



YOUTH HEALTH CLUB MEMBERS CONDUCTING DOOR-TO-DOOR SESSIONS IN SOMALI REGION.

GENDER ANALYSIS FINAL REPORT EMPOWERED COMMUNITIES FOR BETTER HEALTH PROJECT

Ethiopia Performance Monitoring and Evaluation Service

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ETHIOPIA PERFORMANCE MONITORING AND EVALUATION SERVICE (EPMES) ACTIVITY FINAL REPORT, GENDER ANALYSIS

Empowered Communities for Better Health Project

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ACRONYMS

ADS	Automated Directives System
ANC	Antenatal Care
ART	Antiretroviral Therapy
CBHI	Community-Based Health Insurance
CDCS	Country Development Cooperation Strategy
CPR	Contraceptive Prevalence Rate
DHS	Demographic and Health Survey
EMTCT	Elimination of Mother to Child Transmission
FP	Family Planning
GBV	Gender-Based Violence
GOE	Government of Ethiopia
HEP	Health Extension Program
HEW	Health Extension Worker
MCH	Maternal and Child Health
NGO	Non-Governmental Organization
PAD	Project Appraisal Document
PMTCT	Prevention of Mother-to-Child Transmission
PNC	Post-Natal Care
RMC	Respectful Maternity Care
SNNPR	Southern Nations, Nationalities, and Peoples' Region
TB	Tuberculosis
USAID	United States Agency for International Development
WDA	Women's Development Army

I. INTRODUCTION

Over the past two decades, the Government of Ethiopia (GOE) has prioritized the expansion of health facilities, leading to stark improvements in potential access to health care. Health care facility expansion has improved physical access to health services, with an emphasis on primary health care units, resulting in a potential health service coverage of 90 percent.¹ The country's flagship Health Extension Program (HEP), with its system of health extension workers (HEWs), model families, and the Women's Development Army (WDA), has been the primary vehicle for expanding access to health services. HEP emphasizes community ownership and seeks to empower communities to manage health problems.² Additionally, the GOE's encouragement of public–private partnerships for health initiatives since 2009 has enhanced the private sector's role in delivering quality health services.³

Despite gains in potential health care coverage, the utilization of existing facilities remains low, such as with low utilization coverage of skilled birth attendants, and unevenly distributed, due to problems with service quality, logistics, medical and drug supplies, human resources for health, and various socio-cultural factors.⁴ To address health service equity and quality delivery gaps, the GOE's Health Sector Development Transformation Plan calls for the continuation of HEP, the promotion of private-public partnerships, and the incorporation of a new woreda transformation agenda, composed of model financial protection through Community-Based Health Insurance (CBHI) and high performing primary health care units, to improve woreda level performance, increase accountability of service providers to beneficiaries, and encourage active community participation in service delivery.⁵

II. PROJECT SUMMARY

The Empowered Communities for Better Health (Empowered Communities) Project aims to empower individuals and communities to take ownership over their health care. The Project aims to support the United States Agency for International Development (USAID) Ethiopia Mission's Country Development Cooperation Strategy (CDCS).⁶

Further information on the Project design, as well as the final report section on design implications and recommendations, has been redacted from this report due to procurement sensitivity.

¹ World Health Organization. (2018, May). Country cooperation strategy at a glance: Ethiopia.

https://apps.who.int/iris/bitstream/handle/10665/137170/ccsbrief_eth_en.pdf?sequence=1&isAllowed=y

² Federal Democratic Republic of Ethiopia, Ministry of Health. (2015, October). Health Sector Transformation Plan 2015/16 - 2019/20. Addis Ababa. https://www.globalfinancingfacility.org/sites/gff_new/files/Ethiopia-health-system-transformation-plan.pdf

³ WHO Regional Office for Africa. (2013). WHO country cooperation strategy 2012–2015 Ethiopia. WHO Regional Office for Africa, Republic of the Congo.

https://apps.who.int/iris/bitstream/handle/10665/136003/ccs_ethiopia.pdf?sequence=3&isAllowed=y

⁴ United Nations. (2016). Transforming Ethiopia together: United Nations development assistance framework for Ethiopia 2016-2020. <https://ethiopia.un.org/sites/default/files/2019-08/Final%20UNDAF%202016-2020%20for%20web.pdf>

⁵ Federal Democratic Republic of Ethiopia, Ministry of Health 2015.

⁶ Due to procurement sensitivity concerns, descriptions of the theory of change, its design, and its graphic representation have been removed from the document.

III. METHODS

GENDER ANALYSIS PURPOSE & KEY USERS

The purpose of this gender analysis is to provide pertinent information for the USAID/Ethiopia Empowered Communities Design Team to enable gender integration within its Project design and its Project Appraisal Document (PAD). In light of this purpose, the analysis identified design priorities and considerations for the Project, addressing issues such as:

- Relevant gaps in the status and anticipated levels of participation of women and men, including age, ethnicity, disability, location, etc., that could hinder overall Project outcomes;
- Differences in the status of women and men, including economic and political, that could be addressed as a result of the Project; and
- Possible differential effects the Project might have on men and women.

The Empowered Communities Design Team and USAID/Ethiopia's Program Office, particularly the Mission Gender Advisor, are the intended key users of this report.

DATA COLLECTION METHODS

The Gender Analysis Team used two primary data collection methods: 1) a desk review of secondary sources containing qualitative and quantitative data, and 2) stakeholder consultations. See Table I for a summary of the data collection methods and their contributing data sources.

DESK REVIEW

The desk review was the primary mode of data collection for the analysis. In cooperation with the USAID Gender Advisor and the Empowered Communities Design Team, the Gender Analysis Team identified key documents on gender with regards to health care and community empowerment. The team used limited snowball sampling—references or bibliographies in reports reviewed and stakeholder recommendations—to supplement documents provided or identified by USAID. See Annex A: Bibliography for a bibliography of documents reviewed for this analysis.

STAKEHOLDER CONSULTATIONS

The Gender Analysis Team complemented the desk review with in-person and phone-based stakeholder consultations. Stakeholders were purposely identified based on their knowledge of the Project's key themes or areas of interest. The team held an initial consultation with the Empowered Communities Design Team on June 20, 2019 to understand the PAD's stage of development and to understand the Design Team's critical gender-related information needs. The Gender Analysis Team used this information to focus its analysis efforts and proposed recommendations. In total, the Gender Analysis Team conducted five interviews with three stakeholders from July 17, 2019, to August 16, 2019.

Table 1: Summary of Data Collection Methods

DATA COLLECTION METHOD	DATA SOURCES
Desk Review	Previous USAID Project and Activity gender analyses, research and evaluation reports, published articles, and available datasets such as the Ethiopian Demographic and Health Survey (DHS).
Five Stakeholder Interviews	<ol style="list-style-type: none"> 1. Ministry of Health (3 interviews) 2. Pathfinder International/Ethiopia (1 interview) 3. Johns Hopkins University Center for Communication Program (1 interview)

DATA ANALYSIS

The analysis addressed a combination of USAID’s five domains of gender analysis as outlined in Automated Directives System (ADS) 205, as well as the Empowered Communities Design Team’s key priorities and intervention areas as communicated to the Gender Analysis Team during the initial stakeholder consultation. The report findings are organized around these two guiding frameworks, whereas the implications and recommendations elaborate on what the findings imply for the Project design. Figure I lists the five gender domains and the Design Team’s key priorities. Annex B: USAID Gender describes the gender domains in more detail. Depending on the key areas of interest, this analysis included a subset of the five domains with the most relevance to Project design.

