Bottleneck Analysis Report

On Social and Behavioral Change For Family Planning In Ethiopia

Submitted to
Ministry of Health (Ethiopia), WHO and UNFPA

Abebe Abadi Dirar (MD, MPH, MSc, MBA) - Consultant for Bottleneck Analysis on SBC for Family Planning Services in Ethiopia

Contact Address
Phone: +251923772471
Email: abebeabadi2013@gmail.com

October 2024
Addis Ababa, Ethiopia

ACKNOWLEDGEMENT

We would like to express our heartfelt gratitude to the Ministry of Health, Ethiopia (MOH-E), WHO, and UNFPA for their valuable support and funding of this bottleneck analysis,

We also extend our sincere appreciation to the regional health bureaus and all sub-national entities (zonal health departments, Woreda health offices, sub-cities, health facilities) for their indispensable contributions in providing the necessary data during the key informant interviews. Their unwavering support was crucial to the success of this study.

Special thanks are also due to the local and international CSOs who participated in the study, as well as the experts involved in data collection, bottleneck analysis, and the consensus-building workshop. Your dedication and expertise have been instrumental in this endeavor.

LIST OF ABBREVIATIONS

BCC	Behavior Change Communication
CBHI	Community-Based Health Insurance
CIP	Costed Implementation Plan
CSO	Civil Society Organization
DALY	Disability-Adjusted Life Year
DSA	Daily Subsistence Allowance
EBP	Evidence-Based Practice
EDHS	Ethiopian Demographic and Health Survey
FGAE	Family Guidance Association of Ethiopia
FGM	Female Genital Mutilation
HF	Health Facility
HEW	Health Extension Worker
HMIS	Health Management Information System
IEC	Information, Education, and Communication
INS	Insurance
KAPB	Knowledge, Attitudes, Practices, and Behaviors
KII	Key Informant Interview
MNCH	Maternal, Newborn, and Child Health
NGO	Non-Governmental Organization
ODWaCE	Organization for the Development of Women and Children
PMA	Performance Monitoring for Action
RH	Reproductive Health
RHB	Regional Health Bureau
RMNCAH	Reproductive, Maternal, Newborn, Child, and Adolescent Health
SBC	Social and Behavioral Change
SBCC	Social and Behavior Change Communication
SDI	Service Delivery Indicators
SOP	Standard Operating Procedure
SPA	Service Provision Assessment
SRH	Sexual and Reproductive Health
TWG	Technical Working Group
VHL	Village Health Leader
WRA	Women of Reproductive Age
ZHD	Zonal Health Department

LIST OF FIGURES

LIST OF TABLES

TABLE OF CONTENTS

EXECUTIVE SUMMARY

Sustaining healthy behavior requires ongoing investment in Behavior Change Communication (BCC) as part of a comprehensive health program. Social and Behavioral Change (SBC) processes and techniques are essential for motivating and increasing the uptake and maintenance of health service-related behaviors among target audiences. However, socio-cultural, and religious norms can pose significant barriers, as misconceptions about family planning (FP) persist in many communities. These norms can discourage the use of contraceptives and limit the effectiveness of communication interventions. Additionally, regional, and socio-demographic disparities create equity gaps, making it challenging to provide consistent FP services across different areas.

The goal of the assessment was to conduct a bottleneck analysis (BNA) on social and behavioral change in family planning and lay the groundwork for developing the RH/FP/AYH SBC strategy, which would influence behavior change impacting social norms.

The study was conducted in five regional states, representing urban, agrarian, and pastoral communities. Twenty-one key informants, including policymakers, program managers, and service providers with expertise in family planning and SBC, participated in the study. The study used a qualitative method. Data sources included desk reviews for policy alignment, case studies, HMIS, and key informant interviews (KII).

The BNA employed purposive and convenience sampling techniques to ensure a sufficient and representative sample size. Participants were classified into three categories: federal level (Ministry of Health), sub-national level (health facilities), and donors, implementing partners, and CSOs. The WHO generic data collection tool for BNA on SBC in family planning was adapted to the Ethiopian context and validated by experts in a two-day workshop. The desk review highlighted that the National RH Strategy prioritizes integrating family planning services into the broader health system, emphasizing community engagement and addressing demographic and cultural diversity. Case studies on best practices in SBC for FP were collected from two civil society organizations: the Family Guidance Association of Ethiopia (FGAE) and the Organization for the Development of Women and Children (ODWaCE).

A key informant interview (KII) was conducted from June 11-28, 2024, to understand the opinions of key stakeholders on the most significant bottlenecks in Social and Behavior Change (SBC) for Family Planning (FP). The study involved 21 stakeholders, including policymakers, program managers, and service providers, with 30% from the five study regions, 20% from civil society organizations (CSOs), and 15% from the Ministry of Health (MOH). The data collection team, comprising ten individuals with relevant experience, received one-day training on the study's objectives and data collection process.

The key informant findings highlighted several challenges: 47.6% of respondents agreed there is strong political support and leadership for scaling up SBC for FP, but 66.7% indicated that the budget allocated is inadequate. More than half (52.4%) felt that key stakeholders are not adequately consulted about SBC approaches, and a third claimed that technical working groups (TWGs) are ineffective in supporting SBC scale-up. Additionally, 47.6% of respondents noted that community engagement is not tailored to local social and gender norms, and there are insufficient commodities, equipment, and supplies for SBC delivery. Nearly half (47.6%) believed that training on SBC for FP is inadequate, and a third felt that staff across the health system lack the necessary competencies to deliver SBC for FP effectively

A three-day consensus-building workshop was held from August 12-14, 2024, to identify and prioritize major bottlenecks in Social and Behavior Change (SBC) for family planning, conduct root cause analysis, and suggest solutions. Participants individually ranked the bottlenecks and then prioritized them in groups. Root cause identification was performed using a 'Problem tree' and the '5 Why's' technique. Financing emerged as the most critical bottleneck, with insurance scoring the highest. Other significant bottlenecks included budgeting, donor support, and spending. Information-related issues such as Data & HMIS, Guidelines & Tools, and Client IEC were also highlighted. Additionally, challenges in communication, knowledge & awareness, service delivery/supervision, and human resources were identified. Conversely, service delivery aspects like teamwork & coordination, service organization & scheduling, and referral systems were not considered major bottlenecks.

The workshop recommended several actionable solutions to address these challenges. Strengthening existing accountability mechanisms and prioritizing financing for family planning SBC services were deemed essential. Emphasis was placed on equity, prioritization, and scaling up FP social behavioral services at national and sub-national levels. Strengthening health promotion services, including dedicated indicators in the DHIS2, and improving coordination and planning with key stakeholders were also recommended. Adequate budgeting for SBC for FP as a motivation and rewarding mechanism, establishing an effective health management system, and integrating FP SBC into the pre-service curriculum were suggested as crucial steps to overcome the identified bottlenecks

SECTION 1

INTRODUCTION

1.1 BACKGROUND

Health is shaped by a variety of determinants, including social factors such as knowledge, attitudes, norms, beliefs, and cultural practices. Social and Behavior Change Communication (SBCC) programs leverage communication as a powerful and fundamental human interaction to positively influence these social dimensions of health and well-being. Sustaining healthy behavior typically requires ongoing investment in Behavior Change Communication (BCC) as part of a comprehensive health program[1-4].

SBCC is often used in public health programs to address issues such as family planning, HIV/AIDS prevention, maternal and child health, and nutrition. By fostering positive social and behavioral changes, SBCC helps to improve health outcomes and enhance the quality of life for individuals and communities. SBCC is an approach that leverages communication to influence and transform social behaviors and norms. It aims to enhance health and well-being by addressing social determinants of health, including knowledge, attitudes, norms, beliefs, and cultural practices. SBCC programs employ a variety of communication strategies and channels to foster positive behavior change and create an environment conducive to sustaining healthy behaviors[5-7].

The application of various SBCC approaches, communication channels, and increased exposure to interventions has shown the most significant impact on RHFP-AYH interventions. However, there are only a few studies that have documented the effects of large-scale SBCC interventions in Ethiopia. A study conducted by USAID on "The Business Case for Investing in Social and Behavior Change for Family Planning" utilized an evidence-based approach to evaluate the effectiveness, cost, cost-effectiveness, and return on investment of SBC[8-12].

The key findings of the study indicate that SBC is effective in improving health outcomes and is a highly cost-effective intervention. However, the results vary widely across and within different types of interventions. Modeling from Zambia and Guinea demonstrated that scaling SBC is a highly cost-effective health intervention that can generate a positive return on investment[13-15].

SBC enhances family planning programs by addressing service delivery and the enabling environment. SBC processes and techniques are used to motivate and increase the uptake and maintenance of health service-related behaviors among target audiences. This approach focuses on service interactions, including motivating clients to access services (before services), improving client-provider interactions (during services), and boosting adherence and maintenance (after services). It also considers social and cultural norms affecting service use, the physical environment of service delivery, and communication between clients and providers[16-18]

By improving client engagement, enabling community participation, and reinforcing linkages with other health and social sectors, SBC interventions significantly strengthen family planning programs. They complement service delivery and the enabling environment, ensuring that family planning services are more accessible, acceptable, and effective for all individuals. In developing the business case for Social and Behavior

Change (SBC) in family planning, researchers analyzed around 200 studies from various countries to assess the effectiveness and costs of SBC interventions. They examined both the indirect impacts, such as changes in attitudes and communication about family planning, and the direct impacts on modern contraceptive use. By calculating impact factors using odds ratios (ORs), they standardized the relationship between exposure to SBC interventions and outcomes, finding positive correlations, the OR was as high as 2.1 for use of SBC and attitude change in contraceptive use. It also range from 1.1 to 1.9 for SBC and increased use of contraceptives[13, 19, 20]

However, a study by Hagger highlighted a significant gap in the development field: despite the recognized importance of SBC interventions in high-quality health programs, there is a lack of synthesized information on their costs and effectiveness. This gap has led to the under-funding of SBC programs, which does not reflect their actual value and potential impact[8, 21, 22]

The World Health Organization (WHO) has developed a guide for conducting a rapid assessment of bottlenecks that inhibit the national scale-up of evidence-based practices in family planning. This assessment identifies various challenges, such as limited access to services, inadequate healthcare infrastructure, insufficient training for healthcare providers, and socio-cultural barriers that affect the uptake of family planning methods1. The guide aims to provide a systematic approach to identifying and addressing these bottlenecks to improve the effectiveness and reach of family planning programs. Using this guide, WHO in collaboration with Ministry of Health of Ethiopia conducted a bottleneck analysis (BNA) on SBC for family planning[13, 23-25]

1.2 RATIONALE FOR THE STUDY

The government of Ethiopia is making significant efforts to improve the health status of its citizens, with a particular focus on mothers, children, adolescents, and youth. This is being achieved by providing high-quality reproductive health information, education, and services, and by overcoming major barriers such as limited access to these resources and the underutilization of Reproductive Health, Family Planning, and Adolescent and Youth Health (RHFP-AYH) services.

SBC interventions are known to address various behavioral determinants that influence the uptake and continuation of modern contraceptive methods, enabling individuals and couples to achieve their reproductive goals. However, scaling up SBC interventions has been challenging due to bottlenecks at both community and health system levels, despite a high level of understanding, awareness, and acceptance of these practices among family planning stakeholders in Ethiopia

Globally, scaling up the implementation of WHO-recommended evidence-based practices in family planning has become a priority. Despite being an essential component of high-quality family planning programs, SBC interventions remain underutilized in Ethiopia. To address the current gaps in the availability and implementation of SBC interventions, it is essential to understand the bottlenecks and root causes, review existing

ones and develop/adapt strategies to sustain effective SBCC and create an enabling environment for people to adopt desired behaviors related to family planning.

To gain a better understanding of the factors that may help or hinder the scale-up and sustainability of SBC-FP interventions, WHO, in collaboration with the Ministry of Health (MOH), conducted a Bottleneck Analysis (BNA) in Ethiopia which is also part of the 'WHO-FP Accelerator Plus' project.

The BNA at the country level focused on identifying and addressing the challenges to improve the effectiveness of family planning programs.

- **Synthesizing Knowledge**: Analyze the local context, policies, guidelines, tools, strategy documents, plans, and monitoring and evaluation reports to understand the implementation status of interventions in Ethiopia. Identify reasons for their success or lack of success.
- **Reviewing Strategies:** Evaluate strategies and approaches used to address gender norms and inequalities by interviewing policymakers, program managers, service providers, community-based organizations, and civil society. Determine the reasons for their success or failure.

1.3 GOAL AND OBJECTIVE

GOAL

The overall goal of the assessment was to conduct a bottleneck analysis on social and behavioral change in family planning. It aimed to lay the groundwork for developing the RHFPAYH SBCC strategy, which would influence behavior change, potentially impact social norms, and lead to a healthier society.

SPECIFIC OBJECTIVES

- Conduct a policy and guidance alignment assessment to determine alignment with WHO and MOH recommended practices and identify areas for improvement.
- Review national data to assess if policies cover current evidence-based practices.
- Identify Key Barriers that prevent effective SBC interventions in family planning, or influence family planning practices and uptake.
- Gather Stakeholder Insights though conducting interviews and consultations with key stakeholders, including policymakers, program managers, and service providers, to gather diverse perspectives.
- Provide actionable recommendations to address prioritized bottlenecks and enhance the impact of SBC interventions on family planning.

1.4 SCOPE OF WORK

Under the guidance and technical support of the WHO's Ethiopian Office (MNCH Unit) and the MOH (MCAH-LEO), the consultant:

- Prepared a detailed plan of action outlining specific activities and timeframes.
- Adapted the WHO generic data collection tools through tool validation workshops
- Shared ideas and suggestions with the TWG on how to enhance the bottleneck analysis (BNA) for SBC in family planning (SBC-FP).
- Undertook data collection, desk review and drafting BNA report
- Conducted a consensus building workshop to further refine the BNA findings, for ranking of the identified bottlenecks, proposing solutions
- Provided actionable recommendations on how the BNA for SBC-FP could be contextualized and utilized in Ethiopia.

1.5 GUIDING PRINCIPLES

The development of this document followed the accepted General principles and recommended practices of SBC for FP:

- Adopting a people-centered approach by ensuring the participation of relevant stakeholders in the design and implementation processes of SBC interventions.
- Leveraging existing community platforms and social infrastructure, such as civil society groups,
- Following rights-based and gender-sensitive approaches, ensuring reproductive rights and informed choices regarding services and contraceptive methods.
- Addressing societal norms, values, and attitudes related to sex, reproduction, gender, and contraception in FP SBC interventions.
- Coordinating between different authorities and organizations to avoid confusion and mixed messaging and ensuring access to quality family planning services

SECTION 2

METHODOLOGY AND APPROACH

2.1 STUDY AREA

Ethiopia, as a federal state, is divided into 14 administrative regions. Among these, twelve are known as regional states (which are further divided into "zones"), and two (Addis Ababa and Dire Dawa) are designated as city administrations. These 14 administrative regions are categorized into three groups.

