TRANSFORM: PRIMARY HEALTH CARE PROJECT GENDER ANALYSIS

FINAL REPORT

November 5, 2018

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TRANSFORM: PRIMARY HEALTH CARE PROJECT
GENDER ANALYSIS
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The authors’ views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development (USAID) or the United States Government.
Transform: Primary Health Care Project

The Transform: Primary Health Care project is a health program funded by the United States Agency for International Development (USAID) under cooperative agreement No. AID-663-A-17-00002. The program is implemented in collaboration with local government partners by a consortium of organizations led by Pathfinder International, which includes: JSI Research & Training Institute, Inc., Abt Associates Inc., EnCompass LLC, Malaria Consortium, and Ethiopian Midwives Association. Transform: Primary Health Care project seeks to advance health sector actors’ public purpose to contribute to preventing child and maternal deaths, and improving engagement with the Government of Ethiopia on the implementation of its Health Sector Transformation Plan. It focuses primarily on the areas of maternal, newborn, child, and adolescent health and nutrition; family planning and reproductive health; and malaria within Ethiopia’s four major regions of Amhara; Oromia; Southern Nations, Nationalities, and Peoples’ Region; and Tigray.
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<th>Definition</th>
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<tr>
<td>CBHI</td>
<td>Community-based health insurance (program)</td>
</tr>
<tr>
<td>CRC</td>
<td>Caring, respectful, and compassionate</td>
</tr>
<tr>
<td>CSA</td>
<td>Central Statistical Agency</td>
</tr>
<tr>
<td>RMNCAH-N</td>
<td>Reproductive, maternal, newborn, child, and adolescent health and nutrition</td>
</tr>
<tr>
<td>SNNPR</td>
<td>Southern Nations, Nationalities, and Peoples’ Region</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually transmitted infection</td>
</tr>
<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
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</table>
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EXECUTIVE SUMMARY

INTRODUCTION

In the past two decades, Ethiopia has experienced significant improvements in its health system and the health status of its population. Yet, despite such advancements, the population still has limited access to clean water, sanitation facilities, and quality health services, and some areas are characterized by low literacy and persistent food insecurity. Further, as evidenced by a body of existing research, the social determinants of health affect women, men, girls, and boys in different ways.

In response, the 5-year Transform: Primary Health Care project, funded by the United States Agency for International Development, provides technical assistance to the Government of Ethiopia to support its implementation of the Health Sector Transformation Plan, with the ultimate goal of preventing child and maternal deaths. The project focuses primarily on the areas of reproductive, maternal, newborn, child, and adolescent health and nutrition within four major regions of Ethiopia—Amhara; Oromia; Southern Nations, Nationalities, and Peoples’ Region; and Tigray. The project takes a holistic approach to health systems strengthening by addressing four result areas:

1. Improved management and performance of health systems
2. Increased sustainable quality of service delivery across the continuum of care
3. Improved household and community health practices and health-seeking behaviors
4. Enhanced program learning to impact policy and programming related to preventing child and maternal deaths

Between October 2017 and May 2018, EnCompass LLC carried out a comprehensive gender analysis for the Transform: Primary Health Care project in Ethiopia. The purpose of this analysis is to support the Transform: Primary Health Care project in integrating gender-transformative activities through its implementation by addressing multi-leveled power hierarchies across its four result areas for the duration of the project. This report presents the methodology, findings, conclusions, and recommendations of the gender analysis.

METHODOLOGY

In addition to conducting a document review on key themes related to gender equality and its influence on health and health-seeking behaviors in the Ethiopian setting, primary data collection was conducted using two qualitative research methods, with semi-structured guides. Key informant
FINDINGS

The gender analysis findings are presented below by project result area, and where appropriate, are further organized by overarching themes and sub-themes that emerged from the data.

RESULT AREA 1: IMPROVED MANAGEMENT AND PERFORMANCE OF HEALTH SYSTEMS

1.1 Workplace Policies to Support Gender Equality

1. Government officials, health facility managers, and healthcare providers in all four regions knew of affirmative action and its role in hiring female health providers. However, understanding and application of the policy varied.
2. Male and female government representatives, health facility managers, and healthcare providers in all four regions reported that policies and practices for promotion, professional development, salary, and scheduling were applied equally to all staff, regardless of sex.
3. Formal policies on maternity leave existed across regions, although accommodations were informal and inconsistent for female healthcare providers returning to work after having a child and for paternity leave.
4. Across the four regions, government representatives, health facility managers, and healthcare providers described transfers as based on experience, evaluation scores, and affirmative action. However, they reported that female healthcare providers were given special considerations for transfer and placement.

1.2 Factors That Support Female Healthcare Providers’ Performance and Leadership

5. Interviewees reported that they valued learning and sharing, but their organizational culture did not always encourage women’s advancement and leadership, even with supportive policies.
6. Health facility managers and healthcare providers from all four regions stated that community support and acceptance were important to providers’ professional advancement and motivation.
7. Health facility managers and healthcare providers across regions stated that family and spousal support enabled them to stay in their positions.
8. Male and female government representatives, health facility managers, healthcare providers, and health extension workers across regions identified factors in the education sector as opportunities to increase the number of female health workers.
9. Government representatives, health facility managers, and healthcare providers in most regions identified separation from family, weak community infrastructure, and
insufficient compensation and incentives as challenges to increasing and retaining female healthcare providers.

10. Across the four regions, key informants did not view sexual harassment in the facility as a great concern. However, the threat of sexual violence by community members and, to a lesser degree, by male colleagues was a barrier to retaining female healthcare providers.

1.3 Measurement of Gender Equality in Health System Management

11. Male and female interviewees stated that sex discrimination in the workplace did not exist, gender equality did not need to be measured, and measures in place lacked standardization.

RESULT AREA 2: INCREASED SUSTAINABLE QUALITY OF SERVICE DELIVERY ACROSS THE CONTINUUM OF CARE

2.1 Perspectives on Caring, Respectful, and Compassionate Services and Quality of Care

12. Interviewees and group discussion participants stated that warm, welcoming attitudes and behaviors were important for client satisfaction. Group discussion participants also cited a range of healthcare providers’ attitudes and behaviors that negatively affected healthcare-seeking behavior.

13. Group discussion participants described “quality” care as multidimensional, encompassing factors such as availability of services and supplies, length of wait times, and obtaining a positive health outcome.

14. Users of the community-based health insurance program said they were pleased with the scheme, but reported receiving poor quality of care as a result of their participation.

15. Young, unmarried, male group discussion participants in three regions shared that they did not feel healthcare services addressed their needs.

16. Female group discussion participants said they were happy with maternal health services, especially when providers were friendly and caring.

17. Group discussion participants and interviewees said confidentiality in family planning, and HIV and sexually transmitted infection testing and treatment were important. They also noted a few breaches of privacy.

18. For the most part, group discussion participants shared positive experiences with child health, nutrition, and malaria services. However, some shared complaints about poor services.

RESULT AREA 3: IMPROVED HOUSEHOLD AND COMMUNITY HEALTH PRACTICES AND HEALTH-SEEKING BEHAVIORS

3.1 Decision Making

19. Male and female group discussion participants said decision making about seeking health services for themselves or their children was a collaborative process. However, women stated that they often did not have complete autonomy regarding their healthcare, and that men influence women’s decision making in myriad ways.

3.2 Enablers and Constraints to Accessing Reproductive, Maternal, Newborn, Child, and Adolescent Health and Nutrition Services
20. Interviewees and group discussion participants in all four regions reported widespread male opposition to family planning; yet, women were able to access family planning services.

21. Male and female group discussion participants preferred support in seeking healthcare.

22. Male group discussion participants and interviewees reported that women accessed healthcare for reproductive health or maternal and child health services.

23. Group discussion participants across all four regions said they possessed knowledge, attitudes, and practices that positively influenced health outcomes. However, infrastructure barriers persisted, and traditional healers and medicines were valued and used.

24. Group discussion participants and interviewees noted that many cultural and religious taboos about contraception directly affected girls’ and women’s health by limiting their access to family planning services.

3.3 Community-Based Health Insurance Program

25. Male and female group discussion participants across regions said that access to the community-based health insurance program influenced women’s ability to independently access healthcare services.

26. Male and female group discussion participants across the four regions stated that community-based health insurance program contributes to better health-seeking behaviors. They also remarked on implementation challenges, and offered suggestions to strengthen and expand the program.

RESULT AREA 4: ENHANCED PROGRAM LEARNING TO IMPACT POLICY AND PROGRAMMING RELATED TO PREVENTING CHILD AND MATERNAL DEATHS

4.1 Collection and Use of Data

27. Interviewees reported that data collection systems support managers in monitoring and evaluation, and decision making on service delivery.

28. Health facility managers and government representatives reported data gaps, and that collection of sex- and age-disaggregated data varied based on health areas, populations, and health management information system capabilities.

4.2 Respondents’ Recommendations for Expanded Programming

29. Interviewees across the four regions consistently highlighted three areas where expanded programming is needed: (1) gender-based violence prevention and response; (2) male engagement in family planning; and (3) community sensitization to gender inequality.

CONCLUSIONS

Overall, the findings show that the Government of Ethiopia and other key stakeholders recognize gender disparities in the health sector, from the facility to the community level, and have made strides in addressing those inequalities. However, significant efforts are still needed in a number of areas to address both the supply and demand sides of the health sector for a holistic strengthening of health systems. For instance, on the supply side, there is a need to improve both awareness and the
implementation of policies and standard operating procedures in healthcare facilities, as well as to consistently expand the provision of caring, respectful, and compassionate services by providers. On the demand side, among other potential areas for engagement, there is a need to enhance women’s autonomy in healthcare decision-making, and to mitigate men’s opposition to the use of family planning services.

**Recommendations**

Drawing from the findings and the data consultation meeting, a number of recommendations emerged under each result area with regard to how the Transform: Primary Health Care project can work with and support its partners to strengthen gender integration, build on what is working, and improve areas that are impeding achievement of outcomes intended by the project and government. A full list of these recommendations is provided in the Recommendations section of the report.
INTRODUCTION

This report presents the methodology, findings, conclusions, and recommendations of the gender analysis carried out October 2017 through May 2018 for the Transform: Primary Health Care project in Ethiopia, funded by the United States Agency for International Development (USAID).

