ethiopia, 2021

S. N	Name of Partner/Stakeholder	Length of partnership	Remark
1	MoH	21 years	
2	Oromia RHB	16 years	
3	Amhara RHB	-	No data
4	SNNP RHB	Over 10 years	
5	West Gojam ZHO	Over 12 years	
6	East Shewa ZHO	Over 10 years	
7	Gurage ZHO	Over 12 years	
8	EH	Over 20 years	
9	MSIE	Over 15 years	
10	FGA	Over 15 years	
11	DKT	Over 15 years	
12	PSI	5 years	
13	CHAI	4 years	
14	ESOG	Over 15 years	
15	EMWA	-	No data
16	CORHA	19 years	
17	Packard Foundation	-	No data