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USAID/ ETHIOPIA HAPN GENDER ASSESSMENT



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USAID/ETHIOPIA HAPN Gender Assessment

Prepared by:

Margaret Greene
Patty Alleman
Jessie Gleckel
Alemnesh Haile-Mariam
Workwoha Mekonen
Diana Santillán
Yelfign Worku

Country Map



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LIST OF ACRONYMS

ANC	Antenatal Care
ART	Anti Retroviral Therapy
AYSRH	Adolescent and Youth Sexual and Reproductive Health
CORHA	Consortium of Reproductive Health Associations
CDCS	Country Development Cooperation Strategy
CDC	Centers for Disease Control and Prevention
CCRDA	Consortium of Christian Relief and Development Associations
CSA	Central Statistics Authority
CPR	Contraceptive Prevalence Rate
EDHS	Ethiopia Demographic and Health Survey
EmOC	Emergency Obstetric Care
ENGINE	Empowering New Generations to Improve Nutrition and Economic Opportunities
HAPN	Health, AIDS, Population and Nutrition
FGC	Female Genital Cutting
FGM	Female Genital Mutilation
FP	Family Planning
GBV	Gender-based Violence
GEM	Gender Equitable Men
GHI	Global Health Initiative
GOE	Government of Ethiopia
GPI	Gender Parity Index
GTP	Growth and Transformation Plan
HDA	Health Development Army
HAPCO	HIV/AIDS Prevention and Control Office
HTPs	Harmful Traditional Practices
IGA	Income Generation Activities
IPOs	Implementing Partner Organizations
KOOS	Kabele Oriented Outreach Service
MARPs	Most at Risk Populations
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MDGs	Millennium Development Goals
MNCH	Maternal, Neonatal & Child Health
MOE	Ministry of Education
MOH	Ministry of Health
MSM	Men who have sex with men
NAP-GE	National Action Plan for Gender Equality
NGOs	Non-governmental Organizations
PEPFAR	President's Emergency Plan for AIDS Relief
PLWHA	People Living with HIV/AIDS
PMI	President's Malaria Initiative
PMP	Performance Monitoring Plan
RFA	Request for Applications

RFP	Request for Proposals
RH	Reproductive Health
SRH	Sexual and Reproductive Health
PMTCT	Prevention of Mother to Child Transmission
SNNPR	Southern Nations Nationalities and Peoples
STIs	Sexually Transmitted Infections
TAC	Technical Advisory Committee
TB	Tuberculosis
TOT	Training of Trainers
UHEP	Urban Health Extension Program
USAID	United States Agency for International Development
USG	United States Government
VAW	Violence against women
VCT	Voluntary Counseling and Testing
WASH	Water, Sanitation and Hygiene
WDA	Women Development Army
WGGE	The Women-, Girl- and Gender Equality (WGGE)- Centered Approach
YFS	Youth Friendly Services

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EXECUTIVE SUMMARY

Gender inequalities influence many health and development outcomes in Ethiopia. USAID/Ethiopia is committed to addressing these inequalities throughout its programs. This gender assessment was conducted to provide the Mission with guidance on how to build on its current work and to set in motion processes to expand on the good work already being done.

Objectives of the Assessment

The objectives of this gender analysis were to identify critical gender-based constraints to equitable participation and access to USAID/Ethiopia programs, provide specific recommendations on how the Mission could contribute to increasing access, generating demand for services and strengthening the health system through addressing gender-related norms, roles and practices; identify key gender issues outside the Mission's current set of activities and investments; assess the institutional context supporting gender mainstreaming in the Mission and in Ethiopia; and provide recommendations to improve the Mission's and partners' practices and structures supporting gender equality and improved health outcomes.

Team Composition

The team was comprised of Margaret Greene (Team Leader), Patty Alleman (USAID/Washington), Kuleni Berhanu, Jessie Gleckel (CDC), Alemnesh Haile-Mariam (USAID/Ethiopia), Workwoha Mekonen, Diana Santillán (USAID/Washington), and Yelfign Worku.

Methodology

This gender assessment was conducted through reviewing project and research documents, meetings with beneficiaries, and interviews with government officials, cooperating agencies, sub-grantees, other donors and key players in health and gender. The Team made numerous visits to organizations in Addis, and then visited many USAID programs in three regions to observe and discuss gender integration in project activities.

Major Findings

Many programs in the current HAPN portfolio are working to challenge the gender inequitable norms and practices that undermine health. The recommendations for the HAPN portfolio are presented according to the three pillars of the GHI Results Framework. They are followed by recommendations for institutional strengthening on gender and health in the HAPN office and among its partners.

Pillar 1: Increasing access:

Women are often prevented by their demanding domestic roles and the low value accorded them from accessing the services they need. Men, for their part, are more likely to take certain risks with their health and at the same time are often influenced by male norms to be slow in seeking out health services. In largely rural Ethiopia, both men and women face obstacles to access by virtue of the distance from services and time required to reach them.

In order to overcome obstacles to access, programs need to address systematic gender inequalities and work toward a fuller integration of comprehensive services that respond to the different health needs of males and females throughout Ethiopia.

Short-term recommendations

- Consult with and inform women using maternal health services so as to improve their experiences of those services.
- Increase men's knowledge and awareness of and participation in health care.

Medium-term recommendations

- Given that women are largely subject to the will of their husbands, the HAPN portfolio needs to pay more systematic attention to household resource allocation and decision-making.
- Find ways of addressing distance to services, which remains an obstacle to accessing health services for many rural Ethiopians.
- Having traveled long distances, patients need to be referred within health facilities to other services they may need.

Long-term recommendations

- The gender assessment demonstrated a need to strengthen linkages between projects and services, both in and outside of USAID's portfolio and sometimes outside the health sector. With regard to gender-based violence, for example, programs need to:
 - Raise awareness of new laws and the rights of women covered under recent laws;
 - Increase awareness and sensitivity within the judicial system and law enforcement;
 - Reinforce Community Action Groups, which are often holding perpetrators of various violations accountable.
- The team recommends reaching out to specific underserved populations, including adolescent girls and men in general, and within these large populations, specific challenges to health in the Ethiopian context call for special attention to trafficked girls and to men who have sex with men. Programs that effectively serve them will have to address social norms, but there are many advantages from a public health perspective to improving their health.

Pillar 2: Generating demand:

Women's health is often given low priority in the household economy. Furthermore, women's care for children and their daily roles in the house and fields make seeking out healthcare more difficult. Increasing demand for and use of services requires raising awareness raising about health conditions and identifying the need to seek out services; working to alter the gender norms that determine who is deemed worthy of health care; and improving the quality of services so that people view them as interesting and worth seeking out at considerable time and often expense.

As the findings of the gender assessment have indicated, programs are working – and must do more – to reduce cultural barriers to accessing existing services. Many small and creative accommodations within large, technically and sectorally focused programs can improve the acceptability of services and generate greater demand.

The gender assessment team’s overarching recommendation is to look for ways to address underlying unequal gender norms, roles, relations, attitudes, and practices that drive unhealthy behaviors and limit utilization of services. Addressing these challenges helps develop informed demand for services.



Short-term recommendations

- University students have among the highest rates of HIV of any sub-population in Ethiopia. A great opportunity exists to promote gender equality and mutual respect at the university level in support of young people’s – especially young women’s – health and their studies.
- Programs must go beyond providing information and support on ual violence and HIV specifically, to work with university administrations to do away with the climate of impunity and create one of mutual respect.

Medium-term recommendations

- USAID could support the health sector in collaborating more effectively with schools to create safe environments that promote mutual respect and safety and are thoroughly girl friendly – i.e., protective and supportive of girls’ needs and rights.
- Women’s lack of decision-making power and their heavy chore burdens pose considerable challenges to their health and need to be addressed directly in programs to improve their health. There is a clear need to increase the linkages between economic livelihood interventions and household burden reduction strategies.
- Although women are more likely than before to deliver in facilities, community preparedness and response to obstetric emergencies in Ethiopia could be strengthened considerably.
- The Model Family concept has effectively driven demand for services, and the gender assessment team found it a creative and interesting tool for the health system. Ethiopia has an opportunity to integrate select gender-equitable practices within the Model Family package that allow families to “graduate.”

Long-term recommendations

- One opportunity for the health sector, and for USAID HAPN programs, is to work more closely with the education sector. School-based work reaches young people while they are establishing what will become their future health practices and attitudes toward peers and future sexual partners.

- Health programs in Ethiopia can engage men in many positive ways to improve health outcomes. Providers and community members acknowledge the important roles men play in supporting and, at times, impeding, women's health.
 - A first need is to increase outreach to men as clients, generalizing EngenderHealth's work and social campaigns and marketing with high-risk groups to men at large.
 - Programs like the Population Council's husbands curriculum that promote gender equitable norms among men could be expanded to reach more men.
 - Supporting and promoting men's roles as allies and leaders in transformational change has been shown in other settings to improve health outcomes for them and many in their families and communities.
 - Many good curricular and other materials on men and gender equality exist and could be adapted from other settings.
- Community norm change on health and gender equality is happening through several HAPN programs. These efforts could be expanded via theater, and perhaps even radio, in areas where radio is already established.
- The gender assessment team identified an important opportunity to work on norm change efforts with children and adolescents. School is an important place in which to cultivate solidarity among children.

Pillar 3: Strengthening Health Systems:

Ethiopia has made enormous progress in strengthening the health system, and in devolving responsibility to health extension workers. It continues to struggle with the need to build human capital in the health workforce, to expand on systems for getting supplies out to the people who need them, to build up the health infrastructure, and so on.

Short-term recommendations

- Given the demands on women's time, and the reliance on volunteer labor in the health system, consider drawing on groups of men, including farmers' groups, from which to recruit outreach workers and promote discussions about HIV prevention, partner reduction, spousal communication, and so on.
- Make the gender training curriculum used for health system staff less abstract, passive and informational and instead re-orient it toward values clarification, reflection and application of the concepts to their work.
- Although the Ethiopian government has elected not to work with TBAs, their persistent role in the community suggests it may make sense to give them a referral role to facility-based delivery.
- To cover the expenses families incur for health, Ethiopia needs to expand financing strategies (e.g., revolving funds, microinsurance) so that people can afford health services when they need them.
- The FMOH Gender Directorate continues to need systematic support and strengthening in its efforts to integrate gender into its work on health at various levels, from strategy development to implementation.

- To strengthen the health system's ability to address the far-reaching social challenges of gender inequality, it is necessary to build collaboration with ministries other than the MOH, at the federal, regional and *woreda* levels.
- USAID could develop stronger partnerships and exchange with other key donors and multilaterals in support of the GOE ministries working to address gender inequality and its connections with health. Part of this may involve being more present and visible in high-level donor networks.

Medium-term recommendations

- The HAPN office could usefully measure, focus on, and reduce maternal *morbidity* (which far exceeds maternal mortality in scale) as well as maternal mortality in all maternal health programs. As part of this, USAID could work with the GOE to develop strategies for integrating fistula identification and treatment into system-wide programs on community and maternal health.
- On the basis of observation at health facilities and interviews with staff and beneficiaries, increase the gender sensitivity of facility design with special attention to privacy and the ability to accommodate other family members.
- Establish gender quality "credentials" for health facilities, including criteria that touch on outreach, counseling protocols, facility setup, and so on.
- Systems for keeping nurses in the UHEP program safe from danger in the urban communities in which they work are needed, including community introduction and facilitation and the organization of community brigades to escort nurses and women seeking services at night.
- Support the strengthening of data collection efforts on the causes and consequences of gender disparities across diseases and conditions so as to inform and structure appropriate programs. The GOE is working hard to collect data on a broad range of topics in the HMIS. More could be done to link gender with these health indicators.
- USAID partners collect gender-related indicators that are not ultimately required in reporting, and grantees should be required to report on the gender-related data they collect.

Long-term recommendations

- USAID partners and others involved in supply chain need support to understand the gender dimensions of commodities procurement and delivery.
- USAID could work with civil authorities to strengthen the marriage age check and structure a system for checking in with and providing information to young people about to marry.
- USAID's partner CORHA could play an expanded role in working with their 100+ member organizations (many receiving USAID funds) to develop and implement institutional policies on gender, including personnel policies.

Institutional strengthening on gender at USAID and among its partners:

In addition to the recommendations for strengthening USAID's HAPN portfolio, specific steps for integrating gender more fully into HAPN structures and processes are recommended below.

Immediate next steps

Schedule stakeholders meeting of USAID's partners to discuss integration of gender throughout the HAPN portfolio. Some preparations will be required in terms of deciding HAPN priorities in light of this gender assessment.

Longer-term recommendations

Clarify and reinforce USAID/Ethiopia's commitment to integrating gender into its programming.

- Develop a Gender Strategy for HAPN, based on the experience of the Disability Strategy recently developed for the mission, with a slightly different process that highlights the role of USAID/HAPN. A similar strategy for Health and Gender could provide clear USAID/E guidance on gender and health priorities, taking all global guidance and GOE priorities into consideration. This strategy could be shared with the broader mission as an example that could be replicated in other offices, and perhaps eventually developed into a mission gender and development strategy.
- The Ethiopia Mission would benefit from having Gender Mission Order along the lines of the one developed at USAID/Rwanda; the new USAID gender policy states that all Missions "[...adopt or revise, and periodically update, a Mission Order (MO) on Gender...]"
- As part of developing the HAPN gender strategy, consider how to achieve buy-in and consistently monitor addressing gender inequality in programming from others in the Mission and from external partners.

Increase capacity within HAPN to address gender inequality through its health and development programs; a number of opportunities exist to strengthen USAID's internal capacity to integrate gender more fully:

- Strengthen staff capability and build human resources on gender. USAID and its partners need highly skilled people in gender, but also need everyone on staff to have basic competency in this work.
- Establish and clarify accountability for gender within USAID and among its partners. The commitment to gender must be incorporated into workplans and must be the responsibility of specific individuals. The recommendations section enumerates specific ways to accomplish this.
- Strengthen collection and make better use of strategic information, measuring the impact of HAPN gender mainstreaming on programs and their health outcomes.
- Develop more strategic partnerships on gender and more of them, including being more present and visible in high-level donor networks and working more closely with other donors and multilateral organizations, and developing new collaborations with diverse government and civil society partners such as the MOWCYA at the *woreda* level, the World Faiths Development Dialogue, Center for Inter-Faith Action, and the MenEngage Alliance working to change male norms that harm health.
- Convene partners to share experiences and reinforce the importance of working to address gender inequality. Reward partners for innovative work on gender and build consistency in gender-related curricular materials across programs and organizations
- Sharpen communications and be more strategic in representing the gender portfolio. This includes strategically representing HAPN's gender and health portfolio with GOE and other donors rather than relying on USAID partners to represent USAID interests.

- Carry through on commitment to gender equality in monitoring and evaluation. The connections between gender inequality and health are generally recognized, and in some cases are integrated into programming. Yet the gendered dimensions of the programming are generally neglected in favor of standard health outcomes in reporting.

I. INTRODUCTION

In January 2012, USAID/Ethiopia's Health, AIDS, Population and Nutrition (HAPN) Office solicited a gender assessment of its overall portfolio of programs. The gender assessment team was comprised of an external Washington-based consultant (Team Lead), the USAID/Ethiopia gender advisor, a technical advisor and a gender advisor from USAID/Washington's Bureau for Global Health, a CDC/Atlanta staff member, and three local consultants.

The purpose of the gender assessment was to inform the development of a strategic/operational plan to guide and improve gender integration in the HAPN portfolio of programs, especially in the context of the Global Health Initiative (GHI) focus on "women, girls and gender equality." This report summarizes the findings of the gender assessment and provides recommendations based on these findings to strengthen gender integration in the HAPN portfolio.

Assessment Methodology

A highly participatory and inclusive approach was employed incorporating continuous guidance and feedback from key USAID/Ethiopia HAPN staff members. A preliminary briefing was held with key HAPN staff to review the scope of the assessment and determine key issues and priority questions to be included in the review, and before leaving Ethiopia, the assessment team held two debriefing meetings to present the major findings and recommendations of the assessment to USAID/Ethiopia and USG partners.

The HAPN office is one of ten offices of USAID Ethiopia and is currently divided into four teams: HIV/AIDS, Malaria, HSS and Health. HAPN's comprehensive objectives are to achieve sustainable improvements in the well-being and productivity of the people of Ethiopia. The office's programming addresses child, maternal and reproductive health.

The gender assessment examined the extent to which the current HAPN portfolio of projects addresses the links between gender and health-related development outcomes, and identified opportunities to strengthen current programming and address gaps in future programming priorities.

A qualitative methodology was employed to conduct the gender assessment in order to capture the depth of USAID/Ethiopia's health programming. The following methods were utilized to collect assessment data (detailed lists of questions and materials appear in the Annexes of this report):

1. Comprehensive literature review of pertinent documents, including:
 - Published literature and background documentation regarding the relationships between gender and social norms in influencing health and related development outcomes in Ethiopia
 - Existing formal laws, policies and strategies that govern issues related to gender and health/development in Ethiopia
 - Studies and assessments conducted by other donors, non-governmental organizations (NGOs), the Government of Ethiopia and the academic community
 - USAID documents

2. Qualitative, semi-structured, in-depth interviews with key informants, including:
 - USAID/HAPN technical team members and other key USAID colleagues
 - USAID implementing partners and other relevant NGOs working on gender issues
 - GOE officials in Ministry of Health and Ministry of Women, Children, and Youth Affairs
 - Relevant donors and multilaterals
 - Project beneficiaries
3. Participant-observation of selected implementing partners' field activities during project site visits in the following clustered areas:
 - Addis Ababa and surrounding communities
 - Tigray-Mekele
 - Amhara, Bahir Dar, and Gondar
 - Oromia and SNNPR

The selection of key informants and project sites was based on purposive sampling, in consultation and collaboration with key HAPN staff members, in order to gather relevant and useful information from a range of projects in a limited period of time. The semi-structured, in-depth interviews were conducted utilizing an open-ended interview guide (see Annex D) that provided a starting point for discussion and allowed flexibility for further follow-up, probing, and new lines of inquiry, as appropriate. Based on the nature of a qualitative assessment methodology, standard limitations do exist regarding the scope, representativeness, and extent to which generalizations can be made based on the data collected. The contextual depth of analysis that multi-dimensional interviews and field site visits allow compensates for these limitations.

Levels of Analysis

The assessment data focused on various levels of analysis to take into account the multiple layers of programmatic work related to gender reflected in USAID/Ethiopia's investments. Throughout the assessment, the team looked for opportunities to improve health by systematically looking for opportunities to address gender inequalities with work at each of these levels.

At the **individual level** USAID seeks to address women's inability to make decisions that impact their health and lives. Their lack of information and services combine with their lack of life skills and make it difficult for them to care for their own health and practice safer behaviors. In the sexual arena, women are strongly inhibited from talking about their experiences, making them additionally vulnerable to men's preferences and decisions. What access do women have to existing services? How can those services be made more attractive to them through strengthening demand and building the quality and reliability of the health system?

As a consequence of social expectations and inequalities at the **family, household and community levels**, women and girls face heavy workloads and violence, and have little influences over decisions that affect them. Harmful traditional practices put their health at risk, as do families' reluctance to spend money on girls and women's health. A lack of social and economic opportunities and political participation leaves adolescent girls and women with few options in life. USAID is also supporting programs working at this level. Working with families,

households and communities provides a special opportunity to develop demand for services, since demand reflects a shared perspective on the value of services and the need and “worthiness” of specific groups for those services. Growing demand also supports efforts to strengthen health systems.

Challenges at the **facility level** include health facilities, schools, government administrative offices, and other local institutions. Since the great majority of Ethiopia’s population is rural, distance and inaccessibility of services and facilities of all kinds are a problem. Health and education facilities may not be welcoming, and provider bias along gender lines poses challenges for women and girls. Authorities charged with implementing laws against early marriage, HTPs and gender bias of all kinds are not always fully capable or committed to dealing with these challenging issues. Here also, USAID has promoted the supply and quality of services.

Policy and systems is the final level at which improvements in health and efforts to address the connections between gender and health must occur, and USAID has been active at this level. Despite Ethiopia’s very strong policy framework on gender equality, gaps arise between that policy and its translation into the system. From distinguishing the needs and experiences of males and females, to collecting and analyzing sex-disaggregated data, to developing guidance across ministries, to ensuring structures are in place to implement that guidance, strengthening policy and systems is a giant task. “Gender mainstreaming” is an important effort, but when the responsibility for promoting gender equality is everyone’s job, roles can be unclear in ways that weaken multi-sectoral coordination, accountability and monitoring.

Conceptual Framework for this Gender Assessment

USAID Washington’s Interagency Gender Working Group has developed the Gender Continuum, which describes how to assess whether gender has been appropriately and effectively integrated into programs. It describes **gender blind** programs as those that do not recognize, or even ignore, local gender differences, norms, and relations in program/policy design, implementation, and evaluation; and **gender aware** programs, which explicitly recognize local gender differences, norms, and relations and their importance to health outcomes in program/policy design, implementation and evaluation.