Figure 1: Guiding Frameworks for Analysis

GENDER DOMAINS	KEY PRIORITIES
<ol style="list-style-type: none"> 1. Laws, policies, regulations, and institutional practices 2. Cultural norms and beliefs 3. Gender roles, responsibilities, and time use 4. Access to and control over assets and resources 5. Patterns of power and decision-making 	<ol style="list-style-type: none"> 1. Access to health services 2. Male engagement in health care services 3. Community engagement 4. Behavior change communication 5. Service delivery & quality improvement 6. Woreda transformation 7. Private sector engagement

LIMITATIONS

This gender analysis included several limitations. First, this work relies principally on secondary data, with limited key informant interviews. This introduces biases based on the secondary sources. To mitigate this, the Gender Analysis Team triangulated information where possible between data sources. Due to time limitations, four stakeholder consultations per project were agreed upon with USAID. Where possible, this number was exceeded, but the number of stakeholder consultations is insufficient to provide a broad picture of gender issues in Ethiopia. Furthermore, all stakeholder consultations were conducted with Addis Ababa-based stakeholders, thus, the representation of regional gender issues may be limited. The team also prioritized resources from the last eight years, since the last CDCS, though

drawing on older materials if needed to address an information gap. There was a selection bias risk, especially in favor of data that are known to USAID/Ethiopia teams in documents and consultations. The team conducted internet searches to uncover additional secondary material and used snowball sampling to identify new stakeholders for interviews. Lastly, these projects are wide in scope and at various phases in the project design process. The ensuing analysis prioritizes addressing the key questions for Project-level gender analysis as required in ADS 205, while also addressing priorities from the Project Design Team as was feasible.

IV. FINDINGS

ACCESS TO, AND UTILIZATION OF, HEALTH SERVICES

Despite advances in access to health facilities throughout Ethiopia, health service utilization remains low and gender equities persist in health seeking behaviors for select health services. Furthermore, gender disaggregated data on health seeking behavior, health utilization, and related factors remain limited and insufficient to understand the drivers of many gender inequities.

According to the most recent Ethiopian Health Accounts Health Utilization Survey, from 2015-2016, health seeking behavior varied by sex, residence, wealth, age, and regions. Women were slightly more likely than men to seek health care, which appeared to be a new development. Gender-related utilization varied by region. Women were more likely to use inpatient services compared with males in all regions, except for Afar, Dire Dawa, and Gambella, where men reported higher inpatient care utilizations. For both men and women, the survey documented a clear positive association between economic status and health care seeking behavior, as well as a positive association between age and reported incidence of illness. However, individuals aged 65 years and above had the highest burden of illness and both men and women in this age group were less likely to seek care.⁷ General motivators for accessing health services in Ethiopia included having an annual income above the poverty line, having a poor perception of own health status, having more than two illnesses, perceived severity of illness, and having a chronic health problem.⁸

The 2016 Ethiopia DHS found that, on average, 70 percent of women had at least one problem accessing health care for themselves when sick. Getting money for treatment and distance to a health facility, especially for rural women, were the most common barriers, followed by needing to get permission from a husband and not wanting to go alone.⁹ However, findings indicate that access to a health facility is not the only factor driving health service utilization. Another essential driver is the perception that the quality of care at the nearest health facility was too low. Although proximity of health facility to the home was the most common reason individuals chose a facility, men in both rural and urban areas were more likely than women to bypass the nearest facility to receive care at one

⁷ Federal Democratic Republic of Ethiopia, Ministry of Health. (2017, August). Ethiopian health accounts: Household health service utilization and expenditure survey 2015/16. Addis Ababa, Ethiopia. <https://cdn1.sph.harvard.edu/wp-content/uploads/sites/2031/2017/01/Ethiopian-Household-Survey-Report-Brief-FINAL.pdf>

⁸ Bazie, G. W. & Adimassie, M. T. (2017, September 26). Modern health services utilization and associated factors in North East Ethiopia. *PLoS One*. <https://doi.org/10.1371/journal.pone.0185381>

⁹ Central Statistical Agency - CSA/Ethiopia and ICF. (2017). Ethiopia Demographic and Health Survey 2016. Addis Ababa, Ethiopia: CSA and ICF. <http://dhsprogram.com/pubs/pdf/FR328/FR328.pdf>

father away for both inpatient and outpatient services. In another example, high care-seeking behavior was reported in Afar, with 71 percent total, 76 percent of men and 66 percent of women, a region with a large pastoral population where one has to travel a longer distance to reach a health facility. Comparatively, Dire Dawa, a region with more facilities, had relatively lower care-seeking behavior among men and women, with 59 percent of the total population seeking care, 70 percent of men, and 50 percent of women. The reasons behind these observed trends warrant more research.¹⁰

HIV/AIDS

Despite an increase in HIV testing and a decline in new infections and HIV/AIDS related deaths, there are gender differences in HIV prevalence and other indicators, showing that women continue to be disproportionately affected by HIV/AIDS and are accessing testing and treatment at lower rates than men.

According to the 2016 DHS, the proportion of women and men who were tested for HIV in the 12 months before the survey and received the results increased from 2 percent in 2005 to 20 percent in 2011, however, these rates remained unchanged between 2011 and 2016. Age, residence, and education provide further nuance: HIV testing rates for men and women age 15-19, at 80 percent and 75 percent, respectively, are lower compared to men and women aged 25-59, at 41 percent and 46 percent, respectively. Among women, those living in urban areas were twice as likely to have been tested in the past 12 months than their rural counterparts. HIV testing coverage increased with level of education for both men and women.¹¹

In 2017, women constituted 64 percent of the population aged 15+ living with HIV in Ethiopia. New HIV infections among young women aged 15–24 years were more than double those among young men, which is a continuation of a general trend over the past decade of higher rates of infection among women than men.¹² For adults aged 15-64 in urban Ethiopia, there are gender differences in HIV prevalence by age. The difference is most severe among those aged 30-34, where the prevalence of women, at 6.1 percent, is seven times higher than men, at 0.9 percent. HIV prevalence peaks differ for male and female age groups as well: highest prevalence rate for women, at 9.1 percent, occurs among those aged 35-39, where highest prevalence for men, at 5.7 percent occurs among those aged 40-44.¹³ HIV treatment was also slightly lower among women than men, as 65 percent of adult women living with HIV received treatment, compared to 66 percent of adult men.¹⁴

Barriers to accessing HIV detection and treatment services for men and women are varied, but include a lack of knowledge about the disease and its treatment, a lack of spousal disclosure, financial constraints, cultural beliefs about traditional treatment effectiveness, poor quality services and treatment at health facilities, transportation issues, and continued stigma against people living with HIV. In contrast, the availability of mobile voluntary counseling and testing services, including rapid test results; mass media

¹⁰ Federal Democratic Republic of Ethiopia, Ministry of Health 2017.

¹¹ CSA/Ethiopia and ICF 2017.

¹² Federal Democratic Republic of Ethiopia, Ministry of Health 2017.