PROJECT OVERVIEW

The Transform: Primary Health Care project is a 5-year project providing technical assistance to the Government of Ethiopia to support its implementation of the Health Sector Transformation Plan, with the ultimate goal of preventing child and maternal deaths. The project focuses primarily on the areas of reproductive, maternal, newborn, child, and adolescent health and nutrition (RMNCAH-N) within four major regions of Ethiopia—Amhara; Oromia; Southern Nations, Nationalities, and Peoples’ Region (SNNPR); and Tigray.

The project takes a holistic approach to health systems strengthening by addressing four result areas:

1. Improved management and performance of health systems
2. Increased sustainable quality of service delivery across the continuum of care
3. Improved household and community health practices and health-seeking behaviors
4. Enhanced program learning to impact policy and programming related to preventing child and maternal deaths

The project’s results framework is shown in Annex 1: Transform: Primary Health Care Project Results Framework

PURPOSE OF GENDER ANALYSIS

Aligned with the USAID’s Gender Equality and Female Empowerment Policy, the Transform: Primary Health Care project recognizes that gender is a key social determinant of health, and that addressing gender gaps and opportunities is crucial to preventing maternal, neonatal, and child deaths. Recognizing gender equality as an integral component, the project strives to integrate gender-transformative activities throughout its implementation by addressing multi-leveled power hierarchies across its four result areas for the duration of the project. In collaboration with government actors, the project aims to create opportunities for stakeholders to actively challenge gender norms, enable greater social and political influence for women in communities and healthcare leadership, and address power differentials between genders. The project’s gender integration efforts will ensure that policies, practices, and behaviors at all levels of service delivery management and provision are examined, challenged, and transformed into enablers of women’s leadership, male engagement to support gender equality, and gender-equitable access to and delivery of services.

To achieve the project’s gender integration efforts, the gender analysis aimed to answer the following overarching question:

What gender gaps and opportunities does the Transform: Primary Health Care project need to address to achieve its intended results?

BACKGROUND

Aligned with the USAID’s Gender Equality and Female Empowerment Policy, the Transform: Primary Health Care project recognizes that gender is a key social determinant of health, and that addressing gender gaps and opportunities is crucial to preventing maternal, neonatal, and child deaths. Recognizing gender equality as an integral component, the project strives to integrate gender-transformative activities throughout its implementation by addressing multi-leveled power hierarchies across its four result areas for the duration of the project. In collaboration with government actors, the project aims to create opportunities for stakeholders to actively challenge gender norms, enable greater social and political influence for women in communities and healthcare leadership, and address power differentials between genders. The project’s gender integration efforts
will ensure that policies, practices, and behaviors at all levels of service delivery management and provision are examined, challenged, and transformed into enablers of women’s leadership, male engagement to support gender equality, and gender-equitable access to and delivery of services.

While there have been notable improvements in the health sector, the population still has limited access to clean water, sanitation facilities, and quality health services, and some areas are characterized by low literacy and persistent food insecurity. These factors, among others, contribute to a high incidence of communicable diseases, malnutrition, and maternal, neonatal, and child mortality.

The social determinants of health, including laws, policies, regulations, and institutional practices; cultural norms and beliefs; gender roles, responsibilities, and time use; access to and control over assets and resources; and power and decision-making affect women, men, girls, and boys in different ways. Additional background information on each of these critical areas, drawn from the literature review conducted for the purposes of this report, are provided in turn below.

**LAWS, POLICIES, REGULATIONS, AND INSTITUTIONAL PRACTICES**

The following Ethiopian laws, policies, regulations, and institutional practices have contributed to addressing gender inequalities within the healthcare system by creating new policies where none previously existed, or revising policies that were historically inequitable or harmful (Social Impact 2016; Brhane & Kidane-Mariam 2016). A summary of recent laws and policies that promote gender equity in Ethiopia are provided in Table 1.

**Table 1: Recent Laws and Policies for Gender Equity in Ethiopia**

<table>
<thead>
<tr>
<th>Year</th>
<th>Law/Policy</th>
<th>Focus</th>
</tr>
</thead>
<tbody>
<tr>
<td>1993</td>
<td>National Policy on Ethiopian women</td>
<td>To engage more women in the political, social and economic spheres.</td>
</tr>
<tr>
<td>1998</td>
<td>National Policy on HIV/AIDS</td>
<td>Includes the importance of gender equality, and prohibits discrimination against people living with HIV (PLHIV) in employment, education, access to public facilities, and</td>
</tr>
<tr>
<td>Year</td>
<td>Law/Program</td>
<td>Impact/Key Features</td>
</tr>
<tr>
<td>------</td>
<td>-------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>2000</td>
<td>Revised Family Code</td>
<td>Raised the age of marriage from 15 to 18 for both sexes.</td>
</tr>
<tr>
<td>2004</td>
<td>Criminal Code</td>
<td>Criminalizes rape, female genital mutilation and cutting, violence against a marriage partner, and marriage by abduction of a minor (under 18 years of age).</td>
</tr>
<tr>
<td>2006</td>
<td>National Action Plan for Gender Equality</td>
<td>Operationalizes the national policy on women; identifies priorities for interventions by donors and the government of Ethiopia.</td>
</tr>
<tr>
<td>2013</td>
<td>National Strategy and Action Plan on Harmful Traditional Practices against Women and Children in Ethiopia</td>
<td>Institutionalizes national, regional and grassroots level mechanisms to prevent and eliminate all forms of harmful traditional practices.</td>
</tr>
</tbody>
</table>

While such laws and policies have contributed to Ethiopia’s progress, there still remain gaps that affect much of the population. Due to limited funding and lack of enforcement, women and girls remain disadvantaged compared to men and boys in areas such as literacy, health, livelihoods, and basic human rights. For instance, while the government has legal and policy provisions in place to prevent and respond to gender-based violence (GBV), there is a gap between what is written into policy, and what is implemented and enforced (Medie 2013). Services for GBV survivors, especially those who are sexually assaulted, are extremely limited or overwhelmed by the number of cases and
limited capacity and staff (Medie 2013). These services are even more limited for men and boys in rural areas (Social Impact 2016).

Furthermore, in 2010, a gender directorate was established in each of the 23 federal government sectors, which is overseen at the national level by the Ministry of Women and Children’s Affairs. In many cases, however, these directorates are not well integrated into the core units of their respective institutions, limiting their leverage to influence the mandates of these bodies (UN Women 2014). Many of these directorates also lack capacity and funding to achieve their goals (Social Impact 2016; USAID 2016).

**CULTURAL NORMS AND BELIEFS**

A number of long-standing cultural norms and beliefs adversely affect health outcomes for both women and men. Driven by social definitions of masculinity, many men engage in risk-taking behaviors, such as excessive consumption of alcohol and drug use, creating patterns of morbidity and mortality among the male population (PPD 2014). In addition, it was reported that men typically do not participate in testing with their partners; the most common reasons given for their absence was their lack of availability, not seeing the importance of testing, and the belief that their results are the same as their wife’s or partner’s (Ramsey 2012). Men generally consider reproductive health services to be “women’s health services,” and in the event that they accompany their wives to health facilities when accessing such services, HEWs usually approach and tend to women first (Ramsey 2012).

There has been increased awareness on the importance of health centers and services for pre-natal care and child birth, but women continue to opt for home deliveries due to a variety of reasons, including lack of privacy, poor client provider interactions and a lack of continuous care in healthcare facilities (Adinew & Assefa 2017). The physical comfort of being at home and in a known community, which may also provide psychological support, likely influences women to deliver at home rather than in health centers (Adinew & Assefa 2017). Home-birth facilities are gradually becoming more popular at heath centers, but have yet to reach remote locations; this further discourages women from accessing health centers and their services for pre-natal care and child birth (Ramsey 2012).

**GENDER ROLES, RESPONSIBILITIES, AND TIME USE**

Existing research highlights a number of disparities between women and men with regard to roles and responsibilities, as well as associated time use, both within and outside the home. A 2013 study showed that in the four regions where the Transform: Primary Health Care project is active, a woman spends, on average, between 6 and 13 hours a day on household duties such as food
preparation (PRIN International Consultancy & Research Services PLC 2013). Between household duties and childcare, the significant amount of responsibilities attributed to women make it increasingly difficult for them to access health centers and their associated services, as well as to attend informative meetings or take up formal work (PRIN International Consultancy & Research Services PLC 2013). A recent study also showed that husbands agreed that their wives should attend community events and access services that HEWs offer within their communities, while simultaneously agreeing that a woman’s domestic duties remain her first priority (PRIN International Consultancy & Research Services PLC 2013).

Household duties also burden young girls, having particularly detrimental impacts on their educational attainment. A study showed that the rate of female enrollment in secondary education is low due to the fact that girls must prioritize domestic duties, which causes them to fall behind or withdraw from their studies (Abelson & Banerjee 2017). As for higher education, the expansion of universities in Ethiopia has contributed to increased enrollment for both males and females; nonetheless, the percentage of female enrollment is still considerably lower than that of males, thereby affecting their employability in the formal work sector (USAID 2016).

Further, while there has been an increase in the percentage of women hired into the formal work sector, they are typically paid less than men, and tend to take positions in family owned businesses rather than become salaried employees; women are also underrepresented in professional, technical, and managerial roles (CSA, Federal Democratic Republic of Ethiopia and DMISS Plc. 2015; USAID 2016). For example, managerial roles in the healthcare system are generally male-dominated, and female representation across leadership roles and health facility boards is limited. Moreover, in healthcare related occupations, it is more common to find women in lower-status positions as compared to their male colleagues; in particular, there is limited opportunity for women HEWs to move into positions with increased responsibility and commensurate wages (Jackson & Kilsby 2015).

**ACCESS TO AND CONTROL OVER ASSETS AND RESOURCES**

In Ethiopia, women are typically disadvantaged with regard to the ownership and use of resources; they have less access to media such as radio, television, and other technologies (USAID 2016; PRIN International Consultancy & Research Services Plc. 2013), transportation, and face-to-face contact with HEWs, which all contribute to women and girls’ difficulty in accessing reliable and informative healthcare messaging. Lack of transportation is another factor that prevents many women and men from accessing healthcare facilities, which are often located far from residences (Jackson & Kilsby 2015). This lack of transportation also affects the ability of HEWs (who are primarily female) to reach the communities they serve, often leaving community members with inadequate access to
health services and information—a contributing factor to the high morbidity rate among child-
bearing women (Jackson & Kilsby 2015; Greene et al. 2012).