Gender aware programs fall into three categories; USAID programs aspire to be transformative:

- **Gender exploitative** approaches to program and policy, implementation, and evaluation take advantage of gender inequalities, behaviors, and stereotypes in pursuit of health and demographic outcomes. The approach reinforces unequal power in the relations between women and men, and potentially deepens existing inequalities.
- **Gender accommodating** programs approach project design, implementation, and evaluation in ways that adapt to or compensate for gender differences, norms, and inequities. These approaches do not deliberately *challenge* unequal relations of power or address the underlying structures that perpetuate gender inequalities.
- **Gender transformative** programs explicitly engage women and men to examine, question, and change institutions and norms that reinforce gender inequalities, as well as strengthen institutions and norms that support gender equality, and as a result achieve both health and gender equality objectives.

Having documented the key gender inequalities that undermine health and gained a firm understanding of USAID-supported programs and how they respond to these gender-related constraints and opportunities, it is simple to assess where the programs fall along this continuum. USAID's programs should never be gender exploitative, and should try to go beyond accommodating gender-related constraints, ultimately aiming to be gender transformative.

II. BACKGROUND

In Ethiopia, political, cultural and economic factors create and reinforce gender inequality, most often adversely impacting women's access to essential resources and increasing their vulnerability to injury and illness. Gender inequality and discrimination harm girls' and women's health directly or indirectly throughout their life cycle, and can also harm men and boys' health. Women enjoy little independent decision making on most individual and family issues, including the option to use birth control methods, as well as whether to give birth in a health facility or to seek the assistance of a trained provider. Traditional masculine norms contribute to unsafe or risky practices including drug and alcohol use, multiple sexual partners, unprotected sex and other behaviors that damage their health. Harmful traditional practices, including female genital cutting, early marriage and childbearing, gender-based violence, forced marriage, and wife inheritance, all impose huge negative impacts on women's health and wellbeing. The Global Gender Gap Index ranks Ethiopia as 116 out of 130 countries (Hausmann et al 2011), while the Human Development Index places it at 174 among 187 countries (UNDP 2011).

The World Health Organization (WHO) recognizes gender inequality to be an extremely important social determinant of health. WHO and the USAID have both commissioned extensive reviews of the research on the difference that gender equality programming can make to health (Rottach et al 2011; WHO 2007). These reviews present substantial evidence that challenging harmful gender norms and addressing gendered constraints to decision making, mobility and access to resources, to name a few, can lead to better outcomes across at least four of the Millennium Development Goals (MDGs) and can inform a broad range of health problems. In Ethiopia, as elsewhere, efforts to promote gender equality through work with men and women, boys and girls, could make a huge contribution to health and development.

A. USG Policies on Gender Mainstreaming: Special Emphasis on Health

The United States Government established various institutional mandates that explain how to address gender inequality in its work. A number of Presidential Initiatives provide concrete mandates for working on gender. These include the [Global Health Initiative](#), the [Global Health Framework](#), the [President's Emergency Plan for AIDS Relief](#), the [President's Malaria Initiative](#), [Feed the Future](#) and USAID [BEST Practices at Scale in the Home, Community and Facility](#). The March 2012 revision to the USAID [Policy on Gender Equality and Female Empowerment](#) provides guidance on pursuing more effective, evidence-based investments in gender equality and female empowerment, and incorporating these efforts into core development programming. Although these efforts outline strategies and guidance for addressing and/or integrating gender issues they also build a strong case for the need to conduct a gender assessment. The USAID [Automated Directives System](#) provides more process-oriented institutional guidance.

The [Global Health Initiative](#) (GHI) is guided by seven core principles, the first of which is a

focus on women, girls and gender equality (see Box 1). The Woman-, Girl- and Gender Equality-Centered Approach takes a comprehensive life cycle perspective on addressing the health of women and girls and promoting gender equality. Through GHI, various USG programs will be better linked, including health, education and food security, democracy and governance, maternal and child health, family planning/reproductive health. The [Global Health Strategic Framework](#) for 2012-2016 incorporates the principles of the Global Health Initiative, reflects a commitment to marginalized and vulnerable populations.

Box 1: The Seven Core GHI Principles

1. Focus on women, girls, and gender equality
2. Encourage country ownership and invest in country-led plans
3. Build sustainability through health systems strengthening
4. Strengthen and leverage key multilaterals & other partnerships
5. Increase impact through strategic coordination and integration
6. Improve metrics, monitoring, and evaluation
7. Promote research and innovation

All GHI country strategies must be informed by a gender analysis, and GHI monitoring and evaluation plans should be designed to capture progress towards improving the health of women and girls and the promotion of gender equality. The supplemental

guidance on the [Women, Girls and Gender Equality Principle](#) (WGGE; see Box 2) was issued after Ethiopia's GHI Strategy had been drafted, and provides a substantive description of what this principle entails, including 10 elements that help to organize and guide programmatic interventions. The GHI Ethiopia results framework structures this gender assessment, which is organized by the three key pillars: increased access to services, increased demand for services, and improved health systems.

The [President's Emergency Plan for AIDS Relief \(PEPFAR\)](#) is a legislated initiative. "PEPFAR proactively confronts the changing demographics of the HIV/AIDS epidemic, integrating gender throughout prevention, care, and treatment with a focus on:

- Increasing gender equity in HIV/AIDS programs and services,
- Reducing violence and coercion,
- Engaging men and boys to address norms and behaviors,
- Increasing women and girls' legal protection, and
- Increasing women and girls' access to income and productive resources, including education."

PEPFAR integrates a concern with gender inequality at various levels of its work. The program acknowledges the [centrality of addressing gender norms and inequalities to reducing the vulnerability of women and men to HIV infection](#). It states that, "Gender-related disparities compromise the health of women and girls and, in turn, affect families and communities. PEPFAR focuses on women and girls—including adolescent and pre-adolescent girls—in planning, implementation, and monitoring and evaluation." PEPFAR's interagency Gender Technical Working Group provides technical assistance on integrating gender into PEPFAR programs globally.

Currently PEPFAR funds two gender central initiatives: the Gender-Based Violence Response Scale-Up, which focuses on moving GBV programs from pilot efforts to more comprehensive responses through prevention, provision of comprehensive post-GBV care, and development and advocacy of policies; and the Gender Challenge Fund, which provides matching funds to

countries focusing programming on one of the five gender strategy elements. Prior to these initiatives, PEPFAR funded three gender central initiatives on male norms, sexual and gender-based violence, and vulnerable girls. The Public-Private Partnership Together for Girls (TfG) brings together public, private, United Nations, and U.S. agencies to address sexual violence against girls.

Programmatically, PEPFAR includes a significant initiative on Prevention of Mother to Child Transmission of HIV, and the Gender-Based Violence Response Scale-Up and Gender Challenge Fund, both of which promote the integration of attention to gender-based violence into HIV programs. PEPFAR has also collaborated on establishing the PEPFAR Gender Public-Private Partnership Together for Girls (TfG). This partnership brings together public, private, United Nations, and U.S. agencies to address sexual violence against girls. Finally, PEPFAR's Gender Technical Working Group contributes to ensuring that gender is integrated into its programming.

The [President's Malaria Initiative \(PMI\)](#) describes the linkages between sex, gender and malaria in [PMI and Gender](#). PMI appears not to call for a gender assessment per se, but its implementation strategies attempt to reduce gender-related vulnerability of women through a focus on pregnant women, behavior change communications to ensure that most vulnerable groups sleep under insecticide treated bednets every night, engaging non-pregnant women in spraying campaigns to generate income and social capital, and analyzing data to assess gender differences in vulnerability to infection and access to treatment.

[Feed the Future](#) treats [Gender Integration](#) as a focus area, and integrates gender-based analysis into all of its investments and helps partners address the negative impacts of women's unequal access to and control over assets at all stages of the agricultural value chain. Since improving the status of women increases agricultural productivity, reduces poverty and improves nutrition, gender equality and women's empowerment are prominent in Feed the Future hypotheses and strategies. The [Feed the Future monitoring and evaluation system](#) focuses comprehensively on tracking gender impacts through three approaches: 1) engendered performance monitoring, 2) gender-focused impact evaluations, 3) the development and utilization of the Women's Empowerment in Agriculture Index. Through these three targeted and diverse approaches, USAID is cultivating a deep understanding of how Feed the Future is affecting women, men, and the dynamics between them.

The USAID [BEST Practices at Scale in the Home, Community and Facility \(BEST\)](#) initiative began in 2009, when the USG started a process under the Global Health Initiative to work with developing countries to strengthen their health programs, especially those targeting women and children. The program drives the development of country-specific strategic action plans focused on strengthening and integrating maternal, neonatal, child health, nutrition and family planning into health services to improve health for women and children.

B. USAID Ethiopia - Gender Frameworks and Assessments

USAID/Ethiopia does not have a gender strategy at the current time, but will be developing one in the coming months. Opportunities for addressing gender inequality through the Mission's investments include a very favorable policy environment, strong commitment from senior and technical staff, and a history of small but good project investments.

With more than 60 projects in HAPN (of 120 at the Mission) there is much to be done by the Mission Gender Advisor to provide guidance and monitor gender integration. The growing consensus that gender inequality undermines our development efforts is hampered by the challenges of translating this commitment into concrete programming and monitoring. Numerous USG documents on gender exist to guide investments in this area, but they do not consistently get implemented at the field level. Priorities are established at a high level but USAID partners and the government do not always address gender inequalities on a practical day-to-day level. Limited mechanisms exist that oblige technical staff to make gender equality a focus of their work and hold them accountable for doing so. A case in point is PEPFAR's five gender strategies, which are concretely connected with implementation, but which have not been disseminated as fully as the higher-level guidance. Box 2 summarizes some of the key sources of USG guidance for integrating gender into health and nutrition programs.

Box 2: Sources of Guidance on Integrating Gender into USG Programs of Relevance to Health and Nutrition	
Initiative	Guidance on gender
Global Health Initiative	<p>One of the seven guiding principles is a focus on women, girls, and gender equality. The ten elements for promoting the women, girls and gender equality principle are:</p> <ul style="list-style-type: none"> • Ensure equitable access to essential health services at facility and community levels. • Increase meaningful participation of women and girls in planning, design, implementation, monitoring, and evaluation of health programs. • Monitor, prevent, and respond to gender-based violence. • Empower adolescent and pre-adolescent girls by fostering and strengthening their social networks, educational opportunities, and economic assets. • Engage men and boys as clients, supportive partners, and role models for gender equality. • Promote policies and laws that will improve gender equality, and health status, and/or increase access to health and social services. • Address social, economic, legal, and cultural determinants of health through a multisectoral approach. • Utilize multiple community-based programmatic approaches, such as behavior change communication, community mobilization, advocacy, and engagement of community leaders/role models to improve health for women and girls. • Build the capacity of individuals, with a deliberate emphasis on women, as health care providers, caregivers, and decision-makers throughout the health systems, from the community to national level. • Strengthen the capacity of institutions – which set policies, guidelines, norms, and standards that impact access to, and quality of, health-related outreach and services – to improve health outcomes for women and girls and promote gender equality.
President's Emergency Plan for AIDS Relief	<p>PEPFAR identifies five areas of programmatic focus on gender inequality and gender norms as they affect HIV:</p> <ul style="list-style-type: none"> • Increasing gender equity in HIV/AIDS programs and services • Reducing violence and coercion • Engaging men and boys to address norms and behaviors • Increasing women and girls' legal protection • Increasing women and girls' access to income and productive resources, including education •

<p>USAID Gender Policy</p>	<p>Overarching outcomes:</p> <ul style="list-style-type: none"> • Reduce gender disparities in access to, control over and benefit from resources, wealth, opportunities and services – economic, social, political, and cultural; • Reduce gender-based violence and mitigate its harmful effects on individuals and communities; and • Increase capability of women and girls to realize their rights, determine their life outcomes, and influence decision-making in households, communities, and societies. <p>Seven guiding principles underpin this policy:</p> <ul style="list-style-type: none"> • Integrate gender equality and female empowerment into USAID's work; • Pursue an inclusive approach to foster equality; • Build partnerships across a wide range of stake-holders; • Harness science, technology, and innovation to reduce gender gaps and empower women and girls; • Address the unique challenges in crisis and conflict-affected environments; • Serve as a thought-leader and a learning community; • Hold ourselves accountable. • Implementation of the policy will be evaluated in 2015.
<p>Automated Directives System</p>	<p>The Automated Directives System requires gender to be incorporated into planning and programming in an integrated way. Any analysis conducted for the ADS should be structured by two key questions to be addressed at every stage of the planning/program cycle:</p> <ul style="list-style-type: none"> • How will the different roles and status of women and men within the community, political sphere, workplace, and household (for example, roles in decision-making and different access to and control over resources and services) affect the work to be undertaken? • How will the anticipated results of the work affect women and men differently? <p>Findings from gender analyses should help to determine the integral positioning of gender in the procurement process, the project activities, and the performance management systems and evaluations. In sum, the design of all projects and activities must take gender analyses into account.</p>
<p>Feed the Future</p>	<p>The gender analysis conducted for the Feed the Future program defines the following key principles for gender equitable agricultural growth and nutrition programming:</p> <ul style="list-style-type: none"> • Overcome gender-based constraints to agricultural productivity • Address the distinctive needs of women • Improve the resiliency of vulnerable rural populations • Design equitable access to the rewards from agricultural enterprises • Engage men and women in improving nutrition of all household members • Foster equitable participation in decision-making processes at all levels (e.g., community organizations, producer associations, local government) • Promote the use of gender analysis by policymakers and policy analysts as a tool to improve the enabling environment • Improve knowledge of the performance of USG investments in supporting women and reducing gender inequalities in agricultural and nutrition programs. • Strengthen capacity and confidence of USAID personnel in all offices to lead gender-equitable agriculture and nutrition programs.
<p>Ethiopia CDCS</p>	<p>From Feed the Future which is key to informing CDCS</p> <ul style="list-style-type: none"> • Extension services: Most extension services focus on male farmers. The GOE recently increased the number of extension workers to 63,000 but only 12% of those are women. Male extension workers can work with women farmers but must be sensitized to the needs and the time limitations that women have. • Access to credit: Promote different schemes to fit the needs of smallholder farmers as well as mid- and high-level agricultural entrepreneurs, where possible through existing and/or new DCA programs. • Access to land and other productive assets: Help women farmers to get land certificates and promote schemes to allow them access to improved tools and equipment, via the current and future land administration program. • Policy changes: Support changes to policies that are more attuned to the special needs and constraints of women.

USG Ethiopia working group	<p>The working group has committed to focusing on five themes:</p> <ul style="list-style-type: none"> • Trafficking in persons • Gender-based violence (the area in which we can help out) • Girls' education • Women's economic mainstreaming/opportunities • Youth
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As USAID's Inter-Agency Gender Working Group has observed in numerous publications and events (e.g., [IGWG 2000](#)), staff working on acquisitions and assistance often do not have the gender-related awareness and tools to integrate gender fully into their solicitations. There is scope to move beyond brief references to gender in Requests for Applications or Proposals (RFAs/RFPs), and to fully integrate it into the program results framework and PMP development. Beyond the planning stages, many if not most cooperating partner organizations don't have gender focal persons responsible for gender equality programming. Some of these issues are treated in [recent USAID gender trainings and workshops](#).

As the gender assessment team observed, one consequence is that there are widespread misunderstandings about what it means to address gender in health programs. The focus on disaggregation by sex is sometimes seen as an adequate response to "addressing gender." Some staff in cooperating agencies and other partner organizations also believe that working with women *is* addressing gender, e.g., since the Urban Health Extension Program (UHEP) is implemented by female nurses the program must be gender sensitive. Or when specific projects effectively and explicitly address gender inequalities (e.g., the Population Council's Vulnerable Girls Project), other partners may think that other projects do not need to address gender within their mandates.

On the ground in Ethiopia, the gap between policy and implementation occurs largely because of the lack of human capital. As health sector professionals including State Minister Kasete-Berhan noted, the many levels of health professionals in the health sector need their capacity strengthened in an ongoing way. The Health Development Army (HDA), while a truly visionary program, relies on the voluntary work of women with somewhat limited professional skills. Much has been written in the development and gender arenas about relying at a large scale on volunteer female labor.

Ethiopia's national law on Non-Governmental Organizations (NGOs), advocacy and funding has concerned some partners that wanted to work on gender equality; they are fearful their work might be viewed as promoting women's rights. For example, the Consortium of Christian Relief and Development Associations (CCRDA) encouraged its members to mainstream gender in their thematic areas, but members were afraid of the CSO law. Through extensive consultation and clarification, the group came to an agreement on the right approach for mainstreaming gender in members' respective thematic areas.

Work to address gender inequality is not fully appreciated or respected by many in the development field. The request to work on these issues often comes from above and can be seen as an extra responsibility. Program staff can experience the guidance on institutional requirements as "policing." Trainings tend to overemphasize theory and vocabulary and do not offer enough applied hand-holding and accessible examples of how to program in response to

gender inequality. Program staff can be intimidated by the sense that only a gender expert has the authority to say that something meets the “gender gold standard.” Finally, many people don’t realize that they *are* addressing gender in some of their activities, or they feel they don’t have the tools to take it to the next step in programming or monitoring.

This gender assessment acknowledges the considerable work that has been done to address gender inequality and improve health and nutrition in Ethiopia. Our intention is to build on existing efforts and to communicate that the opportunities to address gender inequality are readily accessible.

III. FINDINGS BASED ON LITERATURE REVIEW: ANALYSIS OF GENDER INEQUALITY AND HEALTH IN ETHIOPIA

In this section, we review the published literature and existing data on the relationships between gender and health in Ethiopia. The purpose of this analysis is to describe the social context of health programs in the country and the response of the Ethiopian government.

A. Context of Gender Relations in Ethiopia

Ethiopia is the second most populous country in Africa, with an estimated 85 million people in 2010 (Population Reference Bureau (PRB), 2010).¹ Approximately 44 percent of the population is under age 15 (PRB 2010). High rates of rural-to-urban migration offer work opportunities but leave many migrants, including young girls, very vulnerable to economic and sexual exploitation.

The youth literacy rate is 33 percent for females and 56 percent for males aged 15-24; overall adult literacy is 30 percent (UNICEF, 2008 (UNESCO data)).² Children’s access to basic education varies greatly between rural and urban areas. The educational Gender Parity Index (GPI), the ratio of female to male enrollment, is improving, but between 1999 and 2003, was 0.7 at the primary level, indicating that only 7 girls enrolled for every 10 boys (Federal Civil Service Commission, 2005). This gender gap increases with increasing levels of education. Although access to primary education is steadily increasing, access to higher education is more limited, especially for girls. Girls face household and economic responsibilities and pressures to marry. Interviews conducted by the gender assessment team indicated that many of those girls who make it to university are subjected to harassment, pressures to engage in transactional sex, and rape (Betemariam 2002). University students have among the highest rates of HIV of any sub-population in Ethiopia.

Women are underrepresented in the formal employment sector and account for less than half of all employees in the country (CSA, 2004).³ Approximately 66 percent of women in rural areas are engaged in agricultural work, and of them, 86 percent are unpaid workers most likely

¹ Estimates are based on a recent census; official national data; or PRB, UN, and U.S. Census Bureau projections. The effects of refugee movements, large numbers of foreign workers, and population shifts due to contemporary political events are taken into account to the extent possible.

employed by family members; six out of 10 employed women work for family members (EDHS, 2005).

Gender based violence (GBV) against women has been consistently documented throughout Ethiopia, in rural and urban settings. Women who agree with at least one of the reasons justifying wife beating are more likely to be older, married, to have five or more children, or to engage in unpaid work (EDHS, 2005). An inverse association exists between the level of educational attainment among men and their likelihood to justify domestic violence. Attitudes toward GBV may be moving in a positive direction toward lower tolerance in younger cohorts: a survey of adolescents conducted by the Population Council in 7 regions shows that 51 percent of young women 15-24 agree with beating for one of these reasons (33 in urban and 65 in rural areas) and 42 percent of young men (29 for urban and 52 for rural) (Erulkar et al, 2010).

Gender and Harmful Traditional Practices

Several traditional practices, including early marriage, marriage by abduction, and female genital cutting (FGC) put women at risk for poor health. Ethiopia has witnessed change in these practices in recent years; the EDHS 2011 data will surely show some important shifts, but are not yet available.

Early marriage has a serious impact on young women's SRH, exposing them to early childbearing as well as STIs and HIV (Teshome 2005). In addition, marriage by abduction is still widely practiced; the EDHS 2005 reported that approximately eight percent of currently-married women were abducted and forced into marriage, a custom prohibited by law but only recently enforced. This practice is an example of how harmful gender norms increase women's risk and vulnerabilities in Ethiopia. Often young women are raped during their abduction as a way of forcing the young women's family to marry her off to her abductor. Large gender differences also exist between the age at first sexual activity for women and men (age 20-49): the median age of sexual debut for males is 21.2 while it is 16.5 for females (EDHS, 2005).

