Translating WHO adolescent nutrition guidelines into policies and programs: Lessons learned from Ethiopia

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Background

An important intervention for adolescent girls (10-19 years) in Ethiopia

- **Weekly Iron-Folic Acid Supplementation (WIFAS)**
  - A proven high-impact, cost-effective intervention
- **Anaemia among adolescent girls is a public health problem in Ethiopia**

  (EDHS 2016;National Micronutrient survey 2016;Seifu et.al., 2016))
- **NNP II** recognizes the importance of WIFAS for adolescent girls.
  - However, in 2016, there was no national program implementation framework for future programming

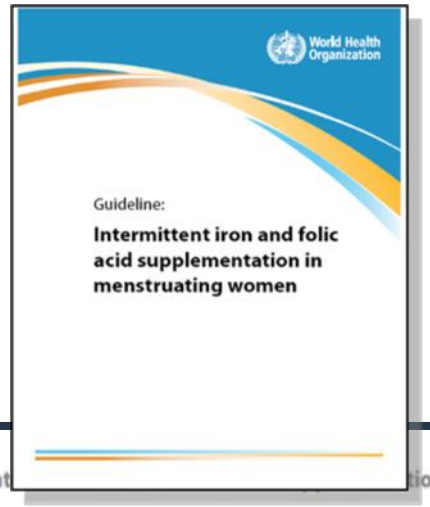


Table 1

Suggested scheme for int ion in menstruating women

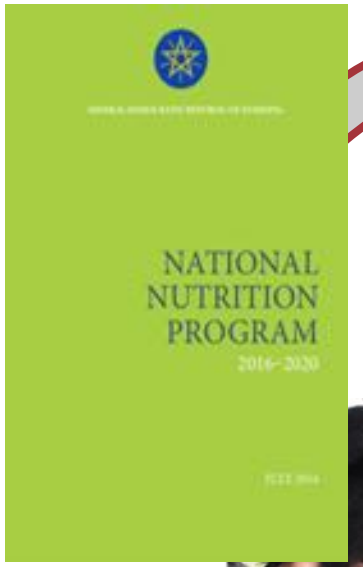
Supplement composition	Iron: 60 mg of elemental iron[a] Folic acid: 2800 µg (2.8 mg)
Frequency	One supplement per week
Duration and time interval between periods of supplementation	3 months of supplementation followed by 3 months of no supplementation after which the provision of supplements should restart. If feasible, intermittent supplements could be given throughout the school or calendar year
Target group	All menstruating adolescent girls and adult women
Settings	Populations where the prevalence of anaemia among non-pregnant women of reproductive age is 20% or higher

[a] 60 mg of elemental iron equals 300 mg of ferrous sulfate heptahydrate, 180 mg of ferrous fumarate or 500 mg of ferrous gluconate.

Background

Project objective

- Test and demonstrate the effectiveness of WIFAS and nutrition education interventions for in- and out-of-school adolescent girls.
- Identify effective delivery modalities to reach adolescent girls with WIFAS and nutrition education.
    - Multiple practical delivery modalities, in agrarian (SNNPR) and pastoralist (Afar) contexts of Ethiopia



National Implementation Model

Project period : October 2016 to December 2017

Implementation Research Methods

Formative research

- To inform design of the **Program Implementation** (including materials and tools) within the agrarian and pastoralist contexts of the country.
  - Domain 2 - Implementing Organization
  - Domain 3 - Enabling Environment & Stakeholders Dynamics
  - Domain 4 - Individuals , Households and Communities

Desk review	In-depth interview	Focus group discussions
✓ Policy and program documents (national & global) ✓ WHO: Guidelines and investment cases ✓ WHO (2011): Best practices – WIFAS	✓ Ministry of Health (MOH) & Ministry of Education (MOE) staffs at all levels ✓ Health workers, health extension workers (HEWs), schoolteachers ✓ Traditional birth attendants (TBAs), health development army ✓ Parents, religious & clan leaders	✓ In-school adolescent girls (ISAGs) ✓ Adolescent girls outside of schools (OSAGs) ✓ In-school boys **Observations** ✓ Schools ✓ Health centers (HCs) ✓ Health posts (HPs)