Access to water has improved over time, but women and girls—especially those living in rural
areas—bear the disproportionate time and energy burden of collecting water. Travelling to water
sources exacerbates women’s and girls’ risk of experiencing GBV (USAID 2016). A recent study has
corroborated the positive impacts of improved access to water and sanitation on development
outcomes in health, productivity, and overall quality of life, especially for women and girls (Social
Impact 2016).

**PATTERNS OF POWER AND DECISION MAKING**

Significant imbalances exist with regard to the overall power dynamics between women and men in
Ethiopia; such imbalances are notable in that they impact healthcare related decision-making.
Although there has been an increase in the use of contraception across Ethiopia, the overall
percentage of married women using contraception remains low (USAID 2016). Women often
require their husband’s or male partner’s consent to acquire and use contraception; some women use
contraception, such as birth control, in private and conceal it from their partners due to fear of
rejection or becoming a victim of violence (Geleta, Birhanu, Kaufman, & Temesgen 2015).

Power imbalances contribute to the perpetuation of myriad forms of GBV; types of GBV in
Ethiopia include sexual coercion and abuse, rape, domestic violence, and harmful practices such as
early and forced marriage (including abduction) and female genital mutilation and cutting. Recent
studies show that 68 percent of women and 45 percent of men agree wife beating is acceptable
(USAID 2016), and 35 percent of ever married women have reported that they have experienced
some sort of violence (physical, emotional, or sexual) from an intimate partner (CSA and ICF,
2016). As noted, laws and policies against GBV exist, but are often not enforced, and there are few
facilities for GBV survivors in the country; hospitals that provide relevant services are also
overburdened (Brhane & Kidane-Mariam, 2016). Although there has been a push by the
government to implement policies and regulations against harmful practices, many communities—
especially those that are led by men—rely on tradition and continue to practice these various forms
of gender-based violence (Social Impact 2016).

Women also face barriers to decision-making in the formal work sector. A 2015 study showed that
many female HEW’s did not feel that they were heard when it came to making decisions in the
workplace, specifically with regard to workload, lack of transportation, and a general lack of
opportunities for career development (Jackson & Kilsby, 2015).
GENDER ANALYSIS APPROACH

The Transform: Primary Health Care project gender analysis employed a unique, collaborative approach that engaged project staff and key stakeholders throughout various stages, from its inception to the development of final conclusions and recommendations. This participatory process was undertaken to help ensure alignment with project priorities and use of the gender analysis findings for relevant, meaningful, and effective gender integration for the duration of the project.

The findings, conclusions, and recommendations reported here will be shared among partners and inform the project’s gender strategy, annual theory of change process, and gender integration in project activities, including capacity building, a landscape analysis of gender-based violence services, male engagement interventions, and other gender-transformative efforts. A gender assessment to be conducted in project year 4 will determine the extent to which the project has addressed the gender gaps and opportunities identified via this gender analysis, and strengthened gender integration across the project’s result areas (see Exhibit 1).
RESEARCH QUESTIONS

The research team designed and delivered a gender analysis design workshop in Addis Ababa on June 6–7, 2017, with project technical staff, USAID representatives, government counterparts from the Ministry of Health, and other project partners. The workshop aimed to collaboratively define the scope, sample, and methodology of the project’s gender analysis. Participants collectively identified key areas of inquiry for the gender analysis for each of the project’s four high-level results. The research team reviewed these inputs, and developed key questions and sub-questions to guide the gender analysis. These questions were then shared with key technical staff to validate them. Based on their feedback, the research team further refined and used the questions to guide the development of the data collection tools, which were translated to local languages. The final key questions are presented in Exhibit 2; the full set of questions and sub-questions is in Annex 2: Gender Analysis Research Questions.

Exhibit 2: Gender Analysis Research Questions by Project Result Area

<table>
<thead>
<tr>
<th>Project Result Area</th>
<th>Key Research Questions</th>
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<tbody>
<tr>
<td>1. Improved management and performance of health systems</td>
<td>• What supports or hinders gender equality in health systems management and performance at the primary healthcare level?</td>
</tr>
<tr>
<td>2. Increased sustainable quality of service delivery across the continuum of care</td>
<td>• What supports or hinders the quality of RMNCAH-N service delivery?</td>
</tr>
<tr>
<td>3. Improved household and community health practices and health-seeking behaviors</td>
<td>• What supports or hinders women and men in seeking RMNCAH-N services?</td>
</tr>
<tr>
<td></td>
<td>• What gender norms and dynamics support or hinder household and community health and nutrition practices?</td>
</tr>
</tbody>
</table>
4. Enhanced program learning to impact policy and programming related to preventing child and maternal deaths

- What supports or hinders managers in collecting and using sex- and age-disaggregated data for reporting, learning, and decision making?
- What research on gender norms and dynamics is needed to inform policy and programming to end preventable child and maternal deaths?

METHODOLOGY

The gender analysis employed an appreciative, qualitative, and participatory methodology to answer the key research questions developed in consultation with project staff and key stakeholders at the gender analysis design meeting held in Addis Ababa in June 2017. This gender analysis design provided an in-depth understanding of the existing gender norms and dynamics relevant to the project’s result areas.

RESEARCH METHODS

The team gathered secondary data from published sources and primary data from a sample of each of the project’s four geographic regions through key informant interviews and participatory group discussions. Together, these data sources were triangulated to inform the gender analysis findings, conclusions, and recommendations. The research methods are described below and the data collection tools are presented in Annex 3: Data Collection Tools.

DOCUMENT REVIEW

The gender analysis team conducted a document review on key themes related to gender equality and its influence on health and health-seeking behaviors in the Ethiopian setting, particularly in Amhara, Oromia, SNNPR, and Tigray regions. The review examined publications, studies, data, and surveys from the Government of Ethiopia and relevant ministries, USAID documents, program reports from Transform project partners, and prior gender- and health-related studies, as well as documents from other organizations in Ethiopia. The document review also included the Transform baseline study carried out by the Transform: Monitoring, Evaluation, Learning, and Adapting project, which gathered preliminary information about the status of access to health services, quality of care, and gender dynamics in the four project regions.

Team members reviewed and summarized the documents using a matrix that organized key information by the gender analysis domains recommended by USAID:

- Laws, policies, regulations, and institutional practices
• Cultural norms and beliefs
• Gender roles, responsibilities, and time use
• Access to and control over assets and resources
• Patterns of power and decision making

The document summaries were then analyzed according to the key research questions presented above, in Exhibit 2. The findings from the document review provided an overall context for the gender analysis, guided the development of the sampling and primary data collection tools, and informed the interpretation of primary data to develop the findings and conclusions.

**PRIMARY DATA COLLECTION**

Primary data collection included two qualitative research methods, using semi-structured guides:

• Key informant interviews (with health providers, health facility managers, health extension workers, and government representatives)

• Participatory group discussions (with both married and unmarried men and women, ranging in ages from 15 to 60 years)

**KEY INFORMANT INTERVIEWS**

Data collection teams conducted semi-structured interviews with key informants, including healthcare providers, health facility managers, health extension workers, and government representatives from the woreda and zonal health offices, and the Women and Children Affairs office. The teams closely followed informed consent processes throughout data collection. To the extent possible, the team recruited an equal number of male and female key informants. However, this proved to be very difficult with health facility managers because women are not equally represented in managerial roles. Interviews took about 1 hour on average to complete.

**PARTICIPATORY GROUP DISCUSSIONS**

The data collection teams conducted participatory group discussions with six types of respondents, after obtaining informed consent:

• Married women aged 15–24
• Married women aged 25–45
• Unmarried women aged 15–24
• Married men aged 15–24
• Married men aged 25–60
• Unmarried men aged 15–24

The division of different groups according to sex, age, and marital status enabled data collection to focus on a diverse set of needs, health-seeking behaviors and experiences in accessing healthcare services. The group selection criteria also took into account key characteristics that influence the comfort level of participants in sharing their experiences in a group setting (i.e., sex, age, and marital status). Each group was comprised of six to eight participants. Group discussions took about 2 hours on average to complete.

Participatory group discussions differ from focus group discussions in that data collectors use participatory activities to complement the questions asked and foster discussion among participants. For the purposes of this gender analysis, the group discussions included community mapping and a “paving stones” activity. Using visual aids, these activities asked participants to identify health resources in their community, as well as factors that support or hinder community members (of the same sex and age group) in accessing healthcare services.

**DATA COLLECTORS TRAINING**

In preparation for data collection, 16 qualitative data collectors and 6 Transform: Primary Health Care project staff participated in a gender analysis data collectors’ training over the course of 4 days, from October 10 to October 13, 2017, in Addis Ababa. The aim of the workshop was to prepare data collectors to conduct key informant interviews and participatory group discussions in a manner that yields data relevant to understanding gender gaps and opportunities in Ethiopia’s primary healthcare system. The training focused on enhancing the capacity of data collectors to (1) exhibit respect and sensitivity toward gender-related issues, while engaging with key informants and participatory group discussions participants; (2) use best practices in qualitative data collection; and (3) articulate the value of the gender analysis. The training methodology gave participants ample opportunities for hands-on practice in:

• Conducting qualitative data collection procedures
• Using techniques for probing
• Addressing ethical issues (including disclosures of gender-based violence)
• Following informed consent processes
• Capturing and producing quality transcripts
A field guide was also prepared and distributed to harmonize the overall field-level data collection procedures, and clarify the expected roles and responsibilities of each data collection team member. On the third day of the training, participants went to Finfine Zuria cluster to pilot the data collection tools and practice interviews with healthcare providers. After the field practice, a reflection session was held to clarify any remaining questions regarding the data collection tools and process.

**DATA COLLECTION**

The gender analysis research protocol was submitted in October 2017 to four regional health bureaus for *ethical clearance*. Once approval of the research protocol was obtained, four data collection teams (one in each region) carried out the interviews and group discussions in 16 *woredas* in November and December 2017. Each team was comprised of four qualitative researchers led by the project’s regional gender officer who acted as team lead, managing the data collection schedule and providing technical oversight and quality control.

Data collectors worked in pairs, with one person responsible for leading an interview or group discussion and the other person responsible for note-taking. Notes were taken as close to verbatim as possible, with recordings used for backup to fill in gaps in note-taking.

Data collectors conducted their work with members of the same sex; that is, only male data collectors conducted data collection with male participants, and only female data collectors conducted data collection with female participants.