Sexual and Reproductive Health

Gender dynamics also have a large impact on sexual and reproductive health, as many believe that it is acceptable for young men to be sexually experienced, while young women are not supposed to engage in premarital sexual activity. This double standard puts both young men and women at risk. Young men feel pressure to live up to a social concept of masculinity that makes them more likely to have multiple relationships and increasing their risk of STIs and HIV; while young women are supposed to remain ignorant about sex issues until marriage, and then to accept their husbands' wishes.

Preliminary data from the 2011 Ethiopia Demographic and Health Survey (EDHS) shows that the total fertility rate (TFR) has decreased from 5.4 births per woman in 2005 to 4.8 in 2011. The TFR for rural areas (5.5 births) is higher than for urban areas (2.6 births). Several factors help to explain why Ethiopia's fertility rate remains well above the global average of 2.5 children per woman, including early sexual debut, early marriage, low contraceptive use, and limited birth spacing. These factors are driven by the high value attached to children and the fact that women are valued for their capacity to give birth to and raise children. Nonetheless, the contraceptive prevalence rate (CPR) has doubled since the 2005 EDHS (29 percent vs 15 percent). Addis

Ababa has the highest CPR at 63 percent, compared with both Afar and Somali at below 10 percent. Contraceptive prevalence in urban areas is much higher than that in rural areas (52 percent compared to 23 percent). Yet the decline in fertility over the last 5 years is due largely to a decrease in fertility in rural areas (from 6.0 to 5.5 births). Injectables (21%) and implants (3%) are the most widely used modern methods. Overall, 25% of currently married women say they wish to stop or delay having children yet are not currently using contraception. Unmet need is highest among women 15-19 (33 %).



Health

Preliminary data from the 2011 DHS show that 34 percent of mothers received antenatal care from a trained health professional at least once for their last birth, an increase of 6 percentage points since the 2005 EDHS. Urban women are more than twice as likely to have received ANC from a trained health professional than rural women (76 percent vs. 26 percent). Despite the increase in use of antenatal care services, only 10 percent of women reported that their most recent births in the last 5 years were delivered by a health professional, double the level reported in 2005 (5%). Women in rural areas are far less likely to report that their births were delivered by health professionals than women in urban areas (5 percent compared to 50 percent).

In Ethiopia, the maternal mortality in Ethiopia is high: the maternal mortality ratio is 673 per 100,000 live births (EDHS, 2005). Gaps in access to quality services between urban and rural populations affect women's vulnerability across the country. To address the needs of adolescent girls and young women, the Government has recently established youth-friendly services. However, there are still insufficient numbers of health personnel adequately trained in youth friendly services to serve the large cohort of young women aged 10-24. In addition, the needs of married adolescents are often overlooked by mainstream SRH and maternal health services as they are considered by many to be adults due to their marital status yet from a physical and psychosocial standpoint, they are still adolescents. Obstetric fistula—a severe morbidity caused by prolonged obstructed labor unrelieved by timely medical intervention—affects approximately 50,000 women in Ethiopia (Ethiopia GHI Strategy, 2010).

Early and/or Unwanted Pregnancy and Unsafe Abortion

Among married youth, use of a modern method of contraception is very low (10.4 percent for those 20-33 and 23 percent for those 15-19) but has increased considerably over the past five years. In the EDHS 2005, unmarried showed higher rates of contraceptive use. More than half of currently married women aged 15-19 were or had been pregnant (EDHS 2005). According to data from 2004, girls under age 15 had a much higher proportion of unintended births (over

50%) than 15-24 year old women (33%) (YouthNet, 2004). A facility-based study on the magnitude of unsafe abortion found that most women seeking induced abortions were young, with a mean of 22 years of age (ESOG, 2000).

Of all of the induced abortions conducted in Ethiopia in 2008, only 27 percent were done in safe conditions (Singh et al 2010). One estimate suggests that unsafe abortion accounts for 6% of maternal deaths in health facilities (FMOH et al 2008). Another study indicated that of the women who came to health facilities having undergone unsafe abortions, over 1 percent died (ESOG, 2000).

HIV/AIDS

In Ethiopia, HIV prevalence levels rise with age and peak among women in their late 30s and among men in their early 40s (EDHS, 2005). The EDHS reports gender differences: among women age 15-19, 0.7 percent are HIV infected, compared with 0.1 percent of men age 15-19. Additionally, HIV prevalence among women 20-24 is over four times that of men in the same age group (1.7 percent and 0.4 percent, respectively). Although a large percentage of youth have heard of HIV, only 16 percent of women and 30 percent of men in Ethiopia have comprehensive knowledge of HIV/AIDS transmission and prevention.

Preliminary data from the 2011 EDHS show that 43 percent of women know that HIV can be prevented by using a condom and limiting sexual partners, compared with 35 percent in 2005. Among men, this percentage also increased from 57 percent in 2005 to 64 percent in 2011. The percentage of men reporting two or more sexual partners in the twelve months preceding the survey is higher than that of women (4% of men and <1% of women), but still quite low. Fewer than 1% of women at any age report having had two or more partners in the preceding twelve months, while the percentage rose decisively among men, with nearly 9% having had two or more partners among men 40-49 (EHDS 2011). Among those with two or more partners, 47 percent of women and 16 percent of men reported using a condom at the last sexual intercourse.

Most at Risk Populations (MARPs)

UNAIDS estimates that 88 percent of all HIV transmissions occur through heterosexual contact; other identified risk factors included blood transfusions, unsafe injections, and vertical transmission (UNAIDS, 2007). Migrant women are very vulnerable due to trafficking, prostitution and domestic work that places them at heightened risk of sexual assault. According to the 2010 Report on Progress Towards Implementation of the UN Declaration of Commitment on HIV/AIDS, there is a “shortage of surveillance information related to MARPs and HIV incidence/prevalence data in HIV hot spots” (UNAIDS, 2010: 57). The Amhara MARPS Survey helped to advance strategic information related to MARPS in Ethiopia; the survey categorizes commercial sex workers, long distance truck drivers, in-school youth, mobile merchants, daily laborers, uniformed services as MARPS. These populations, including men who have sex with men (MSM), often self-report high-risk attitudes and behavioral practices that increased their risk and vulnerability to HIV infection (UNAIDS 2010).

The relevance to this gender strategy of the most at risk groups and men who have sex with men is that norms relating to masculinity are part of the system of gender relations. Many of the men who have sex with men, for example, marry to maintain appearances. A recent study conducted

at Addis Ababa University suggests that men who have sex with men are an important high-risk group and bridge population (Gebreyesus and Mariam, 2010). The degree of stigma around sex with other men exposes them to sexually transmitted infections including HIV, makes them vulnerable, preventing them from protecting themselves and communicating safely about their sexual relationships. Their health and that of their partners, male and female, is harmed by this stigma. From a public health perspective, it is imperative to learn more about these groups and to find effective ways of working with them.

Child Health

In the area of child health, the 2011 EDHS indicates a rapid decline in infant and child mortality, which dropped from 123 per 1000 for the period 5-9 years ago, to 88 per 1000 for the five years preceding the survey. Chronic malnutrition and stunting remain widespread (44% of children under 5), however, and 10% suffer from acute malnutrition and wasting. Nearly 30% of children under 5 are underweight and 44% are anemic (a decline of 10% from 2005).



B. The National Response to Gender Inequality

Since the downfall of the Derg Regime in 1991, Ethiopia has been governed through an ethnic-based federal administrative system, divided into 9 regional states and 2 city administrations (regional capitals, Addis Ababa, and Dire Dawa Administrative Council). Ethiopia is signatory to a number of international agreements of relevance to gender equality and the rights of girls: the Convention on the Rights of the Child, the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), The Millennium Declaration, and others. According to Article 35 of the Constitution, men and women are equal in the eyes of the law. Virtually every major policy document refers to the need to overcome gender inequality and the harm it causes to women and girls.

In 1993, a National Policy on Ethiopian Women was promulgated and a Women's Affairs Office was established for the first time under the Prime Minister's Office. In 2001, this office was upgraded to a ministry level and its structure was extended down to the *woreda* level. In 2005, the newly named Ministry of Women and Children's Affairs extended its structure down through volunteers in *kebeles*, the lowest administrative level of government. In 2010, the ministry was again restructured as The Ministry of Women, Children and Youth Affairs (MoWCYA), at which it strengthened its *kebele* level structure with paid staff replacing the volunteers.

Box 3: Gender Mainstreaming in Health Systems

The Health Sector Development Plan IV explicitly references gender mainstreaming in the health system, describing it as “ a strategy for making women’s as well as men’s concerns and experiences an integral dimension of the design, implementation, monitoring and evaluation of the Health Sector programmes; [and] in all political, economic and societal spheres so that women and men participate and benefit equally from all aspects of development. These dimensions should be mainly addressed through:

- Promoting gender equality & the empowerment of women,
- Enhancing equal opportunities in the participation of economic and social development including health
- Increasing the utilization of health services by women.
- The ultimate goal of gender mainstreaming in all sectoral planning and concerted actions are to achieve gender equality.”

(HSDP IV, 3.6.2.7)

All federal government sectors established Women’s Affairs Departments starting in 1993. Since 2010, a Gender Directorate exists in each of the 23 federal government sectors (Ministries, Commissions, Agencies and Authorities). Its role is to steer and coordinate gender mainstreaming in each sector, with overall facilitation, coordination and monitoring by MoWCYA. The Government of Ethiopia has created a number of mechanisms through which the cross-cutting gender dimensions of its policies can be implemented. At the regional level, the semi-autonomous Bureaus of MOWCYA are directly accountable to the regional presidents, and that has empowered them to engage as equals with the other sectoral bureaus.

A number of policies have been revised in recent years to remove laws that discriminate

against women. The new Family Code (2000) raised age at marriage from 15 to 18 years for both sexes. It also gives women the right to access, own and control property, including land. The Penal Code (2005) for the first time criminalizes rape, FGC (with imprisonment of 3-5 years for infibulation), perpetration of violence that causes injury against a marriage partner, and marriage by abduction (abduction of a minor < 18 is punishable by imprisonment from 5-15 years). The 2006 Government of Ethiopia (GOE) National Action Plan for Gender Equality (NAP-GE) was intended to operationalize the National Policy on Women by identifying priorities for intervention by both donors and the GOE. The NAP-GE was made an integral part of the Plan for Accelerated and Sustained Development to End Poverty that ended in 2010. The 1993 Population Policy is also supportive and states the need to address harmful traditional practices. The Policy includes a demographic analysis on the situation of women that notes that the family laws in place at that time restricted women’s regulation of their fertility.

Ethiopia’s overarching Growth and Transformation Plan (GTP) (2011-2015) guides development and planning for the current five years. The GTP integrates gender into the six sectoral pillars as well as through a standalone area on women and youth. In the gender assessment team’s interviews, other donors and government partners described the GTP gender analysis as weak, with the issues unevenly reflected across the sectors. While the chapters devoted to each sector are detailed and concrete, and it has a strong discussion of education and access for girls, the page and a half dedicated to gender as a cross-cutting issue is relatively weak and vague. Though some of the targets are not quantifiable or may not be realistic, the document takes the initiative to set out specific directions for achieving gender equality.

The GTP only weakly recognizes the coordinating role of the MOWCYA. UN Women is helping MOWCYA identify its activities, indicators and roles. MOWCYA includes two directorates: one for mainstreaming gender into government structures, the other for social mobilization of

women, children and youth. The UN Joint Programme (5 UN agencies plus MOWCYA) under the leadership of UN Women will help the Ministry operationalize many of these efforts and are working to “cascade capacity” on the promotion of gender equality in every sector. The MOWCYA developed the National Gender Mainstreaming Guidelines to implement the commitment to gender equality across all sectors. The MOWCYA is now working to review every ministry’s data system to ensure disaggregation of data by age and sex. The Ministry has also reviewed the 1993 policy on women and has identified opportunities and suggestions for addressing them. This policy will be updated and published soon.

Gender Equality in the Health Sector

The health sector has been especially progressive in its efforts to integrate steps toward gender equality into policies and strategies. The Ethiopian Federal Ministry of Health identified a number of challenges related to gender, HTPs and GBV in its National Reproductive Health Strategy of 2006-2015. The National Policy and Strategy for the Prevention and Control of HIV/AIDS were adopted by the Government of Ethiopia in 1998. The policy recognizes gender inequality as a root cause of the spread of HIV. Provisions under the policy call for the empowerment of women, young people and other vulnerable groups so they are able to protect themselves. The Ministry of Health (MOH) and Ministry of Education (MOE) are called upon to oversee the implementation of HIV/AIDS and STI education in schools, including primary schools.

The FMOH’s impressive National Guideline for the Management of Survivors of Sexual Assault in Ethiopia (MOH 2009) covers all of the steps required to manage the medical, legal and social aspects of cases of sexual assault. Several other supportive documents are currently waiting to be approved—for example, the Strategic Plan for an Integrated and Multi-sectoral Response to VAWC and Child Justice in Ethiopia (draft) and the Operational Plan for an Integrated and Multisectoral Response to VAWC and Child Justice in Ethiopia (draft). Additionally, an updated Development and Social Welfare Policy that focuses in part on women and children is currently in draft.

The FMOH has demonstrated a high level of commitment to addressing gender inequality, and the current Minister is keen to work on these issues. There is a Gender Unit in the Ministry and through the Health Extension Program, the Ministry has sent over 30,000 largely female Health Extension Workers (HEWs) into communities to promote healthy household behaviors and increase use of services. The model provides livelihoods for these women, and provides the basis for addressing sensitive issues. In some communities in Gambela and Afar, however, so few women meet the educational requirements that male HEWs have been recruited; they are, of course, not as able to talk easily about SRH and HTPs with women.

The USAID-funded Integrated Family Health Program (IFHP), Urban Health Extension Program (UHEP) and other initiatives are supporting large-scale health outreach, including some gender dimensions. The FMOH is concerned with having special impact on women as health outreach workers and as household members and patients. The health extension program and women development army (WDA) can promote gender as well as addressing women’s health. The WDA is relatively new, but State Minister of Public Health Kasete-Berhan has already observed a number of changes in Tigray where implementation has been vigorous: First, men and women

are sitting together and talking about their problems, including reproductive health. With the WDA active in Tigray, women are participating more fully, even married women who previously did not attend meetings at all. Another change he noted was that while previously, the male-dominated local associations did not regularly hold meetings, women's groups are more faithful to their plans and meet frequently,

In sum, Ethiopia offers a supportive policy environment for working to address gender equality, particularly in the context of health. Every policy has gender mainstreamed into it, including education and health. The need now is to focus on implementation and strengthening accountability. The Civil Society Organizations law has reduced all forms of advocacy in support of women's rights and to a lesser extent, their health. The law has sharply limited several organizations that would be excellent allies, including the Ethiopian Women Lawyers Association.

IV. FINDINGS FROM INTERVIEWS AND SITE VISITS: GENDER ASSESSMENT BY GHI ETHIOPIA RESULTS FRAMEWORK PILLARS AND INTERMEDIATE RESULTS

This section describes the findings from over 65 site visits in four regions and qualitative interviews with over 200 informants – USAID and cooperating agency staff, NGO partners, donors, government counterparts, and beneficiaries. The analysis is presented according to the three pillars of the GHI Ethiopia results framework as described below.

USAID/Ethiopia's Response to gender-related challenges in health

The HAPN portfolio includes numerous projects that address the connections between gender and health, and the Government of Ethiopia (GOE) appears to welcome USAID's support in this area. This gender assessment takes HAPN's strong portfolio as its point of departure, pointing out good examples that can be replicated and identifying opportunities and gaps for further work.

USAID Ethiopia approaches gender equality in two ways:

- **Gender integration into all programs by way of gender analysis, identification of critical gender issues and subsequent treatment of gender differences and equalities during program design, implementation, monitoring and evaluation**
- **Addressing drivers of inequalities such as access to activities and services, harmful male norms, sexual violence and coercion, legal protection and lack of access to income and resources.**

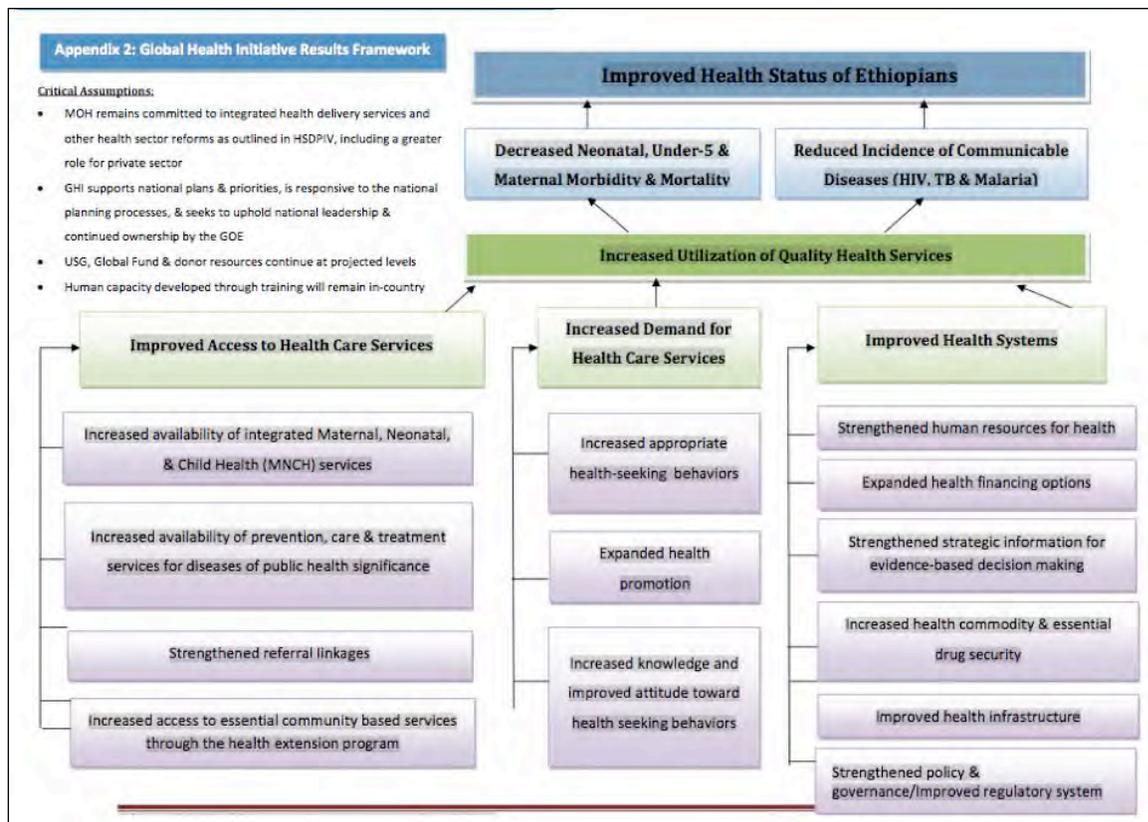
Despite this and other provisions, USAID Ethiopia lacks workable tools and systems at the operational level that support requests for proposals (RFP), performance monitoring plans (PMP), work plans and other processes to translate this commitment into action.

This section is organized according to the CDCS Development Objective 2 and GHI Results Framework pillars (see Box 3):

- **Improved access to health care services;**
- **Increased demand for health services;**
- **Improved health systems.**

The assessment focused on programs that could be developed at the individual, family, household and community, facility, and policy and systems levels.

Box 4: Global Health Initiatives Results Framework



Pillar 1: Improved Access to Health Care Services

The difficulties many people, especially women and young people, face in accessing health care services emerged clearly from the assessment. Most implementing partners of current projects within the HAPN portfolio demonstrated a commitment to overcoming barriers to accessing health care services. Others helped identify gender-based barriers of particular populations and/or revealed gaps in the coordination of projects where beneficiaries would benefit from a comprehensive and coordinated approach to service provision. The assessment showed that these needs cross health areas (e.g., HIV/AIDS, maternal health and safe delivery, malaria, reproductive health and family planning) as well as development sectors (e.g., health, education, income generation, and housing). This section discusses acceptability, affordability, and availability as three prominent factors that impact an individual or population's access to health services.

Acceptability

Established and newly developed services and projects face the common obstacle of acceptability among intended users, clients, and audiences. Implementing partners as well as

beneficiaries identified specific reasons that people are resistant to using certain services; many projects are using innovative approaches to overcome these obstacles. Cultural practices and beliefs were described as barriers to accessing services. The Health Officer at the Adet Health Center in the Amhara Region described, for example, the conventional role mothers and spouses play as decision-makers in pregnant women's health and delivery; and the cultural norm of using (and paying) traditional birth attendants to deliver at home rather than going to the health center.

Poor quality of service, including the inhospitableness of health personnel is a hindrance to facility level delivery. Health personnel, particularly nurses, are often unsupportive and brusque with laboring mothers. As a result, many women do not want to go to facilities unless they have health complications and are strongly advised by a physician; this kind of intervention is likely only if women receive prenatal care. Associated with this is the perception that "a normal delivery is a home delivery, which lowers facility level delivery even when services are available.