¹³ Columbia University. (2018, December). Ethiopia population-based HIV impact assessment: EPHIA 2017-2018. PHIA Project, funded by the President's Emergency Plan for AIDS Relief. https://phia.icap.columbia.edu/wp-content/uploads/2018/12/3511%E2%80%A2EPHIA-Summary-Sheet_v30.pdf

¹⁴ Joint United Nations Program on HIV and AIDS. (2018). Ethiopia. <https://www.unaids.org/en/regionscountries/countries/ethiopia>

on HIV/AIDS; better awareness and understanding about HIV and AIDS in the community; the existence of youth anti-HIV clubs and People Living with HIV associations; knowledge about the confidentiality of HIV counselling and testing; and the availability of free antiretroviral therapy (ART) are enablers of better HIV detection and treatment.¹⁵

For women, economic empowerment issues and fear of gender-based violence (GBV) pose additional barriers to treatment. Studies have documented that some Ethiopian women refuse to enroll in HIV services for fear of revealing their HIV status to their husbands, which could lead to violence against them, divorce, and/or further economic disempowerment.¹⁶

TUBERCULOSIS

Gender disparities are also evident in tuberculosis (TB) cases and treatment, though Tb-related sex-disaggregated data is limited.

A 2017 Ethiopian Public Health Institute report shows that more men were admitted for TB than women in surveillance sites; however, deaths due to TB were higher among women, urban residents, those aged 30-49. It is unknown why the hospitalizations were higher among men than among women, but possible reasons include lower TB infections rates women and differences in health-seeking behavior. When women are involved in TB screening activities, such as through female community health workers, more women are detected and successfully treated.¹⁷

According to the 2019 evaluation of the Ethiopia Challenge TB program, the program design did not include systematic inquiry into barriers for care-seeking, including gender and social barriers. The evaluation found that both men and women are vulnerable to TB in their youth and productive ages, with slightly more men than women among estimated cases. Gender disparities in biological susceptibility and health-seeking behavior, such as gender-related delays in TB diagnoses, treatment interruption, and stigma and discrimination, remain poorly understood.¹⁸

MENTAL HEALTH SERVICES

Mental health services are rarely available for individuals, including mothers, who need psychosocial support. According to the 2012/13-2015-/16 Ethiopian National Mental Health Strategy, mental illness

¹⁵ Wakgari D., Addis, T., Demissie, T., Haile, A., & Manaye, W. (2015, March). Formative behavior change communication (BCC) assessment report. John Snow, Inc: Addis Ababa, Ethiopia. <https://urban-links.org/wp-content/uploads/SEUHP-Behavior-Change-Assessment-1.pdf>; Balcha, T. T., Jeppsson, A., & Bekele, A. (2011, February 11). Barriers to antiretroviral treatment in Ethiopia: A qualitative study. *Journal of the International Association of Physicians in AIDS Care* 10 (2): 119–25. <https://doi.org/10.1177/1545109710387674>

¹⁶ Nudelman, A. (2013, December). Gender-related barriers to services for preventing new HIV infections among children and keeping their mothers alive and healthy in high-burden countries: Results from a qualitative rapid assessment in the Democratic Republic of Congo, Ethiopia, India, Nigeria and Uganda. Joint United Nations Programme on HIV/AIDS. https://www.unaids.org/sites/default/files/media_asset/201312_discussion-paper_Gender-HIV-services_PMTCT_en_0.pdf

¹⁷ Stop TB Partnership. (n.d.). Empowering women & girls to reach more people with TB: TB REACH Wave 7. Accessed October 15, 2019. http://www.stoptb.org/assets/documents/global/awards/tbreach/W7_Gender_Empowerment.pdf

¹⁸ Jayakumar, B., Shimeles, E., Bekele, A., & Mamo, D. (2019, July). Final performance evaluation of the Challenge Tuberculosis Activity. Social Impact, Inc. for USAID/Ethiopia. https://pdf.usaid.gov/pdf_docs/PA00TWSN.pdf

was the leading non-communicable disorder, comprising 11 percent of the total disease burden. Schizophrenia and depression were among the top ten most burdensome illnesses. A 2016 study found that the prevalence of depression was 5.0 percent, and that more than one in ten pregnant women and one in 20 postnatal women suffer from undetected depression.¹⁹ Another study found that more than one-third, 39 percent, of the Ethiopian mothers suffer from common mental disorders.²⁰ Furthermore, GBV and the low level of awareness and training of health workers is linked with the poor referrals and provision of services on maternal mental health.²¹

MATERNAL AND CHILD HEALTH SERVICES

There are positive upward trends for utilization of some maternal and child health (MCH) services, though utilization of many services is still low and there are disparities among women based on demographic factors.

According to the 2019 mini-DHS, the percentage of women who received antenatal care (ANC) rose from 29 percent in 2005 to 74 percent in 2019 and the percentage of women whose births were attended in a health facility rose from 5 percent to 48 percent in the same timeframe.²² However, there are disparities in the utilization of MCH services, based on women's education and literacy levels, household wealth, residence, and region. Women who are less educated or who have poor literacy skills, live in a rural setting, and are in the lower wealth quintiles exhibit lower utilizations of essential MCH services in comparison to their more educated, urban, and wealthier counterparts. Age of the mother is also a determinant of child health: the percentage of children receiving Vitamin A supplements increased with the mother's age. Regionally, Somali and Afar, regions with large pastoralist populations, had the lowest utilization rates, whereas Addis Ababa and Tigray tended to have the highest utilization rates.²³ Table 2 below summarizes disparities in utilization rates for MCH services.

¹⁹ Fantahun, A., Cherie, A., & Deribe, L. (2018, August 8). Prevalence and factors associated with postpartum depression among mothers attending public health centers of Addis Ababa, Ethiopia, 2016. *Clinical Practice & Epidemiology in Mental Health* 14: 196-206. <https://doi.org/10.2174/1745017901814010196>

²⁰ Nguyen, P. H., Saha, K.K., Ali, D., Menon, P., Manohar, S., Tran Mai, L., Rawat, R., & Ruel, M.T. (2014, June). Maternal mental health is associated with child undernutrition and illness in Bangladesh, Vietnam and Ethiopia. *Public Health Nutrition* 17 (6): 1318-1327. <https://doi.org/10.1017/S1368980013001043>

²¹ Stakeholder consultations; Pathfinder International. (2018). Transform: Primary health care gender strategy. <https://www.pathfinder.org/projects/transform-primary-health-care/>

²² Ethiopian Public Health Institute (EPHI) [Ethiopia] and ICF. (2019, July). Ethiopia mini demographic and health survey 2019: Key indicators. Rockville, Maryland, USA: EPHI and ICF. <https://dhsprogram.com/pubs/pdf/PR120/PR120.pdf>

²³ Ibid.