**RESEARCH SITE SELECTION**

The gender analysis teams conducted primary data collection in high-performing and low-performing *woredas* in each of the four geographic regions. *Woreda* selection was done in collaboration with the project’s regional technical coordinators and regional health bureau representatives, and sought to capture religious and cultural diversity, geographic spread within the region, areas with harmful practices and/or under-resourced for addressing significant gender gaps, and varying levels of accessibility to health services (although for practical reasons, all selected *woredas* were accessible from the zonal town).

Interviews and discussions took place in 16 *kebeles*, 1 in each of 16 *woredas*. The number of selected *woredas* varied according to the number of project *woredas* in the regions:

- Two high-performing and two low-performing *woredas* in Amhara
- Two high-performing and four low-performing *woredas* in Oromia
• Two high-performing and two low-performing *woredas* in SNNPR
• One high-performing and two low-performing *woredas* in Tigray

**RECRUITMENT OF PARTICIPANTS**

The project regional gender officers and field research team worked closely with local gatekeepers in each *woreda* to recruit key informants and group discussion participants. Individual participants suggested by local gatekeepers were screened for sex, age, and marital status. To guide the selection of participants, the team assessed basic demographic variables through government or health facility data, where available, and considered local cultural variations and social groupings when composing groups to represent various segments of localities.

**SAMPLE DISTRIBUTION**

A total of 187 data collection events were completed successfully in 16 *woredas* in the four project regions, of which 91 were key informant interviews and 96 were participatory group discussions. The final sample distribution is included in Exhibit 3 and Exhibit 4.

**Exhibit 3: Key Informant Interviews by Region**

<table>
<thead>
<tr>
<th>Region</th>
<th>Providers</th>
<th>Managers</th>
<th>Health Extension Workers</th>
<th>Government Representatives</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Female</td>
<td>Male</td>
<td>Female</td>
<td>Male</td>
</tr>
<tr>
<td>Amhara</td>
<td>4</td>
<td>4</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Oromia</td>
<td>5</td>
<td>7</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>SNNPR</td>
<td>4</td>
<td>4</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Tigray</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>15</td>
<td>17</td>
<td>1</td>
<td>15</td>
</tr>
</tbody>
</table>

**Exhibit 4: Participatory Group Discussions with Community Members, by Region**

<table>
<thead>
<tr>
<th>Region</th>
<th>Married Female</th>
<th>Married Male</th>
<th>Unmarried Female</th>
<th>Unmarried Male</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>15–24</td>
<td>25–45</td>
<td>15–24</td>
<td>25–60</td>
</tr>
<tr>
<td>Amhara</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Oromia</td>
<td>6</td>
<td>6</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>SNNPR</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Tigray</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>16</td>
<td>16</td>
<td>16</td>
<td>16</td>
</tr>
</tbody>
</table>

1 All health extension workers in the research sites were female. Only a handful of male health extension workers exist in Ethiopia, mostly in regions where the team did not conduct the gender analysis.
A review of health management information system and administrative reports was also completed with a field checklist. Overall, the gender analysis data collection process went smoothly in terms of logistics, coordination, and recruitment of appropriate participants, and with the cooperation from woreda health offices, while maintaining required ethical standards.

**DATA CODING AND ANALYSIS**

Upon completion of the data collection, the data collectors typed up their notes in English with the aid of recordings, and regional gender officers and the senior gender advisor reviewed and finalized transcripts in January and February 2018.

Completed, approved transcripts were uploaded to Dedoose Version 7.0.23, a Web-based application for managing, analyzing, and presenting qualitative and mixed-methods research data. Dedoose is a cross-platform application that allows collaborative coding by multiple team members and assessment of inter-coder reliability. The gender analysis team used Dedoose to code and analyze data from the document review, key informant interviews, and participatory group discussions from February to April 2018.

The team developed a draft coding structure based on the gender analysis questions and a review of a sample of transcripts. Then, they piloted the codebook to ensure relevance of the coding structure to the data and consistent code application by the analysts. Each team member involved in the qualitative analysis coded the same subset of three transcripts, then compared and discussed their code applications to ensure high reliability. The team then refined the codebook based on the pilot feedback and applied the revised coding structure to all transcripts during the first stage of deductive analysis. In the second stage, the team examined each code to generate emergent themes through an inductive process, which allowed respondents’ voice and experiences to emerge as salient themes, and avoided predetermined or expected hypotheses to define the findings.

**DATA ANALYSIS AND INTERPRETATION MEETING**

After this thematic coding was finalized, the research team drafted summaries of each theme in preparation for a participatory data analysis and interpretation meeting at EnCompass headquarters on March 19–20, 2018. Eight team members who coded transcripts in Dedoose, and the Transform project manager, technical advisor, and gender advisor, who traveled to EnCompass headquarters, discussed the significance of and interrelationships among the themes, guided by the gender analysis questions. They then jointly identified the next steps for further data analysis,
including additional disaggregation by key descriptors such as sex, age, marital status, region, and health area. This final round of data analysis was used to generate draft findings in April 2018.

DATA CONSULTATION MEETING

The gender analysis team presented draft findings to project staff and key stakeholders in a face-to-face, participatory, 2-day data consultation meeting held in Addis Ababa on May 16–17, 2018, to validate and interpret the gender analysis findings, and collaboratively develop conclusions and recommendations to guide the project. The inputs from the data consultation meeting were taken into account while developing this final gender analysis report.

LIMITATIONS

This gender analysis is limited by the following factors:

Limitations of Qualitative Methods: Because the gender analysis relies on qualitative data gathered with a limited, purposeful sample of participants, the findings should not be interpreted to apply to the whole population of healthcare providers, health services users, government representatives, and other categories of participants. Additionally, while in all cases notes taken during the key informant interviews were supplemented by audio recordings to fill in the gaps, in a few cases, the audio recording failed and gaps in the notes had to be filled in based on memory recall.

Limitations of Sampling Design: Although the sampling design for the gender analysis was based on categories of high- and low-performing woredas, this categorization of woredas shifted over the course of the primary data collection and, therefore, was not part of the data analysis or reporting. Sampling also did not include older unmarried women and men due to negligible number of unmarried individuals in these age groups in the Ethiopian context. Additionally, a different woreda than originally planned was sampled in Oromia due to a conflict and concomitant safety issues that emerged during data collection.

Limitations of Data Sources: While care was taken to minimize bias during the recruitment process, the study relied on local gatekeepers who may have skewed who was selected as participant in the key informant interviews or participatory group discussions. Specifically, one participatory group discussion in a border town needed to be reconvened with participants who were not recent migrants to the area because the facilitator did not know the language of the participants.
FINDINGS

This section presents the gender analysis findings by project result area, organized by overarching themes that emerged from the data.

RESULT AREA 1: IMPROVED MANAGEMENT AND PERFORMANCE OF HEALTH SYSTEMS

The gender analysis for Result Area 1 focused on the enablers of and constraints to gender equality in health systems management and performance at the primary healthcare level.

1.1 WORKPLACE POLICIES TO SUPPORT GENDER EQUALITY

Government officials, health facility managers, and healthcare providers in all four regions knew of affirmative action and its role in hiring female health providers. However, understanding and application of the policy varied.

Government officials, health facility managers, and healthcare providers interviewed in all four regions stated that female applicants were given additional percentage points on their hiring applications, based on their sex. The details of how affirmative action was applied were inconsistent. Some respondents said three points were added to female candidates’ scores, others said five points were added, and others said there were a certain number of positions set aside for female staff members.

No discernable differences in understanding of the policy across regions or respondents’ sex were observed.

_We give 5-percent affirmative action for the female [candidate]. Even if the two [candidates are] competent on the same level, we select the female [candidate]._ —Male health facility manager, Tigray

_If a certain job invites both male and female applicants to hire 15 persons, it is stated as a rule in our office that 10 of the positions are open for competition for both sexes, while the remaining 5 positions should be occupied by females. This is believed to allow females to take up more than 50 percent of the positions._ —Male government representative, Amhara

_There are positions that are left for women, like that of the gender officer position and the health extension workers working in the rural areas. Such positions are set aside for women._ —Male government representative, SNNPR

One government representative in Amhara poignantly noted that although there were men who objected to the affirmative action policy, the policy’s intention was to redress inequalities, not strip men of their power.
Several male staff, even people in the local community, complain about the government’s gender policy. They feel that the government is gender-biased because it adds three points to female applicants who compete with male applicants for a job. The feeling among men can be explained in terms of female dominance in which females are favored in every respect. However, affirmative action is not an agenda to ensure female dominance over males… It is intended to address gender inequality, which has made females less privileged socially, economically, and politically throughout history. —Male government representative, Amhara

One female health facility manager in Amhara seemed to indicate that affirmative action policies were not yet in place in her facility, but stressed the potential of such policies for increasing the number of female health providers.

The second important step we need to consider in helping females’ recruitment in the health profession is affirmative action. This is a process in which recruiters show gender sensitivity by adding some points to female candidates for work. Although I do not think that affirmative action for females is basically important for recruitment, it can still be an option for supporting female candidates. Affirmative action is, actually, necessitated by the need to address females’ disadvantageous positions in the social, economic, and political spheres. —Female health facility manager, Amhara

Despite the affirmative action policies, there was a perception that women were underrepresented in higher level positions, whereas they tended to dominate in lower level positions, such as health extension workers, in part due to the educational requirements of higher level positions.

Except in the case of [health extension workers], the number of the male health professionals is surpassing females. … You can see that there is a decreasing number of females as you go up the ladder from bachelor’s degree to master’s level. —Male government representative, Amhara

Male and female government representatives, health facility managers, and healthcare providers in all four regions reported that policies and practices for promotion, professional development, salary, and scheduling were applied equally to all staff, regardless of sex.

Most male and female government representatives, health facility managers, and healthcare providers in all four regions expressed that policies and practices related to job performance, promotion, professional development, and salary were applied equally to all staff, regardless of sex. A few interviewees mentioned issues of equality within these job aspects, but their perspectives were not the majority.

Across all four regions, interviewees stated that promotion was based on performance, experience, and education, and there was no discrimination based on sex.

Career advancement is the same for both men and women. Anyone whose service is 2 years will receive the career advancement and it will be given… to all staff based on 2 years’ service intervals. —Male health facility manager, SNNPR
Interestingly, only a few government representatives, health facility managers, and healthcare providers in any region commented on the application of affirmative action for promotions. One female government representative reported that female staff seeking promotion were given five additional points on their applications.