Table 1: Administrative Classification and Areas Selected for the BNA on SBC for Family Planning

Category	Regions	Selected for the BNA
a) Agrarian	Oromia, Amhara, Tigray, Southwest Ethiopia Peoples, SNNP, Central Ethiopia, Sidama, Benishangul-Gumuz and Gambella	Oromia and Sidama
b) Pastoral	Afar, Somali	Somali
c) Urban	Addis Ababa, Harari and Dire Dawa	Addis Ababa and Dire Dawa

2.2 STUDY DESIGN

The study design used in this the BNA was a qualitative method. The BNA for SBC-FP was undertaken using relevant standard qualitative methodologies to generate the highest quality and most credible evidence. Hence, the WHO standard data collection tool was adapted to the context of the country (Ethiopia) with successive workshops held with the MOH, implementing partners, and members of the family planning TWG.

The data collection through key informant interviews was conducted in five regions selected for the BNA on SBC-FP (refer to the table above).

2.3 DATA SOURCES AND TARGET POPULATION

The sources of data used for the BNA on SBC-FP included:

- Desk review for policy alignment
- Case studies from relevant SBC-FP projects/interventions
- DHIS-2 data from MOH
- In-depth key informant interviews
- Consensus workshops

Health policymakers and program managers from the MOH, regional health bureaus (RHBs), Woreda/sub-city health offices, CSOs/NGOs, and healthcare workers from selected health facilities were contacted during data collection.

2.4 SAMPLING APPROACH

The BNA employed purposive and convenience sampling techniques. However, the study took meticulous care to ensure that the sample size was sufficient and representative of all regions of the country and all societal segments. Additionally, the study guaranteed that the sample size included all relevant categories and groups for the BNA. Therefore, the study area and participants were classified into different categories:

- Category I: Federal level sector ministries, especially the Ministry of Health.
- Category II: Sub-national level, including regional health bureaus, Woreda health offices (agrarian/pastoral settings), sub-cities (urban settings), and health facilities.
- Category III: Donors, implementing partners, and CSOs working in the areas of family planning, SBC, and related fields were identified and mapped.

The sampling units were determined to be regions, directorates, health facilities, partner organizations, and key informants

2.5 SAMPLE SIZE

The study selected five regional states, three directorates from the Ministry of Health, and five civil society organizations (CSOs). The regions were chosen to represent the three major community categories: urban, agrarian, and pastoral. Specifically, two urban regions (Addis Ababa and Dire Dawa), two agrarian regions (Oromia and Sidama), and one pastoral region (Somali) were included as representative samples.

A total of twenty-one key informants participated in the study; including policymakers, program managers, and service providers with expertise in family planning and social and behavior change (SBC). Additionally, the Ministry of Health was included to represent the national level. Both local and international CSOs were involved due to their significant contributions to family planning services in Ethiopia (see Table 1).

Table 1: Samples and Sample Size for the BNA on SBC for Family Planning

MOH and Regions	National		Sub-National			Total
	MOH	**CSO**	**RHB**	**Sub-City/Woreda*** **	**Health Care Workers**	
MOH*	2					2
Addis Ababa			1	1	1	3
Oromia			1	1	1	3
Sidama			1	1	1	3
Somali			1	1	1	3
Dire Dawa**			1		1	2
Total	**2**	**5**	**5**	**4**	**5**	**21**

**There is no service provider at MOH*
***There are no Woredas or sub-city in Dire Dawa*
****Woredas in agrarian and pastoral settings are comparable to sub-cities in urban settings*

2.6 DATA COLLECTION PROCESS

Data Collection Tool Adaptation and Pretesting: The WHO's standardized generic data collection tool for BNA on SBC in family planning was adapted to the Ethiopian context. This adapted tool was validated by a team of experts during a two-day tool-validation workshop, where it was further customized to consider religious, cultural, and societal values

The questionnaire were reviewed by the BNA Lead and adapted to the local context before being shared with respondents. They were pre tested before the actual field visit.

The standardized WHO generic data collection tool was adapted in to the Ethiopian context. The adapted tool was validated by a team of experts during a two-day tool-validation workshop. Finally, the tools were customized to the Ethiopian context taking in to consideration the religious, cultural, and societal values.

The consultants had got approval on the data collection methods and tools at a tool validation workshop and utilized the Adapted WHO standard data collection tools to collect the KII and case study findings. The key informant data was collected through a face to face data collection with an interview.

OBTAINING OFFICIAL SUPPORT LETTER: for better facilitation of the data collection process, official support letters were obtained for each selected region and CSO from the MOH

SELECTION OF DATA COLLECTORS: a total of 10 data collectors were carefully selected from relevant fields including from different academic backgrounds. The selection process took in to consideration the academic back ground of the data collectors, their relevant experience in the areas of family planning and SBC, previous experience in bottleneck analysis, qualitative and quantitative data collection methods, data entry process, experience in using newer data collection technologies and relevant applications,

DATA COLLECTORS TRAINING: the selected data collectors were made to participate in the tool validation workshop, they were provided with one-day training on the overall goal of the BNA, the specific objectives, and the data collection process, in the training of the data collectors, due emphasis was given on the proper ethical presentation, in avoiding bias.

2.7 CONDUCTING DESK REVIEW

A comprehensive desk review of the necessary documents was conducted, focusing on the purpose and specific objectives of the BNA. This review helped to organize and document the existing knowledge and practices regarding enablers and barriers to SBC for family planning in Ethiopia. It synthesized and extracted relevant lessons on barriers that hinder successful programming and suggested recommendations to ensure the effective implementation of SBC programs.

Global literature, particularly those relevant to the Ethiopian context, was reviewed. This included an examination of all pertinent national and regional policy documents, such as guidelines, strategies, directives, and policy briefs, to address the stated specific objectives. Additionally, the consultant reviewed stakeholder mapping of relevant entities and leaders, including government agencies, non-profit organizations, community-based organizations, and other key players in FP SBC.

Table 2:List of Relevant Documents Reviewed for the BNA on SBC for Family Planning

Category	List of Documents Reviewed	Remark
Strategic/policy document	National RH strategy of Ethiopia	2021-2025
	Health extension program	2021-2025
	Health sector transformation plan	2016-2018 EC (Ethiopian calendar)
	The national AYH strategy,	2021-2025
Guidelines, SOPs	The national FP guideline	2020-2025
	The national FP communication guideline,	2021-2025
Research products including case studies	Social and Behaviour Change Communication – Essential Component of Contemporary Health Care.	Vyas S. *Healthline Journal Volume 7 Issue 1 (January-June 201*.
	Family Planning Workforce Key Indicators.	USAIDS. 2018;
	Effectiveness of a mixed lifestyle program in couples undergoing assisted reproductive technology: a study protocol.	Padideh Malekpour Rh, Mojgan Javedani Masroor, Reza Chaman, Zahra Motaghi. *Malekpour et al Reproductive Health*. 2021;20:112doi:10.1186/s12978-023-01652-6
	Overcoming boundaries in public health: Advances in international and global health.	Ippazio C. Antonazzo, Janet Sultana, Pietro Ferrara. Editorial: 2022;doi:10.3389/fpubh.2022.1044157
	Effect of neighborhood and individual-level socioeconomic factors on breast cancer screening adherence in a multi-ethnic study.	Kasper G, Momen M, Sorice KA, et al. *BMC Public Health*. Jan 2 2024;24(1):63. doi:10.1186/s12889-023-17252-9
	Elevating Social and Behavior Change as an Essential Component ofFamily Planning Programs.	Joanna Skinner HH, Laura Raney, Christine Galavotti, Benedict Light,

		Michelle Weinberger, and Lynn Van Lith. 2021;
	Should Adolescents Listen to Their Hearts? A Closer Look at the Associations Between Interoception, Emotional Awareness and Emotion Regulation in Adolescents.	Braet J. 2024;doi:10.1177/00332941241286435
	Using Social & Behavior Change To Improve Family Planning Outcomes.	USAIDS. 2023;
	National Family Planning Communication Guideline.	FMOH-E. 2021;
	Social and behavior change communication competency among front-line healthcare system actors in Ethiopia: a cross-sectional study.	Simegnew Handebo et.al, 2024;doi:10.1186/s12889-024-18084-x
	Postpartum Family Planning Use and Its Determinants among Women of the Reproductive Age Group in Low-Income Countries of Sub-Saharan Africa: A Systematic Review and MetaAnalysis.	Tesfalem Tilahun Yemane GGB, Gudina Egata ,Tilahun Kassa Tefera. *Hindawi International Journal of Reproductive Medicine* 2021;doi:10.1155/2021/5580490
	The Business Case for Investing in Social and Behavior Change for Family Planning.	USAID.
	Twelve Recommended SBC Indicators for Family Plannin. 2020;	USAIDS. (BREAKTHROUGH RESEARCH PROGRAMMATIC RESEARCH BRIEF)
	Social and Behavior Change Communication.	Muturi N. 2023;doi:10.1007/978-3-030-14449-4_216-1
	USING RESEARCH TO DESIGN A SOCIAL AND BEHAVIOR CHANGE STRATEGY FOR MULTI-SECTO.	USAIDS. 2018;
	SOCIAL BEHAVIOUR CHANGE (SBC): FROM KNOWLEDGE TO ACTION.	GIZ. 2022;
	What are the barriers to scaling up health interventions in low and middle income countries? A qualitative study of academic leaders in implementation science. *Yamey Globalization and Health*	Yamey G. 2012;8:11
	Wolrd congress on public health.	WFPHA. 2023;
	Habit and physical activity: Theoretical advances, practical implications, and agenda for future research.	Hagger M. 2018;doi:10.1016/j.psychsport.2018.12.007

	Repercussions of overturning Roe v. Wade for women across systems and beyond borders. *Coen-Sanchez et al Reproductive Health*	Karine Coen-Sanchez BE, Ieman Mona El-Mowafi, Maria Berghs, Dina Idriss-Wheeler, Sanni Yaya. 2022;19:84doi:10.1186/s12978-022-01490-y
	The Impact of Behavioral Economics-Based Counseling and Mobile Phone Text Educational and Reminder Messages on the Use of Modern Family Planning in Jordan: A Cluster Randomized Controlled Trial.	Heath Prince 1 Nihaya Al-Sheyab 6 KKS, YSK, * , Yara A. Halasa-Rappel 3, Sara Abu Khudair 4 , Rana AlHamawi 4 and Kelley Ready, 2023;doi:10.3390/healthcare11091314
	A Mobile Phone–Based Support Intervention to Increase Use of Postabortion Family Planning in Cambodia: Cost-Effectiveness Evaluation.	Jeremy Hill1 JM, John Cairns; Caroline Free, Chris Smith. 2020;doi:10.2196/16276
	25 Years of Public Health Leadership in Africa: The Ethiopian Public Health Association.	Mariam DH. 2010;doi:10.1007/BF03403961

2.8 KEY INFORMANT INTERVIEWS

Hence, the major aim of the key informant interviews (KIIs) was to understand the opinions of key stakeholders on the most important bottlenecks influencing the scale-up of SBC in Family Planning. Results from the survey are summarized and discussed further during the bottlenecks workshops to allow stakeholders to come to consensus on the important challenges.

The BNA assessment is assumed to help in identifying the major bottlenecks and the challenges of scaling up of SBC on FP at all levels. To this end, data collection was conducted in selected regions, at the ministry of health directorates and CSOs.

- Adaptation and validation of The WHO generic data collection tool in to the Ethiopian context,
- Converting the interview data collection tool in to an electronic format (the tool was converted to Google form),
- Testing of the validated tool was conducted to gain important information of the adapted questionnaire,
- Obtaining Official support letter from MOH all stakeholders engaged in the study process,
- Preparation and submission of proposal for an accredited body for ethical clearance/waiver,
- Mapping and selection of Data collectors based on pre-set criteria,
- Training of Data collectors on the objective of the BNA, the overall data collection process, and the ethical procedures to follow;
- Arrangement of logistics (in consultation with MOH, UNFPA and WHO) for the data collection process including DSA, transportation,

- Deployment of data collection team and regular follow up of the daily activities,
- Conducting the key informant interviews using the validated data collection tool,

Data collection was conducted from 11-28 June, 2024. The location for the data collection were Addis Ababa, Jimma zone of Oromia region, Hawassa town in Sidama region, Dire Dawa city, Jijiga in Somali region and the federal MOH and CSOs in the capital, ADDIS ABABA.

The Bottle Neck Analysis for SBC on FP was undertaken using relevant standard qualitative methodologies to generate the highest quality and most credible evidence of this BNA. The BNA has used a purposive sampling technique. The consultants make sure that the sample size targets all the different categories and groups to be included in the BNA. The sampling units were decided to be regions, directorates, HFs, partner organizations, and KIs.

The key informant for The BNA was conducted in selected regions throughout Ethiopia. The sources of data for the BNA are: Desk review, In-depth Key Informant Interviews and Quantitative data from the DHIS-2 report of the ministry of health. The targets addressed in this BNA include: MOH, RHBs, CSOs, NGOs, private institutions, service providers,

Hence, a total of five regional states, three directorates at the ministry of health, and five CSOs were selected for the study. The regions were selected to represent the three major categories of the society which are the urban, agrarian, and pastoral communities. Hence two urban regions (Addis Ababa and dire Dawa,) two agrarian regions (Oromia and Sidama) and one pastoral region (Somali region) were assumed to be representative samples.

The KII was conducted at the ministry of health, RHBs and CSOs, targeting policy makers and program managers at the national and regional level, facility-based health workers at the regional level, NGOs, and Implementing Partners. Hence, an in-depth interview with an average duration of two hours was conducted with the selected KIs was done. After a few background questions, the respondents were asked to rate out of 5 how much they agree with a series of statements about policy and programme implementation and scale-up.

Each key informant from the 21 selected stakeholders was interviewed in EBP scale-up which includes Policy makers & programme managers: at national and sub-national level, including government and implementing NGOs, Clinicians, facility supervisors, managers, and Civil society representatives

Following a few introductory background questions, the interviewers ask the respondents to rate out of 5 how much they agree with the series of statements about policy and programme implementation and scale-up. Each statement represents a potential bottleneck to scale up. Since some of the statements are broad, the informants were asked to consider a series of points relevant to that statement, elaborating what the statement means.

Then, data was collected from each key informant through a face to face data collection method with an interview in all cases as the most preferred option. The trained data collectors had go over the questionnaire with the respondents.

2.9 CONDUCTING CONSENSUS-BUILDING WORKSHOP

A three-day consensus workshop was conducted from August 12-14, 2024. The workshop aimed to identify the major bottlenecks in SBC for family planning, prioritize these bottlenecks, conduct root cause analysis, and suggest solutions for each one.

2.10 DATA ANALYSIS APPROACHES

The qualitative data collected from the key informant interviews was analyzed in line with the evaluation objectives using a simple Google format analysis. For color-coding of the key informant findings as per level of the bottleneck, the Google format data was transcribed to the WHO data analysis tool. Data was collected using the English version of the questionnaires and no translation to local language was made.

After all the data were collected in the pre designed Google form, the data were downloaded in to a standard excel sheet. The data on the excel sheet then was transferred to the WHO standardized data collection template. However, there were two major challenges in transferring the data to the WHO analysis format. The first was the data extracted directly from the Google sheet in excel did not align with the WHO excel form, the columns in the excel sheet were raw in the WHO format and vice versa.

Hence, there was a need to make a data transposition to align the columns and raw of the Google sheet data with the WHO template. The other problem was the number of columns and raw in the WHO standard template were not equal to the columns and raw on the extracted excel sheet. Then, an adjustment was made so that the number of columns and raw are equal in both formats.