Programs are working – and can do even more – to reduce cultural barriers to accessing services. An implementing partner in the Tigray Region discussed how home-based traditions could be integrated in service settings. The Adi Gudom Health Center, for example, made it possible for accompanying family members to hold coffee ceremonies in the center while they wait for their relatives. Recognizing the importance of maintaining ceremonies associated with delivery, including for women to consume *genfo* porridge at the time of delivery, Adi Gudom Health Center provides *genfo* for up to five women at each delivery. The center has all the required resources (flour, kitchen utensils and other materials) to make the porridge, which is prepared by accompanying women or by nurses and female staff. This support is solicited from the Clinton Foundation based on a proposal of the Health Center. Given its significance to encouraging facility level delivery, the center plans to integrate the activity into its regular budget to ensure continuity even after donor funding ends.

The lack of female- and male-friendly services deters individuals from accessing certain services as well. Staff at JHPIEGO explained that the low percentage of women giving birth in health centers offers fewer opportunities for medical students to learn safe delivery and other obstetric practices. As a result, there are sometimes more than 20 students observing in the delivery room, while family members are often not allowed in. In addition, laboring women often do not choose the positions in which they deliver. Through MCHIP,⁴ in some sites, JHPIEGO is making an effort to change these practices and encourage providers to allow women to decide who is present for the birth and in what position they deliver their babies. When women are not consulted and their privacy and comfort are not attended to, they lose interest in coming to facilities and share their views with others in their communities.

Males, too, face obstacles to accessing services and may not find them appropriate or welcoming. When men perceive health services to be targeting women they may be less likely to seek services and attend to their health needs. In the case of HIV testing and counseling, there is a need to increase outreach to male clients and encourage earlier care seeking behaviors. The

⁴ Since MCHIP was not initiated by USAID, gender-related changes may be more challenging to make, and new indicators more difficult to establish to measure gender-related outputs and outcomes.

Health Officer at Adet Health Center observed that the husbands of women delivering at the health center had received more education and information about health.

Increasing both men's and women's understanding of their health needs can improve health-seeking behaviors and acceptability of existing services for families. The Population Council is currently working the Amhara Region with married adolescent girls and their husbands and providing them with extensive health information as well as joint decision-making skills. Beneficiaries of this program reported new knowledge of family planning and shared responsibility in deciding the best method for them.

Affordability

The cost of health services is a hindrance for many people. Although some services are provided free of charge in government facilities, patients are still often responsible for providing the required materials (for example, they must purchase gloves and other supplies for safe delivery). USAID/Ethiopia's flagship HSFR project is already doing a lot to improve access and affordability through the reforms on fee waivers, retained fees and community based insurance schemes, but the team was unfortunately unable to visit the project. These issues are discussed further in the health systems section.

Although financial barriers are present for males as females, there was considerable discussion among implementing partners about women's inability to decide how money is spent for the family. The Urban Health Extension Program nurses talk specifically about shared household decision-making among couples. On top of a lack of decision making over resources for medical service, women also lack the time required to obtain health services. In most cases they face time constraints due to family responsibilities and the need to obtain permission from their husbands to seek medical attention.

Availability

A third obstacle to accessing health care services in Ethiopia is the availability of appropriate and affordable services. Especially in the rural areas of Ethiopia, comprehensive services are scarce or inadequate. In order to access health centers and hospitals, people may need to travel many kilometers on foot or by animal, often through areas with few roads.

In some communities this is being addressed with smaller ancillary clinics that may or may not have competent providers or adequate supplies and equipment. A case in point was a woman wrongly diagnosed with fistula who was referred far away to Adet Health Center for fistula repair. Her suffering was doubled by an incompetent diagnosis, poor transportation and delayed service and had to return to the original clinic without being treated. Other communities are trying to address distance through innovative community collaborations. In Adi Gudom *woreda*, for example, the district government has made its vehicles available for emergency transportation to the health center, and the drivers of horse-drawn carts have volunteered their services to bring in laboring women and others in need. The Hamlin Fistula Hospital has placed midwives in areas not too distant from five urban or semi-urban centers, with access to ambulances for transporting fistula patients.



Strengthening integration of services in facilities is essential to a more holistic approach to health. Having traveled long distances, patients can be referred within health facilities to other services they may need. The IFHP, for example, has established provider-initiated voluntary counseling and testing, which allows a person to receive HIV services regardless of whether that need was what brought them to the health facility.

Based on interviews with USAID staff (and USG more broadly), it was evident that project services are not always well-linked. Certain implementing partners commented on their projects' limited scope and the need to address their beneficiaries' additional health and social concerns. Women are not always referred to supportive services for gender-based violence, for example. At this time, however, the only facility that offers legal and social services support, as well as the full set of required health services for women who are victims of sexual and gender-based violence is the Mahatma Gandhi Hospital in Addis. The GOE is intending to expand on this pilot, but meanwhile, referrals are needed all around the country.

There is naturally much overlap between the GHI results framework pillars of access-demand-health systems. An example of this overlap is the opportunity to increase access by improving provider capacity to offer appropriate and sensitive services. The GOE and JHPIEGO as a partner recognize that maternal health services are often of rather poor quality, and they are working to train health workers in interpersonal communication as well as developing technical/clinical competencies.

Though the assessment focused on USAID-funded health programs, given the scale of health challenges in Ethiopia, it is necessary to leverage funding sources and existing resources to provide a coordinated and complete services package. In a visit to a project for highly vulnerable children on which Pact is a partner, the team found that although children's needs were addressed holistically, each child had access to a maximum of two inputs. Although Pact's OVC program provides comprehensive services according to the CSI assessment and the 7 GOE service standards, the team found that limited resources had led project staff to prioritize only two services per child. More effective coordination across projects might make it possible to address this weakness.

Pillar 2: Increased Demand for Health Services

The government of Ethiopia and its partners is doing a great deal to expand services and facilitate access to them, but if the men and women of the country do not perceive themselves or others as in need of – or even deserving of – services, they will not show up at health centers. Demand for health services is affected by a number of factors, gender inequality being an important one. Do people have information about how to keep healthy, and which people? On whose health are scarce household resources being spent? Which areas of health are affected by harmful traditional practices? The challenges to health posed by preferences and practices help to shape demand. We have divided the findings concerning demand into three main areas: women's empowerment, male involvement and community mobilization.

Women's Empowerment

Ethiopia's health development army (HDA) is dramatically raising awareness of specific health problems, supporting improved health practices, and facilitating community members' connections to health services, especially to the local health post. Another area in which the HDA is making a difference is in providing many women with local leadership opportunities. In addition, women are proving to be very capable and supportive of the health system in both the mothers' groups for HIV+ pregnant women being organized out of health centers; and the Kabele-Oriented Outreach System (KOOS), which similarly mobilizes women in positive ways in their communities. If these experiences confirm those in other settings, it will be clear what a difference it makes to communities, families and to women themselves to occupy leadership roles and to enjoy the respect of their communities.

A few programs/groups such as EngenderHealth and IFHP, which supports a clinic in Makelle University, for example, are engaging with universities on reproductive health and HIV education. Young women who are far from home, often for the first time, are vulnerable to sexual harassment by fellow students, faculty members and administrators. A wide range of informants described sexual violence as a common problem on university campuses.

Healthcare providers and beneficiaries mentioned the burden that women's domestic roles place on them. These roles directly affect women's health (e.g., participating in agricultural labor during and immediately after pregnancy can contribute to uterine prolapse) and limit them from accessing services (e.g., families/husbands hesitate to allow women to attend meetings or access health services because doing so will leave young children or unfinished tasks at home). The WASH and Urban Gardens projects are working at this intersection, and the new ENGINE project promises to build on these projects. Programs such as the Population Council's Husbands' Curriculum are raising awareness of the ways husbands can support their wives in the household and increase their use of health services.

The GOE's decision not to mobilize traditional birth attendants around labor and delivery is understandable, given its commitment to building its cadre of health workers in the public sector. MCHIP is trying to use HEW-trained TBAs to identify complications, however, and there may be other opportunities to work with them.

Male Involvement

Given the strong need for improvements in maternal and child health and reproductive health in Ethiopia, and HAPN's emphasis on these areas of health, USAID's investments focus strongly on women. Many people have noticed that men's use of VCT services and their adherence to anti-retroviral treatment are far lower than women's. Male gender norms worldwide – men's reluctance to seek out health care, and denial of health problems, for example – limit men's use of services.

Interesting work *has* been done, however, on strengthening men's roles as supportive partners. IFHP has engaged men in supporting their breastfeeding wives and in relieving them from some of the heavier kinds of work soon after birth. The Population Council has consistently worked on these issues in its curricula with husbands, and with young married couples.



Programs that promote gender equitable norms among men are spread across the HAPN portfolio and focus on household task-sharing, shared health decision-making and shared decision-making about household resource allocation. As mentioned above, the nurses in the Urban Health Extension Program are addressing some of these issues at the household level.

Community Mobilization

We have described some of what is being done and could be done with women and with men to increase demand for health services. Also important for creating demand is to mobilize entire communities around their communal needs and the specific needs of community members.

Social and behavior change communication efforts can promote more equitable gender norms that contribute to positive health outcomes. IFHP, the Population Council and others are contributing to community conversations on HIV/AIDS, maternal and child health, how men can support their wives, and so on. When these conversations happen at the community level, they stand a better chance of supporting norm and behavior change than interventions oriented toward individuals.

The GOE – with support from the HAPN programs – has developed health system-based outreach, as well as creating an extensive referral network through the HDA system. The network of horse cart drivers in Adi Gudom makes a strong contribution to overcoming the great distances women must travel to services. These efforts bring together community education about danger signs during pregnancy, labor and delivery, and the creation of communal systems for moving women to where they need to go. At the community level, midwives in the regional fistula hospitals are conducting outreach on stigma and the neglect of women's health that both leads to fistula and reinforces its negative consequences. The Model Family concept has

effectively driven demand for services, and is a creative and interesting tool for the health system.

To conclude this discussion of demand creation, USAID is supporting some very good work in the area on which to build and take to scale. In particular, there is enormous scope to expand the norm change work from its current focus on MARPs to the population at large – building, for example, on the Population Council’s husbands’ curriculum, designed specifically to address household dynamics; or on EngenderHealth’s work on male norms among high-risk groups.

Pillar 3: Improved Health Systems

The sub results according to which this section is organized are the World Health Organization’s six building blocks for strengthening health systems.

Strengthened Human Resources for Health

Strengthening the health system is a time-consuming effort that must take place at a massive scale, and finding the opportunities to address gender inequality through the health system is not always easy. Many people have commented that weak human capital is the greatest challenge facing the health system in Ethiopia.

The government, with USAID support, has sought creative solutions to this problem, mobilizing a huge cadre of health extension workers (HEWs). More recently, the health development army (HDA), Kabele-Oriented Outreach Service (KOOS), mothers’ groups in health centers, and women’s associations have also been mobilized to improve health at the local level. In all cases, the volunteer workers are virtually all women. PACT’s HVC volunteers who conduct the child support index with local children are also mostly women as are PATH’s voluntary providers. The work opportunity in all of these groups and networks gives women exposure to a social network and increased knowledge and they are a respected community presence. Given what so many have said about the time and work burdens women face in their domestic roles, however, the reliance on female volunteers should be analyzed carefully for both the demands it makes on women’s time, and the assumptions it makes about the usefulness of conducting outreach through other groups and populations.

Increasing women’s presence in the health workforce is another important strategy for strengthening the health system. The Bahir Dar Health Science College’s Nursing Program is working hard to address low enrollment of females in the school and lower numbers of women in the nursing profession. This is being done through a number of efforts, including affirmative action, mentoring programs for incoming female students to ensure success in the program, provision of information on sexual and reproductive health for incoming female students. In addition the college has a Gender Club that focuses on improving the academic performance of female students, provides information on sexual and reproductive health, offers life skills training, tutoring programs, and involves male students in efforts for gender equality and female empowerment. Current training specific to gender dynamics in health practice for nurses happens for both clinical nurses and midwives, through the sexual and reproductive health module and the epidemiological and sociological culture of reproductive health module of the programs, respectively. Otherwise, gender is not really covered in other areas of health.

Ethiopia, with HAPN support, has accomplished a great deal in the extent and reach of gender human resource training throughout the Ministry of Health. However, the IFHP and other gender-related training can be somewhat abstract, and does not involve interactive and value clarification exercises. The Gondar Team explained that gender is one topic in UHEW training (a three-month training beyond the clinical nursing training). The gender-related component of this training covers terminology and definitions (e.g., gender vs. sex) and promotion of gender equality—most households are male dominant and men are making most of the decisions. In addition, UHEWs trained to discuss inequalities with women and provide information to them about their rights and services at Women’s Affairs Office as needed. Even after discussions with the JSI team, the gender assessment team was unclear whether this is a required aspect of one of the training modules and teaches skills specific to discussing inequalities or if it is something that is discussed more informally during the training).

Some very good work is going on to mobilize the health system on neglected areas of women’s health: Ethiopia has become the world’s technical leader on fistula surgery, and great efforts are being made to expand capacity on providing caesarian section. Increasing the numbers of trained personnel with skills on specific procedures relating to maternal health is key – and bears with it the risks of a brain drain, as highly skilled health workers elect to go elsewhere to find work. The GOE is responding to this by trying to recruit and train local workers for local posts.

Improved Health Infrastructure

Weak infrastructure plagues the Ethiopian health system, since, for example, even when competent services are implemented, the difficulties of transport, distribution systems and facilities limitations limit people’s access. Ensuring necessary equipment and systems for quality care is likely to require formal and informal efforts outside the health system: a good example of the latter in Tigray is the Adi Gudom model where the *woreda* vehicle fleet has been supplemented by volunteer local horse cart drivers who are willing to transport people in need to the health center.

Urban safety is emerging as an issue with the UHEP program, to which the government has not yet found a systematic response. The UHEWs identified the following concerns as they go into the communities in which they work:

- Delivering positive status results of HIV tests
- Safety if only a man is at home when they go to a house.
- Women’s safety when they are obliged to go to a health facility at nighttime.

We do not have data on the incidence of violence or harassment, but the nurses mention these problems as challenges to the UHEP program.

Strengthened Strategic Information for Evidence-Based Decision Making

The need to generate evidence on the causes of gender disparity is a central part of “health system strengthening” more broadly. Many groups working on specific issues in the health sector realize they *should* focus on building the evidence to support gender mainstreaming, but are uncertain how to do it. An example of the problem can be seen in work on tuberculosis (TB). Although recent data show fewer women enrolled in TB treatment than men, *why* this is

happening is not so clear. There is a lack of understanding about the TB epidemic and if and how it is affected by gender relations.

The GOE is working hard to collect data on a broad range of topics in the HMIS. The Health Policy Project is assisting the MOH gender unit in the analysis of these data and in their use in policy and programming. The Health Policy Project is also working with the MOH and MOWCY to collaborate on using evidence from the HMIS and other sources to show the multisectoral efforts needed to address health outcomes, e.g., maternal health and gender based violence (GBV).

As part of this effort, there is a need to harmonize gender and health related indicators across line ministries, including MOH, MOWCY and MOE. In the Growth and Transformation Plan (GTP), limited gender indicators are reported. Additionally, with support of UNWomen, the MOWCY has identified supplemental indicators to assess GTP and gender progress, yet the data sources for these indicators are unclear. The Health Policy Project is working the gender unit of the MOH to develop their gender and health strategy to provide more detailed guidance on gender programming and monitoring for HSDP IV goals.

The FMOH has specifically requested support from USAID in evaluating the impact of gender programming priorities on health outcomes. Having made the case that gender inequality undermines health, and having invested extensively in efforts to address gender inequality, measuring the impact of work on gender on health is the logical next step.

USAID partners described the range of indicators on which they need to report to USAID. They consistently noted that they are not required to report on some of the measures most relevant to gender. This conveys a mixed message to grantees on the importance the Mission places on addressing gender in their programmatic work.

USAID/Ethiopia Strategic Information (SI) colleagues mentioned the recently developed USAID disability strategy and its rollout. This strategy was led by a mission colleague who formed a short-term task force to develop the strategy. The strategy team was technically multidisciplinary and represented various roles and responsibilities in the USAID programming cycle, including SI. This is potentially an interesting model for the development of the work on gender.

Expanded Health Financing Options

Use of private health services is significant, yet we know little about who is accessing these services, and whether men or women are more likely to do so. We are also just starting to learn about the range and quality of private services. The Abt HSFR award is conducting this analysis.

Another area for addressing gender issues is in the area of increased health commodity and essential drug security. When women come to health centers in labor, they are often obliged to purchase gloves for delivery. Certain drugs and supplies are more readily available at health services, while others may incur costs or are difficult to obtain. Health care financing in the system and the ability – or inability – of individuals to pay drive some of these patterns.

Strengthened Policy and Governance/Improved Regulatory System

The gender mainstreaming effort within the GOE has accomplished a great deal, but more programming on gender and health – as opposed to more institutionalization of the issue – needs

to happen. This support has been requested specifically of USAID by the FMOH Gender Directorate. The Health Policy Project is working with the directorate to develop its gender and health strategy.

The gender assessment team noted that addressing the far-reaching social challenges of gender inequality, it is necessary to build collaboration with ministries other than the MOH, at the federal, regional and *woreda* levels. The Health Policy Project is working in collaboration with the MOH and MOWCY to collaborate on multi-sectoral approaches for some key health outcomes, e.g., MH and GBV. An area to be explored further is collaboration with the MOWCY on work with OVCs, especially considering the Ministry's mandate to work with children and youth.

The multi-sectoral mandate of working on gender-based violence calls for collaborations with livelihoods, justice, police, etc. The Mahatma Gandhi Hospital in Addis is piloting an integrated response system for GBV. This needs to be expanded upon via the trainings of the many health workers around the country: e.g., with UHEP nurses who cover up to 80% of Ethiopia's urban population, JSI currently supports curriculum development for the three-month pre-service training. Can a response to GBV be integrated into this training? This kind of referral will be harder in rural areas where access to a broad range of supportive institutions is limited.

Multilaterals are key partners for the GOE when it comes to policy work, so collaboration is essential. Within the DAG USAID plays a strong role in HPN, but could do more to highlight the gender and health link. USAID is weak in the Donor Group on Gender Equality, with others viewing USAID's representation as rather inconsistent on the gender side. In addition to the DAGs, it is important for USAID representatives to be at the GOE table, and not rely on partners for representation. Further, opportunities to co-fund activities and projects should be explored, e.g., through the work of the Health Policy Project.

V. GENDER ASSESSMENT RECOMMENDATIONS FOR USAID/ETHIOPIA HAPN PORTFOLIO: THREE GHI PILLARS AND USAID INSTITUTIONAL CAPACITY

This section draws on the findings of the gender assessment and offers specific recommendations for how the HAPN office and portfolio can contribute to addressing the intersections of gender and health in Ethiopia. Many programs in the current HAPN portfolio are working to challenge the gender inequitable norms and practices that undermine health. These programs provide excellent experience and information for the development of additional activities going forward, and the strengthening of systems to effectively report gender-related results. Like the assessment above, the recommendations for the HAPN portfolio are presented according to the three pillars of the GHI Results Framework. They are followed by recommendations for institutional strengthening on gender and health in the HAPN office and among its partners.

This report earlier described a classification of approaches to integrating gender in health and development programs that was developed by USAID's Inter-Agency Gender Working Group. Programs that address gender relations through programs in health, population and nutrition can

exploit gender inequalities, behaviors, and stereotypes as a means of achieving health and demographic outcomes. This approach can deepen gender inequalities. Programs can also *accommodate* gender differences, norms and inequalities, taking them for granted rather than challenging the structures and power relations that perpetuate these inequalities. A third approach is to *transform* gender relations, calling upon women and men to question and change institutions and norms that reinforce gender inequalities and strengthen those that support gender equality, *and as a result achieve both health and gender equality objectives*. This is the one that the authors seek to integrate most strongly into the recommendations.

Pillar 1: Access

In order to overcome obstacles to access, programs need to address systematic gender inequalities and work toward a fuller integration of comprehensive services that respond to the different health needs of males and females throughout Ethiopia.

Short-term recommendations

In maternal health programs women must be consulted and informed about the situation instead of being seen only as objects of learning. If the laboring mother is consulted early in labor about the problem of shortage of delivering mothers for students to have practical lesson, she may view it as a privilege to contribute to the training of more doctors and midwives who will help more mothers in the future. MCHIP is starting to work in this area.

The gender assessment team identified a clear need to increase men's knowledge and awareness of and participation in health care. With a better understanding of their own and their families' health there is an opportunity to improve men's use and support of health care services. Increasing men's understanding of their health needs can increase the acceptability of existing services for family members, and can increase their chances of seeking out these services, since men often decide whether a family member accesses services.

Medium-term recommendations

The area of household resource allocation and decision-making needs more systematic attention throughout the HAPN portfolio. Family health programs are understandably oriented toward women, yet they are most often subject to the will of their husbands. Thus programs must explicitly address these household dynamics in their efforts to increase access to services. The Urban Health Extension Program has made some progress in taking on this challenge.