Several interviewees in Tigray, and a few in Amhara, noted that training attendance was tracked by a register to monitor the frequency of an individual’s participation and ensure equity in training attendance. One male government official mentioned that his office encouraged facilities to choose staff members who had not previously attended training; however, he noted that there was no follow-up system to ensure equity in male and female participation, and perhaps there should be one in the future.

There was little mention of applying affirmative action approaches to ensure female health workers had access to in-service training opportunities. One female healthcare provider in Oromia expressed that women should have priority because they have been disadvantaged “from the very beginning.” A health facility manager in SNNPR explained that his facility took an approach similar to affirmative action for professional development, despite the lack of government policy although, he stated, they feared reprisal if other staff challenged its application.

> When there is short-term training or other opportunity, we support women with 4 percent, although this percentile is not regular as affirmative action for the competition… This 4-percent affirmative action is given to women without policy evidence at hand and if someone argues against it, we may void it, fearing the consequences. —Male health facility manager, SNNPR

Interviewees who mentioned salary stated there was no discrimination among facility staff. Some interviewees spoke of a pay scale for health workers through civil service policy based on education and experience. A female government respondent in Oromia explained that they used a point-based system to calculate remuneration, giving points for job performance, behavior, and services provided. One healthcare provider noted the potentially negative consequence on motivation if male and female healthcare providers were not paid the same.

> If women are not paid equally as men, the motivation they have for work would be less and women would complain that they aren’t paid equally with men. Since they do the same work as men, they would be demoralized. —Male healthcare provider, Oromia

Interviewees mentioned that day and night shifts were assigned to men and women equally so there was no discrimination in working hours. However, female healthcare providers noted that night duty could put women in difficult or unsafe circumstances, which should be taken into account.

> During night duty, if female staff are assigned during an emergency, we only come out of our room to serve if the guard calls us. Otherwise, we do not come out because there are a number of cases where men drink and come to the health center. They knock and disturb us. Some of them insult us. —Female healthcare provider, Oromia
Across all four regions, male and female interviewees were aware that women received 3 months of maternity leave. Most indicated that this included 1 month prior to and 2 months after delivery. Some interviewees (both male and female) commented that it was beneficial to work until delivery and take the full 90 days after delivery.

Spontaneous discussion about breastfeeding on the job came predominantly from female respondents. They indicated that the 3-month maternity leave policy made it difficult for women to exclusively breastfeed for 6 months, despite the evidence to support this practice. Some facilities addressed this by making allowances for new mothers to come in late or breastfeed while working, but this was done informally, and required the facility and other healthcare providers to cover the woman’s work during those absences. In Tigray, breastfeeding women were not assigned outreach work, although they were not given time to breastfeed during their work shifts—and if they did, it was noted negatively in their performance evaluations.

*In addition to the maternity leave, she has time to breastfeed her child like leaving work early or coming late to work. [These absences] are covered by the male health workers, but all those activities are done by the willingness of the coworkers. This has to be supported by policy so it will be the right [of female health workers].—Female healthcare provider, Tigray*

*In regard to flexible work schedules, there is a big problem... for female staff who breastfeed. For example, we have three staff who are breastfeeding. They are not given time for breastfeeding so when they are late [due to breastfeeding], their performance is evaluated accordingly. The only support given to breastfeeding staff is they are not assigned to outreach activities. —Female healthcare provider, Tigray*

Interviewees recognized that there was no formal paternity leave policy and some stated that, informally, 5 days of paternity leave was provided to new fathers at the discretion of the facility. One male healthcare provider reported having to use sick leave following the birth of his child.

**Across the four regions, government representatives, health facility managers, and healthcare providers described transfers as based on experience, evaluation scores, and affirmative action. However, they reported that female healthcare providers were given special considerations for transfer and placement.**

Male and female government representatives, health facility managers, and healthcare providers in all regions reported that more male health facility staff were assigned to remote areas than female staff. Male and female interviewees in all four regions stated that women were not transferred to rural or difficult-to-reach places due to insecurity, family and domestic duties, and the belief that men are better suited to traveling long distances by foot. There was some mention of women being accompanied by a security guard or male staff when going to remote areas.
One female healthcare provider in Oromia said female staff preferred to be assigned to health centers closer to towns, and that women received additional points on their transfer applications to allow them to be closer to their families and be transferred from rural areas to towns where there are better facilities. This practice of assigning female providers to health posts in town (over remote posts) was viewed as gender-sensitive and part of the effort to mainstream gender. There were some negative reactions to the practice. For example, a female healthcare provider in Oromia said not being assigned to remote areas denied her per diem associated with the work.

### 1.2 FACTORS THAT SUPPORT FEMALE HEALTHCARE PROVIDERS’ PERFORMANCE AND LEADERSHIP

Interviewees reported that they valued learning and sharing, but their organizational culture did not always encourage women’s advancement and leadership, even with supportive policies.

Male and female interviewees across the four regions, especially married women, reflected on the value they placed on learning opportunities, particularly peer-to-peer learning, even though these opportunities did not often result in increased influence and leadership.

> I got an education opportunity to upgrade from clinical nurse to certified midwife last year… In addition, I had the opportunity to learn from senior staff that are more experienced than me, and attend different trainings that helped me to strengthen my skills. I got training prepared by government and different NGOs [nongovernmental organizations]. —Male health facility manager, Oromia

> Those who have received trainings train other staff in the facility… They gather the whole staff and train them on the issue they acquired from trainings. —Female health extension worker, Amhara

Interviewees remarked that women experienced a degree of animosity about special considerations or opportunities awarded to them. In some cases, men regarded their female colleagues as less productive and participative, and not bringing in results. Male interviewees reported that women excluded themselves from opportunities due to fear of increased responsibilities and being unprepared for leadership positions. Male interviewees also suggested that women’s childrearing and social responsibilities impeded their advancement and leadership.

> There are gentlemen who are not happy with the support rendered to women. Instead of helping women to the position of leadership, they accuse her that she is not capable. Thus, they even discriminate against her to carry out her duties all alone… There are a number of men who do not believe in the capacity of the woman. —Female government representative, Amhara

Interviewees, especially female government representatives, described the gap between the number of educated women in the health sector and the number of women in leadership positions, indicating
that policy dictated that 40 to 50 percent of leadership roles be filled by women, but in reality, the percentage was much lower. In Oromia, interviewees noted that this disparity was particularly great in rural areas. Some male health facility managers also spoke about traditional societal views unfavorable to women in leadership positions. A female government representative said women primarily occupied administrative or support roles, such as in human resources and as secretaries or cleaners.

Traditionally, [society] assumes that males more than females should assume such [leadership] positions, because females are considered timid and incapable of facing challenges. But, given the notion that men and women have equal potential if provided with equal opportunities, we must also consider females’ involvement on the health board. —Male health facility manager, Amhara

Even when opportunities for training are distributed equally among male and female staff, financial constraints can serve as a significant barrier to accessing such opportunities.

I know that educational opportunities in laboratory science, nursing, midwifery, and information technology have been given this year both at zonal and woreda levels. But, educational opportunities in pharmacy are not given for the mere reason that budget is not allocated. This is discouraging. If a health staff cannot enjoy educational opportunities available at woreda or zonal level, he/she can go for further study privately, covering his/her educational costs. But, this also requires the financial ability of the applicant. —Female health facility manager, Amhara

Health facility managers and healthcare providers from all four regions stated that community support and acceptance were important to providers’ professional advancement and motivation.

Male and female healthcare providers and health facility managers from all four regions stated that community support and acceptance were important for their professional advancement and well-being. Younger healthcare providers noted community support as a source of motivation to improve performance more frequently than older healthcare providers.

Health and administrative professionals who were interviewed mentioned that they were valued in the community, recognized in public fora, trusted by neighbors, seen as role models, and encouraged by community leaders. Overall, male and female interviewees from all four regions reported that the community expressed gratitude toward those who had helped with a health-related problem, and that they were strongly motivated to overcome professional challenges because of community support. Female interviewees in all four regions talked about how community members help mitigate some of the barriers they face in their work. There was a single male government representative who said the community acted in a way that harmed his morale.

They [community members] consider health professionals as helpful as next to God, so whenever they meet you, they respect and encourage you to work hard and change your life. They also recognize you when there is a public forum. This encourages me a lot to serve the community in whatever challenges I have. —Male healthcare provider, SNNPR
The moral support I got from the community in different public meetings is… worth mentioning. This is the very reason for me, I believe, to stay stronger, overcoming challenges from different directions. — Male healthcare provider, Ambara

The community encourages me when I am on night duty. I am expected to move at night, and if the community meets me on the road, then they accompany me. When I move to the rural area, as I am female, if they have a motorbike, then they give me a ride. — Female healthcare provider, Oromia

The local community also supported me morally to pursue my study. Sometimes, when I have tight schedule at work and have difficulties in getting my child to school, even my neighbors, let alone my families, would help me in getting her to school. I consider this support as very important because it enabled me to focus on my duty as a health professional. I understand the value of this support also in terms of allowing me to stay working at the health facility than leaving the health institution. — Female health facility manager, Ambara

7

Health facility managers and healthcare providers across regions stated that family and spousal support enabled them to stay in their positions.

Healthcare providers across regions, especially female providers, said support from parents (e.g., financial aid and encouragement to pursue educational opportunities) and spouses (e.g., sharing in household and childrearing responsibilities, being compassionate about late working hours or other job requirements, and helping solve work-related problems) allowed them to keep their jobs. Female interviewees more than male interviewees reported that their family supported them by providing childcare. Younger healthcare providers (34 years and younger) reported this family support more often than other age groups.

I would like to thank my husband. He does a lot for me… When I am on night duty, he brings me dinner, clothing, and comes to take me home when I am working late. At home, he provides what he can and helps me in other activities. — Female healthcare provider, Oromia

Family helps you during good and bad times. My family has been supportive of my work in many ways. For example, as vice president of this office, you might come into conflict with a coworker and go home afterwards. At that time, your families help you and share the burden by giving supportive ideas. — Male government representative, Oromia

One great support I got from my family was when I gave birth to my child. I didn’t have a babysitter, and the support of my family in this regard is considerably immense. I used to take my child to my parents in the morning and fetch it after work. — Female government representative, Oromia

A few respondents noted a lack of support. One female health extension worker and one female government representative said their families felt their jobs created a hardship for the family and their husbands felt abandoned due to the time commitments of the job. These same interviewees said caring for children was an obstacle to work, in part due to the lack of domestic workers and childcare facilities near their workplaces.
Male and female government representatives, health facility managers, healthcare providers, and health extension workers across regions identified factors in the education sector as opportunities to increase the number of female health workers.