After doing these adjustments, the data was transferred from the Google form to the WHO data analysis template. The table below shows the final auto-analysed data of the KII with the standard data analysis template.

The WHO Excel template includes a data summarization sheet designed to facilitate KII data analysis. Ratings for implementation status and the 35 bottleneck factors are entered into a KII respondent column within the sheet. Once all data is entered, mean or median scores are calculated. Conditional formatting is applied to the Excel worksheet to color-code scores, enabling rapid data visualization. The following assumptions were made:

- **Data Accuracy**: All ratings entered are accurate and reflect the respondents' true assessments.
- **Consistency**: The same criteria and scales are used across all respondents to ensure consistency.
- **Completeness**: All necessary data points are entered before calculating the mean or median scores.
- **Visualization**: Conditional formatting is correctly applied to enhance data interpretation.

The mean scores for each bottleneck were then re-categorized and visualized using a color-coding scheme based on the WHO generic tool.

- Mean score of 4.0-5.00: **Dark red** (very important bottleneck)
- Mean score of 3.0-3.99: **Light red** (important bottleneck)
- Mean score of 2.0-2.99: **Light green** (minor bottleneck)
- Mean score of 0.1-1.99: **Dark green** (not a bottleneck)

The additional comments provided by key informants were reviewed and those significant factors not included in the specific questions are listed.

2.11 DATA QUALITY ASSURANCE

During the assessment, the critical importance of adhering to fundamental public health ethical principles was well understood, ensuring the confidentiality and anonymity of the participants, as well as the protection of the data. Throughout the entire study process, the confidentiality and anonymity of the respondents were maintained by securing verbal informed consent from each participant.

Data quality was ensured by taking adequate and fairly representative sample size, providing proper training for data collectors, contextualizing the tool, using an online data collection tool, Pilot testing of the data collection tools, conducting routine follow-ups during data collection, and training data collectors,

2.12 ETHICAL CONSIDERATIONS

The consultant understands the utmost importance of abiding by the basic public health ethical principles, hence, ensured the confidentiality and anonymity of the participants, and the confidentiality and protection of the data. in the study process The confidentiality and anonymity was Ensured through avoiding names of the survey participants in the

questionnaire, data was shared only with relevant personnel, approval and permission to conduct the study was Obtained from the Ministry of Health, the respective Regional Health Bureaus, and the participating CSOs, and Verbal consent was obtained from each participant,

Overall, the study process had ensured that data confidentiality is strictly maintained and reasonable steps such as informing study participants that they have the right to opt-out the interview from the beginning or they have the right to leave in the middle of the interview, ensuring that the assessment is technically accurate and reliable, That The assessment Is conducted in a transparent and impartial manner, and
The study Contributes to organizational learning and accountability were considered.

SECTION 3

FINDINGS OF THE BOTTLENECK ANALYSIS

Conducting a BNA on SBC for family planning involves identifying and addressing the key barriers that hinder effective communication and behavior change efforts including effective implementation and uptake of family planning services. This approach typically includes a comprehensive review of existing policies, strategies, and guidance documents to ensure alignment with SBC principles. It also involves analyzing specific interventions such as mass media campaigns, community engagement activities, and digital platforms to pinpoint obstacles that prevent optimal performance.

During this BNA, the following approaches were employed.

- **Comprehensive Review**: Examining existing policies, strategies, and guidance documents to ensure they align with SBC principles.
- **Intervention Analysis**: Assessing specific interventions such as mass media campaigns, community engagement activities, and digital platforms to identify obstacles that prevent optimal performance.
- **Key Informant Interviews (KII):** Conducting interviews with stakeholders to gather insights and perspectives.
- **Document and Case Study Review:** Analyzing relevant documents and case studies to understand past and current challenges.
- **Consensus-Building Workshops:** Engaging experts in workshops to build consensus on the findings and recommendations.

The findings from these various approaches are compiled and presented to inform future SBC strategies for family planning. The results of the different methods employed are outlined below.

3.1 RESULTS OF THE DESK REVIEW

The BNA on SBC for family planning aimed to assess policies and guidance, and to evaluate how SBC materials and media in Ethiopia align with recommended SBC principles. The review included various types of documents such as:

- Policies, strategies, and guidance expected to incorporate SBC for FP/RH.
- Health promotion and/or SBC policies, strategies, and guidance expected to incorporate FP.
- Policies, strategies, and guidance on specific BNA interventions for RH, including mass media, community engagement (interpersonal communication and group engagement), and digital platforms.
- Policies, strategies, and guidance on related health communication work streams, such as counseling and health promotion.
- Broader policies, strategies, and guidance on social and gender norms for RH.
- Any policy, strategy, or guidance involving behavioral and social norms change was reviewed. Based on this general description, the family planning SBC BNA assessment focused on the three most relevant national policy documents in Ethiopia.

3.1.1 Global Context of SBC in Family Planning

While supply-side barriers continue to hinder the successful implementation of family planning (FP) programs globally, social, behavioral, and normative issues remain largely unaddressed. Social and Behavior Change (SBC) strategies are effective but underutilized in tackling these barriers at various levels. However, challenges such as low awareness of supporting evidence, a focus on short-term outcomes, and a poor understanding of high-quality SBC approaches impede the effectiveness of SBC in FP programs(6).

SBC strategies are essential in addressing the global challenges of family planning. Despite the availability of contraceptive methods, many individuals and communities face significant social, behavioral, and normative barriers that hinder their use. For instance, cultural norms and misconceptions about contraceptives can limit their adoption. SBC interventions aim to address these issues by promoting positive behaviors and attitudes towards family planning, thereby increasing the uptake and consistent use of contraceptives. According to a review, SBC interventions have been shown to increase modern contraceptive use by up to 15% in some regions (7).

Globally, SBC in family planning has demonstrated promising results. Community-based programs that engage local leaders and influencers have successfully shifted norms and increased contraceptive use in various regions. For example, in Ethiopia, an SBC program saw an increase in contraceptive use from 31% to 62% following a multi-component intervention (7). Mass media campaigns, social marketing, and interpersonal communication are also effective SBC strategies that have been employed to reach diverse populations. These approaches help disseminate accurate information, dispel myths, and create an enabling environment for individuals to make informed decisions about their reproductive health.

However, the implementation of SBC strategies faces several challenges. One major issue is the low awareness and understanding of the evidence supporting SBC interventions among policymakers and program implementers. Additionally, there is often a focus on short-term outcomes rather than sustainable behavior change. This can lead to insufficient investment in comprehensive SBC programs that address the root causes of social and behavioral barriers. Furthermore, there is a need for better training and capacity-building to ensure high-quality SBC interventions (8).

As many literatures recommend, enhancing the effectiveness of SBC in family planning, it is essential to adopt a holistic approach that integrates SBC into broader health and development programs. This includes fostering multi-sectoral collaboration, leveraging technology and digital platforms, and ensuring community participation in the design and implementation of SBC interventions. By addressing both supply-side and demand-side barriers, SBC can significantly contribute to the achievement of global family planning goals and improve reproductive health outcomes for individuals and communities

worldwide (7). Implementing Social and Behavior Change (SBC) strategies in low-income countries presents several unique challenges:

- **Limited Resources**: Low-income countries often face financial constraints that limit the availability of resources for comprehensive SBC programs. This includes funding for training, materials, and outreach activities (9).
- **Infrastructure and Access**: Poor infrastructure can hinder the delivery of SBC interventions, especially in remote or rural areas. Limited access to technology and communication channels can also restrict the reach of SBC messages (10).
- **Cultural and Social Barriers**: Deeply ingrained cultural norms and social practices can be resistant to change. In some communities, there may be strong opposition to family planning due to traditional beliefs or misinformation (10).
- **Capacity and Training**: There is often a lack of trained personnel who can effectively design and implement SBC strategies. This includes a shortage of skilled health workers, community mobilizers, and communication specialists (11).
- **Sustainability and Scalability**: Ensuring the sustainability and scalability of SBC interventions is a significant challenge. Programs may be effective in pilot phases but struggle to maintain momentum or expand to larger populations without ongoing support and adaptation (11).

The literatures also illustrated actionable solution to address the SBC-FP challenges and enhance the effectiveness of their family planning programs and improve health outcomes in low-income countries. Strengthening a multifaceted approach that includes securing adequate funding, building local capacity, leveraging technology, and engaging communities in the design and implementation of SBC strategies can be an effective approach.

3.1.2 National Context of SBC in Family Planning

SBC strategies are vital in addressing FP challenges in Ethiopia. Despite significant progress, social, behavioral, and normative barriers continue to impede the uptake of contraceptives. For instance, cultural norms and misconceptions about contraceptives often limit their use. SBC interventions aim to address these issues by promoting positive behaviors and attitudes towards family planning. According to the Ethiopia Mini Demographic and Health Survey (EMDHS) 2019, the contraceptive prevalence rate (CPR) increased from 8% in 2000 to 41.4% in 2019 (12).

Ethiopia has seen promising results from SBC interventions. Community-based programs that engage local leaders and influencers have successfully shifted norms and increased contraceptive use. For example, an SBC program in Ethiopia saw an increase in contraceptive use from 31% to 62% following a multi-component intervention that included mass media, health education, and provider training (13).

Another key finding from the baseline report by the Johns Hopkins Center for Communication Programs (CCP) indicated that integrating family planning messages into broader health communication strategies, such as those addressing maternal and child

health, nutrition, and disease prevention, can enhance the overall impact of SBC interventions. The report emphasized the importance of community engagement and the use of local media to effectively disseminate FP messages, which has been crucial in reaching rural and underserved populations.

Studies on social and behavior change (SBC) for family planning (FP) in Ethiopia highlight the importance of health worker capacity building in improving FP uptake. Research indicates that integrating FP services into primary healthcare and providing targeted training for health workers significantly enhances their ability to deliver effective FP counseling and services. This approach has been shown to increase the use of modern contraceptives, reduce unintended pregnancies, and improve maternal and child health outcomes. Key facilitators include government commitment, supportive policies, and positive attitudes among service providers and clients. However, challenges such as resource shortages (14).

A study examined the effect of women empowerment on family planning utilization in Jimma Zone, and it found that women empowerment dimensions such as increased household decision-making power, having access to health facilities and information about family planning significant factors affecting family planning utilization. (15)

In Eastern Ethiopia, level of effective spousal communication about family planning was 38%. The reasons for the absence of spousal communication were religious prohibition, the belief that discussions are not necessary and cultural taboos. (16)

A study conducted across 13 cities in Ethiopia found that radio exposure and awareness of family planning were significant factors influencing the use of contraceptives (17)

The Ethiopian Family Planning (FP) communication guideline released in 2021 emphasizes implementing communication interventions based on behavior change theories and models, particularly the comprehensive social ecological model. It prioritizes strategic actions such as enhancing individual FP knowledge and community awareness, increasing engagement and support from men, religious and community leaders, and peers, addressing health professionals' attitudes and improving their counseling skills, depoliticizing FP methods and launching tailored interventions for pastoralist or marginalized communities, enhancing multi-sectoral collaboration, and improving the quality of FP service delivery. The guideline also outlines three key strategies for effective health communication on FP: behavior change communication, social mobilization, and advocacy. It highlights the importance of determining the target audience, identifying thematic areas, setting behavior change objectives, and preparing and testing communication methods and materials (18).

The execution of the Ethiopian Family Planning communication guideline has faced several challenges. One significant issue is the shortage of resources, including contraceptive supplies and basic utilities like water and electricity1. Additionally, there is a lack of trained health workers and irregular mentorship and supervision, which hampers the quality of FP service delivery (19).

Socio-cultural and religious norms also pose barriers, as misconceptions about FP persist in many communities (20). These norms can discourage the use of contraceptives and limit the effectiveness of communication interventions. Furthermore, regional and socio-demographic disparities create equity gaps, making it difficult to provide consistent FP services across different areas (21).

The National Guideline for FP services also recommends implementing SBC at various levels-individual, community, and organizational-in a manner that is audience-specific and culturally sensitive. (22)

Behavioral intervention implemented for 6 months in Tigray region with aim of increasing post-partum intention and behavior to use contraceptive methods were found to be statistically significant in addressing barriers and improving modern contraceptive use, long-acting reversible contraceptive use, contraceptive confidence, and self-efficacy. (23)

Ethiopian mothers prefer to use modern contraceptive methods after giving birth to 4 or five children. The perception is that giving birth to more children is helpful to manage land and security, the norm that trigger brides or couples to give birth immediately. This fact is complemented by the disapproval of in-laws to delay in giving birth after wedding as a key challenge in reducing family planning utilization and recommended SBC interventions to address the aforementioned barriers. (24)

A study conducted in Ethiopia assessed the Social and Behavior Change (SBC) knowledge and competence of frontline health professionals. The study found that while many professionals had a basic understanding of SBC concepts, there were notable gaps in their practical application skills. The research highlighted the need for targeted training programs to enhance the competence of these professionals, ensuring they can effectively implement SBC strategies in their communities. Continuous professional development and support were emphasized as crucial for maintaining high standards of SBC practice (25).

Despite sufficient policy support for integrated FP services at the PHC level, resource shortages have hindered performance. Key challenges include gaps in policy implementation, declining donor funds, and issues in supply chain management. Although government budget allocations are increasing, they are insufficient to counteract the decline in donor resources and rising procurement costs. Leadership and ownership of the FP program weaken at regional and local levels, leading to less focus, accountability, and effective planning. High turnover of trained leaders and healthcare providers further complicates implementation. Studies show that while national interest and guidelines exist, lower-level implementation remains underdeveloped due to competing priorities. (26)

The Ethiopian Health Sector Transformation Plan (HSTP II) emphasizes the importance of Social and Behavior Change (SBC) in family planning by integrating services into the primary healthcare system, promoting behavior change communication (BCC) through

media and community engagement, and addressing the needs of diverse groups including adolescents and women with disabilities. It also focuses on community mobilization and the use of social media to convey family planning messages, while ensuring continuous monitoring and evaluation to enhance program effectiveness and sustainability (27).