Distance to services remains an obstacle to accessing health services for many rural Ethiopians. Some innovations have emerged, including community solutions to transporting laboring women. With all of these efforts, it is vital to explore what additional connections can be made to the most remote households and which innovations can be replicated in other rural areas. A systematic analysis of some of these responses would permit their sharing and replication.

The need to identify and strengthen the connections among various areas of health emerged as an important theme in increasing access and overcoming distance. Having traveled long distances, patients need to be referred within health facilities to other services they may need. Regardless of a person's point of entry into a clinic, for example, he or she should be offered voluntary

counseling and testing for HIV. When people come in for HIV counseling, testing or treatment, they should likewise be referred to other services, depending on their needs.

Long-term recommendations

The linkages between services should go beyond the health sector. The gender assessment demonstrated a need to strengthen linkages between projects and services, both in and outside of USAID's portfolio. This requires strengthening the capacity of project staff to refer beneficiaries to other service providers as available and needed. A good example is the need for more systematic referral for women to GBV services. A wide range of supporting activities are needed, including:

- Raising awareness of new laws and the rights of women covered under recent laws;
- Increasing awareness and sensitivity within the judicial system and law enforcement;
- Reinforcement of Community Action Groups, which are often holding perpetrators of various violations accountable.

A final recommendation that emerges from this analysis of the factors affecting access to services is the need to reach out to specific under-served populations. Two groups whose needs are underserved include adolescent girls and men in general. And within these large populations, specific challenges to health in the Ethiopian context call for special attention to trafficked girls and to men who have sex with men. These groups are difficult to work with, and programs that effectively serve them will have to address social norms, but there will be many advantages from a public health perspective to improving their health.

Pillar 2: Demand

As the findings of the gender assessment have indicated, programs are working – and must do more – to reduce cultural barriers to accessing existing services. Many small and creative accommodations within large, technically and sectorally focused programs can improve the acceptability of services and generate greater demand.

The gender assessment team's overarching recommendation is to look for ways to address underlying unequal gender norms, roles, relations, attitudes, and practices that drive unhealthy behaviors and limit utilization of services. Addressing these challenges helps develop informed demand for services, and it is a cross-cutting suggestion for application across the HAPN portfolio.

Short-term recommendations

University students have among the highest rates of HIV of any sub-population in Ethiopia. A great opportunity exists to promote gender equality and mutual respect at the university level in support of young women's health and their studies. A serious intervention should include strong ethical and professional guidelines and training for everyone on campus, as well as strong sexual and reproductive health and rights components for the students and asset building for the young women.

While a few programs/groups such as EngenderHealth and IFHP, which supports a clinic in Makelle University, for example, are engaging with universities, the programs could be more

ambitious. Given the vulnerability of young women not only to their fellow students but to faculty members and administrators, programs must go beyond providing information and support on sexual violence and HIV specifically, to work with university administrations to do away with the climate of impunity and create one of mutual respect.

Medium-term recommendations

Beyond the health and gender content of what is presented at school are the school environments themselves. USAID could support the health sector in collaborating more effectively with schools to create safe environments that promote mutual respect and safety and are thoroughly girl friendly – i.e., protective and supportive of girls’ needs and rights, from establishing teacher codes of conduct to ensuring that girls are called upon in class as much as boys -- so as to maintain enrollment and retention. This will have many positive effects on girls’ health, the timing of marriage, girls’ future childbearing, the health of their children, and their lifetime earnings. An example of this kind of cross-sectoral collaboration in support of girls’ sexual and reproductive health is Pathfinder’s incorporation of Packard-funded scholarships for girls into its work.

Women’s lack of decision-making power and their heavy chore burdens pose considerable challenges to their health and need to be addressed directly in programs to improve their health. Although the WASH and Urban Gardens projects are taking steps to address these issues, and the ENGINE project will take them on more centrally, more could be done to address these realities more systematically across projects. There is a clear need to increase the linkages between economic livelihood interventions and household burden reduction strategies, a real multisectoral opportunity that could have significant effects on health.

The team noted that although women are more likely to deliver in facilities, community preparedness and response to obstetric emergencies in Ethiopia could be strengthened considerably. Communities themselves have not systematically been mobilized to respond to obstetric emergencies the way they have in some other settings. Indonesia’s *Suami Siaga* (“alert husband”) program and Bolivia’s rural transport system provide good examples of what can be done in places where geographic remove keeps women from the services they need.

The Model Family concept has effectively driven demand for services, and the gender assessment team found it a creative and interesting tool for the health system. Ethiopia has an opportunity to integrate select gender-equitable practices within the Model Family package that allow families to “graduate.” These could include, for example, a family that sends both boys and girls to school; a family in which the husband helps with chores, especially when the wife is pregnant; a family that feeds boys and girls equally, and so on.

Long-term recommendations

One opportunity for the health sector, and for USAID HAPN programs, is to work more closely with the education sector. School-based work, reaching young people while they are establishing what will be their health practices and attitudes toward peers and future sexual partners.

Reproductive health-related programs focus mostly on women, but there is much to be done with
Short-Term Technical Assistance and Training in Gender Task Order DevTech Systems, Inc.

men. Providers and community members acknowledge the important roles men play in supporting and, at times, impeding, women's health. Men can be engaged in many positive ways to improve health outcomes.

A first need is to increase outreach to men as clients, for example, and this is a great opportunity through mobilization of male community outreach workers. EngenderHealth's work with high-risk groups has general applicability to men at large. In general, social marketing efforts that encourage men to use condoms and access health services could be bolder and incorporate more "lifestyle"-oriented messages that are support men in questioning harmful ideas about masculinity and male sexuality, and go beyond the promotion of condoms or use of VCT services.

Current programs – such as the Population Council's Husband's Curriculum -- that promote gender equitable norms among men could be expanded to reach more men more systematically. There is in particular more to be done beginning with youth, when their attitudes are developing.

The most ambitious approach to engaging men is to support and promote their roles as allies and leaders in transformational change. This has been shown in other settings to improve outcomes for them and many in their families and communities. This approach often calls for identifying positive deviants—religious leaders, husbands, and members of farmers' groups – whose attitudes and behaviors make these men gender equitable role models in their communities.

In working to change male gender norms, good resources and models include:

- The Stepping Stones curriculum (<http://www.stepsstonesfeedback.org/index.php/page/About/gb>), whose components lend themselves to promoting full community conversations about norms and how they may help or harm communities and specific community members.
- The organizations Men Can Stop Rape (www.mencanstoprape.org), Instituto Promundo (www.promundo.org.br), and others that work "upstream" on the discriminatory attitudes toward women that lead to violence and poor health and development outcomes. Of particular interest would be to use their materials at the universities to address sexual violence against young women.
- The Addis Ababa Scouts would be an interesting group with which to work to change male gender norms. In settings as diverse as Pakistan and Kenya, boy scouts have been mobilized to support their sisters in attending school, escorting them, helping with chores and so on.
- Reaching men through markets and labor unions is an additional opportunity. The gender assessment team did not have the chance to meet with Save the Children to learn whether their Transactions project is working in these settings.

Community norm change on health and gender is happening through several HAPN programs. These efforts could be expanded via theater, and perhaps even radio, in areas where radio is already established. Save the Children has recently developed a new curriculum in Nepal to help keep girls in school and delay marriage. Developed for use in remote communities – Nepal's

mountains make distances huge in that country – *Promises* focuses on the community as a whole to promote positive discussions about what parents want for their children and the value of girls.

The gender assessment team identified an important opportunity to work on norm change efforts with children and adolescents. As the State Minister of the MOWCYA noted during our interview with her, mobilization has to occur with everyone: men, women and children. School is an important place in which to cultivate solidarity among children. Any health education that takes place within schools can be a vehicle for messages about mutual respect and support, and can contribute to developing a sense of fairness that boys and girls can apply to understanding gender and other inequalities. Here also, Save the Children has developed and tested a curriculum (*Choices*) for working with 10-14 year-olds that gives girls and boys the chance to analyze and discuss norms and decide how they want to act or respond.

Pillar 3: Improved Health Systems

Short-term recommendations

Effective mobilization of large cadre of female volunteer workers has greatly expanded the reach of the GOE health system. But this work makes significant demands on women's time. One of the recommendations the gender assessment team therefore suggests identifying other groups, especially those comprised mostly of men, from whom to recruit outreach workers. Farmers' groups seem especially promising. They unfortunately do not include many women, but this might be an advantage if it can be turned to support discussions among men about HIV prevention, partner reduction, spousal communication, and so on.

The gender assessment team observed that the gender training curriculum used in the health system is quite abstract and removed from what "working on gender" means in practical terms. We recommend evaluating and improving gender training for human resources cadres, including *woreda* health managers and health extension workers. IFHP and UHEP and their partners should look for opportunities to make their gender-related training an opportunity for values clarification, reflection and application of the concepts to their work as opposed to more passive and informational. The point is to change the way people understand health issues and do their work. This can happen only if a commitment to gender equality is internalized at an emotional level. As part of this effort, it would be ideal to integrate gender into each of the 16 health packages for the HEWs, making the clear connections between gender norms and health beliefs and practices.

The Ethiopian government has elected not to work with TBAs. Given the extent to which women mentioned the persistent role of TBAs in the community, however, it may make sense to create or strengthen at least a referral role for them, to health center-based delivery. MCHIP is trying to use HEW-trained TBAs to identify complications. An incentive system for referrals by TBAs might also be productive, with the added benefit of making up for the livelihoods these women have lost.

To cover the expenses incurred for health, whether they arise in the public or private sectors, Ethiopia needs to develop financing strategies (e.g., revolving funds, microinsurance) families are able to afford health services when they need them. USAID/Ethiopia's flagship HSRF project

is doing much to address these issues. Rwanda's experience in establishing a system of microinsurance for almost all of its citizens could be of great relevance to Ethiopia. The team was not able to meet with Abt Associates, and it is unclear whether gender disaggregated differences are analyzed in their award.

USAID has already supported the FMOH's Gender Directorate in its efforts to integrate gender into its work on health. The Directorate continues to need systematic strengthening to address gender in its planning, financing and programming.

The Health Policy Project is working with the Gender Directorate to develop its gender and health strategy. However, an area of work that needs further support is working with the MOH gender points of contact and MOWCY representatives at the decentralized levels. This is important for building their capacity to influence the annual regional/district programming and planning, and implementing national guidelines and proven approaches.

To strengthen the health system's ability to address the far-reaching social challenges of gender inequality, it is necessary to build collaboration with ministries other than the MOH, at the federal, regional and *woreda* levels. This strengthens opportunities for referral, as noted above, and it also allows for stronger accountability and coordination. The Health Policy Project is working in collaboration with the MOH and MOWCY to collaborate on multisectoral approaches for some key health outcomes, e.g., MH and GBV. An area to be explored further is collaboration with the MOWCY on working OVCs, especially considering the Ministry's mandate to work with children and youth.

USAID needs to develop stronger partnerships and exchange with other key donors and multilaterals in support of the GOE ministries working to address gender inequality. Multilaterals are a key partner for the GOE when it comes to policy work, so collaboration is essential. Part of this may involve being more present and visible in high-level donor networks. Within the DAG USAID plays a strong role in HPN, but highlighting the gender and health link is needed. USAID is weak in the Donor Group on Gender Equality, with others viewing USAID's representation as rather inconsistent on the gender side. In addition to the DAGs, it is important for USAID representatives to be at the GOE table, and not rely only on our partners to represent USAID. Further, opportunities to co-fund activities and projects should be explored, e.g., through the work of the Health Policy Project.

Medium-term recommendations

An assessment last year of the work being done to address fistula in Ethiopia noted the need for USAID to work with the GOE to develop strategies for integrating fistula into system-wide programs on community and maternal health (Bangser et al, 2011). A related recommendation emerging from that assessment was the need to measure, focus on, and reduce maternal morbidity (which far exceeds maternal mortality in the numbers of women it affects) as well as maternal mortality in all maternal health programs. The strategies for reducing maternal mortality also address morbidity. USAID/Ethiopia and partners should consider supporting training and service delivery for prolapsed uterus in government medical training programs and government hospital services, among civil society organizations, and even to create special surgical initiatives via camps for intensive training.

On the basis of observation at health facilities and interviews with staff and beneficiaries, the gender assessment team recommends paying greater attention to the gender sensitivity of facility design. An issue of primary concern is privacy, something MCHIP is trying to address with its clinical protocols, but which is made more challenging by the configuration of space. Another issue is the extent to which a facility can accommodate the presence of family members during labor, for example. Family members need to be able to be present to support women yet their presence cannot complicate service provision.

Another recommendation is to develop gender quality “credentials” for health facilities. HEWs are offered certificates for the training they receive in gender; the same sort of recognition could be offered to facilities that meet certain “gender equitable standards”. This kind of thing has been done successfully in other settings, as in Pakistan’s Greenstar facilities, and includes criteria that touch on outreach, counseling protocols, facility setup, and so on.



Nurses in the UHEP program described to the gender assessment team some dangers facing nurses and other women in the urban communities in which they work. These concerns need to be taken very seriously and addressed systematically. One step is to ensure that the nurses are introduced to and get known by everyone so that the community steps in to protect them. Male community brigades could also be organized to support the nurses and to accompany women to facilities when they need to seek out services at night.

Data collection on the connections between health and gender is an ongoing challenge for the health system in Ethiopia. In each area of health, including TB and malaria, programs need to marshal evidence on the causes of gender and other disparities in infection, disease progression and access to services. Evidence on the causes of disparity between men and women allows the health system to respond to the causes and to structure appropriate programs.

The GOE is working hard to collect data on a broad range of topics in the HMIS. More could be done to link gender with these health indicators. These efforts should be expanded and conducted in a more systematic way, which may include discussions with Measure Evaluation and Tulane University (supported by the CDC). Indicators of various line ministries’ plans, e.g., Health Sector Development Plan IV, should be harmonized with the overall reporting of the Growth and Transformation Plan, but should also include additional indicators that are key for internal ministerial priorities.

The findings referenced including the collection of gender-related indicators that are not ultimately required in reporting. This conveys a mixed message to grantees. USAID can

demonstrate its commitment to gender in the programs it funds by requiring that grantees report on the gender-related data they collect.

An example: There is a question about why the significant scale-up of PMTCT services has not led to a parallel increase in utilization. The current National Guidelines for PMTCT are being revised with more programmatic focus on male involvement. Husbands are likely not always supportive of ANC use and PMTCT adherence, but other factors are probably in play. The gender assessment team recommends a closer analysis of the gender-related factors keeping women from using PMTCT, ANC, and couples testing services. USAID could evaluate male involvement in PMTCT from a gender perspective – not simply accepting that male involvement is itself a “gender” measure, looking at how successful couples counseling and testing is, and whether or not related gender inequities such as GBV can be measured through PMTCT.

Long-term recommendations

With regard to commodities, community-level demand often drives the supply and cost of specific health supplies. Given the importance of demand, it is clear that the availability of supplies might affect men and women differently. The gender assessment team found that JSI and others involved in supply chain need to receive support on the gender dimensions of delivery.

Working with civil authorities to strengthen the marriage age check is another example of the possibilities in this area. The structure for checking in with young people intending to marry is a great opportunity to have contact with girls and could be used for more meaningful engagement with them. There are important opportunities to build more into this administrative contact with girls (and boys).

With regard to cultivating internal gender policies among USAID partner organizations, USAID may wish to support CORHA in an additional role: As part of CORHA’s annual plan, they could work with their 100+ member organizations (many receiving USAID funds) to develop and implement gender institutional policies.

GOE Suggestions on Ways to Strengthen the Health System

The achievements in the health sector in Ethiopia over the past ten years have been remarkable. The first wave of people who were more inclined to use services have been brought in, and the next wave of people – others from the same community who are resistant for a variety of reasons – will likely be harder to reach than those who have been reached already. When asked about additional support the FMOH might want from USAID, State Minister Kasete-Berhan suggested a number of specific areas of need:

- Support for institutional capacity building, including technical assistance, training, documents and materials;
- Strategic and continued support to the FMOH Gender Directorate that has been working with numerous USAID partners, but ad hoc, including IFHP, Health Policy Project/Initiative and the Population Council;
- Support in strengthening the health sector’s response to GBV. The health sector is currently not prepared to care for women who have suffered violence. With support from UNICEF and FIGO the FMOH is starting to change this. Gandhi Memorial Hospital

demonstrates the multisectoral team approach. To date, USAID has focused on household violence only via general support for training health extension workers. The FMOH needs support in developing task-sharing systems for lower level workers to address GBV in rural areas;

- The Ministry of Health wants to collaborate with others to make a difference to harmful traditional practices, early marriage (which is declining) and abduction. The FMOH would benefit from USAID support in this area;
- The FMOH has created and is rolling out (by the end of 2012) the new family folder where all vital events will be recorded for 18 million families. All vital events will be recorded in the family folder. The government is preparing a proclamation to ensure mandatory registration of all vital events including birth registration, age at marriage, first pregnancy and so on via HEWs. This also will require additional training of health sector staff.
- The FMOH Gender Directorate specifically asked for support from USAID on implementation of its annual plan, to include monitoring efforts. This will require the USAID gender advisor to sit down with this Directorate to strategically map USAID's existing support (e.g., IFHP, Health Policy Project, Population Council), and consider future investments.

Institutional strengthening on gender at USAID and among its partners

In addition to the recommendations we offer for strengthening USAID's HAPN portfolio, this gender assessment recommends some specific steps for integrating gender more fully into HAPN structures and processes.

Immediate next steps

The gender assessment team recommends scheduling a stakeholders meeting of USAID's partners to discuss integration of gender throughout the HAPN portfolio partners. Some preparations will be required in terms of deciding HAPN priorities in light of this gender assessment. USAID/HQ staff Diana Santillán and Patty Alleman will be able to play a role in supporting this work going forward.

Longer-term recommendations

Clarify and reinforce USAID/Ethiopia's commitment to integrating gender into its programming.

- Develop a Gender Strategy for HAPN, based on the results of the Disability Strategy recently developed for the mission, but consider a slightly different process to highlight the role of USAID/HAPN. Strategic Information colleagues see the USAID Disability Strategy as a model for efforts to highlight and address gender inequality. Developing a similar strategy for Health and Gender could provide clear USAID/E guidance on gender and health priorities, taking all global guidance and GOE priorities into consideration. It could cover how these priorities need to be translated into part of program and projects' results frameworks, may include projects being directed to have a gender results statement and budget for their project, highlight the indicators for programming that can be part of their PMPs (which link to the PPR and other mission and USG reporting frameworks), and clarity on how to incorporate gender in project monitoring visits, assessments and evaluations. Considering the large gender and health portfolio of HAPN, the recommendation is to start the strategy development process with a task team from HAPN, including senior leadership, the gender advisor, program staff from the various pillars, and SI colleagues. This strategy could be shared with the broader mission as an example that could be replicated in other offices, and perhaps eventually developed into a mission gender and development strategy.
- The Ethiopia Mission would benefit from having Gender Mission Order. The Rwanda Gender Mission Order has language that could serve as a model: "Each Results Framework shall incorporate gender in SO/AO and Intermediate Results (IR) statements when gender is a key variable in achieving the results sought; appropriate sex-disaggregated and gender-sensitive performance indicators shall be included." See also Box 4 below. A recommendation for HAPN might therefore be to discuss this document as a possible step for the program office to pursue.
- As part of developing the HAPN gender strategy, consider how to achieve buy-in and consistently monitor addressing gender inequality in programming from others in the Mission and from external partners. A seemingly successful example of this outside USAID is the Technical Advisory Committee (TAC), currently chaired by the Population Directorate of the MOF and MOH. Donors participate, USAID is always there, and the TAC has also recently included MOE, MOWCYA and Disaster Risk Management and the Food Security Sector (DRMFSS), under the Ministry of Agriculture. The TAC looks at the activities of its members, then hears quarterly reports on all of it and reflects on what is happening to address gender, giving participants feedback on USAID's programs.

Box 4. Concrete Guidance from the Rwanda Gender Mission Order

During activity identification and design processes, it must be determined whether gender is relevant and in what ways, through gender analysis. In simplified form, the following questions shall be answered:

- Who needs to be reached for action or change to occur? (by sex and other relevant variables).
- Why, or so what? What difference would it make if these groups participate or not? What are the implications for achieving objectives?
- How can these groups be reached? What are the motivations or important interests of the group? What gender-based constraints and barriers exist and what are the best means to overcome them? What are the best means of communication or outreach?
- How will we know? What information is needed to determine who participates and anticipate changes that might occur as a result and how would unexpected consequences be addressed to minimize the risk of power dynamics?
- What happened? Will we know if the expected results are being achieved? If the results are not achieved, can we find out why? Is there sufficient flexibility in the design to allow changes to improve results?