Table 2: Disparities in Utilization Rates for MCH Services²⁴

	OVERALL	NO EDUCATION	MORE THAN SECONDARY EDUCATION	LOWEST WEALTH QUINTILE	HIGHEST WEALTH QUINTILE	URBAN	RURAL
Percentage of women who received ANC care from a skilled provider for their last pregnancy	74%	62%	100%	46%	95%	85%	70%
Percentage of women who received a Post-Natal Care (PNC) check-up in the first 2 days	34%	22%	71%	13%	62%	48%	29%
Percentage of women who delivered in a health facility	48%	33%	93%	20%	86%	70%	40%
Percentage of women whose births were delivered by a skilled provider	50%	35%	93%	22%	87%	72%	43%
Percentage of children age 12-23 months who have received all basic vaccinations	43%	6% (mother)	35% (mother)	25%	65%	57%	37%
Percentage of children age 6-35 months who received Vitamin A supplements in past 6 months	47%	44%	61%	-	-	53%	45%

Reported factors that contributed to the low utilization of MCH services include issues with quality of care, health infrastructure accessibility, levels of economic empowerment, and prohibitive social norms or beliefs about health facility care. For rural, poor, and less educated women, the inaccessibility of health facilities and professionals, lack of transportation services, lack of knowledge of the importance of MCH, likelihood of unemployment, lack of decision-making ability, and insufficient funds to pay for

²⁴ Ibid.

transport or other expenses to bring family members to health facilities remain barriers to utilization.²⁵ Some promising determinants for increasing maternal health services included men's involvement in maternity care, as described in Men's Involvement in Maternal Care, and mass media exposure.²⁶

ELIMINATION OF MOTHER-TO-CHILD TRANSMISSION

Despite country-driven scale-up of provider-initiated HIV counseling, testing, and prevention of mother-to-child transmission (PMTCT) - now elimination of mother-to-child Transmission (EMTCT) - services since 2005, the coverage and utilization of PMTCT/EMTCT services in Ethiopia remains low.

The proportion of men and women who reported knowing that mother-to-child transmission of HIV can be reduced by the mother taking special drugs has increased steadily from 2005 to 2016. However, recent figures still show that only 23 percent of women received HIV counselling during an ANC visit, and only 34 percent of women had an HIV test and received the test results during either an ANC visit or while they were in labor, and only nine percent of infants born to HIV-positive mothers received antiretroviral prophylaxis for PMTCT.²⁷

Barriers to the utilization PMTCT/EMTCT services include a lack of knowledge and understanding about the benefits of PMTCT/EMTCT; confidentiality issues; fear of stigma and discrimination; dissatisfaction with the health services including poor counseling by health professionals, long wait times, time shortages, and shortages of private rooms at health facilities; lack of support from a partner or husband; and transportation problems. Motivators for the utilization of the PMTCT/EMTCT services include free counseling, ART, antiretroviral prophylaxis, and the ability to deliver a healthy child even if the mother is HIV-positive.²⁸

FAMILY PLANNING SERVICES

Ethiopia has seen an overall positive upward trend in its contraceptive prevalence rate (CPR), though overall modern contraceptive prevalence remains low. The fertility rate is 2.4 in urban areas and 6.0 in rural areas, and Somali and Afar have the highest fertility rates with 7.2 and 5.2, respectively.²⁹ The high fertility rates among rural women, coupled with poor availability of, access to and use of health services, mean that rural women face more significant health risks. While most women in Tigray, the Southern Nations, Nationalities, and Peoples' Region (SNNPR), and Amhara have knowledge about modern family

²⁵ Gebre, E., Worku, A., & Bukola, F. (2018, July 4). Inequities in maternal health services utilization in Ethiopia 2000-2016: Magnitude, trends, and determinants. *Reproductive Health* 15 (119): 1–9. <https://doi.org/10.1186/s12978-018-0556-x>; United Nations Children's Fund & PATH. (2016, January). Literature review on barriers to utilization of health extension services: Draft report. <https://www.childhealthtaskforce.org/sites/default/files/2019-05/Literature%20Review%20on%20Barriers%20to%20Utilization%20of%20Health%20Extension%20Services%20Draft%20Report%28UNICEF%2CPATH%2C2016%29.pdf>

²⁶ Gebre et al. 2018; Mohammed, B.H., Johnston, J.M., Vackova, D., Hassen, S.M., & Yi, H. (2019, January 14). The role of male partner in utilization of maternal health care services in Ethiopia: A community-based couple study. *BMC Pregnancy and Childbirth* 19 (28): 1–9. <https://doi.org/10.1186/s12884-019-2176-z>

²⁷ CSA/Ethiopia and ICF 2017; Gebresillassie, B.M., Emiru, Y.K., Erku, D.A., Mersha, A.G., Mekuria, A.B., Ayele, A.A., & Tegegn, H.G. (2019, July 24). Utilization of provider-initiated HIV testing and counseling as an intervention for PMTCT services among pregnant women attending antenatal clinic in a teaching hospital in Ethiopia. *Frontiers in Public Health*. <https://doi.org/10.3389/fpubh.2019.00205>

²⁸ Wakgari et al. 2015.

²⁹ CSA/Ethiopia and ICF 2017.

planning (FP) methods, at least 88.2 percent, self-efficacy and outcome expectancy relating to use of modern FP methods remain very low, especially in Oromia.³⁰

Overall, 41 percent of currently married women were using modern FP methods in 2019, up from 35 percent in 2016 and 14 percent since 2005. CPRs for women of reproductive ages vary according to residence, household wealth, education, and age. Urban, educated, and wealthier women are more likely to use modern contraceptive methods. Women aged 20-24 are more likely to use modern contraceptive methods than women aged 15-19 and women aged 45-49.³¹

Table 3: Disparities in Modern Contraception Utilization Rates³²

OVERALL CPR	NO EDUCATION	MORE THAN SECONDARY EDUCATION	LOWEST WEALTH QUINTILE	HIGHEST WEALTH QUINTILE	URBAN	RURAL	AGE 15-19	AGE 20-24	AGE 45-49
41%	32%	58%	28%	53%	48%	38%	37%	52%	18%

The main barriers to FP included the perception that FP methods cause irregular and excessive menstrual bleeding, infertility, weight gain or loss, serious headache, face discoloration; poor knowledge about the use and benefits of the methods; religious concerns; low partner involvement; poor spousal communication about FP methods; and long waiting hours at health facilities. In contrast, the main facilitators to contraceptive method utilization included high awareness and knowledge about the methods; easy accessibility of FP methods; economic problems associated with having many children and ability to limit family size through fertility control; involvement of religious leaders; and the continued, concerted social mobilization efforts.³³

CULTURAL NORMS AND BELIEFS

The desk review and stakeholder consultations revealed that different cultural norms and misperceptions about health issues was a barrier to health service utilization and a contributor to gender inequities in health outcomes.

Cultural norms around masculinity and femininity can influence one’s risk and knowledge of health issues and willingness to seek services, especially those related to HIV/AIDs and other sexually transmitted infections. Stakeholders reported that traditional notions of masculinity are strongly associated with a wide range of risk-taking behaviors and expectations, such as an expectation for men to be more knowledgeable and experienced about sex; yet, because men are also socialized to be self-reliant and to not show emotions, men may not seek assistance in times of need or stress. Meanwhile, norms around the virginity of unmarried women and expectations for women to be ignorant about sex increase the

³⁰ Kaufman, M., Kapadia-Kundu, N., & Dam, K. (2017). Ethiopia baseline report: Communication for health. Johns Hopkins Center for Communication Programs. <https://jhuccpeth.org/resources/send/8-ccp-ethiopia-communication-for-health-publications/47-baseline-report-final>

³¹ EPHI and ICF 2019.

³² Ibid.

³³ Wakgari et al. 2015.

risk of acquiring sexually transmitted infections for women and girls and pose a barrier to treatment, for fear of social stigmatization.