Formative Research: Lessons Learned

Identified enablers

- National and global policy & strategy documents
- Multiple practical delivery modalities – WHO program experience documents
- Supportive government structures and delivery platforms for multisectoral nutrition interventions
- Peer educators and female counsellors at schools
- Community structures (women's development groups and TBAs)
- School health services for students by HEWs from nearby HPs
- Adolescents and MOH & MOE staff at all levels believe trained teachers can provide WIFAS and nutrition education for in-school adolescent girls

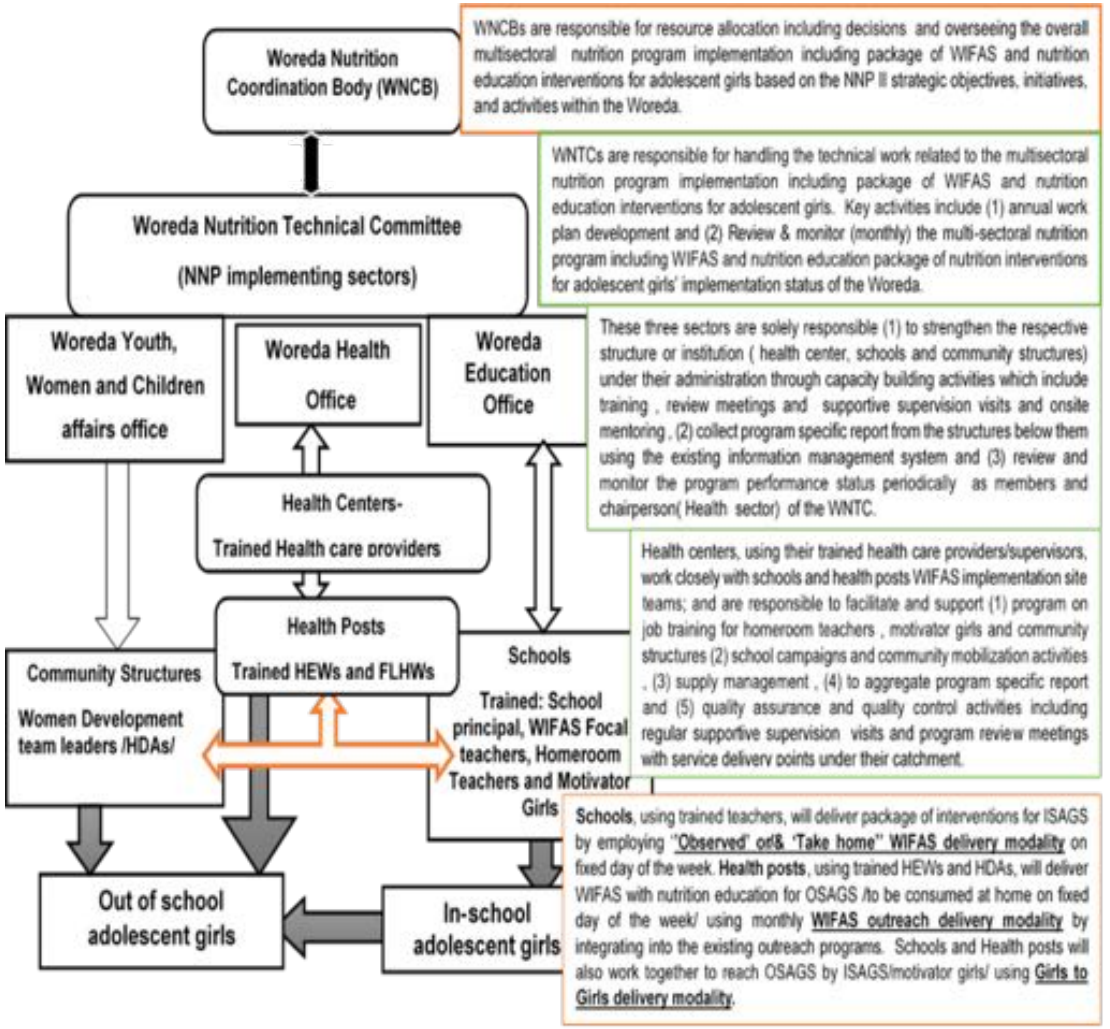
Identified barriers

- Poor interaction with the health system by adolescent girls outside of schools
- Lack of system to access adolescent girls outside of schools
- Mobility of communities in pastoralist setting
- Lack of readiness for youth-friendly services on the side of the health facilities (e.g., most health facilities have no functional youth-friendly service centers)
- Poor knowledge and attitudes towards the intervention from program officers at lower level and frontlines, adolescents, parents, religious & clan leaders