Increase capacity within HAPN to address gender inequality through its health and development programs

We see seven general opportunities to strengthen USAID' internal capacity to integrate gender more fully into its health and development portfolio:

1. Strengthen staff capability and build human resources on gender

Ensure the systems and training needed to take these recommendations forward are in place at USAID and within partner organizations. Human resources policies on hiring and general competency on gender: We need highly skilled people in gender area, but also need everyone to have a basic competency. This can be pursued through several routes:

- Potential hiring of additional strategically placed staff with expertise in gender, personal capacity for internal advocacy, and the authority to influence the nature of HAPN investments. This gender point of contact should be included in recruitment panels, particularly recruitment of technical people;
- Training (PD&M), tools, and technical assistance on integrating gender into programming on health and development;
- Establishing human resources requirements for partners that reflect a commitment to gender equality. Pathfinder, for example, has a policy regarding affirmative action and it is operationalized through monitoring of the proportion of women at all levels in the organization. They insist that partner organizations similarly hire women throughout their operations, though they are flexible in some rural areas where it is very difficult to find qualified women.

2. Establish and clarify accountability for gender within USAID and among its partners.

The commitment to gender must be incorporated into work plans and must be the responsibility of specific individuals.

- Specify the USAID staff responsible for following up on specific recommendations refer to roles and responsibilities in gender integration matrix
- Establish a Gender Task Force to assist the gender advisor in overseeing the gender sensitivity of projects and providing guidance

- Consider at least one of the inequality drivers relevant to the technical area in any solicitation as mandatory
- Require partner organizational policies on gender, a process that could be implemented systematically through CORHA's membership.
- Include gender-related criteria in RFAs, particularly in the results framework – gender analysis and programming response. See the IGWG's RFA/RFP guide as a resource.
- Include gender in PMPs and work plans.

3. Strengthen collection and make better use of strategic information

- Work with SI teams to develop a process or evaluation for measuring the impact of HAPN gender mainstreaming on programs and their health outcomes.
- Use existing data on gender-related factors from Population Council, the EDHS and other sources to guide programming. Specific sources of impact data on gender and health include the Population Council's vulnerable girls project, EngenderHealth's Men as Partners project;

4. Develop more strategic partnerships on gender and more of them.

- Be present and visible in high-level donor networks. Within the DAG USAID plays a strong role in HPN but is weak in Donor Group on Gender Equality – USAID's representation is inconsistent on the gender side.
- Work more closely with other donors and multilateral organizations: Packard and other smaller donors are able to test models of health and gender equality, and many of these models have been taken up by USAID and other donors and implemented in their portfolios. USAID could explicitly cultivate the relationships with Packard and others to test new models for later expansion.
- New partnerships for USAID could include:
 - MOWCYA representatives at the *woreda* level. Their major linkage with the MOH is through the ASRH program, and this connection could be expanded, perhaps to include something like youth, sports and norm change.
 - The World Faiths Development Dialogue is inventorying the contributions of religious organizations of various kinds to development in Ethiopia.
 - MenEngage Alliance collaboration to popularize male norm change efforts

5. Play a convening role to share experiences and reinforce the importance of working to address gender inequality

- Bring partners together to share experiences of working on gender or consider ways to document (include gender in the regular HAPN reporting and communication mechanisms) and reward partners for innovative work (e.g., recognize good activities at regular partner meetings/at mission events)
- Build consistency in curricular materials across programs and organizations
- Partnering with GOE to scaling up good practices through their policy and structure

6. Sharpen communications and be more strategic in representing the gender portfolio

- Strategically represent HAPN's gender and health portfolio with GOE and other donors. Do not rely solely on USAID partners to represent USAID interests.
- USAID could advance the Gender and Health Agenda of the DAG HPN and HIV Technical Working Groups. This could be through:
 - Representing the HAPN gender Advisor to the TWGs in addition to other USAID representation
 - Seeing how the Gender and Health agenda of the DAG and HSDP IV of the government can best be engendered
 - Assign responsibility for participation in donor and other groups for gender equality and make the commitment to participate in them.

7. Carry through on commitment to gender equality in monitoring and evaluation

The connections between gender inequality and health are generally recognized, and in some cases are integrated into programming. Yet the gendered dimensions of the programming are generally neglected in favor of standard health outcomes in reporting. See Box 5 for a list of USG indicators for tracking the gender dimensions of various programs. USAID's health team recognizes that there is a need to start aggregating data from across projects to report on health indicators. However, there is no agreement and guidance on what those shared indicators on gender and health should be.

The programs are collecting sex-disaggregated data on outputs and outcomes. IFHP also collects data on the number of cancelled early marriages and fistula cases identified and referred. EngenderHealth collects data on attitudinal changes in the people who participate in norm change activities, but their reporting is entirely on behavioral changes, condom use and so on. Colleagues working on the UHEP noted that the PEPFAR indicator requirements came out after they received their grant. Thus JSI is obliged to make two reports; one for PEPFAR and one for USAID, which requires more detail. Their training for health extension professionals includes gender and sexuality, and they could likely report on the gender indicators for PEPFAR using the data they have.

- Share expectations with partners for data collection, analysis, use and reporting that carry through on institutional commitments to working on gender
- Include sex and age disaggregation, and links to USG policy and directives frameworks

Box 5. USG Indicators for Tracking Gender Dimensions of Programs	
7 PPR indicators for GHI	
Number of laws, policies, or procedures drafted, proposed or adopted to promote gender equality at the regional, national or local level	
Proportion of female participants in USG-assisted programs designed to increase access to productive economic resources (assets, credit, income or employment)	
Proportion of females who report increased self-efficacy at the conclusion of USG supported training/programming	
Proportion of target population reporting increased agreement with the concept that males and females should have equal access to social, economic, and political opportunities.	
Number of laws, policies or procedures drafted, proposed, or adopted with USG assistance designed to improve prevention of or response to sexual and gender based violence at the regional, national or local level	
Number of people reached by a USG funded intervention providing GBV services (e.g., health, legal, psycho-social counseling, shelters, hotlines, other)	
Percentage of target population that views Gender-Based Violence (GBV) as less acceptable after participating in or being exposed to USG programming	
PEPFAR gender indicators	
Male Norms and Behaviors: Number of people reached by an individual, small-group, or community-level intervention or service that explicitly addresses norms about masculinity related to HIV/AIDS.	
Gender Based Violence and Coercion: Number of people reached by an individual, small group or community-level intervention or service that explicitly addresses gender-based violence and coercion related to HIV/AIDS.	
Women's Legal Rights and Protection: Number of people reached by an individual, small-group, or community-level intervention or service that explicitly addresses the legal rights and protection of women and girls impacted by HIV/AIDS.	
Number of people reached by an individual, small group, or community-level intervention or service that explicitly aims to increase access to income and productive resources of women and girls impacted by HIV/AIDS.	
Feed the Future gender indicators	
Domain	<ul style="list-style-type: none"> • Indicators relating to:
Production	<ul style="list-style-type: none"> • Input in productive decisions • Autonomy in production
Resources	<ul style="list-style-type: none"> • Ownership of assets • Purchase, sale, or transfer of assets • Access to and decisions on credit
Income	<ul style="list-style-type: none"> • Control over use of income
Leadership	<ul style="list-style-type: none"> • Group member • Speaking in public
Time	<ul style="list-style-type: none"> • Workload • Leisure
MEASURE Evaluation indicators on gender	
Percent of women who have completed at least four years of schooling	
Percent of women who have completed at least ten years of education	
Percent of women who earn cash	
Percent of women who mainly decide how their own income will be used	
Percent of women who own property or productive resources in their name	
Participation of women in household decision-making index	
Percent of women who have weekly exposure to mass media	
Age at first marriage	
Law requires free and full consent of parties to a marriage	

ANNEX A: SCOPE OF WORK FOR ETHIOPIA GENDER ASSESSMENT (13 PAGES)

Statement of Work for Gender Assessment of USAID/Ethiopia's Health Programs
(16 December 2011 Draft)

I. PURPOSE

USAID/Ethiopia is committed to integrating gender across all its development endeavors, as increasing equity between women and men is essential to achieving national development goals. USAID/Ethiopia's Health, AIDS, Population and Nutrition (HAPN) Office would like to solicit the services of a team of external consultants to work collaboratively with HAPN staff and other key stakeholders to conduct a gender assessment of its overall portfolio of programs. The assessment will inform the development of a strategic/operational plan to guide and improve gender integration in the HAPN portfolio of programs, especially in the context of the Global Health Initiative (GHI) focus on "women, girls and gender equality."

II. BACKGROUND

A. Country Profile

Ethiopia has a population of over 80 million⁵ and is the second most populous country in Sub-Saharan Africa. It is a low-income country. Although improvements have been made, as in other Sub-Saharan countries, the health status of Ethiopians is still low. Infectious and communicable diseases account for about 60-80% of the health problems in the country.⁶ Life expectancy is 53 years, the infant mortality rate is 51 per 1,000 live births and the child mortality rate is 88 per 1,000 live births.

In spite of a favorable policy environment and the establishment of gender offices in all government structures at all levels, inequality between the sexes is unacceptably wide. The Global Gender Gap Index places Ethiopia 122 out of 130 countries, while the Human Development Index places it at 157th of 169 countries.

In Ethiopia, multiple political, cultural and economic factors create and reinforce gender inequality, adversely impacting women's access to essential resources and increasing their vulnerability to injury and illness, including HIV/AIDS. Those factors include unequal access to education for girls, gender-based violence, harmful traditional practices, trafficking of persons, vulnerability to food insecurity, regional and internal conflict, and lack of economic power and freedom.

⁵ Based on the 2007 National Census (Central Statistical Agency) and extrapolated to include a 2.6% annual population growth rate.

⁶ Health Sector Strategic Plan (HSDP III) 2005/06-2009/10. Federal Ministry of Health.

Gender inequality and discrimination harm girls' and women's health directly or indirectly throughout their life cycle. Women enjoy little independent decision making on most individual and family issues, including the option to use birth control methods, as well as whether to give birth in a health facility or to seek the assistance of a trained provider. Harmful traditional practices, including female genital mutilation/cutting, early marriage and childbearing, gender-based violence, forced marriage, and wife inheritance, all impose huge negative impacts on women's reproductive health. Studies have shown that 49% of women in Ethiopia will experience physical violence from a partner at least one in their life time and 59% will experience sexual violence at least once in their life time. Ethiopia has a high maternal mortality rate at 673 per 100,000 births and according to the 2005 Ethiopia Demographic and Health Survey (EDHS), only 10% of births are attended by a skilled attendant. Women and girls are more vulnerable to HIV/AIDS than men and boys. The HIV prevalence rates for girls aged 15-19 is 4.2% compared with 2.3% for boys of the same age; for girls aged 20-24 the rate is 9.1% but only 4.3% for boys in this age range (HIV/AIDS in Ethiopia an Epidemiological Synthesis, 2008). Women/girls represent 59% of HIV/AIDS infected population and will continue to suffer disproportionately. Commercial sex workers, students and daily laborers are among the most at-risk groups, according to the Amhara Regions study (Feb. 2009).

Early marriage underlies many of the gender related issues facing girl/woman throughout their life cycle. The 2005 EDHS reflects that 31% of rural girls and 10% of urban girls are married during early adolescence, by their 15th birthday. In the nation's second largest region, Amhara region, 46% of girls are married by their 15th birthday. The vast majority of early marriages are arranged by family and not chosen by girls. Among rural Ethiopian girls married before the age of 15, 89% report their marriages were arranged. Girls married early experience early sexual initiation and early first births. Eight percent of Ethiopian women have begun childbearing by age 16 and 25% by age 18. Among first time mothers below the age of 20, 93% deliver in the home, increasing the risk of maternal mortality and morbidities, including fistula.⁷ Early marriage also impacts a girl's education. Once married, a girl rarely remains in school. Among girls under the age of 24, more than 78% of those never married were attending school, while only 8.9% of married girls were in school.

Addressing gender inequities, gender-based violence, lack of adequate health care for women and girls and other development challenges are of critical importance to the United States Government. USAID strives to mainstream gender into all programs and to implement projects focused on: reducing violence and coercion; increasing women's legal protection; addressing male norms and behaviors; improving women's access to income and productive resources; and increasing gender equity in activities and services.

In the health sector, USAID works with the Ministry of Women, Children and Youth Affairs to protect the rights of out-of-school girls in urban areas by reducing their social isolation and providing them with health information on HIV prevention and services to address sexual exploitation and abuse. USAID builds the capacity of male and female community volunteers to support efforts aimed at combating gender-based violence. USAID trains law enforcement officials on legal provisions to protect women's rights, and supports school sensitization

⁷ Central Statistical Agency (CSA) and ORC Macro. 2006. Ethiopia Demographic and Health Survey 2005. Addis Ababa Ethiopia and Calverton MD: CSA and ORC Macro.

programs that include role model and mentoring programs for female students. Recognizing men's pivotal role in making decisions regarding the health of their families, our programs reach men with services and education that enable them to play constructive roles in promoting gender equity and health in their families and communities.

B. Mission Gender Assessment

USAID/Ethiopia recently requested a mission-wide gender analysis to inform its future programming and to provide background information for the Mission's Country Development Cooperation Strategy (CDCS). The assessment team, knowing that this HAPN-specific gender assessment was planned, provided some comments and recommendations intended to complement the findings of the HAPN gender assessment. These are provided below:

The HAPN Office proposed comprehensive approach related to the provision of health services, especially related to improving maternal, neonatal and child life expectancy is a sound one. If there is any hope that the distressing health situation of Ethiopians will be improved, it has to be through an integrated approach that involves all the members of the household, as well as the community, and the health service providers.

Maternal and child mortality can be improved with better services but as important, is the age and health of the mother at time of birth. Harmful practices of early marriage, abductions, FGM, and other methods of violence against young girls needs to be curtailed or stopped, which will improve maternal and neonatal health. Equally important as providing services, is allowing girls to attend and complete their schooling.

The only way to protect girls from the often-cited harmful practices is through an all-of-society approach that will vie for the elimination of these deleterious practices. These efforts cannot be successful unless the families, the communities and the schools, along with authorities at all levels are on board.

Another intervening factor related to the provision of health services, and specifically to family planning and reproductive health services, is the lack of power that women have to access these services, even when the services are available. Decision-making by women, or jointly with their partners, is an important dimension to explore in relation to ensuring access to a clinic or hospital, birth control methods, and medicines.

Programs related to maternal and child care, as well as those related to family planning need to include men in their approach to service delivery, and involve them in the service provisions and on the expected outcomes.

Men's health issues also have to be taken into consideration and their health needs have to be considered in order to attain a healthy population.

Although GBV is an issue that needs to be addressed in all programs, it has tremendous implications related to health issues. The dominance of men and coerciveness related to access to health care is usually manifested by violent behavior. Clinics and community health services

need to be prepared to address GBV when they recognize the symptoms during routine health visits. Programs to curtail GBV should be available at all health delivery facilities.

In summary, we recommend that the HAPN Office:

- Explain what special approach will be taken with regard to adolescent females.
- Explain how gender issues related to HIV/AIDS prevention and care will be addressed, especially as they intersect with other health issues and services.
- Explain how women and men’s health needs and services will be addressed through the various IRs and what the expected results are.
- Explain what approaches will be taken with respect to gender-based violence in relation to health services, especially reproductive issues and HIV/AIDS prevention.

C. HAPN Office Organizational Structure

USAID/Ethiopia’s HAPN is one of the ten offices of USAID Ethiopia. HAPN’s comprehensive objectives are to achieve sustainable improvements in the wellbeing and productivity of the people of Ethiopia. Programming includes addressing child, maternal and reproductive health issues.

The HAPN office is currently divided into four teams: HIV/AIDS, Malaria, HSS and Health. The following are operating units in HAPN Office:

- Office Chief
- HIV/AIDS Team
 - Strategic Information
 - Logistics & Facility Readiness
 - Capacity Development and Policy/Health Systems Strengthening
 - Family and Community Services
 - Facility Based Clinical Care
 - Prevention and Social Services
- Health Team
 - Family Planning/Reproductive Health
 - Maternal and Child Health
 - Infectious Disease
 - Health System Strengthening
- President’s Malaria Initiative Team
- Health Systems Strengthening Team

D. Global Health Initiative

The President’s Global Health Initiative (GHI) commits \$63 billion dollars over six years to support partner countries, including Ethiopia, in improving and expanding access to health services. As one of its guiding principles, the GHI emphasizes improving health outcomes among women and girls, both for their own sake and because of the centrality of women to the health of their families and communities. The GHI’s women, girls, and gender equality principle states that “Gender-related inequalities and disparities disproportionately compromise the health of women and girls and, in turn, affect families and communities”. The GHI will focus on women and girls—including adolescent and pre-adolescent girls—in the

planning, implementation, and monitoring and evaluation of health and development programs and policies.” Ethiopia is a “GHI plus country,” has developed a strategy and is in the process of developing a GHI implementation plan with the Government of Ethiopia (GOE). The implementation of Ethiopia’s GHI strategy presents an opportunity to not only assess the challenges and successes of integrating gender into current programs, but also to explore how to integrate and monitor gender sensitive interventions across health programs in a more synergistic fashion. The GHI Supplemental Guidance on Woman, Girls and Gender Equality (WGGE) Principle requires countries to conduct a gender analysis, develop a narrative on how they will implement the principles, develop an M&E strategy and include key elements in their programming. This assessment will assist USAID/Ethiopia in meeting these requirements.

III. SCOPE OF WORK

A. Objectives

The main objective of the gender assessment is to provide a strategic/operational plan that includes immediate, medium and long terms steps the Mission can take to effectively integrate gender in the HAPN portfolio and improve measurement and evaluation of the quality of programs that serve women and girls and address gender equality. The plan should include, but is not limited to, training/TA recommendations to improve existing and future projects, development of new projects, suggestions for operational research, and suggestions for improving the internal USAID system (e.g., M&E frameworks, training/TA mechanisms for staff).

Listed below are specific tasks of the assessment.

1. Identify a framework that maps key gender issues, the policy environment in Ethiopia, and the USG policy environment (including GHI), for achievement of health programming and related development goals
 1. Examine published literature and background documentation regarding the relationships between gender and social norms in influencing health and related development outcomes in Ethiopia.
 2. Analyze existing formal laws, policies and strategies that govern issues related to gender and health/development in Ethiopia.
 3. Examine key USG gender and health/development guidance (including GHI)
2. Per the framework established above, assess the extent the current HAPN portfolio of projects addresses the links between gender and health/related development outcomes. Provide a draft methodological workplan for mission review pre-TDY that documents current programmatic strengths and weaknesses, and proposes in-country meetings that will further generate evidence for development of a strategic/operational plan. This draft methodological plan may include questions for USAID managerial/technical team colleagues. These meetings should include, but are not limited to, a subset of HAPN projects to be examined in detail, informational interviews with key Ethiopian government, USAID/USG staff, multilateral, donor and other partners.
3. Conduct pre-assessment briefing with USAID, in-country meetings, draft recommendations that will be elaborated in the final strategic/operational plan, and conduct debrief(s) with key USAID colleagues.

4. Provide a draft operational/strategic plan for mission review and comment (plus review by anyone else the mission chooses to engage). Provide a final operational/strategic plan addressing and/or incorporating all comments received.

B. Methodology

Since the purpose of the review is primarily for internal use and the findings are to be used for planning purposes, the approach for this assessment should be highly participatory and inclusive of staff and partners. Review of documents, staff surveys, focus groups, interviews or other approaches to gathering feedback should be considered. Consensus building and collaborative techniques for setting strategic priorities, planning future directions and necessary steps must be used to ensure inclusiveness and buy-in from staff. The final operational/strategic plan will be shared and monitored with staff in an open manner.

It is recommended that the following approach be undertaken which includes a combination of a desk review, key informant interviews and site visits. The exact number of interviews and site visits will be finalized in collaboration with the consultant team prior to the visit.

- Comprehensive literature review of pertinent documents including studies and assessments conducted by other donors, non-governmental organizations (NGOs), the Government of Ethiopia and the academic community, and USAID documents including but not limited to:
 - The existing USAID/Ethiopia Strategic Plan
 - Project Monitoring Plans (PMPs), PEPFAR indicators, assessments and evaluations
 - Project solicitations and proposals
 - USAID's Automated Directives System (ADS)
 - GHI WGGE Principle guidance including programmatic and measurement
 - Ethiopian government policies and strategies on women, gender, health, and related development sectors (e.g., education), including but not limited to Ethiopian MDG, Growth and Transformation Plan
- Discussions and interviews with key donors, multilaterals, NGOs active in gender, GOE officials, including, but not limited to:
 - Ministry of Women, Children and Youth
 - Ministry of Health
 - Ministry of Education
 - UN Women
 - Christian Relief and Development Association (CRDA)
- Meetings with each USAID/HAPN technical team, and any other USAID colleagues the mission requests.
- Meetings with USAID implementing partners and site visits to selected implementing partners' field activities (see Annex 1 of selected implementing partners and projects)
- Possible site visits to other related GOE and/or other donor activities

C. Deliverables

Deliverables will include:

- Approved Methodological Work Plan: Including key research questions, methods, and tools; timeline for key activities, including product due dates. USAID/Ethiopia will provide documentation as requested, including USAID strategies, information on projects and a list of proposed stakeholders to interview. USAID will also confirm the attendees and schedule of formal pre-assessment and debriefing presentations to USAID.
- Pre-Assessment Briefing: The assessment team will hold a preliminary meeting with key HAPN staff to review the scope of the assessment and determine key issues and priority questions to be included in the review.
- Debriefing Meeting: The assessment team will hold a debriefing meeting before departing Ethiopia to present the major findings and recommendations of the assessment to USAID/Ethiopia.
- Draft Operational/Strategic Plan: Submission of a draft operational/strategic plan for review by HAPN. Draft plan must include methodological framework, literature review, findings from assessment of partners and projects, and short, medium and long-term recommendation to include, but not limited to, training/TA recommendations to improve existing and future projects, development of new projects, suggestions for operational research, and suggestions for improving the internal USAID system (e.g., M&E frameworks, training/TA mechanisms for staff). Draft report should be submitted to mission within ten business days after return travel is complete and the team should allow 2 weeks for review and comment. The mission may request a telecom to verbally share comments.
- Final Report: The final assessment report should include the sections mentioned above for the draft report. The report should be no longer than 50 pages, including annexes. The final report should be submitted to mission within 2 weeks of receiving comments on the draft report.