The continued stigma towards both individuals living with HIV and individuals with TB hinders access to health services, especially for women. Participants in a 2013 study held the view that women living with HIV should not get pregnant, as they believed that the mothers will soon die and the babies will be born with HIV. This key finding discouraged pregnant women from getting tested for HIV and following up with antiretroviral drugs. Some pregnant women living with HIV internalized these beliefs and reported going through periods of depression upon learning of their HIV-positive status, though they did not seek treatment because they believed there was no hope.³⁴ Additionally, the 2016 DHS found that discriminatory attitudes are higher in women than in men. 48 percent of women and 35 percent of men thought that children living with HIV should not be able to attend school with children who are HIV negative, and 55 percent of women and 47 percent of men reported they would not buy fresh vegetables from a shopkeeper is living with HIV.³⁵

Norms, preferences, and cultural factors affect women’s access to and utilization of ANC, PNC, and contraceptives. A selection of the cultural norms is provided in Table 4 below.

Table 4: Norms and Preferences Affecting Service Utilization

SERVICE TYPE	INFLUENTIAL CULTURAL NORMS AND PREFERENCES
ANC	<ul style="list-style-type: none"> • Norm that a pregnant woman only needs to go to the health facility if she feels physically unwell.³⁶ • The first ANC checkup in Amhara, Oromia, Tigray and SNNPR is normally at 16 weeks/four months, which is not consistent with World Health Organization guidance for expectant mothers, which says to initiate their first contact at less than 12 weeks gestational age.³⁷ • Preference of female professionals in FP, ANC, and delivery utilization challenge utilization in pastoralist and agro-pastoralist societies.³⁸
PNC	<ul style="list-style-type: none"> • Women do not commonly visit health facilities within seven days of delivery because of the social norm that a woman should not leave her home within a month after delivery.³⁹

³⁴ Nudelman 2013.

³⁵ CSA/Ethiopia and ICF 2017.

³⁶ Storey, D., Kapadia-Kundu, N., Dam, K., Tamene, H., Ayele, M., & Eniyew A. (2018, September). Exploring sociocultural determinants of health service use and health behavior in Ethiopia. Sociocultural Study Report. Johns Hopkins University Center for Communication Programs.
https://www.thecompassforsbc.org/sites/default/files/project_examples/Exploring%20Sociocultural%20Determinants.pdf

³⁷ Ibid.

³⁸ Henok A. & Takele, E. (2017, September). Assessment of barriers to reproductive health service utilization among Beng Maji Zone pastoralist communities. *Ethiopian Journal of Health Sciences* 27 (5): 523-530.
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5615014/>

³⁹ Storey et al. 2018.

SERVICE TYPE	INFLUENTIAL CULTURAL NORMS AND PREFERENCES
Health Facility Delivery	<ul style="list-style-type: none"> • Home is considered a natural space for delivery because of rituals that are practiced during labor and after delivery.⁴⁰ • Traditional birth attendants are still culturally acceptable and considered competent health workers.⁴¹
Use of modern contraceptives	<ul style="list-style-type: none"> • Perception that FP methods cause irregular and excessive menstrual bleeding, infertility, weight gain or loss, serious headache, face discoloration. • Cultural and religious norms that favor large families affect access to FP services.⁴²
Nutrition	<ul style="list-style-type: none"> • Fear of a “big fetus/baby” and the practice of fasting during pregnancy are prevalent in Amara, Oromia, Tigray and SNNPR affect nutrition-related care for pregnant women.⁴³

PATTERNS OF POWER AND DECISION-MAKING

For many women, health care decision-making is still largely controlled by men, which limits the access of women and children to health services.

Studies show that women’s autonomy, as measured by women’s participation in financial and household decision-making, freedom of movement, and attitudes toward violence, is positively associated with health service utilization.⁴⁴ The 2016 DHS shows a promising trend in women’s autonomy indicators: 71 percent of currently married women, in both urban and rural areas, said they participate in three specified household decisions (own health care, household purchases, and visits to their family), and the majority of women earning cash reported that they either jointly make decisions about their earnings with their husbands, at 62 percent or by themselves, at 30 percent. At the same time, the DHS also reports that needing permission from a husband to seek care is a barrier to access, and other studies report that male partners sometimes refused to allow pregnant women to visit antenatal clinics because they did not trust in the efficacy of the services, did not want to pay a fee for transport or for the services, or they were afraid of the stigma that might be directed at them if their own HIV-positive status was somehow discovered through their wives’ treatment.⁴⁵ Husband’s disapproval of women seeking care at health facilities is especially true in pastoralist areas, such as the Bench Maji zone, Afar, and Somali.⁴⁶

⁴⁰ Kaba, M., Bulto, T., Tafesse, A., Lingerih, W., & Ali, I. (2016, April 11). Sociocultural determinants of home delivery in Ethiopia: A qualitative study. *International Journal of Women’s Health* 8: 93-102. <https://www.ncbi.nlm.nih.gov/pubmed/27114718>

⁴¹ Shiferaw, S., Spigt, M., Godefrooij, M., Melkamu, Y., & Tekie, M. (2013, January 16). Why do women prefer home birth in ethiopia? *BMC Pregnancy and Childbirth* 13 (5). <https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/1471-2393-13-5>

⁴² Pathfinder International 2018.

⁴³ Storey et al. 2018.

⁴⁴ Tiruneh, F.N., Chuang, Y., & Chuang, Y. (2017, November 13). Women’s autonomy and maternal healthcare service utilization in Ethiopia. *BMC Health Services Research* 17 (1): 1–12. <https://doi.org/10.1186/s12913-017-2670-9>

⁴⁵ Nudelman 2013.

⁴⁶ Henok & Takele 2017.

In general, women who are young, poor, unemployed, and uneducated are more likely to need their husband's permission to seek health services and are at risk of not being treated. Women's decision-making autonomy and health seeking behavior is positively correlated with her age, the education-level of both herself and her husband, household wealth, family size, involvement in income generating activities, and exposure to mass media.⁴⁷

GENDER ROLES, RESPONSIBILITIES, AND TIME USE

WORKLOAD AND EMPLOYMENT

Gender roles affect the workloads of men and women differently and their ability and willingness to participate in health service utilization.

In addition to their productive and social responsibilities, housework responsibilities fall disproportionately on women. This domestic burden reduces the time women have available to spend on their personal needs, such as attending to their personal sanitation, health, and education, which results in higher prevalence of wasting, illiteracy and sickness among women as compared to men in many pastoral areas.⁴⁸

As previously mentioned, the inability to pay for health services poses a significant barrier health care access. Literature reviewed and stakeholder interviewed assert that women in Ethiopia, especially in rural areas, are more likely than men to be unemployed and thus dependent on their husbands for money.⁴⁹ Additionally, because men are more likely to be employed, they are often unavailable during home visits by HEWs and the operating hours of health facilities may not be conducive them.⁵⁰

MEN'S INVOLVEMENT IN MATERNAL CARE

Male involvement in maternal health care services is low and research on the effects of this low involvement is nascent. Still, available evidence suggests that involving men in maternal health care can increase its utilization, but this involvement can pose risks to women.