3.1.3 Policy document alignment

a. Scale-up of SBC interventions

The desk review of Ethiopian family planning national policy documents, including the National Reproductive Health (RH) Strategy, Family Planning (FP) Guideline, and FP Communication Guideline, highlights several key points. The National RH Strategy prioritizes integrating family planning services into the broader health system, emphasizing community engagement and addressing demographic and cultural diversity. The FP Guideline focuses on enhancing the quality and accessibility of family planning services. It outlines standards for service provision, including training healthcare providers in counseling and ensuring informed choice for clients. The FP Communication Guideline emphasizes the importance of behavior change communication (BCC) strategies to promote family planning. It includes using mass media, community mobilization, and social media to disseminate information and engage various population groups. These documents collectively aim to improve family planning uptake, reduce unmet needs, and support the overall health and well-being of the population. They also highlight the importance utilizing community health workers for RMNCAYH promotion, including FP, and applying mass media, interpersonal communication, group counseling, and digital health to promote FP. Additionally, they strongly recommend community engagement, including working with community leaders, religious figures, and other trusted opinion leaders, to effectively address barriers related to social and cultural norms of FP. The document does not recommend the need to Scale up of SBC-FP.

b. Social and Gender Norms

Ethiopian national FP and RH policy documents, including the national RH strategy, FP guideline, and FP communication guideline, also emphasize the importance of addressing social and gender norms that inhibit the use of family planning (FP). These documents highlight the need to involve men in FP initiatives, promote healthy couple communication, and strengthen the knowledge, attitudes, beliefs, and self-efficacy of women and girls. They aim to create an equitable environment where both men and women can make informed decisions about reproductive health.

c. Community Empowerment and Promoting Community Agency

The similar policy documents also outline the importance of community empowerment and promoting community agency. These documents highlight the need to engage communities in the planning and implementation of family planning (FP) and reproductive health (RH) programs. They stress the importance of building community capacity, fostering local leadership, and ensuring that community members have the knowledge and resources to make informed decisions about their reproductive health. By promoting community agency, these policies aim to create sustainable and culturally appropriate health interventions that are driven by the needs and priorities of the community.

d. Adherence to Recommended and Evidence-Based Principles for SBC

The national FP communication guideline, among the reviewed national policy documents, emphasizes adherence to recommended and evidence-based principles for SBC. It highlights the importance of rights-based programming, ensuring that interventions respect and promote individual rights. The guideline also stresses the need for community participation, adapting strategies to fit local contexts and target populations. Furthermore, it underscores the use of structured design processes based on evidence, and the importance of continuous monitoring, evaluation, and learning to refine and improve interventions.

e. Effective Approach with Strong Evidence in the Local Context

Although most of the reviewed documents are not in line, the national FP communication guideline document advises that effective approaches should be tailored to the local context, leveraging strong evidence to ensure relevance and impact. It recommends using data and research specific to the target population to design interventions that resonate with the community's unique needs and circumstances. This approach not only enhances the effectiveness of the interventions but also fosters greater community engagement and ownership, ultimately leading to more sustainable outcomes

f. Presence of Clear Indicators for Success for SBC

Most of the reviewed national policy documents, including the FP communication guideline, lack clear indicators for success in social and behavior change (SBC) related to family planning. The SBC activities for family planning are measured with proxy indicators.

g. Alignment with Recommended Principles of SBC

The Ethiopian national FP communication guideline and the FP2030 Ethiopia Government Commitment document align with recommended principles of social and behavior change (SBC). These documents emphasize rights-based programming, community participation, and adaptation to local contexts and target populations. They also

highlight the importance of using evidence-based structured design processes and robust mechanisms for monitoring, evaluation, and learning to ensure the effectiveness and sustainability of family planning interventions.

SBC materials produced at the national level and at the sub-national level also align with recommended principles of SBC. These materials include mass media campaigns (radio/TV, advertising, influencer campaigns), community engagement materials (leaflets, training guides), and digital content (SMS campaigns, videos, apps, social media). Reviews indicate that these materials, produced by NGOs, health implementers, community-based organizations, and faith-based organizations, generally adhere to global and national SBC principles.

Table 4: Findings on Policy and Guidance Alignment for SBC for Family Planning

#	Question	Level of policy and guidance alignment	Rationale for Level Assigned	Information Sources
1	Do the FP/RH policy & guidance documents recommend scale-up of SBC interventions?	Partial	The policy and guidance documents advocate for the use of SBC in family planning. However, they do not provide recommendations for scaling up SBC interventions.	• The national FP communication guideline, (2021-2025)* • The national RH strategy-(2021-2025)** • The national FP guideline-(2020-2025)** • The national AYH strategy, (2021-2025)
2	Do the FP/RH policy & guidance documents recommend use of community health workers for RMNCH health promotion, including FP?	Full	All reviewed policy documents recommend use of community health workers for RMNCH health promotion, including FP	• The national FP communication guideline, (2021-2025) • The national RH strategy, (2021-2025) • The national FP guideline, (2021-2025) • The national health extension program, Ethiopia • The national AYH strategy, (2021-2025)
3	Do the FP/RH policy & guidance documents recommend use of mass media to promote FP?	Full	The national FP communication guideline, the national RH strategy, the national FP guideline, and the national AYH strategy all recommend the use of mass media to promote family planning.	• The national FP communication guideline, (2021-2025) • The national RH strategy, (2021-2025) • The national FP guideline, (2021-2025)2020
4	Do the FP/RH policy & guidance documents recommend use of community	Partial	The national FP communication guideline, the national RH strategy, the national FP guideline, the national health	• The national FP communication guideline, (2021-2025) • The national RH strategy, (2021-2025)

	engagement, including interpersonal communication and groups, to promote FP?		extension program, and the national AYH strategy all recommend community engagement to promote family planning. However, they do not strongly advocate for group communication	• The national FP guideline, (2021-2025) • The national health extension program, Ethiopia • The national AYH strategy, (2021-2025)
5	Do the FP/RH policy & guidance documents recommend use of digital health to promote FP?	Full	Most FP/RH policy & guidance documents recommend use of digital health to promote FP	• The national FP communication guideline, (2021-2025) • The national RH strategy, (2021-2025) • The national FP guideline, (2021-2025)
6	Do the FP/RH policy & guidance documents aim to address social and gender norms that may inhibit use of FP?	Full	Most FP/RH policy documents and guidance address social and gender norms that may inhibit use of FP	• The national FP communication guideline, (2021-2025) • The national RH strategy, (2021-2025) • The national FP guideline, (2021-2025) • The national health extension program, Ethiopia • The national AYH strategy, (2021-2025)
7	Do the FP/RH policy & guidance documents aim to involve men and promote healthy couple communication?	Full	All reviewed FP/RH policy and guidance documents encourage male involvement and promote healthy couple communication.	• The national FP communication guideline, (2021-2025) • The national RH strategy, (2021-2025) • The national FP guideline, (2021-2025) • The national health extension program, • The national AYH strategy, (2021-2025)
8	Do the FP/RH policy & guidance documents aim to strengthen the knowledge, attitudes, beliefs, and self-efficacy of individual women and girls?	Partial	Self-efficacy activities of individual women and girls is not strengthened as women and girls are not fully empowered economically and politically	• The national RH strategy, (2021-2025)
9	Do the FP/RH policy & guidance documents recommend community engagement, including working with community	Full	Most policy documents recommend community engagement, including working with community leaders, religious leaders, or other trusted opinion leaders, to promote FP	• The national FP communication guideline, (2021-2025) • The national RH strategy, (2021-2025) • The national FP guideline, (2021-2025)

	leaders, religious leaders, or other trusted opinion leaders, to promote FP?			• The national health extension program, Ethiopia • The national AYH strategy, (2021-2025)
10	Do the FP/RH and SBC policy & guidance documents adhere to recommended and evidence-based principles for SBC including: • adherence to rights-based principles • community participation • adaptation to local context • use of evidence-based structured design processes • monitoring, evaluation and learning	Partial	There are no clear indicators for use of evidence-based structured design processes.	• The national RH strategy, (2021-2025) • The national FP guideline, (2021-2025) • The national AYH strategy, (2021-2025)
16	Do the FP/RH and SBC policy & guidance documents advise on effective approaches for SBC in FP, along with strength of evidence in the local context?	Partial	Although they recommend effective approaches for SBC in family planning, along with strength of evidence in the local context, there are not regional and sub-national policies on FP/RH	• The national RH strategy, (2021-2025) • The national FP guideline, (2021-2025) • The national AYH strategy, (2021-2025)

3.1.4 Case Study findings

A case study on best practices in SBC for family planning was collected from two civil society organizations (CSOs): the Family Guidance Association of Ethiopia (FGAE) and the Organization for the Development of Women and Children (ODWaCE).

ODWaCE is an Ethiopian local organization dedicated to reducing the prevalence of the top five harmful traditional practices: female genital mutilation, early marriage, marriage by abduction, uvulectomy, and milk teeth extraction. The organization focuses on awareness-raising campaigns and works with young people to achieve its goals.

FGAE, established in 1966, is a volunteer-based association and a pioneer in the country's family planning program. It has tested various innovative approaches, including youth-friendly services and community and workplace-based distribution of contraceptives. FGAE primarily targets underserved and marginalized segments of the population

A CASE STUDY-I

FGAE has documented a case study from its Rutgers project, implemented by the Family Guidance Association of Ethiopia (FGAE). The project aimed to provide comprehensive family planning services to reproductive-age groups at FGAE health facilities. It also focused on raising awareness about these services at the community level through trained peer educators, the distribution of tailored messages, and the effective use of various media channels including radio and TV channels.

The project was implemented across various locations, including the Akaki medium sexual and reproductive health (SRH) Clinic and Saris medium SRH Clinic in Addis Ababa city administration; Bahir-Dar and Dessie Model Clinics, and Gondar and Woldia MSRH Clinics in the Amhara region; and Mekelle Model Clinic in the Tigray region.

Desired Behavioral Outcomes and Achievements- The project aimed to achieve several key outcomes: increasing knowledge and practice of family planning utilization, minimizing barriers and misconceptions related to family planning, and enhancing community participation.

Achievements: The project achieved several qualitative results: it increased knowledge and practice of family planning methods, minimized barriers to family planning utilization (such as misconceptions) through tailored SBC materials, health information provision, and collaboration with Health Extension Workers (HEWs). The project also utilized satisfied clients to share their experiences and effectively used media channels like websites, Facebook, and collaborations with media professionals. Additionally, it enhanced knowledge about the importance of family planning services and involved community-level influential people through orientation and participation.

Health Systems Factors for Project Success: The project's success was attributed to several health systems factors: the availability of trained, skilled, and committed staff for effective counseling and services; user-friendly and confidential clinic services; quality and comprehensive SRH services, including other MNCH services; dedicated health facilities providing 24/7 services; a consistent supply of required commodities and supplies; the presence of policy guidelines and strategies; and the availability of a method mix to support service provision.

Challenges and Lessons Learned: The project faced several challenges, including budget shortages, high turnover of trained and skilled service providers, and opposition from community groups. Key lessons learned from the implementation of the project include

the importance of partnership and collaboration, the availability of user-friendly services, and the integration of other SRH services in the clinic, and the presence of skilled service providers and a committed management body. These were crucial in enabling the successful provision of services by the project.

Table 5: Summary of Case Study Findings, Rutgers Project FGAE-Ethiopia

Title of project or programme	Location of the project/ programme	Implementer	desired behavioral outcomes and achievements	health system factors for the success of the project	Challenges faced	other relevant information and lessons learned
The Rutgers project aims to provide comprehensive family planning services to reproductive-age groups in FGA E health facilities. The strategy involves raising awareness at the community level through trained peer educators, distributing tailored messages, and effectively utilizing various media platforms.	The Addis Ababa city administration (Akaki MSH Clinic and Saris MSRH Clinic) Amhara region (Bahir-Dar Model Clinic, Gondar MSRH Clinic, Dessie Model Clinic and Woldia MSRH Clinic) Tigray region (Mekelle Model Clinic)	Family Guidance Association of Ethiopia	Knowledge and practice in utilizing family planning methods have increased, while barriers such as misconceptions have been minimized through tailored SBC materials, health information provision, collaboration with HEWs, testimonials from satisfied clients, and effective use of media like websites and Facebook. Additionally, knowledge on the importance of family planning services has been acquired, supported by orientation sessions and participation of influential community members.	The availability of trained, skilled, and committed staff ensures effective counseling and services, while user-friendly and confidential clinic services enhance accessibility. Quality and comprehensive SRH services, including MNCH services, are provided in a dedicated health facility operating 24/7. Consistent availability of necessary commodities and supplies guarantees uninterrupted service provision, all guided by established policy guidelines and SOPs.	Challenges include budget shortages, high turnover of trained and skilled service providers, and opposition from community groups	Partnership and collaboration, along with the availability of user-friendly services and the integration of other SRH services in the clinic, have enabled us to provide comprehensive care. Skilled service providers and a committed management body further support this effort. Additionally, the availability of a method mix has been a crucial factor in our ability to deliver these services effectively

B. CASE STUDY II

ODWaCE has documented a case study from its project titled "Enabling Young People to Enhance Their Reproductive Health and Key Stakeholders' Engagement in Gender-Just Societies (RHRN2 Program)." Implemented in collaboration with various CSOs, government offices, schools, the education office, the health office, and the women and

children affairs office, the project aimed to advocate for sexual and reproductive health (SRH) services for adolescents with compounded vulnerabilities through an inter-sectionalty lobby and advocacy approach (Make Way Program, Ipas, and VSO Projects), and to combat female genital mutilation (FGM) within internally displaced people (IDPs) and host communities in Debre Birhan (Women Action Against FGM, Japan-based project) town. The project was implemented both nationally and sub-nationally, in Addis Ababa and the Amara region.

Desired Behavioral Outcomes and Achievements: The project aimed to achieve increased budget allocations in the health sector while fostering collaboration and synergy among various sectors to reduce gender gaps and empower women.

Achievements: The project achieved several qualitative results, including fostering the implementation of adolescent and youth reproductive health policy, creating extensive awareness among health professionals about adolescent and youth health (AYH) services and inclusivity, successfully advocating for 24/7 policy implementation in Addis Ababa, reaching thousands of youths in youth centres and IDP camps, facilitating collaboration between schools, health centres, and youth centres, promoting inclusivity by initiating training on sign language for health workers through GOs and CSOs, and reaching thousands of people, particularly primary level students and IDPs, to bring about behavioural change regarding FGM.

Health Systems Factors for Project Success: The health sector staffs at Addis Ababa and national levels are keen and collaborative, working in synergy with various CSOs willing to partner. Additionally, the availability of sufficient policies and strategies along with structures like youth centers to enhance SRH services, has been instrumental. FGM being a priority area for health and other sectors has also provided significant support.

Challenges: The project faced challenges such as lack of coordination among sectors (e.g., health, education, youth, and sport offices), opposition to SRH initiatives (evident in the absence of reproductive health education within the curriculum), and overall poor integration among sectors.

Lessons learned and planned activities to scale up the best practices

- **Better Utilization of Social Media Campaigns:** Leverage social media platforms like Facebook, Twitter, and Instagram to raise awareness and engage younger audiences in SRH issues.
- **Host Community Dialogues:** Organize forums and discussions where community members can voice their concerns and share experiences related to SRH.
- **Create Educational Resources:** Design brochures, posters, and digital content that highlight key SRH topics and best practices for community dissemination.
- **Implement Advocacy Training for Youth:** Equip young people with advocacy skills to ensure they can actively participate in SRH discussions and efforts.
- **Build a Coalition of Advocates:** Form a network of passionate individuals and organizations committed to SRH advocacy for a unified voice in the community.