- Engaging with female students in secondary school through clubs, site visits, and other activities
- Supporting university students
- Identifying local women who have obtained a health degree and returned to their communities to practice
- Generally promoting gender equality in education

More specifically, interviewees described a number of specific actions to support and increase the numbers of female students in the healthcare fields, including (1) financial support at all levels of education for tuition and room and board; (2) university and secondary school tutoring programs; (3) engaging with student health clubs and girls’ clubs; (4) class visits to health services; (5) student volunteering opportunities at health posts; (6) talks by healthcare providers or women’s affairs officers at schools; (7) youth-friendly health facilities with areas for sports to bring youth to the health center; (8) waiving fees for competency exams; and (9) increasing the number of sites where health science education courses are taught.

*There are different school clubs, such as anti-malaria club, anti-HIV club, hygiene club… We [health professionals] provide training to the health-related clubs at school… The existence of different clubs initiates the female students to enjoy and stay in the health field. When we go out for supervision or house-to-house visits to teach the community, the young female students in the community are eager to know more about health issues, and they ask questions.* —Female healthcare provider, Amhara

Providing female health extension workers with opportunities to “upgrade” their education and be promoted to nurse was also suggested as an efficient way of retaining female health workers, particularly health extension workers whose presence can increase the community’s access to health services.

*Give them the opportunity to upgrade their education level… I think they become health extension workers after they have 10+1 education level… These workers stay [in the position] for a long period of time and they know it very well. I don’t see why it is difficult for them to upgrade to become a nurse. There are also short trainings provided, and these trainings should be given to health extension workers to upgrade [their skills]… If we can work on the health extension workers, we can address every woman in every rural kebele.* —Female government representative, Amhara
To a lesser extent, male and female healthcare providers and government representatives, as well as male facility managers, said preventing child marriage, supporting girls’ education, and decreasing household work for girls could promote increasing the number of female health workers.

_The women affairs and women association members of our catchment have actively participated on prevention of early marriage. They work with the schools to prevent school dropout of females, and they support school materials to poor female students. This may help indirectly to improve female participation in the field of health science._ —Female healthcare provider, Tigray

Government representatives, health facility managers, and healthcare providers in most regions identified separation from family, weak community infrastructure, and insufficient compensation and incentives as challenges to increasing and retaining female healthcare providers.

Male and female interviewees across roles and the four regions said working in a facility away from her family contributed to a female healthcare provider’s decision to leave her post. Interviewees attributed this to the important family roles women play; some also said that women’s workloads at home had to be lightened to keep them in the workforce. Weak infrastructure at facilities and in the surrounding communities—specifically housing, water, electricity, and transportation—was a barrier to retaining female healthcare providers at these sites.

_One of the midwives who was married and living with her husband got transferred to another health center in the same district, separating her from her family. She has one child. Once transferred, she could not get a chance to reunite with her family. This has forced her to submit a letter of resignation._ —Male health facility manager, Oromia

_After recruiting potential female applicants as health staff, we need to retain them by creating favorable working conditions that are flexible, based on the different roles females play in the community. This is because females are mothers and are more involved in social affairs, like in the socialization of children or managing household tasks. The implication is that they have more social responsibilities, both at home and outside the home, and we need to give value to these roles as well._ —Male health facility manager, Amhara

_There is a road, but the problem is that there is no easy transportation for the girls to use in the morning to go to work. They have a problem of getting transportation to move from one place to another. Due to such problems, they don’t want to stay working at the health post for long, and they leave. Then they get a job with a low salary in the urban areas, due to the fact that there are such problems to work in the rural areas._ —Female government representative, Amhara

Conversely, interviewees across the four regions said compensation and opportunities for advancement were motivation for female healthcare providers to stay in their jobs. Other incentives interviewees in Amhara and SNNPR mentioned included recognition and awards, responsive management, training and education, and duty and risk payments for night shifts and remote postings. Interestingly, among health extension workers, observing others receiving non-financial incentives was also motivating.
With regard to encouragement, reward has not yet been given to us in terms of money or in-kind, except giving recognition by saying you did great and stood first. But if a certain hard-working health extension worker receives recognition in her work, is encouraged, and receives award, other health extension workers will work hard to be rewarded like her. This should be done to make us hopeful, for there are many things which may make us to be dismayed. Anyway, the zone has rewarded me in this year. —Female health extension worker, Amhara

Across the four regions, key informants did not view sexual harassment in the facility as a great concern. However, the threat of sexual violence by community members and, to a lesser degree, by male colleagues was a barrier to retaining female healthcare providers.

When asked about sexual harassment policies, interviewees across the four regions reported on sexual harassment and gender-based violence in the community, rather than at the facility. When probed, they typically noted that sexual harassment at the facility was not a pressing issue. Interviewees from all regions also said there was no specific sexual harassment policy at health facilities, although some mentioned other facility-level guidelines and disciplinary policies that could be applied in instances of harassment. A male health facility manager described internal rules and regulations to raise awareness among staff members to eliminate the occurrence of sexual harassment. One male government representative described a policy for disciplining staff more generally, noting it was not specific to sexual harassment. At the facility level, however, a male health facility manager indicated he had no “legal grounds” to take measures against the criminal; the only thing he could do was report the incident to the authorities. A female health facility manager in Amhara noted that there were no instances of sexual harassment or any policies concerning sexual harassment in her facility. Instead, she indicated that a coffee ceremony is used to introduce new staff members. These ceremonies aim to build relationships between male and female staff as a way to prevent harassment.

Four years ago, the head of this health center was a female and one of the male health providers abused her. A case was reported to the Gender Office of the woreda, and they investigated each detail and concluded that the male staff member was guilty. Then, they punished him with a monthly salary, a warning letter, and a transfer to a remote health center in the woreda. —Male health facility manager, SNNPR

Since the problem of sexual harassment does not occur here, in our health facility, we do not normally discuss on sexual harassment during coffee ceremonies we hold for welcoming new staff members. I strongly believe that the coffee ceremonies have enormous contributions to make staff's integrity and ensuring common understanding. This, hopefully, will maximize staff's friendly relationships to the extent that male and female staff members see each other as brothers and sisters, thereby avoiding any sense of sexual harassment. —Female health facility manager, Amhara

Male and female healthcare providers and a few male health facility managers identified the threat of sexual violence, especially for women stationed in remote health facilities, as an obstacle to retaining female staff. A smaller number of interviewees, mostly female, described cases where female staff were sexually harassed by male colleagues. Some interviewees pointed to specific actions the facility
took to protect women from the threat of sexual violence, including secure housing, separate rooms and toilets for female staff at the facility, and assigning companions for outreach activities. A few respondents said not enough was done to make women feel safe.

*If the women used motorcycles like men, then that may open up the opportunity for sexual assault. For this reason, we arranged schedules for the female providers to use ambulances when it came to fetch patients. We also facilitated for the female providers to live at the health center. When they go out for community mobilization, we assigned someone to assist them. When they go out for family planning, we again assigned a motorist who could give them a ride. Furthermore, when they are on night duty, female healthcare providers have separate rooms from male providers.* —Male health facility manager, Oromia

### 1.3 MEASUREMENT OF GENDER EQUALITY IN HEALTH SYSTEM MANAGEMENT

Male and female interviewees stated that sex discrimination in the workplace did not exist, gender equality did not need to be measured, and measures in place lacked standardization.

Male and female interviewees alike stated that gender equality did not need to be measured because sex discrimination did not exist in the health facility, but that there were mechanisms for measuring equality in terms of access to resources and opportunities, regardless of sex.

*It is evident that female and male staff members here, in our health facility, have been treated equally in all respects because the rules and regulations work for both sexes indiscriminately.* —Male health facility manager, Amhara

*There are no differences made between female and male staff members, due to the fact that we don’t have significant number of female staff members. For example, we only have one female healthcare provider in the health office, whereas there are more than 10 male healthcare staff.* —Male government representative, Oromia

*As far as I know, there is no difference between female and male staff in our health facility. To be clear, both female and male staff members have their own duties and responsibilities, and are treated equally without discrimination.* —Female health facility manager, Amhara

Interviewees where measurement was occurring described a lack of standard processes for measuring gender equality. However, many also outlined areas where gender equality measurement would be helpful. Interviewees commented that their health facilities lacked standard and consistent processes and indicators to collect and use data on gender equality in the workplace or changes over time. Methods of data collection interviewees in all four regions described were mostly in response to an event or situation, such as regular staff meetings or deliberate group discussions with staff, and informal conversations between staff and leadership.

*There is no standard or unit of measurement we are using to check whether men and female staff are treated equally.* —Male health facility manager, SNNPR
We do assessments, but most of the time, it is the staff that ask for equal treatment when a problem happens. With this, the different meetings we are holding regarding good governance are an important occasion for the staff to raise the issue of equal treatment. —Male government representative, Ambara

Some of the health staff may reflect their own interest at the expense of others’ needs, and it is necessary to cross-check staff concerns with data and records; for example, referring to training registries when the complaint was about training opportunities. —Male government representative, Ambara

Female interviewees remarked less on measuring gender equality than male interviewees, in part because most of those interviewed on the question were health facility managers and government officials, who were predominantly male. One female government official said she did not “see anything” in the health sector regarding measuring whether female and male staff were being treated equally in the health system.

I don’t see anything in our sector. We come to work early in the morning, we perform our work, we leave the office on time. We get our salary on monthly bases. That’s it, mainly. We don’t see anything that benefits the women or men specifically. There is no training opportunity. We do our daily work based on the plan, if we have to go out to the site, we will. —Female government representative, SNNPR

In Tigray, more interviewees than in other regions described efforts to measure equity among staff, especially through the use of a training registry for training opportunities. A male government official reported monitoring access to promotions, training, work schedules, and professional growth and development activities to address staff’s gender-based malpractices, attitudes, and beliefs. A female government interviewee described the existence of a steering committee composed of all female gender focal persons from each sector, including health, which met monthly to discuss gender issues, such as how many men and women accessed training opportunities, how many women were promoted, and whether female staff faced any challenges. At the end of the meeting, the committee identified issues requiring action. The steering committee also reviewed the health sector’s annual plan for progress in meeting gender-related targets.