Even though men have important decision-making roles related to MCH issues, the involvement of male partners in MCH in Ethiopia is low and varies by region. 28 percent of male partners in Addis Ababa participated in four or more of six PMTCT activities, 40 percent of male partners in Gondar were

⁴⁷ Ibid; Alemayehu, M., & Mengistu M. (2017, April 19) Health care decision making autonomy of women from rural districts of Southern Ethiopia: A community based cross-sectional study. *International Journal of Women's Health* 2017 (9): 213-221. <https://doi.org/10.2147/IJWH.S131139>; Wado, Y.D. (2017, November 17). Women's autonomy and reproductive health-care-seeking behavior in Ethiopia. *Women & Health* 58 (7): 729-743. <https://www.tandfonline.com/doi/full/10.1080/03630242.2017.1353573>

⁴⁸ Balehey, S., Tesfay, G., & Balehegn, M. (2018, August). Traditional gender inequalities limit pastoral women's opportunities for adaptation to climate change: Evidence from the Afar pastoralists of Ethiopia. *Pastoralism* 8 (1): 1–14. <https://doi.org/10.1186/s13570-018-0129-1>

⁴⁹ CSA/Ethiopia and ICF 2017.

⁵⁰ Lailulo Y. A., Susuman A. S., & Blignaut R. (2015, December 7). Correlates of gender characteristics, health and empowerment of women in Ethiopia. *BMC Women's Health*. 15 (116): 1–9. <https://doi.org/10.1186/s12905-015-0273-3>

involved in HIV counselling and testing during their wife’s pregnancy, and 20 percent of male partners in Mekelle accompanied their pregnant wives to maternal health care services.⁵¹

The involvement of male partners in MCH services in Ethiopia and in sub-Saharan Africa broadly has both promise and potential risks. Male involvement is associated with increased uptake of maternal, child, and sexual and reproductive health services, including ANC, facility-based delivery, skilled attendant birth, contraception use, mother-to-child transmission treatment, HIV testing, adherence to ART, and a lower risk of HIV infection in infants.⁵² Though there is a lack of evidence on adverse effects of male involvement in Ethiopia, some studies from other sub-Saharan African countries caution that male involvement can lead to domestic discord, emotional and physical violence against women, loss of economic support to women, and blame and abandonment of women.⁵³

Barriers to male involvement in maternal and childcare include the time use of men, a lack of knowledge about service benefits, cultural norms dictating parenting responsibilities, and treatment at health facilities. MCH is viewed as the mother’s responsibility in Ethiopia, especially in a child’s early years, as men are more responsible for breadwinning and distant attention over immediate needs.⁵⁴ Because men are responsible for providing for the family, their attendance at health facilities competes with the time they can spend earning an income. Some studies also report the men can be mistreated at health facilities, which discourages them from accompanying their wives. Further, the maternal health care systems and the training of health care workers does not target men or adopt “father-inclusive” practices.⁵⁵

Current incentives across sub-Saharan Africa to increase male involvement in ANC include giving women who attended ANC with their husbands preferential treatment throughout the ANC process, publicly acknowledging and commending men who attended ANC visits, and the facilitation of father support groups by health workers to encourage knowledge sharing. To more directly address barriers to participation, some studies suggest that programs will have to be restructured to be “male-friendly” and offer couple-services, and include activities like listening to the fetal heartbeat, giving counseling on obstetric danger signs, HIV testing, and giving access to information on their partners’ medications and ANC schedule. Programs could also explore engaging local chiefs or other traditional leaders to better address gender norms around men’s participation in childcare.⁵⁶

⁵¹ Mohammed et al 2019.

⁵² Ibid; Gebresillassie 2019.

⁵³ Mohammed et al 2019.

⁵⁴ Mulugeta, E. (2014, December 15). Gender assigned roles and parenting – Ethiopia case study. United Nations Children’s Fund Office of Research - Innocenti. <https://www.slideshare.net/UNICEFIRC/emulugeta>

⁵⁵ Forbes, F., Wynter, K., Wade, C., Zeleke, B. M., & Fisher, J. (2018, May 9). Male partner attendance at antenatal care and adherence to antenatal care guidelines: Secondary analysis of 2011 Ethiopian Demographic and Health Survey data. *BMC Pregnancy and Childbirth* 18 (145). <https://doi.org/10.1186/s12884-018-1775-4>

⁵⁶ Aborigo, R.A., Reidpath, D.D., Oduro, A.R., & Allotey, P.A. (2018, December). male involvement in maternal health: Perspectives of opinion leaders. *BMC Pregnancy and Childbirth* 18 (1). DOI: 10.1186/s12884-017-1641-9; Yargawa, J. & Leonardi-Bee, J. (2015, February 19). Male involvement and maternal health outcomes: Systematic review and meta-analysis. *Journal of Epidemiology and Community Health* 69 (6). <https://doi.org/10.1136/jech-2014-204784>

COMMUNITY ENGAGEMENT & WOREDA TRANSFORMATION

Community-level interventions are targeting and increasing access to and use of health services, especially for women. However, these programs are challenged by lack of sex-disaggregated data, community awareness issues, coordination and supply issues, and work-related vulnerabilities of HEWs and WDA leaders.

CBHI is a key part of the woreda transformation agenda. The GOE is developing a CBHI manual for implementation, data management and reporting, and clinical audits, for dissemination to CBHI implementing woredas. Studies suggest that CBHI contributes to health service utilization, women's economic empowerment, and decision-making.⁵⁷ A recent evaluation of USAID's Health Sector Finance Reform Activity found that the CBHI surpassed its target for outpatient service utilization, achieving 0.78 per capita visits per year against the target of 0.60 visits.⁵⁸ Moreover, female-headed households were more likely than male-headed households to participate in CBHI, as were more educated households.⁵⁹ According to stakeholders interviews, a lack of sex-disaggregated data on CBHI membership and service utilization poses a challenge to fully understanding the gender dynamics and trends of CBHI membership and its effects on health outcomes for men and women. Furthermore, a lack of awareness of communities about CBHI benefits, a lack of coordination among different government offices, over-utilization of CBHI, and increased costs in some communities negatively influence CBHI programs. The issue of CBHI awareness is in line with a 2017 study, which found that participants who had poor knowledge about CBHI schemes were less likely to comply with the CBHI requirements and were more likely to reduce participation.⁶⁰

The HEP, with its cadre of HEWs and support from the WDA, is credited with increased health service utilization and the resulting health outcomes. In spite of these successes, the program still faces challenges, including the productivity and efficiency of HEWs; collaboration and respectful relationships among HEWs, community members, and health center staff; the working and living conditions of HEWs and WDA leaders; and the capacity of health posts.^{61,62} A 2018 Johns Hopkins study found that most households in Amara, Oromia, Tigray and SNNPR do not have a copy of the Family Health Guide, as the guides are primarily given to pregnant women due to a shortage, and many women reported that the

⁵⁷ Atnafu, D. D., Tilahun, H., & Alemu, Y. M. (2018, August 8). Community-Based Health Insurance and healthcare service utilisation, North-West, Ethiopia: A comparative, cross-sectional study. *BMJ Open* 8 (8): 1–6. <https://doi.org/10.1136/bmjopen-2017-019613>; Kassie, G. & Tefera, B. (2019, May 9). Effects of community-based health insurance on modern family planning utilization in Ethiopia. International Conference on Family Planning. <https://doi.org/10.12688/gatesopenres.12960.1>

⁵⁸ Alebachew, A., Osika, J., Mitiku, W., Demissie, E., & Aboset, N. (2017). Final Evaluation Report Midterm Evaluation Health Sector Financing Reform / Health Finance & Governance (HSFR/HFG) Activity.