D. Timing and Schedule

Total Level of Effort (LoE) is 33 days, cognizant that a five-day work week is authorized in Ethiopia. The assessment will be conducted in January 2012. The team will be comprised of 4 external and 3 local consultants, including the USAID/Ethiopia gender advisor.

Below is a list of the specific tasks to be accomplished by the consultant team, with an estimated LoE for each task. The assessment team will finalize a schedule and exact dates for the assessment together with USAID at the time of approval of the work plan and methodology.

Prior to arrival in country	
Review literature and background documents Develop and submit detailed work plan/methodology and any survey/analysis tools for review by USAID/Ethiopia staff Conduct pre-assessment/planning call(s) with USAID/Ethiopia gender specialist and relevant staff	5 days
International travel days for external consultant team	2 days (<i>arrive Jan 9</i>)
In country work (<i>January 10-27, 2011</i>)	
Conduct pre-planning meeting of assessment team	1 day (<i>Jan 10</i>)
Conduct planning meeting to discuss/refine methodology and complete schedule in consultation with USAID gender specialist and other relevant USAID staff	1 day (<i>Jan 11</i>)
Conduct meetings, focus groups, and interviews, etc. with selected individuals in Mission, GOE, stakeholders and implementing partners	2 days (<i>Jan 12&13</i>)
Conduct site visits to selected partners	5 days (<i>Jan 16-20</i>)
Conduct individual and group meetings and next steps planning with staff	3 days (<i>Jan 23-25</i>)
Prepare and conduct debriefing meetings prior to departure	2 days (<i>Jan 26-27</i>)
Post country work	
Travel days for consultant team	2 days (<i>leave Jan 28</i>)
Prepare draft report; Incorporate feedback from USAID/Ethiopia staff on draft and prepare & submit final report	10 days
Total	33 days

E. Team Composition

The gender assessment will be conducted using a participatory process involving the different HAPN teams, key partners and other relevant stakeholders.

A seven-member technical assessment team is proposed. Between them, the team members should have substantial knowledge of gender issues and health programs in Africa. Four external international and three local consultants are proposed. Three of the four external consultants will be from USG HQ (2 USAID and 1 CDC) and one of the three local consultants will be from USAID/Ethiopia. An additional local consultant will also provide logistical support.

F. Roles and Responsibilities

Overall Guidance: Alemnesh Haile-Mariam, HAPN Gender Advisor, will provide overall direction to the assessment team and will be part of the official assessment team. She will coordinate the participation of other HAPN staff, Mission colleagues, implementing partners and key stakeholders in the assessment. Jeanne Rideout, the Health Team Leader, will provide backup for Alemnesh.

Responsibilities:

USAID will support coordinating and facilitating assessment-related field trips, interviews, and meetings, making hotel reservations, transportation arrangements, etc.

USG staff will be responsible for their own per diem and transportation. The firm selected for this assignment, DevTech Systems, Inc. will pay the per diem, accommodation and transportation expenses for the non-USAID external consultant and well as the local consultants.

Annex 1: Selected Implementing Partners and Projects

Criteria for Selection

In selecting the projects to be examined in some detail, USAID/Ethiopia decided to use selected key program elements to help improve the health of women and girls and increase gender equality outlined in the Global Health Initiative Supplemental Guidance on Women, Girls, and Gender Equality Principle (January 2011) as a guide. The selected elements are:

1. Ensure equitable **access to essential health services** at facility and community levels.
2. Increase the meaningful **participation of women and girls** in the planning, design, implementation, monitoring and evaluation of health programs.
3. Monitor, prevent and respond to **gender-based violence**.
4. **Empower adolescent and pre-adolescent girls** by fostering and strengthening their social networks, educational opportunities, and economic assets (and in general a focus on engaging **youth**).
5. **Engage men and boys** as clients, supportive partners, and role models for gender equality.
6. Address social, economic, legal and cultural determinants of health through a multisectoral approach (focusing on USAID/Ethiopia's **economic strengthening** activities).
7. Strengthen the capacity of institutions -- which set policies, guidelines, norms and standards that impact access to, and quality of, health-related outreach and services -- to improve health outcomes for women and girls and promote gender equality (with a focus on USAID/Ethiopia's programs that **build the capacity of local civil society organizations**).

In addition, USAID/Ethiopia thought it important to focus on a key priority of the GOE:

8. Programs that address the high maternal mortality in Ethiopia, including those that build the capacity of Ethiopia's successful health extension worker program.

Finally, USAID/Ethiopia thought it important to identify our "**flagship**" projects, or those that are representative of the broader portfolio of 60+ projects we implement.

Projects Selected

Prime Implementing Partner	Project Name	Project Objective(s)	Start Date	End Date	Geographic Coverage	AOTR/COTR & Project Management
Population Council Subs: Ethiopian Orthodox Church Ethiopian Muslim Development Agency	HIV Prevention Project for Vulnerable Adolescent Girls	To prevent new HIV infections, promote abstinence & mutual faithfulness by addressing the HIV risk among the most vulnerable adolescent girls in Ethiopia & their partners.	12/21/07	12/31/13	Amhara & Addis Ababa	Alemnesh Haile-Mariam Annabel Erulkar, Country Director, 011-663-1712/16/20, 0911 72-9384, aerulkar@popco

Prime Implementing Partner	Project Name	Project Objective(s)	Start Date	End Date	Geographic Coverage	AOTR/COTR & Project Management
John Snow, Inc.	Ethiopia Urban Health Extension Program	Improve access & decrease barriers to health services for MARPs through engagement of household & communities. Increase demand for health services through active engagement of MARPs, household & communities using BCC for health prevention, promotion & risk reduction. Improve quality of UHEP service delivery through training & professional development of UHEWs, including HIV services for MARPs. Support enabling environment to implement a sustainable UHEP including support for community information systems to support a multi-sectored HIV/AIDS & health program.	09/30/09	09/29/12	Addis Ababa, Dire Dawa, Harar, Bahir Dar, Debremerkoss, Dessie, Gondar, Adama, Jimma, Nekemet, Shashemene, Arbaminch, Hawassa, Hosana, Welaitasodo, Adigrat, Axum, Mekele & Sherie	uncil.org Faris Hussein Samuel Yalew, Chief of Party, 0911 246355, syalew@JSI-LTENK.org.et
3 World Learning Subs: 13 local partners	Grants Solicitation and Management Project	Sub-grant to selected Ethiopian organizations to provide HIV/AIDS prevention and care services in high prevalence areas in Amhara, SNNPR, Oromiya, Gambela, Afar and Tigray regions Build capacities of local organizations in program management, monitoring and evaluation, and finance and grants management. Provide capacity building support to prime and sub-recipients of the Global Fund (NEP+ and EIFDDA).	9/1/04	9/ 28/12	Amhara, Oromiya, & SNNPR	Petros Faltamo Adele Djekoundade, Chief Party, (011) 46702-96/13/16, 0114-670162, Adele.Djekoundade@worldlearning.org

Prime Implementing Partner	Project Name	Project Objective(s)	Start Date	End Date	Geographic Coverage	AOTR/COTR & Project Management
4 Pact, Inc. Subs: Abebech Gobena Uehetsanat Kebekabem Limat Mahiber (AGOHELMA) Africa Network for the Prevention and Protection of Children Amhara Development Association (ADA)	Ethiopia Highly Vulnerable Children Program (Ye Kokeb Berhan)	The program will reach 500,000 highly vulnerable children through a systems approach resting on four pillars: 1) Addressing child development needs; 2) Ensuring availability of and access to high quality services; 3) Strengthening community support; and 4) Promoting evidence-based decision-making and policy development.	4/20/11	4/19/16		Walegn Mehertu Samson Radeny, Project Director, 011 662 3793/94/95, 0911-20 30 61, 011 662 3789, samson@pactet.org
PATH Subs: International Relief & Development International Training & Education Centre on HIV Westat Family Guidance Association of Ethiopia Propride Mekdim Ethiopia National Association Southern Ethiopia Peoples' Development Association Organization for Relief and Development of Amhara Hope for Children Organization	Strengthening Communities' Response to HIV/AIDS	Improve access to comprehensive HIV/AIDS community and home-based care services offered by local CSOs. Strengthen coordination with and linkages of among communities, government bodies & public health facilities for quality of referral linkage. Create demand for quality and comprehensive services offered by CSOs and health facilities	4/1/09	9/30/12	Oromia, Amhara, SNNPR, Tigray, Afar, Gambella, Benshangul Gumuz, Dire-Dawa	Guda Alemayehu Abenet Birhanu, Chief Party, 0115 504 371, 0911 638880, aberhanu@path.org
Pathfinder International Sub: John Snow Inc., CORHA	Integrated Family Health Program (IFHP)	Improve family health by strengthening and promoting increased use of high impact family planning, maternal, newborn and child health practices, products and services	06/25/08	06/30/13	Amhara: 71 woredas Oromia: 114 woredas SNNPR: 54 woredas Tigray: 35 woredas Others (B/Gumuz & Somali)-12 woredas	Eshete Yilma Mengistu Asnake, Chief of Party, 011 320 3512/ 011 320 3501/70/72, (0911) 22 7430, 011 320 3572, Masnake@ifhp-et.org , Masnake@pathfind.org

Prime Implementing Partner	Project Name	Project Objective(s)	Start Date	End Date	Geographic Coverage	AOTR/COTR & Project Management
JHPIEGO Sub: Save the Children-US	Maternal & Child Health Integrated Program (MCHIP)	Increased use of and coverage of high impact maternal and newborn interventions and reduction of maternal to child transmission of HIV	10/01/10	09/29/13	Amhara: Mecha, Yilmanadensa, Kombolcha and Tehuledere woredas; Dessie and Bahir Dar towns Oromiya: Kore and Arsi Negele woredas, Shashemene Town Tigray: Dega Temben woreda and Mekele town SNNPR: Misha, Gibe, Mirab Abaya and Arbaminch zuria woredas; Arbaminch and Hadiya towns	Dr. Zewditu Kebede Hannah Gibson, Country Director, 0913-770808, 251-115-502124 hgibson@jhpiego.net
Save the Children Federation Inc. U.S.	Empowering New Generations to Improve Nutrition and Economic Opportunities (ENGINE), An Integrated Nutrition Program	To improve the nutritional status of women and young children through sustainable, comprehensive, and coordinated evidence-based interventions. Strengthen the capacity and institutionalization of nutrition programs and policy, Improve the quality and delivery of nutrition and health care services, Improve prevention of undernutrition through community-oriented nutrition care and practices, and Adopt a rigorous and innovative learning agenda. In addition, as a cross-cutting area,	9/27/11	9/26/16		Danielle Nyirandutiye Habamu Fekadu, Chief of Party, 0911-513640 hfekadu@savechildren.org

Prime Implementing Partner	Project Name	Project Objective(s)	Start Date	End Date	Geographic Coverage	AOTR/COTR & Project Management
		the program aims to mainstream nutrition within GOE ministries and to promote rigorous monitoring and evaluation.				
Hamlin Fistula Ethiopia	Fistula Treatment and Prevention	To increase access to fistula patient treatment and care. To prevent occurrences of fistula cases.	06/20/06	08/31/12	Amhara, Bahir Dar, Tigray, Mekele, Southern Nations, Nationalities & Peoples Regions	Jeanne Rideout Mark Bennett, Chief Executive Officer , 011 371 6544, 0911 88 8923, markb@hamlinfistula.org
Management Sciences for Health Sub-partners NNPWE EIFDDA IMPACT EPHA ANECCA	MSH Project	To provide comprehensive and integrated HIV prevention, treatment, care and support services to PLHIVs and affected individuals	09/14/11	09/16/16	Amhara and Tigray	Helina Worku

ANNEX B: LIST OF MEETINGS, INTERVIEWS, SITE VISITS AND CONTACT INFO

Organizations and Individuals Consulted for USAID Ethiopia HAPN Gender Assessment – January 2012

Organization	Name	Position	Telephone/Email
ADDIS ABABA			
UNICEF	Ellen Alem	Gender and Development specialist	
WHO	Dr. Sofonias Getachew	Officer for managerial process for national Health & coordinator of Health system cluster	
	Dr. Nebreed Fessaha	Officer for making pregnancy safer	
UNFPA	Berhanu Legesse	National Programme Officer for Gender and Advocacy	
	Bethlehem Kebede	Gender Expert	
USAID	Hilina Worku (MD)	TB/HIV advisor	Worku, Helina (ADDIS/HAPN) Hworku@usaid.gov 0911405707
	Afewerk Negash	Care and Support Advisor	Negash, Afework (ADDIS/HAPN) Anegash@usaid.gov 0911663524
	Zewuditu Kebede (MD)	RH Specialist	Kebede, Zewditu (ADDIS/HAPN) Zkebede@usaid.gov 0911107019
	Fikru Bekele	Logistics Specialist	Bekele, Fikru (ADDIS/HAPN) fbecke@usaid.gov 0911236358
	Mequanent Fentie	Public Health Specialist	Fentie, Mequanent (ADDIS/HAPN) Mfentie@usaid.gov 0911704197
	Yared Kebede Haile (MD)	Senior Infx Disease Advisor	Haile, Yared Kebede Yhaile@usaid.gov
	Daniele Nyirandutiye	Health & Nutrition Advisor	251-91-150-9469 (has left Mission)
	Jeanne Rideout	Health Team Leader	Jrideout@usaid.gov, 251-91-121-6598
	Patricia Mengech	HSS/PEPFAR	pmengech@usaid.gov 251-91-121-8185
	Padma Shetty	Health Officer	pshetty@usaid.gov 251-91-121-8178
	Yirga Ambaw	Strategic Information Office	
	Samson Oli	Strategic Information Office	
	Sileshi Kassa	Strategic Information Office	
	Semunegus Mehrete	Strategic Information Office	
	Mequanent Fentie	Strategic Information Office	
	Sheri–Nouane Duncan-Jones	HIV/ HAPN	Snduncan-jones@usaid.gov 251-91-157-1432
	Edson Muhwezi	Paediatric Program Advisor	EMuhwezi@usaid.gov 251-91-150-9475
	Kristin Saarlans	Evaluation Coordinator	Saaksaarlas@usaid.gov 251-91-214-0501
	Meri Sinnitt	Chief, HAPN	Msinnitt@usaid.gov 251-11-130-6775, 251-91-120-1050
	Shawntel Hines	Director, Program Office	shines@usaid.gov
Kassa Mohammed	Prevention & Social Services (HIV)	kamohammed@usaid.gov 0911485690	
Renee DeMarco	Cluster Lead, Prevention & Social Services (HIV)	Demarco, Renee (ADDIS/HAPN) Rdemarco@usaid.gov 0911240590	

Organization	Name	Position	Telephone/Email
	Faris Hussein	HIV HSS	Hussein, Faris (ADDIS/HAPN) Fhussein@usaid.gov 0911474932
	Petros Faltamo	HIV HSS	Faltamo, Petros (ADDIS/HAPN) Pfaltamo@usaid.gov 0910115305
	Samuel Hailemariam		shailemariam@usaid.gov 0911477791
	Scott Hocklander	Chief, Office of Assets and Livelihoods in Transition	25191 123 7166, 251 11 130 6634, shocklander@usaid.gov
	Konjit Eshetu	Resource Management Specialist, ALT	keshetu@usaid.gov
Ministry of Women, Children and Youth Affairs – MOWCYA	HE Frenesh Mekuria	State Minister MOWCYA	
	Atsede Guta	Advisor to the Minister	
	Tesfaynesh Lema Argaw	Director, Gender and Youth Mainstreaming Directorate	
Federal Ministry of Health	HE Kesete-Berhan Admasu	State Minister of Public Health	
	Alemayehu Bogale	Assistant Director, Gender Directorate	251-91-187-1315, 251-11-5501940 abogale98@gmail.com
PACT	Samson M. Radeny (PhD)	COP, Yekokeb Berhan Program for Highly Vulnerable Children	251-11-663-4344/50, 251-91-188-2315 sradeny@pactworld.org sradeny@yahoo.com
	Lucy Steinitz (PhD)	Senior Technical Advisor	251-91 188 2317 lsteinitz@pactworld.org
Pathfinder International	Dr. Mengistu Asnake (MD/MPH)	COP, Integrated Family Health Program	251-11-320-3512 masnake@ifhp-et.org
CORHA	Dejne Getahun	Monitoring and Evaluation Officer	251-91-169-3950, 251-11-663-6367 corha@ethionet.et, dejneadane@yahoo.com
	Tsegay Abebe	IEC/BCC& Networking Officer	251-91-175-4158 corha@ethionet.et
PATH/SCRHA	Asalif Demissie	CE Specialist	251-92-357-9288
	Yemisrach Gezahegn	Palliative Care Specialist	251-91-161-8658
	Tariku Teka	ES Advisor	251-91-166-5789
World Learning GSM	Allahleude "Adele" Dejekoundade	Project Director	251-92-088-7746 adele.djekoundade@worldlearning.org
	Abrha G/Tsadiq	Deputy Director/Grant	251-91-192-0309
	Gemech Teferi	M & E Specialist	251-92-005-9558
	Gimbowgesh Kebede	Gender Specialist	251-91-163-2570
Love for Children	Ms. Lemlem Tikuye	Executive Director	251-91-122-8836
	Mehale Solomon	Program Facilitator	251-91-314-4125
	Tsige Gonfa	Program Officer	251-91-145-8633
	Meron Aragaw	Program Officer	251-91-130-5378
	Yosef Asrat	Social Worker	251-91-131-0724
JSI – Urban Health Extension Program	Samuel Yalew	Chief of Party	251-91-124-6355
	Zelalem Adugna	Deputy Chief of Party	+251-11-663-0309, +251-91-192-1206, zadugna@uhep.net
	Eftu Ahmed	Technical Manager	251 -912-924-820
	Worku Berhe	M&E Advisor	251 -911-696-216
Packard Foundation	Sahlu Haile	Regional Director	251-(11)-662-7074, 251-91-120-3853 shaile@packard.org
Hamlin Fistula Hospital	Mark Bennett	CEO	251 11 371 6544, 251 11 3720082, 251-91 1888923, markb@hamlinfistula.org
JHPIEGO	Alemnesh Tekleberhan		251 115 502 124/ 251 911 156 263
DFID	Jillian Popkins	Director, Girl Hub Ethiopia	+251-911-25-50-58 jillian.popkins@girlhub.org
	Mieraf Mergia		m-mergia@dfid.gov.uk

Organization	Name	Position	Telephone/Email
CCRDA	Dr. Meshesha Shewarega	Executive Director	251-11-4392389, 251-91-1865875 meshehas@crdaethopia.org
UN Women	Maria Karadenizli	Program Specialist	251 92 057 2987, 251 11 552 1041 Maria.karadenizli@unwomen.org
	Yelegn Abegaz	Gender Advisor	251 91 163 8494 Yelifigne.abegaz@gmail.com
	Dr. Mira Ihalainen	Country Program Manager	
EngenderHealth	Adinew Mohammed	Program Officer	251 0911 45 45 14
	Dr. Afework Gelete Balcha	STA	251 0911-41-45-19, abalcha@engenderhealth.org
	Berhanu Teshome	Senior Program Officer	251 0911 10 31 48, bteshome@engenderhealth.org
	Mr. Pierre Moon	Acting Country Director	251 0923 801 615
Population Council	Annabel S. Erulkar	Country Director	251-0-116-631-712/4/6 aerulkar@popcouncil.org
	Woldemariam Girma	Deputy Chief of Party	
	Ms. Aster Tefra	Married Girls Program Officer	
	Ato Habtamu Demele	Program officer on the Project Adolescent Girls	251 0911 619-229
Addis Ababa Women's Association	Ato Musie Yasin	Project Director	251 91 179 6880
ESOG	Dr. Yirgu	Director	251 91 122 4790, yirgug@yahoo.com
	Ms. Selamawit Kifle	Program administrator	Selakia2004@yahoo.com
MSH	Bud Crandall	Chief of Party	251 11 662 0781, 251 91 260 8164 bcrandall@msh.org
	Nelia Matinhure	Team Leader, Program Advisor, Care & Support	251 91 150 4535
	Elke Konings	Director, M&E	251 91 306 0775
	Dr. Lemma Ketema	HIV/MNCH Advisor	251 91 123 8476
	Tsegazeab Kassu	Technical Director	251 91 000 1891
ENGINE	Dr. Habtamu Fekadu	Chief of Party	251 91 151 3640