Table 6: Summary of the Case Study Findings, RHRN2 Project of ODWaCE

Title of project or programme	Location of the project/ programme	Implementer	desired behavioral outcomes and achievement	health system factors for the success of the project	Challenges faced	other relevant information and lessons learned
Enabling the young people enhance their reproductive health and Key Stakeholders Engagement in gender-just societies(RHRN2 Program)	The program is implemented in Addis Ababa and national level	ODWaCE in collaboration with CSOs and Government offices	Budget increment in the health sector, (2022), Fostered collaboration and synergy among sectors(MoWSA and Auditor General)to narrow gender gap and empower women	The health sector staffs (Addis Ababa and national level) are keen and collaborative to work in synergy Availability of different CSOs who are willing to work in collaboration Above all the availability of sufficient policies, strategies and manuals	Lack of coordination among sectors(for instance between health, Education, Youth and sport offices) Opposition to SRH (for instance absence of Reproductive health education with in the education curriculum)	•Better Utilization of Social Media Campaigns: Leverage social media platforms like Facebook, Twitter, and Instagram to raise awareness and engage younger audiences in SRH issues. •Host Community Dialogues: Organize forums and discussions where community members can voice their concerns and share experiences related to SRH, •Create Educational Resources: Design brochures, posters, and digital content that highlight key SRH topics and best practices for community dissemination, •Implement Advocacy Training for
To *Advocate on SRH services for Adolescent* youth with Compounded Vulnerabilities through institutionalizing Intersectionality lobby & advocacy approach(Make way program, Ipas and VSO Projects)	Addis Ababa, Amara region(Debrebirhan) and national level	ODWaCE in collaboration with CSOs and Government offices	Fostered the implementation of Adolescent and youth reproductive health policy, extensive awareness among health professionals on the area of AYH service and inclusivity Successful in advocating for 7/24 policy implementation in Addis Ababa Able to reach	the availability of sufficient policies, strategies and manuals Availability of different structures to enhance SRH service(for instance Youth centers)	Opposition to SRH Poor integration among sectors	

			thousands of youths in youth centers and IDP camps Assisted collaboration between schools, health centers and youth centers Fostered inclusivity and initiated GOs and CSOs to provide training on Sign language for health workers			Youth: Equip young people with advocacy skills to ensure they can actively participate in SRH discussions and efforts, •Build a Coalition of Advocates: Form a network of passionate individuals and organizations committed to SRH advocacy for a unified voice in the community.
Combating FGM Within Internally Displaced People/IDPs/ & Host Community in Debrebirhan(Women Action Against FGM, Japan based project	Amhara region Debrebirhan city	ODWaCE in collaboration with schools, Education office, health office and Women and children affairs office	Reached thousands of people particularly, primary level students and IDPs brought behavioral change regarding FGM	FGM is one of the priority area of health and other sectors, thus supported us		

3.2 National data review - Quantitative data findings

As shown in the table below, data Disaggregated by age category and by residence (urban vs. rural) for women of reproductive health could not be found as they are not part of the national and sub-national HMIS. The lack of such data will have a negative effect in measuring the impact of SBC in FP. (See Table 7)

Table 7: Desk Review Findings, National Data Review

Background: Current FP status	Module	Potential Data source	Suggested breakdown	All WRA	Rural WRA	Urban WRA	15-19 WRA	20-24 WRA
Modern contraceptive prevalence (% among women of reproductive age)	All	EDHS or PMA	Rural/urban, Regions, 15-19, 20-24, 25-49	41%				
% all women of reproductive age relying on Long Acting or Permanent methods of FP	All	EDHS or PMA	Rural/urban, Regions, 15-19, 20-24, 25-49	9.2%				
% all current contraceptive users relying on Long Acting or Permanent methods of FP	All	EDHS or PMA	Rural/urban, Regions, 15-19, 20-24, 25-49	23.7%				
% of women with unmet need for FP	All	EDHS or PMA	Rural/urban, Regions, 15-19, 20-24, 25-49	22%				
% of women knowing at least 3 modern methods	All	EDHS or PMA	Rural/urban, Regions, 15-19, 20-24, 25-49	ND				
% of FP users with full method information index (informed of side effects, told what to do if experience side effects, informed of other methods of FP)	SBC	EDHS or PMA	Rural/urban, Regions, 15-19, 20-24, 25-49	ND				
% of women intending to use FP in the future (or next 12 months)	SBC	EDHS or PMA	Rural/urban, Regions, 15-19, 20-24, 25-49	ND				
% of women practicing covert FP use	SBC	EDHS or PMA	Rural/urban, Regions, 15-19, 20-24, 25-49	ND				
% of women not using FP due to health concerns or fears of side effects	SBC	EDHS or PMA	Rural/urban, Regions, 15-19, 20-24, 25-49	ND				
% of non-user women intending to use FP in the future	SBC	EDHS or PMA	Rural/urban, Regions, 15-19, 20-24, 25-49	ND				
% of women using FP; and decision on use of FP was made by themselves or made jointly with their husbands)	SBC	EDHS or PMA	Rural/urban, Regions, 15-19, 20-24, 25-49	ND				
% of women who are not using Fan and decision on not to use FP was made by themselves or made jointly with their husbands)	SBC	EDHS or PMA	Rural/urban, Regions, 15-19, 20-24, 25-49	ND				

% of FP clients involved in decisions about their care during FP consultations	SBC	EDHS SPA FP exit	Rural/urban, Regions, 15-19, 20-24, 25-49	ND				
% of women exposed to different FP messages (via different channels: radio/TV, newspapers, mobile phone, online)	SBC	EDHS	Rural/urban, Regions, 15-19, 20-24, 25-49	ND				
% of women exposed to different media in the population (in past month or year) -TV, Radio - online/digital	SBC	KAPB or media surveys	Rural/urban, Regions, 15-19, 20-24, 25-49	ND				
% of women with access to phones: - mobile phones - smart phones	SBC	KAPB or communi cation surveys	Rural/urban, Regions, 15-19, 20-24, 25-49	ND				
% of facilities with available visual aids for FP (flip charts, leaflets)	SBC	DHS SPA Inventory		ND				
No. or % of districts with active health promotion teams	SBC	HMIS (?)		ND				
No. or % of health facilities with community outreach for RMNCH	SBC	HMIS (?)		ND				
No. of organizations (NGOs, media, faith-based organizations) implementing SBC activities related to FP (either nationally or in selected regions (illustrative).	SBC	Estimate from reports		ND				

3.3 Results of the Key Informant Interview

Key informant interviews were conducted to gather insights and perspectives from key stakeholders on the main bottlenecks hindering the scale-up of SBC for family planning. The survey results were summarized and further discussed during bottleneck consensus building workshop, allowing stakeholders to reach a consensus on critical challenges.

Key informant interviews (KIIs) were conducted with a sample of 21 stakeholders involved in the scale-up of evidence-based practices for social and behavior change in family planning (SBC-FP). This sample included policymakers and program managers at both national and sub-national levels, government and implementing NGOs, healthcare workers, health facility supervisors/managers, and civil society representatives. Some of these participants were also invited to the consensus-building workshop.

The 35 bottleneck factors were entered into a template containing a data summarization sheet to support KII data analysis. The ratings for implementation status were also recorded in a KII respondent column within the sheet. After all data were entered, mean scores for implementation status and each bottleneck were generated. Conditional formatting was applied in the Excel worksheet to color-code scores for rapid data visualization.

- **Mean score of 4.0-5.00: Dark red (very important bottleneck)**
- **Mean score of 3.0-3.99: Light red (important bottleneck)**
- **Mean score of 2.0-2.99: Light green (minor bottleneck)**
- **Mean score of 0.1-1.99: Dark green (not a bottleneck)**

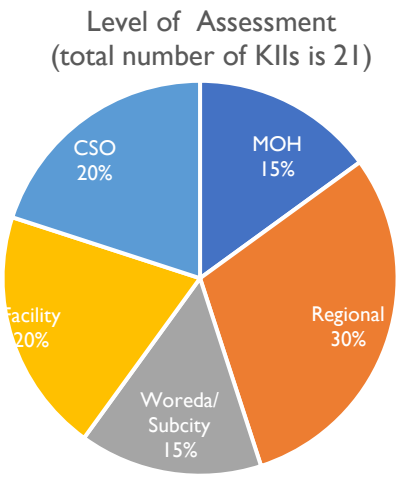
Average scores were categorized and charted. The additional comment boxes in the questionnaires were reviewed and analyzed to identify other important factors that may be inhibiting national scale-up **of SBC-FP**.

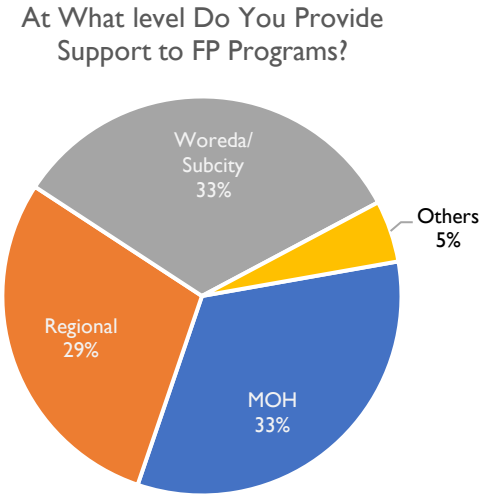
3.3.1 Major Findings of the Key Informant Interview

Based on the level of assessment, 30% of the informants were from the five study regions, 20% were from civil society organizations (CSOs), and 15% were from the MOH. Regarding the level of support provided to family planning (FP) programs, nearly 67% of the respondents offered support at both the Woreda Facility/Community level (33.3%) and the National level (33.3%) (see figure 1).

Among the 21 key informants interviewed, 70% work for the government, while the remaining 30% are employed by NGOs or civil society organizations. One-third of the respondents (33.3%) have been providing support for 5-10 years. Additionally, 38.1% have supported FP programs for over 10 years, and the remaining 28.6% for less than 5 years. Informants who had been supporting the program for less than one year were not included. Nearly two-thirds of the respondents (71.4%) are serving at the program management and policy level, while the remaining 26.4% are clinicians or health workers operating at the community or facility level.

Figure-1: Level of Assessment of the Study Participants





Sources: Assessment finding, BNA for SBC for FP, July, 2024

Table 8: Summary of Key informant Interview findings

Bottleneck Category	Theme	Statement	Response	Mean Score	Remark (key points the respondents condiered in their response)
Implementation Status	Adequacy Of Implementation and Scaled-Up of SBC for FP	SBC for FP is adequately implemented and scaled-up nationally	33.3% strongly agree 4.8% strongly disagree	**2.19**	• Whether SBC for FP is effectively implemented and scaled across both public and private/NGO health sectors. • The integration of SBC for FP into broader development programming. • The presence of mass media campaigns aimed at addressing social and gender norms that impact reproductive health and promote FP.
Governance	Governance, Leadership, & Commitment	There is strong leadership and commitment to support scale-up of SBC in FP	47.6% agree	**2.24**	• Commitment from policymakers, program managers, and governance at all levels for Implementation of the SBC-FP policy document • Allocation of manpower, budget, transportation, and other necessary

			14.3% disagree		logistics and supplies for the SBC-FP
	Regulation	There is strong regulation to ensure effective SBC for FP	61.9% agree 28.5% disagree.	**2.38**	• Absence of laws or policies requiring partner consent to receive FP • No policies restricting access for adolescents or unmarried women • No limitations on promoting contraception in the mass media • Adequate regulation of public, NGOs, and CSOs in their SBC activities
	Accountablity across institutions and among policy makers and programme managers	There is strong accountabilit y for SBC for FP	42.8% agree 38.1% disagree.	**2.90**	• Presence of accountability and coordination across different institutional structures to enable effective SBC policy development and programming • Accountability of policymakers and program managers to deliver the scale-up of SBC for FP at both the national and regional levels
	Guidance Formulation	there is sufficient guidance for SBC in FP	70.5% agree	**1.86**	• presence of Policy & practice guidance to support implementation of SBC for FP, • adaptation of SBC International standards and guidance to the national context,
Financing	**Financing And Budgeting**	There is adequate budget available at all levels for scale-up of SBC for FP.	19.2% agree 66.7% disagree	**3.57**	• presence of costed implementation plan for scale-up of SBC for FP, • inclusion of SBC for FP in the FP2020/30 CIP, • allocation of funds in national and regional budgets,
	Donor Priority	Donors sufficiently contribute to financing	(38.2%) agree	**3.24**	• Donors' commitments are sufficiently financed in budgets;

		scale-up of SBC for FP	(52.4%) disagree with this.		• Donors priorities are aligned with MOH policies and priorities
	Insurance Coverage	the National health insurance scheme covers access to contraceptio n	90.5% disagree	**4.48**	• the National health insurance scheme cover contraception through CBHI
	Spending Allocation	There is appropriate utilization of the allocated budget for SBC intervention	23.8% are neutral a third of the responde nts agree	**3.19**	• the government utilizes the allocated budget appropriately.
	Planning	there is a coherent national plan for SBC scale-up	57.2% agree 19% do not agree 23.8% neither agree nor disagree	**2.57**	• Existence of a strategic plan for expanding coverage of FP related SBC, • Identification and proactively addressing Potential challenges of SBC in FP
	Equity	there are financing mechanisms and policy actions in place to ensure equitable scale-up of SBC,	38.2% agree 33.3% Disagree	**3.05**	• Budget is allocated to areas where rates of FP use are low and unmet needs for FP are high, • Budgeting and programming address the needs of adolescents and women from rural contexts
PEOPLE, COMMUNIC ATION, KNOWLEDG E, & AWARENESS	**Knowledge, & Awareness**	There is a high level of knowledge and awareness of recommende	57.1% agree 19% disagree • 23. 8% neutral	**2.43**	• Presence of effective national dissemination platform for relevant policies and guidance,

		d SBC policies and practices			• Full Understanding and Knowledge of the recommended principles of SBC in FP by Policymakers & programme managers of • Presence of effective communication channels to ensure stakeholders engagement
	Acceptability	there is acceptance of recommended SBC policies and practices by key stakeholders.	71.4% agree 9.6% disagree 19% neutral.	**2.19**	• Recommendations on SBC interventions and activities are supported by local evidence, • Policymakers & programme managers, agree with the need to scale-up SBC for FP, • Facility managers see SBC for FP as relevant to their work
	Consultation	Key stakeholders are adequately consulted about SBC recommended approaches, guidance and rollout	52.4% disagree	**2.76**	• adequate consultation during the creation of SBC practice guidance of Stakeholders including those who may oppose FP promotion • presence of established mechanisms for feedback, monitoring, and evaluation to ensure that the scale-up is effective
	Coordination	there is good coordination between different stakeholders to ensure effective scale-up of SBC for FP.	42.8% agree 38.1% disagree 4.8% do not have any knowledge	**2.95**	• National policies and budgeting are effectively transferred to regions, • The MOH effectively coordinates the different public, NGO and private stakeholders, • There are regular interagency meetings, • Health facilities work with civil society and NGOs, • Woreda health teams and facilities coordinate with schools or educational departments.