⁵⁹ Kibret, G. D., Leshargie, C. T., Wagnaw, F., & Alebel, A. (2019, January 17). Willingness to join community based health insurance and its determinants in East Gojjam zone, Northwest Ethiopia. *BMC Research Notes* 12 (31). <https://doi.org/10.1186/s13104-019-4060-3>

⁶⁰ Workneh, S. G., Biks, G. A., and Woreta, S. A. (2017, June 14). Community-based health insurance and communities' scheme requirement compliance in Thehuldere District, Northeast Ethiopia: Cross-sectional community-based study. *ClinicoEconomics and Outcomes Research* 9: 353-359. <https://doi.org/10.2147/CEOR.S136508>

⁶¹ Yitbarek K., Abraham, G., & Morankar, S. (2019, March 29). Contribution of women's development army to maternal and child health in Ethiopia: A systematic review of evidence. *BMJ Open*. 9 (5). <https://doi.org/10.1136/bmjopen-2018-025937>

⁶² Yibeltal, A., Gelaw, A.G., Hill, P.S., Taye, B.W., & van Damme, W. (2019, March 26). Community Health Extension Program of Ethiopia, 2003-2018: Successes and challenges toward universal coverage for primary healthcare services. *Globalization and Health* 15(1): 1–11. <https://doi.org/10.1186/s12992-019-0470-1>

guides do not last long due to improper use or storage.⁶³ HEWs themselves are confronted with challenges such as poor working and living conditions, excessive work burdens, and a lack of incentives.⁶⁴ Another 2018 study found that volunteer WDA leaders in Amhara are less likely to be married, more likely to be divorced or separated, more likely to experience some aspects of food insecurity, more likely to report greater levels of psychological distress and more stressful life events, and they report receiving slightly less social support than other women.⁶⁵

The Family Health Team approach, a GOE pilot initiative, has been found to be effective in terms of broadening health services and targeting female-headed households, pregnant women, women with children under the age of five, high health risk groups, low-income and vulnerable individuals. The approach is also effective at improving cooperation between health centers and HEWs, and meeting women's maternal health needs, such as FP and ANC. However, family health teams do not include mental health professionals and social workers, which is a significant gap, given that maternal mental health issues are prevalent in Ethiopia.⁶⁶

SERVICE DELIVERY & QUALITY IMPROVEMENT

Poor quality services influence both health facility choice and health services utilization. Considering that the majority of health services supported by the government and donors target women and children, they are most affected by the poor quality.

Ethiopia has made huge progress in improving access to health services, but it is still at an infancy stage in improving the quality of health services. Poor service quality has caused men and women to not seek care, or to bypass services as the nearest health facility.⁶⁷ Respectful maternity care (RMC) is another driver of maternal care, as women who perceive the quality of facility-based care to be poor may choose to avoid facility-based deliveries. Obstetric violence, such as physical abuse, neglect, non-consented care, non-dignified care, or non-confidential care, continues to be reported in Ethiopian health facilities.⁶⁸ The 2016 Ethiopia Emergency Obstetric and Newborn Care Assessment found

⁶³ Storey et al. 2018.

⁶⁴ Yitbarek et al. 2019.

⁶⁵ Maes K., Closser, S., Tesfaye, Y., Gilbert, Y., & Abesha, R. (2018, February 14). Volunteers in Ethiopia's women's development army are more deprived and distressed than their neighbors: Cross-sectional survey data from rural Ethiopia. *BMC Public Health* 18 (258). <https://doi.org/10.1186/s12889-018-5159-5>

⁶⁶ Kerie, S., Menberu, M., & Niguse, W. (2018, August 29). Prevalence and associated factors of postpartum depression in Southwest, Ethiopia, 2017: A cross-sectional study. *BMC Research Notes* 11 (623). <https://bmcrsnotes.biomedcentral.com/articles/10.1186/s13104-018-3730-x>. Kerie et al. found the rate of postpartum depression from mothers giving birth in the last 12 months to be 33.85 percent and Fantahun et al. found a rate of 23.3 percent in Addis Ababa.

⁶⁷ Yakob, B., Gage, A., Nigatu, T. G., Hurlburt, S., Hagos, S., Dinsa, G., Bowser, D., Berman, P., Kruk, M. E., & Tekle, E. (2019, January 4). Low effective coverage of family planning and antenatal care services in Ethiopia. *International Journal for Quality in Health Care* 31 (10): 725-732. <https://doi.org/10.1093/intqhc/mzy251>

⁶⁸ Wassihun, B., Deribe, L., Worede, N., & Gultie, T. (2018, July 1). Prevalence of disrespect and abuse of women during childbirth and associated factors in Bahir Dar Town, Ethiopia. *Epidemiology and Health* 40. <https://doi.org/10.4178/epih.e2018029>; Alemayehu, M., & Mekonnen, W. (2015, October 4). The prevalence of skilled birth attendant utilization and its correlates in North West Ethiopia. *BioMed Research International*. <https://doi.org/10.1155/2015/436938>; Mihret, M. S. (2019, September 18). Obstetric violence and its associated factors among postnatal women in a Specialized Comprehensive Hospital, Amhara Region, Northwest Ethiopia. *BMC Research Notes* 12 (1): 600. <https://doi.org/10.1186/s13104-019-4614-4>

disparities in health facility management types. Private, for-profit health facilities scored lower on RMC readiness than public health facilities or private, non-profit facilities.⁶⁹ Additionally, 46 percent of individuals who used inpatient services bypassed their nearest inpatient health facility to seek health care at another health facility. The main reasons for bypassing the closest facility was unavailability of medicines at 29.0 percent, lack of beds at 19.1 percent, and lack of qualified staff at 18.9 percent.⁷⁰

Though health protocols and standards exist at the national level, there are inconsistent patterns their use and enforcement. The government is not the main actor in terms of addressing quality initiatives.⁷¹ Stakeholders suggest that enforcement of national guidelines and models for quality improvement is inconsistent, and that partners, not the government, are the main driver of quality initiatives. Further, the low capacity of HEWs to deliver services, shortages of laboratory and pharmacy technicians, the lack of ambulance services, the lack of waiting rooms, high staff turnover, and the unavailability of health workers all affect quality of health services.⁷²

PRIVATE SECTOR ENGAGEMENT

Government health services continue to provide most inpatient services in Ethiopia, particularly in lower wealth brackets. While there are examples of private care facilities helping to improve health outcomes, in general there is a lack of data about gender-related differences between public and private facilities.

Government health facilities, including government hospitals and health centers, accounted for 80.1 percent of total inpatient services, while private health facilities provided 18 percent of inpatient services and non-governmental organization (NGO) health facilities were responsible for the remaining two percent. Individuals living in the richest households were about four times more likely to use private hospitals and about five times less likely to use government health centers or NGO hospitals, compared with those living in the poorest households. Individuals living in rural areas predominantly use government hospital, followed by government health centers and private clinics.⁷³

The abundance of private health care facilities in the country points both to the large role of the private sector in improving healthcare outcomes. Social franchising of contraceptives in Ethiopia has increased the provision of short-acting methods in the private sector and has contributed to an increase in the modern CPR.⁷⁴ However, some studies have found variations between in the practices of public and private facilities. A 2014 study found that the caesarean section rate was twice as high in private facilities, at 41.7 percent, as the rate in public institutions. The study posited two factors for the high

⁶⁹ Ethiopian Public Health Institute, FMOH, Federal Democratic Republic of Ethiopia, Ministry of Health & Columbia University. (2017, September). Ethiopian emergency obstetric and newborn care (EmONC) assessment 2016. <https://www.ephi.gov.et/images/pictures/download2010/FINAL-EmONC-Final-Report-Oct25-2017.pdf>

⁷⁰ Federal Democratic Republic of Ethiopia, Ministry of Health 2017.