Tigray – Mekele Area			
Organization	Name	Position	Telephone & email
IFHP/PFI	Awala Equar	RRM	251-91-472-2161
	Desta G/Egziabher	M&E	251-91-472-2223
	Girmay Adane	FP/Gender Officer	251-91-472-2149
	Teklu G/Medhin	Adigrat Cluster Coordinator	251-91-473-1047
Atsbi Woreda Health Office	Kifle Girmay	MCH Expert	251-91-404-3268
Adimesanu Health Post	Azmera Gebre	HEW	251-91-419-8754
	Assefa Shiferaw	Program Officer	251-91-472-5696
Population Council	Munira Mohammed	Project Coordinator	251-91-472-0899
	10 Girls' mentors, 15 adolescent girls and housewives		
	4 boys' mentor and 8 boys		
PATH/SCRHA FGAE	Wro. Atsede Beyene	Area Manager	251-91-470-1718
	Sr. Yenealem	M&E Officer	251-91-474-8346,

	Girma		nahudag23@yahoo.com
Raey Betegbar	Sr. Degen Bahrey	Generalist	251-91-477-9530
	Alemnesh Dagne	"	251-91-477-7376
	Mulugeta Gebru	Volunteer	251-91-478-3463
Mekele Fistula Hospital	Dr. Melaku Abraha	Medical Director	
	Sr. Hiwot Alemayehu	Theatre Nurse	251-91-470-5141
	Sr. Azeb Kalayou	Ward Nurse, Center Coordinator	251-91-472-5689
REST (PACT/OVC)	Atsbeha Berhe Fekadu	HVC Coordinator	251-91-470-4704
	Yirgalem Hailemariam	Program Officer	251-91-473-2216
	Tesfaye Kinfe	MERL Officer	251-91-448-1152
REST/PSNP	Gebrehiwot Hailu	PME Expert	251-91-472-8891
REST	Tekeste G/Kidan	Livestock Expert	251-91-413-7242
	Meseret Kahsu	Gender Expert	251-91-476-0912
MSH	Yohannes Tewelde	Program Manager	251-91-402-3500, ytewelde@msh.org yohanneskifle07@gmail.com
	Fentahun Tadesse (Dr.)	Technical Manager	251-91-106-9020, ftadesse@msh.org
	Mebratu Abera (Dr.)	Regional Technical Advisor for ART/TBHIV/HCT/NTPS	251-91-476-0683, mabraha@msh.org
Adi Gudom Health Centre	Mekonen Nigusse	HC Head	251-91-473-1712
ADHC Adolescent and Youth RH Clinic	Sr. Berhanu Woldenigus	Clinical Nurse	Not available

Amhara, Bahir Dar, Gondar			
Organization	Name	Position	Telephone and email
North Gondar Zone Health / IFHP gov't POC	Temiro Azanaw	Health Officer and Head of Zonal Health Office	
PACT/HVC	Abebayitu Alemu	Project coordinator	0918-760-713
	Col. Hailu Kinfe Michael	Idir chairman	0918-725-175
	Messele Berihun	Union chairman	
	Feleke Yigzaw	Union general secretary	
PACT/HVC (Iddir Union) Medhaitlu Kebele Women, Youth and Children office	Mulunesh Kesless	Community committee representative	0918703778
	Emiru Asfaw	Community committee representative	0918703778
PACT/HVC (Iddir Union) Project	Yalamberhan Tadesse	Community Volunteer	
	Meseret Belete	Community Volunteer	
PACT/HVC ANCAPAN Gondar City	Tewodros Balew	Project Officer	
	Tesfa Kassie	MERL officer	
UHEP-(JSI) Gondar	Asheber Ayalew	UHEP Regional Coordinator	
	Nega Norahur	Government, Head of health office	
	Dawit Tesefamichael	UHEP Officer	
	Endanle Asegnenn	UHEP Officer	

	Addire Tilahun	Nurse Extension worker		
	Hiwot Tesfa	Nurse Extension worker		
	Kidist Birhanu	Nurse Extension worker		
Population Council	Sisay Mellese	Regional Pop Council Senior Program Officer	09 13 50 6544, smellese@popcouncil.org	
	Mekonnen Addisu	Gondar Pop Council Program Officer	9187005250 maddis@popcouncil.org	
	Wondimagegnehu Workneh	Gondar Pop Council Project Coordinator	0910093597 wworkneh@popcouncil.org	
	Yeshumnesh Mengistu	HEW in Gondar Zuria		
	Husbands' mentor and 19 husbands			
	Wives' mentor and 25 wives			
Boys' mentor and approximately 45 boys				
PATH/SCRHA Regional NIP (MENA), and CSO (FreHiwort)	Tsehainesh Getinet	MENA Regional Program Coordinator	0918-783-913	
	Sr. Muluken Messeha	MENA Nurse Supervisor		
	Fikre Getnet	CSO Generalist		
	Yayewsew Wubneh	CSO Generalist	0918-703-491	
	Worku Gobeze	CSO leader	0918-804-387	
	Fre Hiwot	CSO Charitable manager		
PATH/SCRHA National NIP (ESSWA), and CSO (Mgbare Senay Nedayan)	Yehuwalla Demessie	ESSWA Fellow		
	Tekawar Gethun	Mgbare Senay Nedayan CSO Generalist		
	Destaw Demit	CSO Accountant		
	Meseret Muiusta	CSO Volunteer Provider		
	Tsehat Abat	CSO Volunteer Provider		
	Fikad Betete	CSO Volunteer Provider		
Assafa Hane	CSO Volunteer Provider			
Awraamba (Equality Community)	Zumra	Leader who started the community		
MCHIP (JHIEPIGO), Adet Health Center	Mesafini Ewunetu	Health Officer, Head of Clinic		
MCHIP (JHIEPIGO), Bahir Dar Health Science College	Birhanie Kindu	Coordinator of Nursing Program		

OROMIA and SNNPR			
Organization	Name	Position	Telephone and email
Hadiya Development Association	Demeke Ertiro	Program Development Management Team Leader	251 046 5552420
PATH/SCRH project, Hosana	Getahun Gashe	Generalist	251 0465552420
Arsi Negele Health centre/IFHP	Wayu Bedaso	Director/ Delegate	251 115 502 124
Family Guidance Association of Ethiopia- Wolkite	Bekre Nasib	Head Nurse	251 0113301010
FANA PHLA Association Wolkite	Meseret Gebre	Leader	251 0113302559
JHPIEGO Hosana Health Science College, Midwifery Training	EjigayehuDimanu	Assistant Dean of Teaching Learning of the Health Science College	251 046 555 2315
	Tamiru Belachew	Coordinator of Midwifery	251 0465552315
IFHP (JSI); Urban	Zelalem Adugna	Deputy chief of Party	251 0911 92 12 06

Health Extension Program	Matheos Kebede	SNNPR Program Coordinator	251 0911 47 54 97
	Bekalu Tesfa	Regional Manager	251 091139 1998
Urban Health Extension Program Shashemane	Fitsum Wasihun	Coordinator, Urban Health Extension	251 0910157156
	Sr Bezawit Worku	Health Extension Professionals supporting Households (Nurse)	2510461100556
	Sr. Ensete Jemaneh	“ “ “	251 0461100556
	Sr. Medina Tulu	“ “ “	251 0461100556
	Sr. Urgi Bule	“ “ “	251 0461100556
	Sr. Gelgele Qumbi	“ “ “	251 0461100556
IFHP (JSI); Urban Health Extension Program Hosana	Desalegn Ereso	Hosanna town program officer	251 0911817555
	Sr. Tsegayenesh Wanna	Health Extension Professionals supporting Households (Nurse)	251 0911962805
	Sr. Zelalem Kidane	“ “ “	251 0913104133
	Sr. Kassech Haydeo	“ “ “	251 0916 756736
West Arsi Negele Gawe Langan Health Center NGO called SIM	MS Kim Scheel	Nurse Practitioner	251 0911 85 0474

ANNEX C: INTERVIEW INSTRUMENTS USED IN ASSESSMENT (6 PAGES)

The United States Government takes gender inequality very seriously and is committed to addressing it in its programming and investments. Gender assessments are fundamental to moving forward on any of these efforts, so what precisely *is* a gender assessment?

A gender assessment combines: 1) a gender analysis of the situation in a given setting, 2) a review of programs, 3) an assessment of programming gaps, and 4) recommendations for future programming.

First, it analyzes the circumstances of women and men and the realities of gender inequality in a given setting. It reviews the activities and programs the Mission and others are currently supporting that respond to those realities. It assesses the contributions of and gaps in that programming to addressing the gender inequalities that harm health. And it identifies opportunities for work the Mission could support, offering suggestions for how the Mission might want to invest in its future programming. While this guide focuses on health, it is essential to link with other relevant sectors. In brief, a gender assessment analyzes the ways that gender influences the outcomes of interest, and then translates this understanding into activities consistent with the focus of the Mission.

Box 6. Four Steps of a Gender Assessment

- Analyze the circumstances of women and men and the realities of gender inequality in a given setting and how these affect outcomes of interest (this is called a gender analysis)
- Review activities and programs currently being supported by the Mission and others
- Assess programming gaps as current investments address the gender inequalities that harm health
- Make recommendations for future programming

The measure of success for a gender assessment is the action the Mission takes to implement the recommendations into its strategic plan and build its capacity to address gender inequality

Any analysis conducted for the ADS should be structured by two key questions to be addressed at every stage of the planning/program cycle:

- How will the different roles and status of women and men within the community, political sphere, workplace, and household (for example, roles in decision-making and different access to and control over resources and services) affect the work to be undertaken?
- How will the anticipated results of the work affect women and men differently?

The design of all projects and activities must take gender analyses into account (ADS 201.3.11.6). Findings from gender analyses should help to determine the integral positioning of gender in the procurement process, the project activities, and the performance management systems and evaluations.

Step 1: Describe the Context

Analyze the circumstances of women and men and the realities of gender inequality in a given setting and how these affect outcomes of interest (this is called a ***gender analysis***). To set the stage for a thorough analysis of how gender norms and inequalities may undermine health and should be addressed in programming, a gender assessment should describe the social, economic, policy, and institutional context in the country or setting. It should collect data on gender relations, roles, and identities relevant to the achievement of program outcomes and analyze data for gender-based constraints and opportunities that may affect, impede or facilitate program objectives. It should also identify trends and emerging issues that USAID may take up in the future.

A good resource for this work is the Interagency Gender Working Group's (IGWG) [A Manual for Integrating Gender into Reproductive Health and HIV programs, chapters 4 and 5](#). In getting a sense of the context, you should be able to draw on gender analyses conducted by other actors in the US Government's health work or by other donors. The basic information you are trying to collect is, in general terms:

- What are the different constraints and opportunities faced by women and men, boys and girls, according to gender?
- What is happening in this setting to address gender inequality?
- How do gender relations (in different domains of activity) affect outcomes and the achievement of sustainable results?
- How will proposed results affect the relative status of men and women?

Questions to Guide the Document Review:

Provide a broad overview of the significant gender-related challenges to health and development in a given country. The overview should touch upon gender as it affects economic growth, democracy and governance, health, and education, using aggregate/macro indicators to highlight the realities in each sector.

- What are gender roles for men and women in this country? How they differ among various ethnic and religious and geographical groups? How have they changed over time and how do they differ by age?
- What do the major social, economic and political indicators tell us about gender inequality in this setting? What are the most acute inequalities?
- Describe the general framework of policies and laws in the country or region relevant to health
- What do people here understand by the word "gender"? Do people use this word/concept in talking about health and development issues in this setting?
- What "positive" gender relations exist here that could be built upon to achieve gender equality?

Questions for Donors:

- What are the key gender issues that you are currently addressing in your portfolio?

- Do you provide funding and/or TA to address gender issues? Is it primarily one or the other?
- Is there a person in your organization who is assigned to function as the gender advisor or mainstreaming expert?
 - If yes, what does this person do?
- Who are the major players among the donors in terms of work on gender?
- Is there a donor coordination group on gender?
 - Who participates? Is the government involved as well as NGOs?
 - Does USAID participate?
- Is USAID viewed as committed to gender integration in its work?
- Do you have any publications on gender issues in this country?
- Tell us about some of your successes in gender integration in your programs.

Questions for USAID Staff, Including Mission Gender Advisor:

Substantive

- What is the status of the major pieces of legislation related to gender in the country that form the context for USAID's work, and what is missing?
- What do you see as the major gender issues in the sectors in which USAID plans to work/in health?
- What do you see as the key work USAID needs to carry out on gender to accomplish its health and development objectives?
- What are USAID's strengths in addressing the links between gender and health, and who are USAID's key partners?
- How and by whom is gender inequality and health being addressed now (if it is being addressed)?
- Which donors work on gender and/or women's issues in this country?
- Who is seen as providing the major "push" on gender in the country? Donors? The government? Citizens? Coalitions?
- Where have you seen progress in addressing gender inequalities? Are there any programs that you know of that provide especially strong examples of good practices?
- Which NGOs work on gender issues with women and men? What are they doing? As a group, are the NGOs seen as high in capacity? Which are the strongest?
- What is the government architecture on gender? What are the major offices that handle gender issues in the executive and legislative branches of the government? How committed and how powerful are these offices? What is their level of authority/resources? Do they coordinate efforts? How?

Structural

These questions cover the context of specific programs supported by USAID and assess USAID's capacity and commitment to gender in its work.

- Is there a designated Gender Advisor in the Mission?
- What are his or her duties with respect to gender?

- How much time does the GA spend working on gender issues, as opposed to other responsibilities?
- How was the GA selected? Does he or she have expertise in gender?
- Is the FO supportive of gender integration in the Mission?
 - If yes, how do they make this known?
 - Is staff rewarded for attending to gender integration?
- When I send emails and info related to gender to the gender assessment, does this material get circulated around the Mission?
- What is the typical language re: gender in activity approval documents?
 - Does this language reference the specific gender issues that were raised via gender analysis, as required by the ADS?
 - Is there any established Mission procedure to insure that the gender statements in AADs conform to the requirements of the ADS?
 - Are AADs ever turned back because the gender language is not strong enough?
- Do SOWs in all RFPs, RFAs, etc contain language specifically referring to the gender issues that were revealed by gender analysis and which the offerer is required to address (as required by the ADS)?
 - Do proposals generally adhere to these requirements?
 - Do committees evaluate proposals on the basis of responsiveness to gender issues?
 - Do evaluations of proposals look at gender across multiple dimensions in the proposals (e.g., in program or activity design, presence or absence of a gender expert in the submitting organization, gender policy in place at the organization, gender composition of the proposed Team, etc.)?
- Do any other staff at the Mission (in addition to the GA) that have gender responsibilities built into their work plan?
- Is there a Mission order on gender?
 - If yes, can I get a copy?
- Do grants and contracts include specific reference to the gender issues that were identified and that the offerer said would be addressed by the program?
 - Are they explicit in requiring that the implementers submit sex-disaggregated data?
 - Do they?
 - Do COTRs monitor whether implementers submit sex-disaggregated data?
- Has the GA received any gender training? Have other Mission staff received any gender training?
- What is the mechanism or process that is in place to insure that AO or program design teams carry out gender analysis?
 - Does the responsibility for carrying out such analysis fall equally on men and women?
- How does the Mission insure capacity in terms of the ability to conduct gender analysis across offices and staff at the Mission?
- What gender resource materials are available for staff?
 - Is there a library of SOWs, and sample language in other docs that relate to gender?
- Is there a gender working group at the Mission?

- To your knowledge, were any concrete changes in procedures instituted after the last gender assessment was done at this Mission?
- Are there any cross-donor other working groups on gender in which USAID participates?
- Who is the current person on your Team who oversees gender integration efforts, if anyone?
- How do you identify gender issues in your sector/programs?
- What are the key gender issues that you are addressing in your current portfolio?
 - What gender issues are you planning to address in upcoming programming?
- Are there gender issues that differ for men and women by age, geographic location, ethnic group membership, etc?
- If the programs you are planning resemble those you have already been funding, have you identified any instances of good practices, with respect to gender integration?
 - Are there any lessons learned from these programs in terms of gender?
 - Are there any current implementers of USAID programs in this sector that you think would be able to provide some examples of good practices in gender integration?
- What kind of language do the grants and contracts in your portfolio include with respect to gender? How detailed is it?

Step 2: Review activities and programs currently being supported by the Mission and others

This step will involve a review of documents and workplans of the Mission and other major institutional players in this setting, as well as conversations with key informants on how these programs relate to one another. The review should begin with a look at the Mission's strategic priorities and how they have guided its work to date. Key areas of review should include:

- USAID's strategic priorities for the sector, and their alignment with government priorities
- Gender constraints and disparities as they relate to strategic priorities above
- What are the opportunities to redress gender gaps and promote women's leadership in each strategic priority? Which programs have responded to these opportunities?
- What are the best practices to address gender constraints and opportunities?

The purpose of this effort is to describe or map out, as completely as possible, what current programming in health and gender looks like.

Questions for implementing partners:

- Please provide me with a brief overview of your program.
- Does it include any components that are specifically designed to address gender issues?
 - If not, was gender integrated throughout the proposal?
- When you submitted your original proposal to USAID, were you asked to address specific gender issues or more generally, to identify gender issues in your proposal?
 - How specific was the language in this regard?
- During the design of this program, how did you identify gender issues that were likely to impact your program or the ability of men and women to achieve equal outcomes as a result of participating in the program?
- Have you identified gender issues as the program has been implemented?
 - If yes, how have you addressed these?

- Is there someone on your staff who is responsible for over-seeing gender integration across your organization’s portfolio?
- What is the gender balance of the employees in your organization?
 - At the leadership level?
- In your Reports to USAID, do you describe or discuss gender issues?
- In your program, do you collect:
 - Sex-disaggregated data?
 - If yes, is this primarily output data (e.g., the number of men and women trained) or do you also collect outcome or impact data that is disaggregated?
 - Do you collect other sex-disaggregated data beyond what USAID requires?
 - Gender-sensitive data?
- What response (if any) do you get from USAID on your gender reporting (with respect to either the content or the data that you report?)
- Do you have any examples from this program that you consider to represent good practices with respect to gender integration?
- In your work in this sector overall:
 - What would you say are the major gender issues impacting both women and men?
 - Have these been changing over time?
 - What examples do you know of from work in this sector that illustrates best practices in integrating gender or addressing gender issues?

Step 3: Assess gaps in current investments addressing the gender inequalities that harm health

The next step takes the analysis further. Now that you know what is happening, what are the gaps, in light of what *needs* to happen to achieve improved health outcomes? Questions for assessing these gaps, ideally conducted with USAID and other donors, include:

- Where are the barriers to health that have not been addressed by the existing programmatic portfolio?
- What are the underlying reasons for the gaps in programming? What processes, resources or capacity need to be in place to address these gaps?
- What are best practices from the country or region for addressing specific gaps?

Again, the IGWG’s *Gender Manual*—chapter three on the [Gender Continuum](#) – will be useful for this analysis. The Gender Continuum describes a tool for identifying and assessing the extent to which gender has been appropriately and effectively integrated into programs. Its advice to program managers on more fully addressing gender differences and unequal power relations in the context of health program design and implementation sheds light on what may need to happen in the current Mission portfolio to strengthen its effectiveness.

Step 4: Make recommendations for future programming

Once gaps have been identified, it is time to make recommendations for USAID’s programming. How can the portfolio be adjusted or expanded to address some of these gaps and to more effectively integrate gender into its programming on health? This analysis should include the identification of key trends and emerging issues that should shape future programming for USAID:

- Potential results (and associated indicators) that could be incorporated into program planning and activity design
- Potential supporting strategies and national resources, including activities or initiatives by other donors, host country government institutions, and civil society groups, and any potential areas of collaboration or partnership
- Potential for specific activities, as related to gender equality in the country program and the possible need to target particular issues relating to gender equality and women's empowerment
- Resources required to strengthen the gender equality dimensions of the country program, including human resources, training needs, and additional planning/design tools
- Anticipated areas of resistance or constraints, and how to cope with these

ANNEX D: DOCUMENTS REVIEWED AND RESOURCE DOCUMENTS (2 PAGES)

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For more information, contact:

US Agency for International Development
E3/GenDev RRB 3.8-005
1300 Pennsylvania Ave., NW
Washington, D.C. 20523

http://www.usaid.gov/our_work/cross-cutting_programs/wid/

DevTech Systems, Inc.
1700 North Moore St.
Suite 1720
Arlington, Virginia 22209

<http://www.devtechsys.com/practices/gender/>