	Networks	there are effective Technical working groups (TWG) supporting scale-up of SBC for FP	47.6% agree a third of the respondent disagree	**2.90**	• FP/SBC prioritization and planning to support SBC scale up are supported by TWGs, • SBC is actively and regularly promoted through professional networks • there are networks or communities of practice that support SBC scale-up and help with coordination of efforts,
	Community Engagement	There is engagement of communities on SBC for FP and it is tailored to address local social and gender norms,	52.4% agree 47.6% disagree/ neutral	**2.76**	• Health services/Woreda health teams deliver community outreach on FP, • SBC coordinators/health promotion teams work with men to promote male engagement in SRH,
	Information And Reporting	INFORMATION AND REPORTING on SBC for FP activities is adequate	23.8% agree 28.8% neutral 47.6% disagree	**3.43**	• presence/absence of agreed reporting standards and key performance indicators for monitoring of SBC for FP activities, • presence/absence of an agreed goal or target for SBC coverage, • whether SBC approaches are routinely monitored and evaluated
	Data & HMIS	There is an effective HMIS to support data collection on SBC activities and/or referral from demand-generation activities and data is used regularly for performance management	61.9%, disagree	**3.71**	• sharing of Data trends on SBC coverage or outcomes of FP with district health teams, facilities, • HMIS used by facilities and/or HEWs capture referrals from community outreach, • Data on SBC and its outcomes is not used regularly

	Guidelines & Tools	Updated guidance on SBC for FP is available and widely used	half of the key informants disagree	**3.29**	• Existence of Guidance on facility-based health promotion and education on FP • Health facilities are equipped with guidance and tools to deliver community outreach for FP
	Client SBC/IEC	There are SBC/IEC materials to support SBC for FP,	73.4% agree	**2.33**	• Presence of SBC/IEC materials/apps on FP provision for both health facilities and community outreach work, • SBC/IEC materials/apps on FP are routinely distributed and available
	Health Promotion	SBC Communication on FP is integrated with health promotion activities	33.4% disagree The remaining of the respondents agree	**2.38**	• Presence of Successful behavioral interventions through mass media, IPC and through community groups to promote social norm change and FP uptake,
MEDICINES & TECHNOLOGY/ INFRASTRUCTURE		there is adequate platform including message delivering channels to deliver SBC for FP,	19.1% disagree 81.9% agree	**2.76**	• Mass media and mobile phone technologies have sufficient market penetration/population coverage to be used as effective SBC tools, • There is Community platform for message delivery for health promotion • presence of effective linkages between community health and static health facilities;
	Supplies	Woreda health teams, health facilities and community health programmes have sufficient commodities,	61.9% agree 38.1% disagree	**2.76**	

		equipment, tools, and other supplies including all method mix required to deliver SBC for FP,			
	Service Delivery And Management	There is effective health management to support SBC,	42.8% agree a third – neutral 23.8% disagree	**2.71**	• presence of designated manager for SBC activities, • inclusion of SBC Implementation in performance review, Quality control and audit processes, • promotion capacity of health care managers to monitor trends in SBC activities and outcomes,
	Supervision	there is adequate supervision at all levels to support SBC in FP,	42.8% agree 57.2% disagree	**3.19**	• availability of trained supervisors to advise on quality-assurance of health promotion and SBC efforts for FP, • SBC supervisions are conducted regularly or in integration with the joint supportive supervision.
	Team Work & Coordination	Community health teams and HEWs work in a coordinated way with health facilities	85.8% agree 14.3% disagree	**1.81**	• Presence of assigned HEW supervisors at health facilities, • dedication of health care providers at each health post in supporting Regular meetings
	Service Organization & Scheduling	The organization of services makes SBC feasible	71.4% agree 28.6% disagree	**2.38**	• Health services have capacity to deliver SBC interventions and demand generation, • Health service operating hours are accessible for the whole community including adolescents,

	Referral Systems	the referral systems between community outreach workers, VHL/HEWs and health facilities are effective	90.0% agree 4.8% disagree	**1.81**	• Presence of referral tool from VHL to HEW, • Presence of referral tool from HEW to Health facilities, • Presence of feedback mechanisms.
	Service Fee	there are no fees for accessing FP services, or specific methods in Ethiopia	95.2% agree	**1.29**	
	Human Resources, Training & Education	there is adequate training on SBC for FP	33.3% agree 47.6% disagree	**3.43**	
	Staff Capacity	the Staff working on FP across the health system have capacity to deliver SBC for FP,	19% strongly agree nearly half - agree 23.8% disagree 9.5% neutral	**2.38**	• relevant competencies to deliver counseling and other health education and communication on FP to clients • if the staff turnover is low,
	Roles	SBC is included in the relevant provider and manager job descriptions.	**72.4% disagree**	**3.29**	• inclusion of SBC for FP in role descriptions of FP technical programme managers at all levels, • HEWs have defined roles of SBC, • There are assigned roles in health facilities

	Skills & Competencies	FP and health promotion technical staff have sufficient skills and competencies to design and implement effective SBC approaches	**52.4% agree** The remaining disagree	**3.00**	• Staffs working to support FP across the health system have relevant skills and competencies for SBC
	Motivation Of Health Workers	SBC for FP health workers are motivated in their service provision	81% agree 14.3% remain neutral	**1.90**	• Attitude of Health workers and HEWs involved in SBC towards the national FP communication guideline, • if the Facility-based FP providers and HEWs are motivated to inform, educate, and counsel clients • if they have non-judgmental, empathetic, respectful attitude towards the community,

3.2.2 SUMMARY OF THE KII

Hence, based on the key informant findings:

- One third of the respondents (33.3%) strongly agree that SBC for family planning is adequately implemented and scaled-up nationally, ("National" refers to the decision at the federal/national level especially by the MOH to implement the policy document)
- Nearly half of the respondents (47.6%) agree that there is strong political support, leadership and commitment to support scale-up of SBC for FP *("Political support" refers to the willingness of the policy makers, program managers and the overall governance at all levels including at the national and sub-national level for the implementation of the policy document through allocation of man-power, budget, transportation and other necessary logistics and supplies)*
- There is no any policies that restrict access for adolescents or unmarried women, and There are no limitations to promoting contraception in the mass media
- Majority of the respondents (66.7%) said that the budget allocated is not adequate.
- Only 38.2% of the respondents agree that there are financing mechanisms and policy actions in place to ensure equitable scale-up of SBC.

- More than half of the respondents (52.4%) do not agree with the fact that Key stakeholders are adequately consulted about SBC recommended approaches, guidance and rollout.
- A third of the respondent claimed that Technical working groups (TWG) are not effective in supporting scale-up of SBC for FP including FP/SBC prioritization and planning to support SBC scale up.
- 47.6) of the respondents claim that community Engagement is not tailored to address local social and gender norms,
- A great majority of the key informants, 61.9%, claim that There is an effective HMIS to support data collection on SBC activities
- Nearly 40% of the study participants claim that there are no sufficient commodities, equipment, tools, and other supplies including all method mix required to deliver SBC for FP,
- Although majority of the respondents feel that The organization of services makes SBC feasible Health service operating hours (28.6%) disagree with it.
- Almost all respondents (95.2%) agree that there are no fees for accessing FP services, or specific methods in Ethiopia.
- Nearly half of the key informants (47.6%) do not believe that the training on SBC for FP is adequate.
- Nearly a third of the key informants believe that the Staff working on FP across the health system do not have capacity relevant competencies to deliver SBC for FP, if they have to deliver counseling and other health education
- Nearly equal proportion of the respondents does not feel that FP and health promotion technical staffs have sufficient skills and competencies to design and implement effective SBC approaches for SBC.

Other Challenges, Barriers, and Bottlenecks:- Respondents were asked to mention any additional challenges, barriers, or 'bottlenecks' not covered in the interview that inhibit the effective scale-up of SBC for FP in Ethiopia. In responding, key informants were reminded to consider the different SBC interventions used for FP (mass media, community engagement, digital engagement) and the various objectives of SBC (social norms change, healthy couple communication, and improved knowledge, attitudes, beliefs, self-efficacy).

TABLE 9 QUESTIONAIRE ANALYSIS OF KEY INFORMANT INTERVIEW FINDINGS

	Bottlenecks category	KII Mean score
1.	Implementation status	**2.19**
2.	Governance/Leadership & commitment	**2.24**
3.	Governance/Accountability	**2.90**
4.	Governance/Regulation	**2.38**
5.	Governance/Guidance formulation	**1.86**
6.	Financing/Budgeting	**3.57**
7.	Financing/Donors	**3.24**

8.	Financing/Insurance	**4.48**
9.	Financing/Spending	**3.19**
10.	Financing/Planning	**2.57**
11.	People/Communication, knowledge & awareness	**3.05**
12.	People/Acceptability	**2.43**
13.	People/Consultation	**2.19**
14.	People/Coordination	**2.76**
15.	People/Networks	**2.95**
16.	People/Community engagement	**2.90**
17.	Information/Reporting	**2.76**
18.	Information/Data & HMIS	**3.43**
19.	Information/Guidelines & tools	**3.71**
20.	Information/Client IEC	**3.29**
21.	Information/Health promotion	**2.33**
22.	Medicines & technology/Infrastructure	**2.38**
23.	Medicines & technology/Supplies	**2.76**
24.	Medicines & technology/Innovation	**2.76**
25.	Service delivery/Management	**2.71**
26.	Service delivery/Supervision	**3.19**
27.	Service delivery/Teamwork & coordination	**1.81**
28.	Service delivery/Service organization & scheduling	**2.38**
29.	Service delivery/Referral systems	**1.81**
30.	Service delivery/Fees	**1.29**
31.	Human Resources/Training & education	**3.43**
32.	Human Resources/Capacity	**2.38**
33.	Human Resources/Roles	**3.29**
34.	Human Resources/Skills & competencies	**3.00**
35.	Human Resources/Motivation	**1.90**

As summarized in the table below, Analysis of the key informant interview has shown that financing, guidelines and tools, supervision, communication, skill and competencies are found to be among the major bottlenecks for effective implementation and scale up of social behavioral change in family planning services in Ethiopia.

Table 10: List of the Major Bottlenecks Identified through KII

Bottleneck Sub-Category	Score	**Level**
Insurance	4.48	Very Important Bottleneck
Budgeting	3.57	Important Bottleneck
Donors	3.24	Important Bottleneck
Spending	3.19	Important Bottleneck
Data and HMIS	3.43	Important Bottleneck
Guidelines & Tools	3.71	Important Bottleneck

Training & Education	3.43	Important Bottleneck
Client IEC	3.29	Important Bottleneck
Roles	3.29	Important Bottleneck
Supervision	3.19	Important Bottleneck
Communication, Knowledge & Awareness	3.05	Important Bottleneck
Skills & Competencies	3.00	Important Bottleneck

SECTION 4

CONSENSUS BUILDING WORKSHOP

4.1 KEY BOTTLENECKS IDENTIFICATION AND PRIORITIZATION

APPROACH

The consensus workshop was conducted for three days from August 12-14, 2024. The workshop had brought experts from the national and sub-national government sectors and CSOs. Most of the participants were those experts who had been key informants.

the BNA findings of key informant interviews, data reviews, and national policy and guideline alignment for SBC in FP, case studies were presented by the consultant,

After presentation of bottlenecks framework update, the participants divided into three groups: Group 1: Governance and Financing, Group 2: People and Information, and Group-3 Medicines/Technology, service delivery and Human resources.

For easy of the work flow, each group had selected a chairperson and a reporter.

In the process of the bottleneck identification, each group was guided by the facilitator to consider the extent of the problem in preventing scale-up of SBC in FP, If it is possible to see improvements in scale and quality of SBC in FP If this problem is addressed, Whether the problem has nationwide effect in preventing scale-up of SBC in FP, The urgency of need to solve this bottleneck and The number of other bottlenecks that this problem may cause,

The prioritized bottlenecks were Presented to the groups by the lead consultant, and the groups had gone through the potential bottlenecks giving due attention to the details. Then after, The Group participants first individually ranked the bottlenecks they have been allocated, in terms of priority factors inhibiting scale-up of SBC,

the average ranking score for each bottleneck factor was Calculated and the top ranked 5 factors were identified from each sub group. Then, each Group came to consensus through discussion on the final top 5 priority bottlenecks.

Then, all workshop participants had convened to one large group and identified the most important bottlenecks out of the total 15.

IDENTIFIED BOTTLENECKS

SBC Workshop: Governance & Financing People & Information Medicines & Technology / Service Delivery / Human Resources 15 bottlenecks were identified from the three groups. Finally out of the 15 bottlenecks, nine of them were prioritized.

Table 11: Prioritized bottlenecks for SBC in FP

	Bottleneck	Category
1	Accountability	Governance & Financing
2	Insurance	Governance & Financing
3	Equity	Governance & Financing
4	Health Promotion	People & Information
5	Report	People & Information
6	Supply	Medicines & Technology / Service Delivery / HR
7	Motivation	Medicines & Technology / Service Delivery / HR
8	Management	Medicines & Technology / Service Delivery / HR
9.	Skills And Competency	Medicines & Technology / Service Delivery / HR

4.2 ROOT CAUSE ANALYSIS

The large group was again divided into three sub-groups. Then, the 9 key bottlenecks already identified (3-3-3), were allocated to each group,

In the due course, the facilitator had ensured that groups are mixed representation again. Then, each group had developed a 'Problem tree' for each of their 3 bottlenecks assigned to them. They First write the effect (i.e. the bottleneck), and then asked The 5 Why's to analyze the root cause of the bottleneck and some solutions.

Table 12 Summary of Root Cause Analysis

	Root Cause	Effect	Bottleneck
1	There is no accountability for SBC at national and sub-national level	There is no accountability for SBC at national and state level	Accountability
2	Financing for SBC-FP service is not prioritized as it is supported by donors.	There is no national health insurance scheme that cover access to contraception through community health workers	Financing
3	Equity for the scale-up of SBC is not given appropriate attention and prioritization in the national and sub-national family planning agendas	There is no equity for SBC at the national and regional level.	Equity

4	There is a system gaps in strengthening, capacitating and integration of health promotion of SBC with FP program	FP service demand generation and community engagement is not integrated with SBC activities	Health Promotion
5	Reporting on SBC-FP is not given appropriate attention and prioritization in the national and sub-national family planning performance review and reporting	There is inadequate reporting on SBC activities, leading to poor tracking of SBC interventions.	Reporting
6	There are gaps in advocating resource mobilization	There is inadequate commodities, equipment, supplies and tailored tools required to deliver SBC for FP service uptake	**Supply**
7	SBC-FP is not adequately budgeted in the national and subnational family planning programs to motivate, train, recognize and promote/reward health workers implementing SBC-FP	The motivation of health workers involved in SBC activities is low	Motivation
8	There is no adequate advocacy to the leadership on the importance of effective health management to support SBC in family planning	There are limitations for effective health management to support SBC	**Management**
9	There is no adequate advocacy to the leadership on the importance of effective health management to support SBC in family planning	The skill and competency of health care providers is low on SBC	**Skill And Competency**

(See annex for the details)

4.3 PROPOSED SOLUTIONS FOR IDENTIFIED ROOT CAUSES

Some of the suggested solutions such as Updating the Pre-service Curriculum to ensure that new graduates are well-prepared to meet contemporary healthcare challenges on SBC-FP may be challenging as they involve multi-sectoral approaches. However, the ministry of health and other relevant stakeholders need to struggle for them.