⁷¹ Federal Democratic Republic of Ethiopia, Ministry of Health. (2018, September). National HIV service quality improvement tool kit. <https://www.afro.who.int/sites/default/files/2019-04/Ethiopia%20National%20HIV%20service%20quality%20improvement%20tool%20kit%202018.pdf>

⁷² Damen et al. (2018).

⁷³ Federal Democratic Republic of Ethiopia, Ministry of Health 2017.

⁷⁴ Riley, C., Garfinkel, D., Thanel, K., Esch, K., Workalemahu, E., Anyanti, J., Mpanya, G., Binanga, A., Pope, J., Longfield, K., Bertrand, J., & Shaw, B. (2018, February 14). Getting to FP2020: harnessing the private sector to increase modern contraceptive access and choice in Ethiopia, Nigeria, and DRC. *PLoS ONE*. <https://doi.org/10.1371/journal.pone.0192522>

rate: first, that private facilities may conduct caesarean sections without clear medical indications or on maternal request; and second, because clients perceive the service provided by the private sector to be of better quality and mothers with complications that genuinely need caesarian sections may prefer them.⁷⁵ In general, there appears to be a lack of data on gender-related differences between public and private health care facilities.

LAWS, POLICIES, REGULATIONS, AND INSTITUTIONAL PRACTICES

While there are policies and strategies in place, systemic and structural problems and inadequate integration of gender compromise the quality of health care.

The Ministry of Health uses the concept of “quality health services” and “equity” interchangeably. Quality health services are defined as “comprehensive care that is measurably safe, effective, patient-centered, and uniformly delivered in timely way that is affordable to the Ethiopian population and appropriately utilizes resources and services efficiently.”⁷⁶ Developed by the Ministry of Health, the quality improvement manual for community health services aims to provide equal care, regardless of gender, ethnicity, geographic location, and socioeconomic status.⁷⁷ However, systemic and structural problems and inadequate integration of gender in different programs and activities of the ministry compromise the quality of health care. Given that the majority of health services that are supported by the government and donors target women and children, they are most affected by the poor quality.

In 2017, the GOE established the 2016-2020 National Reproductive Health Strategy for “improving the health of women, children, adolescents and youth through access and quality reproductive health services.”⁷⁸ The strategy incorporates health systems and strengthens building blocks while focusing on primary health care. Large parts of the strategy rely on consistent community outreach through HEWs, the Health Development Army, and education through teachers, women’s organizations, and youth groups. The strategy also aims to increase the leadership of women and girls on reproductive health matters, empower men and women to seek care, train male role models on FP, and create an enabling framework for gender-equitable decision-making, including eliminating harmful traditional practices. While the strategy is strong on paper, there is not yet evidence of if or how it has affected reproductive health service access and quality, or if it has been effective in engaging women, men, and youth.⁷⁹

The 2016-2020 National Adolescent and Youth Health Strategy aims to improve the “health of adolescents and youth through the development and strengthening of an integrated health sector

⁷⁵ Gebremedhin, S. (2014, February 14). Trend and socio-demographic differentials of caesarean section rate in Addis Ababa, Ethiopia: Analysis based on Ethiopia demographic and health surveys data. *Reproductive Health* 11 (14). <https://doi.org/10.1186/1742-4755-11-14>

⁷⁶ Federal Democratic Republic of Ethiopia, Ministry of Health. (n.d.). Ethiopian national health care quality strategy. <https://docplayer.net/23467453-Ethiopian-national-health-care-quality-strategy-transforming-the-quality-of-health-care-in-ethiopia.html>

⁷⁷ Ibid. pp. 3.

⁷⁸ Federal Democratic Republic of Ethiopia, Ministry of Health. (2016a). National Reproductive Health Strategy (2016-2020). <http://corhaethiopia.org/wp-content/uploads/2016/08/RH-strategy-2016.pdf>

⁷⁹ Ibid.

response and implementation of effective health promotion, prevention, and care programs.”⁸⁰ The strategy will help to deliver better health services for youth, including sexual and reproductive health, HIV/AIDS, nutrition, noncommunicable diseases, mental and psychosocial health, substance abuse, and injury and violence. The preceding strategy, from 2006-2015, had challenges with insufficient collaboration, limited stakeholder and youth participation, under-resourcing, and social and cultural barriers to young people accessing health services. The updated strategy aims to address these issues and encompasses training curriculum development and delivery, research, communication and outreach, and the development of service protocols and guidelines. It will also precede national guidelines and a minimum service package for youth-friendly services, though progress is unclear from the literature.⁸¹

⁸⁰ Federal Democratic Republic of Ethiopia, Ministry of Health. (2016b). National Adolescent and Youth Health Strategy (2016-2020). https://www.researchgate.net/publication/323525792_NATIONAL_ADOLESCENT_AND_YOUTH_HEALTH_STRATEGY_2016-2020_Federal_Democratic_Republic_of_Ethiopia_Ministry_of

⁸¹ Ibid.

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ANNEX B: USAID GENDER DOMAINS

DOMAIN	DESCRIPTION
Laws, Policies, Regulations, and Institutional Practices	The gender analysis will identify the extent to which laws, policies, regulations, and institutional practices contain explicit gender biases (e.g., explicit provisions that treat males and females differently; laws and regulations that criminalize and/or restrict individuals on the basis of their gender identity or expression) or implicit gender biases (e.g., the different impacts of laws, policies, regulations, and practices on men and women because of different social arrangements and economic behavior).
Cultural Norms and Beliefs	Every society has cultural norms and beliefs (often expressed as gender stereotypes) about what are appropriate qualities, life goals, and aspirations for males and females. Gender norms and beliefs are influenced by perceptions of gender identity and expression and are often supported by and embedded in laws, policies, and institutional practices. They influence how females and males behave in different domains and will be explicitly identified in the gender analysis because they affect potential participation of males and females in project activities.
Gender Roles, Responsibilities, and Time Use	The most fundamental division of labor within all societies is between productive (market) economic activity and reproductive (non-market) activity. This is the central social structure that characterizes male and female activity. The gender analysis will examine what males and females do in these spheres, including roles, responsibilities, and time use during paid work, unpaid work (including care and other work in the home), and community service to get an accurate portrait of how people lead their lives and to anticipate potential constraints.
Access to and Control over Assets and Resources	A key component of gender analysis is an examination of whether females and males own and/or have access to and the capacity to use productive resources – assets (land, housing), income, social benefits (social insurance, pensions), public services (health, water), technology – and information necessary to be a fully active and productive participant in society. Analysis of this domain will also include an examination of how a society’s acceptance (or lack thereof) of individuals’ gender identity and/or expression may influence their ability to access and control resources. Gender gaps in access to resources will be identified.
Patterns of Power and Decision-making	This domain of gender analysis examines the ability of women and men to decide, influence, and exercise control over material, human, intellectual, and financial resources, in the family, community, and country. Issues of power often crosscut the other domains of gender analysis as well.