The monitoring and evaluation of female and male equal treatment of staff members are done by the policies that we have in our hands: the program in each facility is done by sex mix and all of them have same salaries for the same job promotions. This is done by adding affirmative actions on top of the total result that she got, and there is [sic] maternity leaves of 3 months, and females are given priorities for trainings and other opportunities… There is registration to track who gets which training, there is monthly and daily work schedule in each facility—using these tools, we monitor and evaluate differences. In addition, there is a system for individuals to complain about some problems to committees inside facilities, even beyond the facility. We here, in woreda, have heard and monitored issues and referred them to the Ministry of Women’s Affairs and women’s associations, in addition to police and legal cases in general. —Male government representative, Tigray

There is an all-women steering committee. Members of this steering committee are gender focal person of their respective sectors, including health sector. There are 11 members in this steering committee and we meet every month. In our meeting we discuss issues related with gender. This includes how
many male and female [staff] have taken training, how many women are promoted, and also if they have faced any challenges. At the end of our meeting, we pinpoint issues that needs [sic] to be addressed in the future, and we evaluate whether the issues were addressed or not in our consecutive meetings. In addition, at the beginning of the year, each sector sends us their annual plan. In those plans, we make sure that female staffs are incorporated in the different opportunities the office provides. For example, when it comes to training, the office must include the number of female staffs that are going to take trainings. If they don’t incorporate this, we will talk to the gender focal person of each office during our steering committee meetings and we strive to solve the problem. Not only do they send us their plans, but also their implementation. So, we cross-check whether they have achieved what they set to achieve or not regarding gender. —Female government representative, Tigray

Interviewees offered extensive examples of measures and approaches that could be used to assess gender equity. These examples drew on diverse data sources, such as health sector annual plans, training registries, attendance sheets for staff, employee annual work plans, assessments conducted by facility managers and staff members to learn about issues, and suggestion boxes. Respondents in Oromia, SNNPR, and Tigray mentioned balanced score cards used to assess staff performance.

One possible way to make sure that female and male staff members are treated equally in our health center is to conduct interviews with female health staff by a third party. In fact, the focus of the interview needs to be on identifying the challenges they might encounter in accessing opportunities. In addition, we can think of posting notices allowing female staff in general to give suggestions or comments secretly on the accessibility of all opportunities available at the health center. Definitely, this will provide fertile ground for the health facility management to conduct assessments and address pressing problems that can be raised by female staff. —Male health facility manager, Amhara

RESULT AREA 2: INCREASED SUSTAINABLE QUALITY OF SERVICE DELIVERY ACROSS THE CONTINUUM OF CARE

Result Area 2 aims to strengthen the quality of RMNCAH-N services through targeted training and technical assistance to support the development, revision, and implementation of updated standards, protocols, guidelines, and job aids, thereby raising the skill level of providers in terms of technical competencies and caring, respectful, and compassionate service provision.

2.1 PERSPECTIVES ON CARING, RESPECTFUL, AND COMPASSIONATE (CRC) CARE AND QUALITY OF CARE

Interviewees and group discussion participants stated that warm, welcoming attitudes and behaviors were important for client satisfaction. Group discussion participants also cited a range of healthcare providers’ attitudes and behaviors that negatively affected healthcare-seeking behavior.

Interviewees and group discussion participants shared clear ideas about which providers’ behaviors and attitudes support or hinder CRC and friendly services. Attentiveness, equal treatment, interpersonal skills, and counseling were consistently cited as supports. Healthcare providers and
group discussion participants remarked that a warm and welcoming approach to client interactions had a positive impact on client satisfaction with services. Health extension workers and healthcare providers said they were attentive to connecting with people on a personal level by asking about their families and making small talk before inquiring why they were seeking healthcare. Many also described aspects of attentive listening, such as eye contact and not interrupting. Some noted that they sought to treat clients as equals. In Tigray, four providers mentioned a need to address male clients with formal titles (translated as “sir”), while one of these also said women should be addressed as “madam.”

I always stand… when clients come into the room. I make them feel friendly. I laugh with them and ask what they feel. Some providers inform me to just do my job and send the clients back, but I am hesitant. I enjoy spending time with and listening to them. That makes them feel comfortable. — Female healthcare provider, SNNPR

During the interviews, several health facility managers in Amhara and Tigray, a few government representatives in Amhara and SNNPR, and a couple of health service providers in Oromia offered (unprompted) “caring, respectful, and compassionate care” after being asked about client satisfaction or quality of care.

Quality healthcare is defined as, if patients get all the needed services from the facility as quickly as possible with full standard. Qualified health staffs should be fulfilled. Supply enough medicine as much as needed. Compassionate respect and care (CRC) service delivery to the clients. — Female healthcare provider, Oromia

Group discussion participants referenced the importance of being received in a personable way at a health facility and that healthcare staff’s reception colored the entire care-seeking experience. Some said the feeling of being cared for contributed to their health. These comments were more common from older stakeholder groups. All but one of the group discussions in Tigray included this topic.

A welcoming face by the staffs of the health center will cure us before seeing a doctor. I once went to the health center and I didn’t wait that much at the reception, and when I entered into the room where the doctor sat in, he invited me to come in with smiley face. After I sat, he asked me what brought me there and carefully examined my whole body and he found out that my disease was not treatable at their center. Then, he calmly explained why he is writing the referral paper and that I am going to be okay. He arranged ambulance to take me to Shire and I fully recovered there. The word referral freaks out every one in here and the doctor calm[ed] me down rather than saying, “Go to Shire.” — Female participant, group discussion with married women, ages 15–24, Tigray

Counseling was a valued part of healthcare services for group discussion participants and providers alike, especially in family planning decision making; correct condom use; how to take medications; potential side effects; HIV and sexually transmitted infection (STI) testing, prevention, and treatment; nutrition and activity during pregnancy; delivery planning; and young child feeding.

…A couple came for the service, to be counseled and get the treatment. They told me about their history. They didn’t decide to get married, but they were on the way to. They were very much tensioned with their expectation of the result. Having the guideline as my directive, I just taught them
everything they need to be oriented with. Later, they decided to be examined. However, giving their blood sample for the laboratory, they were crying much in fear of the result. They were in tears as they get back into the VCT [voluntary counseling and testing] room for the result. It is hard to describe that situation—what they did as I told them the result. They just get knelt down and praised me, kissing my shoes. They just celebrated much and told me later that “whatever the result was, for the orientation you gave us was helpful, we were deciding to live together.” Such an occasion is worth mentioning regarding the way we are serving and the clients’ reaction towards the service provision.

—Male healthcare provider, Amhara

Group discussion participants also greatly appreciated outreach efforts and health education in the community, which helped build relationships between community members and providers, increasing the likelihood of clients’ seeking care.

In contrast to client satisfaction, group discussion participants shared that dissatisfaction with services was in large part due to poor attitudes and lack of attentiveness from providers and facility staff, such as shaming clients, eating lunch or holding meetings while people waited to be seen, serving friends first, ignoring specific groups of clients (e.g., those who appeared to be from rural areas or certain cultural groups), rushing through consultations, and violating confidentiality. Some group discussion participants called out specific healthcare providers for being inattentive, whereas others commented that the inattentiveness was pervasive among all facility staff. Complaints of inattentive staff were more common from males of all ages and unmarried females.

*I wish the health extension workers would give the service whenever we come to get the service. We are not coming to the health post to play; it’s because we get sick. They sometimes say, “It’s our lunch time; come later.” This is not good. For me, I live very close to the health post, but for people who are coming from far away, it is difficult to go and come back. They could have given a chair to sit and wait. They should have treated people in a good manner. —Female participant, group discussion with unmarried women, ages 15–24, SNNPR*

Around half of all group discussion participants mentioned inequitable treatment of clients, mostly among respondents from Oromia. They described discrimination at health facilities as based on a set of personal characteristics, such as personal contacts, way of dressing, urban versus rural appearance, education, and wealth. These same respondents noted that inequitable treatment affected who was seen first and what kind of medicine a client received. Male respondents most often attributed bias of providers to their personal connections because family members and friends were perceived to be served first. Female respondents saw discrimination based on place of residence—rural versus urban—as often as that based on personal networks.

*Most of the health facility workers at the health center, ranging from the guard to health professionals, giving varieties of services have problems of partiality while treating patients from the countryside and the town. They mostly favored the latter from easily granting cards to supplying some highly demanded medicines. —Female participant, group discussion with unmarried women, ages 15–24, Oromia*

*There is a clear difference in service delivery between urban and rural medical treatment seekers at the health center… When I took my child for vaccination, the healthcare providers refused to serve me,
saying the time is for lunch and to come tomorrow. However, the health worker served an urban woman who came after me and got the service, but refused to see me… Healthcare providers and other workers at the health center do not treat us equally as they treat urban people.—Male participant, group discussion with married men, ages 15–24, Oromia

When asked about quality of care, group discussion participants and healthcare providers frequently mentioned health outcomes. Group discussion participants tended to express gratitude for specific instances of life-saving care. There were more comments about happiness with services due to positive health outcomes from men than women, and more from Amhara and Tigray than other regions.

I gave birth at health center with health complication. I had prolonged bleeding and I was at risk of death. But, health professionals helped me to stay alive by giving me blood supply. Because of their help, I am alive and for me, they are my life savior.—Female participant, group discussion with married women, ages 15–24, Amhara

For group discussion participants, quality of care was also linked to the availability of medicine, scope of services, and waiting times. The frequency of drug stock-outs at facilities was mentioned in all group discussions across the four regions, with slightly more comments from SNNPR. When medicines were not available, clients were instructed to purchase drugs from pharmacies that were either far away or cost-prohibitive. For those who participated in the community-based health insurance program—known by technical specialists as CBHI and locally, in Amharic, as Ye tena medin wastena—having to pay for medications despite having insurance was an additional source of frustration.

Sometimes, they don’t give us medical service well when we go there with… our health insurance card. They would say to us that there is no medicine. Then, after, we go to private pharmacy and would buy medicine.—Female participant, group discussion with unmarried women, ages 15–24, Amhara

Lack of equipment and supplies (e.g., laboratory equipment, x-ray machines, oxygen) to provide comprehensive services had an impact on group discussion participants’ perceptions of quality. It was also noted that health extension workers lacked water and electricity, which impaired their ability to deliver care. There were no differences between regions or by stakeholder group.