Table 13: Solution suggested for the identified major bottlenecks of SBC in FP in Ethiopia

Root Cause	Proposed Solutions	Feasibility of the solution	Level of impact	Supporting stakeholders
There is no accountability for SBC at national and sub-national level	Assigning dedicated person for SBC who is also responsible for accountability	Moderate	High	MOH, RHB, ZHD, WoHO, Facility, Partners, community
	Creating clear understanding of the importance of accountability in SBC for family planning			
	Set accountability mechanism of SBC for family planning			

	give priority for setting accountability mechanism of SBC for family planning			
Financing for SBC-FP service is not prioritized as it is supported by donors.	Increase adequate budget allocation to finance contraceptive methods	Moderate	High	MOH, RHB, ZHD, WoHO, Facility, Partners,
	Include contraceptive financing in the insurance scheme			
Equity for the scale-up of SBC is not given appropriate attention and prioritization in the national and sub-national family planning agendas	Prioritize equity issues related to SBC-FP in the upcoming RMNCAH strategic plan.	High	High	MOH, RHB, ZHD, WoHO, Facility, Partners,
	Promote advocacy for SBC-FP at both national and subnational levels to ensure it becomes a key national agenda.			
	Enhance collaboration with donors, FP implementing partners, and other sectors to prioritize SBC interventions for underserved regions and communities.			
There is a system gaps in strengthening, capacitating and integration of health promotion of SBC with FP program	Implement the SBC strategy effectively	High	High	MOH, RHB, ZHD, WoHO, Facility, Partners,
	Strengthen the intra-sectoral integration efforts across health system at national and sub-national level (region, Woreda, HF SBC team/focal and FP team).			
	Assign skilled SBC experts / advisors			
	strengthening and capacitate the integration of SBC activities with FP program			
	Create accountability mechanism to integrate FP demand generation and community engagement activities with SBC interventions			
Reporting on SBC-FP is not given appropriate attention and prioritization in the national and sub-national family planning performance review and reporting	The SBC-FP interventions/program should have clearly defined goals and targets in both national and sub-national action plans.	High	High	MOH, RHB, ZHD, WoHO, Facility,
	The national and sub-national RMNCAH program action plans should include clear KPIs, which should be flagged in the HMIS.			
	Managers at national, sub-national, and health facility levels should routinely monitor SBC-FP activities using standard KPIs.			
	SBC-FP activities and performance, including reporting, should be integrated into routine RMNCAH services, and facilities should be held accountable.			
There are gaps in advocating resource mobilization	**Improve** Human, financial and logistics resource allocation.	High	High	MOH, RHB, ZHD, WoHO, Facility, Partners,
	Strengthen the coordination and planning process with key stakeholders			

	Advocate for resource mobilization across health system			
SBC-FP is not adequately budgeted in the national and subnational family planning programs to motivate, train, recognize and promote/reward health workers implementing SBC-FP	SBC-FP activities should be meticulously planned and budgeted at both national and subnational levels, including health facilities.	High	High	MOH, RHB, ZHD, WoHO, Facility, Partners,
	SBC-FP activities need to be institutionalized at the facility level, ensuring they are included in the job descriptions of healthcare providers.			
	The performance of SBC-FP activities should be periodically evaluated, with top performers recognized and promoted.			
	Health workers should receive training on SBC-FP to enhance their knowledge and confidence			
There is no adequate advocacy to the leadership on the importance of effective health management to support SBC in family planning	**Develop and effectively utilize** management tools to monitor performance of SBC in family planning	High	High	MOH, RHB, ZHD, WoHO, Facility, Partners,
	Establish structure and assign dedicated managers at the national and sub-national levels including in health facilities who are fully accountable for SBC in family planning			
	advocate for the health system leadership and governance on the importance of SBC structure and its implementation across all levels			
Health Science education pre-service curriculum is not designed based on current evidence and needs assessments. Additionally, the in-service program lacks adequate support for on-the-job training	Update the Pre-service Curriculum: Redesign the health science education pre-service curriculum to align with current evidence and needs assessments. This ensures that new graduates are well-prepared to meet contemporary healthcare challenges on SBC-FP*	Moderate	High	MOH, RHB, MOE, WOWSA, Partners,
	Enhance In-Service Training: Provide robust support for on-the-job training within the in-service program. This includes regular workshops, mentorship opportunities, and access to updated resources to help healthcare professionals continuously improve their skills			
	Enhance multisectoral collaboration with higher education institutions, the Ministry of Education, the Ministry of Health, and development partners to improve health science education programs, particularly in the SBC-FP program.			

SECTION 5

CONCLUSION AND RECOMMENDATION

5.1 CONCLUSION

The Bottleneck Analysis (BNA) on Social and Behavioral Change (SBC) for Family Planning (FP) in Ethiopia has identified several critical barriers that hinder the effective implementation and scale-up of SBC interventions. The comprehensive review of existing policies, strategies, and guidance documents revealed gaps in alignment with SBC principles. Key informant interviews also highlighted significant challenges, and bottlenecks. The consensus-building workshop further prioritized these bottlenecks, emphasizing the importance of accountability, equity, and effective health management. The workshop participants identified nine major bottlenecks, including the lack of accountability for SBC at national and sub-national levels, inadequate financing and insurance coverage for FP services, and insufficient integration of health promotion activities with SBC interventions. These bottlenecks were analyzed using root cause analysis, which provided a deeper understanding of the underlying issues and informed the development of targeted solutions. The following are identified as the key bottlenecks.

Financing emerged as the most critical bottleneck, with insurance scoring 4.48, indicating its high importance. Among the financing sub-components, budgeting (3.57), donors (3.24), and spending (3.19) were also significant bottlenecks. Information-related issues, including Data & HMIS (3.43), Guidelines & Tools (3.71), and Client IEC (3.29), were highlighted as major challenges according to key informant interviews. Additionally, communication, knowledge & awareness (3.05), service delivery/supervision (3.19), human resources/training & education (3.43), human resources/roles (3.29), and human resources/skills & competencies (3.00) were identified as significant bottlenecks. Conversely, service delivery/teamwork & coordination (1.81), service delivery/service organization & scheduling (2.38), and service delivery/referral systems (1.81) were not considered bottlenecks for SBC in family planning.

In conclusion, the BNA on SBC for FP in Ethiopia provides a comprehensive framework for addressing the key barriers to effective SBC implementation. By prioritizing the key bottlenecks and implementing the feasible and impactful solutions, Ethiopia can enhance the impact of its family planning programs. The proposed solutions, if implemented effectively, have the potential to significantly improve the uptake and sustainability of SBC interventions, ultimately leading to better reproductive health outcomes for individuals and communities across the country.

5.2 RECOMMENDATIONS

To address these challenges, the BNA report recommends several actionable solutions.

- **Strengthening Existing Accountability Mechanism** - There is a need to create an accountability mechanism for SBC in family planning at national and sub-national level through Assigning dedicated person for SBC and Creating clear understanding of the importance of accountability in SBC for family planning to the governance body,

- **Strengthening Domestic Financing** - although financing of family planning commodities is currently covered with international donors, donor funding are declining over the years. Moreover, access to contraception is not covered either through social insurance or through the national health insurance scheme. Hence, strengthening of Financing and prioritization of Family Planning SBC services is mandatory.

- **Improving Equity** – family planning services in general and SBC for FP in particular are not radially accessible at the pastoral and developing regions, urban slums, and hard-to-reach segments of the population in Ethiopia. Hence, it is crucial to improve the quality and equity of these services among regions and underserved segments of the population. Hence, Serious attention should be given for Equity, prioritization and scale-up FP social behavioral services at the national and sub-national family planning agendas

- **Strengthening, and Capacitating Of Health Promotion Services** - although health promotion service is an integral component of the FP services in Ethiopia, There is a system gaps in strengthening, capacitating and integration of the service especially for SBC in FP program. Hence, there is a need to effectively implement the broader SBC strategy of MOH. There is also a need to develop a specific SBC strategy and a capacity building training package (training materials) for FP and strengthening the FP health promotion services by all means available.

- **Enhancing Recording and Reporting** – data are increasingly become major sources of evidence based decision making. The current recording and Reporting on SBC-FP is not adequate as there are no dedicated indicators in the formal reporting mechanism of the country. The data for SBC in family planning come from proxy indicators. Hence, there is a need to improve the recording and reporting mechanism and to include dedicated indicators in the DHIS2.

- **Sustainable Logistics and Supply** – as per the study findings, it was clearly indicated that availability of commodities, equipment, supplies and tailored tools is inadequate to deliver SBC for FP service uptake. Hence, Advocate for resource mobilization across health system and particularly for SBC in FP; and Improving Human, financial and logistics resource allocation; and Strengthening the coordination and planning process with key stakeholders is mandatory,

- **Adequate Budgeting of SBC for FP** - there is no budget specifically allocated for social behavioral services in family planning both at the national and sub-national level in the country. Moreover, there is no dedicated assigned professional for SBC in FP in Ethiopia. The gap is filled by other professional. Moreover, there is no motivation and recognition mechanism for program managers or service providers in the areas of social behavioral change in family planning. Hence, establishing a system to assign dedicated professionals and creating a means of motivation and rewarding mechanism are important.

- **Establishing Effective Health Management System To Support SBC In FP** – it is recommended to conduct ongoing high level advocacy to the leadership on the importance of effective health management to support SBC in family planning, developing management tools to monitor performance of SBC in family planning, to Establish structure and assign dedicated managers at the national and sub-national levels including in health facilities who are fully accountable for SBC in family planning and to create SBC structure and its implementation across all levels

- **Integration of SBC-FP in the Pre-Service Curriculum** – family planning social behavioral services are not part of the Health Science education preserve curriculum in Ethiopia. SCB in family planning knowledge and skills for program managers and service providers are provided only through an ad-hoc in-service training. Hence it is important to collaborate with the ministry of education and other stakeholders to include the social behavioral aspects of family planning in pre-service curriculum of the Health Science educations.

Table 14 Summary of the recommendations

Objective	Challenges	Actions
Strengthening Existing Accountability Mechanism	• no significant accountability especially at the lower level	• Institutionalization of SBC for FP especially at the subnational level including the Structure, focal person, and processes, • Assign dedicated personnel for SBC • Educate governance bodies on the importance of accountability in SBC for family planning. • Develop guidance documents including National Strategic Plan and Operational Plan for SBC in FP, • Strengthening coordination and collaboration mechanism for social inclusion in SBC for FP at public and private institutions, and NGOs, • Integrate PF SBC interventions in the services providers job descriptions

Strengthening Domestic Financing	• Declining international donor funding. - Lack of coverage for contraception through social or national health insurance.	• Prioritize and strengthen financing for family planning SBC services • Allocate resources through annual program planning and budgeting for FP-SBC, • Advocate for increased funding for the integration of SBC interventions for FP and for the integration of SBC in the FP domain at the various stakeholder levels at all levels
Improving Equity and strengthening partnership	• Limited access in pastoral areas, urban slums, and hard-to-reach populations.	• Focus on equity, prioritization, and scaling up SBC services in national and sub-national family planning agendas, • Strengthen Partnership through joint planning, Advocacy with partners to support participation of stakeholders in the strategic communication leadership to facilitate their support. • Reinforcement and promotion of community engagement activities with focus on rumors and negative FP norms through workshops and meetings • Explore partnerships with the private sector, including pharmaceutical companies and telecommunications firms, to co-finance SBCC campaigns that support FP messaging
Strengthening and Capacitating Health Promotion Services	• Gaps in system integration and capacity building for SBC in family planning.	• Implement the broader SBC strategy of the Ministry of Health (MOH).- • Develop specific SBC strategies and training materials for family planning.- • Strengthen health promotion services through all available means. • Designing all FP-SBC programs with the community as a core intervention, • Ensuring that all Programs and interventions are tailored as per the need of the community, • Establishing and Mobilization of key community influencers including mother group, and community leaders for change harmful behavior and norms, • Develop and implement a capacity-building plan for health professionals on SBC family planning interventions, and and Reinforce the coordination and mentorship system, • Develop SOP, job aids and other communication tools for FP's SBC interventions and Train FP service providers on SBC interventions,

Enhancing Recording and Reporting	• Inadequate recording and reporting with no dedicated indicators- Reliance on proxy indicators.	• Enhance the recording and reporting system.- • Set clear indicators and targets with Agreed standards and formats for recording and reporting for SBCC, • Include dedicated indicators in the DHIS2. • Develop M&E system for SBCC activities to ensure progress tracking and accountability, • Form national and provincial task forces or working groups for SBC in FP, involving representatives from health, population welfare, education, and communication sectors • Dissemination of findings from BNA (webinar, publications, stakeholder meetings, etc.) • Strengthen Documentation of best experiences
Ensuring Sustainable Logistics and Supply	• Inadequate resources for delivering SBC services.	• Advocate for resource mobilization across the health system.- • Improve human, financial, and logistics resource allocation.- • Strengthen coordination and planning with key stakeholders.
Adequate Budgeting for SBC in Family Planning	• No dedicated budget or assigned professional for FP-SBC – Hence, Lack of motivation and recognition mechanisms for program managers and service providers	• Establish a system to assign dedicated professionals.- • Create motivation and reward mechanisms.
Establishing an Effective Health Management System	• the leadership do not have comprehensive knowledge on the importance of health management system	• Conduct high-level advocacy to leadership on the importance of effective health management. – • Develop management tools to monitor SBC performance. – • Establish structures and assign dedicated managers at all levels.- • Implement SBC structures across all levels
Integrating FP SBC in Pre-Service Curriculum	• SBC knowledge and skills are currently provided only through ad-	• Collaborate with the Ministry of Education and other stakeholders. –

	hoc in-service training.	• Include social behavioral aspects of family planning in pre-service Health Science education
Other major activities	• No clear evidence and policy on FP-SBC	• Evidence generation for policy analysis and advocacy through Conduct operational researches on FP behaviors • Training of national trainers, technical staff and FP service providers, the media and other stakeholders on SBC for FP • Identify/appoint champions for SBC-FP at the national/sub-national level to initiate the interest of technical and financial partners,

REFERENCES

1. Vyas S. Social and Behaviour Change Communication – Essential Component of Contemporary Health Care. *Healthline Journal Volume 7 Issue 1 (January-June 201*.