Key Activities

- **Technical assistance –**
  - **6** field officers deployed
- **Capacity & motivation building**:
  - 272 key intermediaries
  - Direct program & on-site trainings
  - Distribution of CBT manuals & job aids
- **WIFAS supply distribution to targeted schools & HPS**
- **Fidelity monitoring activities with program learning**:
  - 235 supportive supervision visits in 74 schools & 53 HPs
  - Eight district level learning sessions
  - Monthly and quarterly multisectoral coordination meetings

Program Implementation Framework



Implementation: Service Delivery

	Chifera	Damote Gale	Total
# of schools	36	38	74
# of HPs +HCs	26	27	53
Trained Teachers	72	76	148
Trained Frontlines HEWs	46	54	100

	School	Health Facility (HF)
Service Providers	Teachers & Motivator Girls	HEWs, community structures, schoolgirls
Delivery Approach	**Weekly sessions** 1. Fixed Day: Section Based 2. Fixed Day: Fixed Site	**Monthly sessions** Integrated with: 1. Existing HF outreach service delivery 2. School delivery modalities
Delivery Modalities	Observed	Outreach service HF
	Take Home	Woman to Girl
		Girl to Girl

Implementation: Coverage & Adherence

Acceptance

Adolescent girls who have ever consumed at least one iron-folic acid tablet:

ISAGs: Program reach at 88 %

OSAGs: Program reach at 85%

District		Identified	Enrolled in the program
Damote Gale	ISAGs	11,814	10,385 (87.9%)
	OSAGS	871	871 (100%)
Chifera	ISAGs	2,804	2, 517(89.7%)
	OSAGs	831	571 (68.7%)
Total		16,320	**14,344(87.8%)**

Effectiveness (Client Outcome)

Adherence to **12+ WIFAS consumption** in six months:

ISAGs: Adherence at 92.9%. Median 21 tablets.

Better adherence in later adolescent period (95%), in high school (94%) and in Damote Gale district (95%) (p<0.005).

OSAGs: Adherence at 92.0%. Median 21 tablets.

Higher adherence in the Damote Gale district (93.4%) compared to those in the Chifera district (88.5%) (P<0.005).

Implementation: Lessons Learned

Barriers

- **Lack of basic student amenities in schools**
  - *Safe water*
  - *School feeding program*
  - *Quality menstrual hygiene management services and infrastructures*
- **Poor school attendance**
  - *Absenteeism reported to be main reason for poor adherence*
- **Misconceptions, refusal and bullying**
  - *Especially in the first 3-4 weeks of service delivery*

Facilitators

- **Motivation and engagement of homeroom teachers & girls**
  - *Time management and follow-up*
  - *WIFAS sessions took 5-7 minutes on average*
- **Boys' involvement**
  - *Adolescent girls tend to be influenced by the opinions of boys towards the program*
- **Multisectoral coordination**
  - *For effective integration*

Conclusion

- The demonstration project provides evidence of reach, acceptability and adoption of program components
- Program can be scaled up sub-nationally and nationally
- Confirmed the need for both in-school and out-of-school delivery platforms

Sub-national scale-up using the National Implementation Model endorsed by the government and key partners

- Nov 2017-March 2020: Right Start project
  - *Using five intermediary organizations to support the implementing woredas*
  - *Additional 68 woredas in five region*
  - *Nearly 400,000 adolescent girls reached*
- Since April 2020: ISG 2019 project
  - *Focused support, government ownership, maintenance and scalability*
  - *88 Woredas in 4 regions*
- Since 2019: More than 114 woredas with UNICEF and World vison support

"We are faced with the paradox of non-evidence-based implementation of evidence-based programs."

(Drake, Gorman & Torrey, 2002)

Thank You

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