2. USAIDS. Family Planning Workforce Key Indicators. 2018;

3. Padideh Malekpour Rh, Mojgan Javedani Masroor, Reza Chaman, Zahra Motaghi. Effectiveness of a mixed lifestyle program in couples undergoing assisted reproductive technology: a study protocol. *Malekpour et al Reproductive Health*. 2021;20:112doi:10.1186/s12978-023-01652-6

4. Ippazio C. Antonazzo, Janet Sultana, Pietro Ferrara. Editorial: Overcoming boundaries in public health: Advances in international and global health. 2022;doi:10.3389/fpubh.2022.1044157

5. Kasper G, Momen M, Sorice KA, et al. Effect of neighborhood and individual-level socioeconomic factors on breast cancer screening adherence in a multi-ethnic study. *BMC Public Health*. Jan 2 2024;24(1):63. doi:10.1186/s12889-023-17252-9

6. Joanna Skinner HH, Laura Raney, Christine Galavotti, Benedict Light, Michelle Weinberger, and Lynn Van Lith. Elevating Social and Behavior Change as an Essential Component ofFamily Planning Programs. 2021;

7. Braet J. Should Adolescents Listen to Their Hearts? A Closer Look at the Associations Between Interoception, Emotional Awareness and Emotion Regulation in Adolescents. 2024;doi:10.1177/00332941241286435

8. USAIDS. Using Social & Behavior Change To Improve Family Planning Outcomes. 2023;

9. FMOH-E. National Guideline for Family Planning Services In Ethiopia. 2019;(National Guideline for Family Planning Services in Ethiopia)

10. FMOH-E. National Family Planning Communication Guideline. 2021;

11. Simegnew Handebo RS, Tesfaye Simireta, Hailemariam Addissie, Getnet Bayih Endalew, Eshetu Girma, Kenzudin Assfa Mossa. Social and behavior change communication competency among front-line healthcare system actors in Ethiopia: a cross-sectional study. 2024;doi:10.1186/s12889-024-18084-x

12. Tesfalem Tilahun Yemane GGB, Gudina Egata ,Tilahun Kassa Tefera. Postpartum Family Planning Use and Its Determinants among Women of the Reproductive Age Group in Low-Income Countries of Sub-Saharan Africa: A Systematic Review and MetaAnalysis. *Hindawi International Journal of Reproductive Medicine* 2021;doi:10.1155/2021/5580490

13. USAIDS. The Business Case for Investing in Social and Behavior Change for Family Planning. (The Business Case for Investing in Social and Behavior Change for Family Planning)

14. USAIDS. Twelve Recommended SBC Indicators for Family Plannin. 2020;(BREAKTHROUGH RESEARCH PROGRAMMATIC RESEARCH BRIEF)

15. Muturi N. Social and Behavior Change Communication. 2023;doi:10.1007/978-3-030-14449-4_216-1

16. USAIDS. USING RESEARCH TO DESIGN A SOCIAL AND BEHAVIOR CHANGE STRATEGY FOR MULTI-SECTO. 2018;

17. GIZ. SOCIAL BEHAVIOUR CHANGE (SBC): FROM KNOWLEDGE TO ACTION. 2022;

18. HEALTH FDROEMO. NATIONAL ADOLESCENTS AND YOUTH HEALTH STRATEGY (2021-2025). 2021;

19. Yamey G. What are the barriers to scaling up health interventions in low and middle income countries? A qualitative study of academic leaders in implementation science. *Yamey Globalization and Health* 2012;8:11

20. WFPHA. Wolrd congress on public health. 2023;

21. Hagger M. Habit and physical activity: Theoretical advances, practical implications, and agenda for future research. 2018;doi:10.1016/j.psychsport.2018.12.007

22. Karine Coen-Sanchez BE, Ieman Mona El-Mowafi , Maria Berghs, Dina Idriss-Wheeler, Sanni Yaya. Repercussions of overturning Roe v. Wade for women across systems and beyond borders. *Coen-Sanchez et al Reproductive Health* 2022;19:84doi:10.1186/s12978-022-01490-y

23. Heath Prince 1 Nihaya Al-Sheyab 6 KKS, YSK, * , Yara A. Halasa-Rappel 3, Sara Abu Khudair 4 , Rana AlHamawi 4 and Kelley Ready The Impact of Behavioral Economics-Based Counseling and Mobile Phone Text Educational and Reminder Messages on the Use of Modern Family Planning in Jordan: A Cluster Randomized Controlled Trial. 2023;doi:10.3390/healthcare11091314

24. Jeremy Hill1 JM, John Cairns; Caroline Free, Chris Smith. A Mobile Phone–Based Support Intervention to Increase Use of Postabortion Family Planning in Cambodia: Cost-Effectiveness Evaluation. 2020;doi:10.2196/16276

25. Mariam DH. 25 Years of Public Health Leadership in Africa: The Ethiopian Public Health Association. 2010;doi:10.1007/BF03403961

26. https://www.engenderhealth.org/wp-content/uploads/2023/03/Understanding-Barriers-to-FP-Integration-in-Ethiopia.pdf

27. https://extranet.who.int/countryplanningcycles/planning-cycle-files/health-sector-transformation-plan-ii-hstp-ii-202021-202425

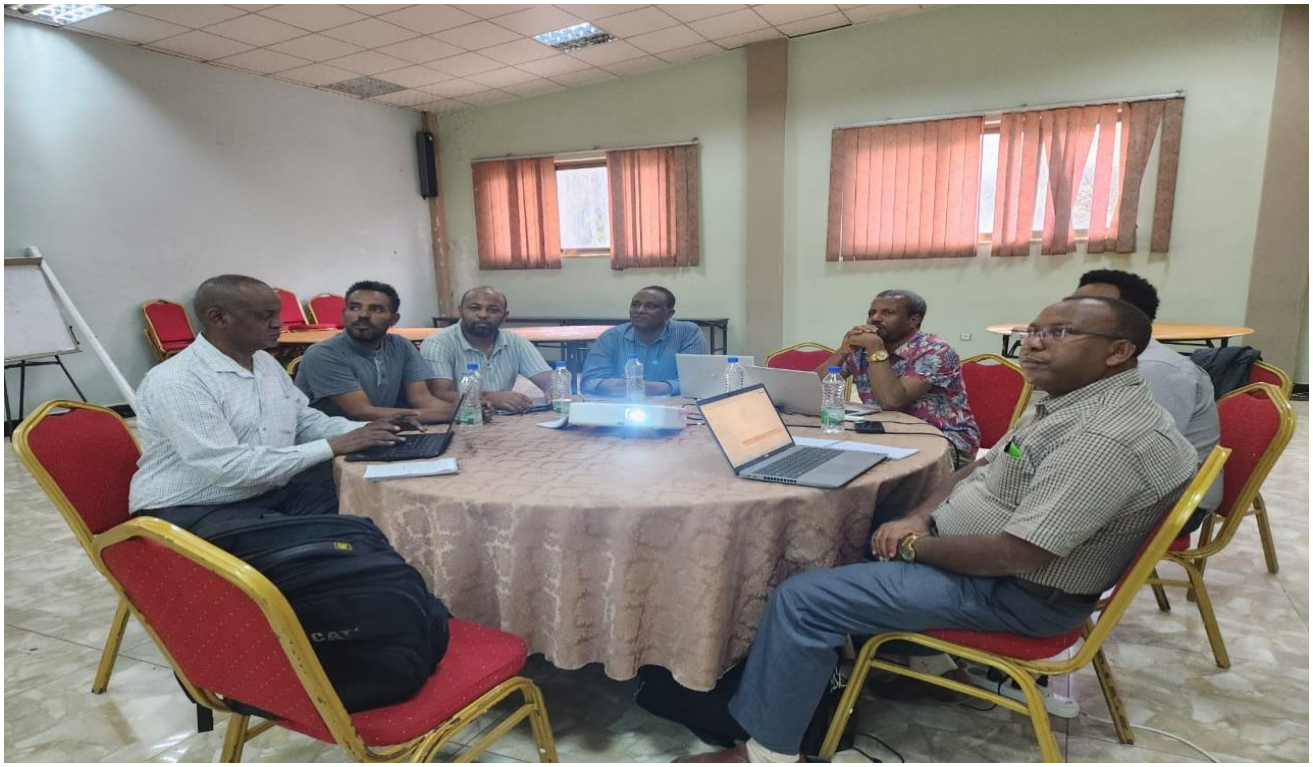
ANNEX

ANNEX-1: Photos of workshops

1

2

3



4

ANNEX-2: The 15 bottlenecks identified at the consensus workshop (5 major bottlenecks were identified from each category)

	Governance & Financing	People & Information	Medicines & Technology / Service Delivery / Human Resources
1.	Accountability	Reporting	Supplies
2.	Insurance	Data & HMIS	Motivation
3.	Equity	Client SBC/IEC	Management
4.	Planning	Health Promotion	Skill and Competencies
5.	Donor	Consultation	Capacity

ANNEX -3: ROOT CAUSE ANALYSIS

ACCOUNTABILITY

Effect: *There is no accountability for SBC at national and sub-national level*

Q1: ***Why*** *is there no accountability?*

A1: Because there is no dedicated person assigned for SBC

Q2: ***Why*** *there is no dedicated person assigned for SBC to ensure accountability?*

A2: because there is no clear understanding of the importance of accountability in SBC for family planning

Q3: ***Why*** *there is no clear understanding of the importance of accountability of SBC for family planning?*

A3: Because there is no clearly set accountability mechanism of SBC for family planning

Q4: ***Why*** *there is no clearly set accountability mechanism of SBC for family planning?*

A4: Because the management and leadership do not give priority for setting accountability mechanism of SBC for family planning

*Q5: **Why** don't the management and leadership give priority for setting accountability mechanism of SBC for family planning?*

A5: Because they assume that it is part of the overall accountability mechanism in the health system

INSURANCE

***Effect:** the national health insurance schemes doesn't cover access to contraception*

*Q1: **Why** is that the national health insurance scheme does not cover access to contraception?*

A1: Because contraceptive services are exempted services.

*Q2: **Why** are contraceptive services exempted?*

A2: Because contraceptive services are donor dependent and most commodities are donations.

*Q3: **Why** contraceptive services are donor /support dependent?*

A3: Because the country do not allocate adequate budget to finance all required contraceptive methods

Q4: Why is that the country do not allocate adequate budget to finance all required contraceptive methods?

A4: Because it is not prioritized

*Q5: **Why** the nation doesn't prioritized financing FP commodities?*

A5: because family planning commodities are funded by donors.

EQUITY

Effect: There is no equity for SBC at the national and regional level.

Q1: Why is there no equity for SBC at the national and regional level in Ethiopia?

A1: Because the equitable scale-up of SBC programming lacks commitment in policy design and implementation.

Q2: Why does the equitable scale-up of SBC lack commitment in policy design and implementation?

A2: Because the issue of equity for the scale-up of SBC is not highlighted in the national health sector plan

Q3: Why is the issue of equity for the scale-up of SBC not highlighted in the national health sector plan?

A3: Because there is a perception that equity can be addressed through implementing cross-cutting agendas, and there is no dedicated budget or human resources.

Q4: Why is there no dedicated budget or human resources for ensuring the equitable scale-up of SBC?

A4: Because ensuring the equitable scale-up of SBC is not included in the annual action plan at both national and sub-national levels, and there are no performance indicators for which both national and sub-national implementers are accountable.

Q5: Why is the equitable scale-up of SBC not included in the annual action plan at both national and sub-national levels, and why are there no performance indicators for which implementers are accountable?

A5: Because the issue of equity for the scale-up of SBC is not given appropriate attention and prioritization in the national and sub-national family planning agendas, particularly considering underserved populations and areas with high unmet need for FP.

HEALTH PROMOTION

***Effect:** FP service demand generation and community engagement is not integrated with SBC activities*

*Q1: **Why** FP service demand generation and community engagement is not integrated with SBC activities?*

A1: Because there is SBC strategy is not implemented effectively.

*Q2: **Why** SBC strategy is not implemented effectively?*

A2: Because there is a week intra-sectoral integrated efforts across health system of national/ regional /Woreda, HF SBC team/focal and FP team.

*Q3: **Why** there is intra-sectoral integrated efforts across health system of national/ regional /Woreda, HF SBC team/focal and FP team?*

A3: Limitation to assign skilled SBC experts and/or advisors

*Q4: **Why** is there limitation to assign skilled SBC experts and/or advisors?*

A4: Attention given for SBC intervention is low and generalizing SBC activities during planning and implementation

*Q5: **Why** Attention is not given for SBC intervention and generalizing SBC activities during planning and implementation?*

A5: Because there is no accountability mechanism to integrate FP demand generation and community engagement activities with SBC interventions

*Q6: **Why** no accountability mechanism to integrate FP demand generation and community engagement activities with SBC interventions?*

A6: There is a system gaps to strengthening and capacitate the integration of SBC activities with FP program

REPORT

Effect: There is inadequate reporting on SBC activities, leading to poor tracking of SBC interventions.

Q1: Why is there no adequate reporting on SBC activities in Ethiopia?

A1: Because there are no standards or KPIs for monitoring SBC for FP activities, and it is not incorporated into the national HMIS.

Q2: Why are there no standards or KPIs for monitoring SBC for FP activities?

A2: Because there are no agreed-upon goals and targets for SBC coverage/reach for FP activities.

Q3: Why are there no agreed-upon goals and targets for SBC?

A3: Because SBC-FP is not well highlighted in the national and sub-national action plans and is not considered a routine activity.

Q4: Why is SBC-FP not well highlighted in the national and sub-national action plans and not considered a routine activity?

A4: Because Reporting on SBC-FP is not given appropriate attention and prioritization in the national and sub-national family planning performance review and reporting.

SUPPLY

Effect: *There are inadequate commodities, equipment, supplies and tailored tools required to deliver SBC for FP service uptake*

Q1: ***Why*** *inadequate commodities, equipment, supplies and tailored tools required to delivering SBC for FP service uptake?*

A1: Because there is resource limitation (Human, financial and logistics) and allocation.

Q2: ***Why*** *there is resource limitation and allocation?*

A2: Because there is no proper coordination and planning process with key stakeholders

Q3: ***Why*** *there is no proper coordination and planning process with key stakeholders?*

A3: Because there are limitations to advocate for resource mobilization across health system

Q4: ***Why*** *there are limitations to advocate for resource mobilization across health system?*

A4: Because there are gaps on resources and skill gaps to advocate resource mobilization

MOTIVATION

Effect: The motivation of health workers involved in SBC activities needs to be improved.

Q1: Why does health workers involved in SBC have no positive attitude towards SBC activities?

A1: Because health workers do not consider SBC as part of the routine FP services.

Q2: Why do health workers not consider SBC as part of the routine FP services?

A2: Because health workers are not held accountable, and SBC activities are not well highlighted in job descriptions and performance evaluations.

Q3: Why are SBC activities not considered routine by health workers?

A3: Because SBC activities are not well planned or institutionalized at the national and health facility levels.

Q4: Why are SBC activities not well planned and institutionalized at the national and health facility levels?

A4: This is because the SBC-FP is not adequately budgeted in the national and subnational family planning programs to train, recognize, and promote/reward health workers implementing SBC-FP

MANAGEMENT

***Effect:** There are limitations for effective health management to support SBC*

*Q1: **Why there are** limitations for effective health management to support SBC?*

A1: because there are no management tools to monitor performance

Q2: Why there are no management tools to monitor performance of health management to support SBC?

A2: Because the attention given for the development of management tools to monitor SBC performance is low.

Q3: Why is the attention given for the development of management tools to monitor SBC performance is low?

A3: Because there is no designated manager in health facilities who is fully accountable for SBC activities

Q4: Why there is no designated manager in health facilities who is fully accountable for SBC activities?

A4: Because there is no any system and structure to assign SBC manager across the health system

Q5: Why there is no any system and structure to assign SBC manager across the health system?

A5: Because there are gaps in the health system leadership and governance in clearly understanding the importance of SBC structure and its implementation across all levels

Q6: Why there are gaps in the health system leadership and governance in clearly understanding the importance of SBC structure and its implementation across all levels?

A6: Because there is no adequate advocacy to the leadership on the importance of effective health management to support SBC in family planning

SKILLS AND COMPETENCY

Effect: FP and health promotion technical staffs have no sufficient skills and competencies to design and implement effective SBC approaches for SBC

Q1: Why FP and health promotion technical staffs have no sufficient skills and competencies to design and implement effective SBC approaches?

A1. Because, the SBC program is not adequately integrated into the pre-service and in-service training which results in health workers not being well-trained or equipped with the necessary skills.

Q2: Why the pre-service and in-service program does not give attention to SBC and health promotion?

A2: Because the pre-service and in-service programs primarily emphasize clinical services. Additionally, the health science curriculum tends to prioritize theoretical knowledge over practical application, especially in the areas of program design and implementation.

Q3: Why does the pre-service and in-service program give focus more on the clinical service and the health education program also focuses on theory than practice particularly in program design and implementation?
A3: Because the health education pre-service curriculum is not designed based on current evidence and needs assessments. Additionally, the in-service program lacks adequate support for on-the-job training.

Q4: Why is not SBC in FP part of the health education pre-service curriculum?
A4; because there is no adequate understanding/advocacy to the leadership on the importance of effective health management to support SBC in family planning