The health extension worker here, in our kebele, is doing well in her capacity to provide health services, although the service provision is often affected by lack of water and electricity.—Male participant, group discussion with unmarried men, ages 15–24, Amhara

There is no laboratory service at the health center. They prescribe drugs just by guessing from the symptoms which are exhibited by the patient.—Male participant, group discussion with married men, ages 15–24, SNNPR
The issue of long waiting times at facilities was raised in more group discussions in Tigray than other regions, and more by women than men. However, providers were more likely to say waiting times were important to quality of care for men than for women. Long wait times were often attributed to staff shortages. Problems reported were sometimes limited to one part of the facility (e.g., reception or the laboratory).

_The doctors are not that many in number, hence we have to wait in line to get the service. At the reception also, waiting in line is a common thing. If waiting in line is involved in the health center, we don’t call it welcoming and friendly. Despite this, even though the doctors are few in numbers, they examine us carefully and after examination, they prescribe medicines that are effective._ —Female participant, group discussion with married women, ages 25–45, Tigray

The cleanliness of facilities as a dimension of quality of care was mentioned less frequently by group discussion participants, more often by women, and across all four regions. Around half of the comments about cleanliness expressed satisfaction with the condition of facilities, and providers’ hygiene and safety practices. The other comments reported problems with facility cleanliness.

_I gave birth here and during that time, the facility had well-kept sanitation of bedrooms and its overall compound._ —Female participant, group discussion with married women, ages 15–24, Oromia

Having a healthcare provider of the same sex was raised only a handful of times and only in female group discussions in Amhara, Oromia, and SNNPR. The issue arose more often in interviews with providers, although only in Amhara and Oromia, who said they accommodated clients’ preferences for the sex of the provider.

A few group discussion participants mentioned problems accessing ambulance services due to cost, or reported negligence or management issues. Another issue noted was that ambulances might bring women in labor from difficult-to-reach places, but not transport them and their infants back home after delivery. There were also positive accounts of using ambulances, both for transport to the health center and from the health center to higher level facilities.

_My child was severely sick in 2014… and I took him to health center. For medical staff, it was difficult to treat the child. The child was referred to hospital in another district. The ambulance came to take my child and requested me 200 birr. Unfortunately, I did not have the money on that spot. I asked the medical staff and the driver, “Since I do not have the money, let me sign you an agreement to take my child to the hospital, so that I can pay it later.” All of them refused and the driver left the health center…. I took my child back home without getting treatment._ —Male participant, group discussion with married men, ages 15–24, Oromia

Users of the CBHI said they were pleased with the scheme, but reported receiving poor quality of care as a result of their participation.
to non-CBHI users. Across the four regions, primarily male (married and unmarried) CBHI users said they were not greeted respectfully at the health centers, were made to wait longer, and were not given required medication—all of which they attributed to their participation in the CBHI. These same respondents shared that they were often turned away from pharmacies or forced to buy medications from private pharmacies owned by healthcare providers.

If I have health insurance and go to the health center for treatment, in our district, there is no medicine and health workers do not respect us, since we are using free of payment. Therefore, I prefer to go the private health facility, where they have medicine and treat me well with better respect and care. —Male participant, group discussion with married men, ages 25–60, Oromia

Group discussion participants who did not use the CBHI held poor impressions of the quality of service received by CBHI users, noting similar concerns about treatment by healthcare providers and access to medications. Group discussion participants and interviewees in Amhara expressed concern over the quality of care delivered to CBHI users. In Oromia and SNNPR, only one government representative in each region attested to the problems in initiation of the program. In Tigray, no comments were noted about CBHI quality or initiation.

I heard people complaining on the equity and fairness of obtaining services at the health facilities, although they have membership cards. They felt cheated and failed to receive reasonable services, and facility workers applying extended rules before giving them medical services, giving them expired medicines, and charge them double of the services and medicines they obtained from the center. —Male participant, group discussion with unmarried men, ages 15–24, Oromia

Young, unmarried, male group discussion participants in three regions shared that they did not feel healthcare services addressed their needs.

Roughly, one-quarter of the young, unmarried, male participants in the group discussions across Amhara, Oromia, and SNNPR expressed dissatisfaction with healthcare services because they were not tailored to their needs. The discussions about youth-friendly services were unprompted, and happened most often in conversations about male adolescent health among providers in Amhara, Oromia, and Tigray, and among unmarried males, ages 15–24, in one group discussion in Oromia. Most interviewees said there were youth-friendly services in their woreda, and healthcare providers said that adolescents who came for services needed a patient, open approach. They said youth were especially shy about discussing sexual histories and making their needs known, including requesting condoms, counseling on their use, and HIV testing.

In my understanding, the healthcare delivery for unmarried young men like us is partly satisfying and partly not. If you take medical care at the hospital, for instance, health workers ask young unmarried men more about their sexual practices. But, most young people do not like this approach and avoid going to hospital when getting sick. —Male participant, group discussion with unmarried men, ages 15–24, Amhara

Married men come to take condom. In addition, if they get sick in relation to STI like girls, we give them advice about STI and HIV. Similarly, we give advice on STI and HIV for young boys. If young
boys come to this facility, we give them service they need in isolated room. This room is [a] youth friendly room. They come here after being treated at OPD [outpatient department] and given the necessary information and advice regarding STI and HIV. To make men feel respected and cared, unless we are extremely busy, we treat men and boys with due respect very well when they come to us. For example, they may come late at 5:00 p.m. to take condom when no one is available so that no one is able to see them. Therefore, we keep/place the condom at emergency room so that they can access it easily any time. Besides, we keep their privacy. We do not share any information concerning them with other persons even to their family members or with any other health professional without their permission. —Male healthcare provider, Oromia

Group discussion participants voiced concerns about the quality of youth-friendly services, particularly with respect to male contraceptives.

In my evaluation, I was afraid to say their service is good, since they have no any [sic] means to educate youths like me, there is no condom in a free space, and they are not teaching the people about HIV/AIDS. For instance, last week, I and my friends came to the health center to get condoms, but it is only the carton—you can see no condoms inside, so how is it possible to say it is good? —Male participant, group discussion with unmarried men, ages 15–24, SNNPR

Female group discussion participants said they were happy with maternal health services, especially when providers were friendly and caring.

In terms of the friendliness of providers and facilities for labor and delivery, and the health outcomes of mothers and babies, more clients reported positive experiences than negative ones. Female group discussion participants said they felt cared for during and after labor, sometimes forging bonds with midwives or other providers. Female group discussion participants shared several stories of challenging labor and life-threatening situations that ended well. In other cases, these participants said the quality of care they received during labor and delivery was affected by the staff available at the facility and/or the facility itself. In some locations, participants said one health post or health center was known for providing caring service and the other local facility was not. These group discussion participants also relayed rumors of others’ negative experiences with maternal health services.

My positive experience is a recent happening: I went to the health center along with my daughter for delivery. I witnessed careful and respectful treatment given to her from the health workers at the delivery room. On the opposite, users accused some healthcare providers in the facility for their partiality and favoritism while rendering services. —Female participant, group discussion with married women, ages 25–45, Oromia

There are some committed and responsible healthcare providers who are willing to serve patients during their spare time. While some negligent healthcare professionals were sleeping at their rooms, the midwife, who was off the duty, helped my laboring daughter after being summoned from her home at midnight. —Female participant, group discussion with married women, ages 25–45, Oromia

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A pregnant woman died 3 months back in the district health center while she was in labor, due to lack of proper treatment from health staffs. She was supposed to give birth to twins. Once she gave birth to the first child... she returned back home without delivering the second child. She was taken back to hospital and died there. This was due to lack of qualification and experience in health staff. —Male participant, group discussion with unmarried men, ages 15–24, Oromia

A few group discussion participants noted that health services seemed to give priority to maternity care over other health areas, and that women in labor would be seen immediately. Although this prioritization was widely seen as a positive indicator of quality of care, several young men’s groups expressed some negative feelings about it.

Older women in group discussions addressed the friendliness of maternity services more often than other groups; however, there was little difference between their responses and the responses of younger women and men. Several older respondents indicated that the friendliness of maternity care had improved greatly from years past.

I delivered recently. While I was in the health facility, the midwife treated me well... she was assisting me like a sister, even crying with me when I was crying. —Female participant, group discussion with married women, ages 15–24, Amhara

Group discussion participants also reported receiving counseling on how to take care of themselves during pregnancy. Providers interviewed gave examples of counseling pregnant women on the same matters, but often with specific information for the husband on the woman’s diet and work during pregnancy and in preparing for delivery.

When asked what made a health facility welcoming, group discussion participants across regions noted that the provision of coffee and porridge for a coffee ceremony after a woman delivers made women feel at home in the facility. However, group discussion participants expressed some concern about quality of services delivered to poorer women or those from remote areas, and the lack of providers on night duty. Maternal waiting homes were mentioned less frequently and with more variable satisfaction in terms of treatment of clients staying in the homes, cleanliness, and other factors.

Group discussion participants and interviewees said confidentiality in family planning, and HIV and STI testing and treatment were important. They also noted a few breaches of privacy.

By and large, group discussion participants reported satisfaction with the family planning counseling, options, and services they received, particularly those provided by health extension workers. Most instances of clients seeking emergency contraception that group discussion participants reported involved in-school youth. Many providers interviewed stressed the importance of maintaining confidentiality. A few instances of confidentiality breaches were reported.

There are mothers who come for family planning secretly. If we do not guarantee privacy and disclose such secrets, they won’t come again. Because it remains secret between me and her, she continues to
For the most part, group discussion participants shared positive experiences with child health, nutrition, and malaria services. However, some shared complaints about poor services.

Several group discussion participants across regions said they were happy with the services their children received during illnesses. In Amhara, one group discussion participant reported that the service for children was good because her child had a positive outcome, but that services were delivered too slowly.

_The memorable experience I had is that this health post granted me a support letter to receive free treatment for my sick son at the health center. I got welcoming and friendly services from the healthcare provider on duty; the child was treated well, given medicine, and got well in the meantime._ —Female participant, group discussion with married women, ages 25–45, Oromia

In Oromia, group discussion participants were divided on their level of satisfaction with child health services at health centers, with some reporting they did not use the government facilities because of previous negative experiences, such as absence of providers, having to pay for laboratory tests, and other complaints. A higher proportion of male group discussion participants were displeased with child health services than female group discussion participants.

_My son seriously fell sick at 8 p.m.… He almost fainted. I and my wife called on motorcycle and took the child to the health center. Only one care provider was there. He told us that he could not help us and gave us an appointment for next morning. I didn’t know what to do… we returned home without any medication. Thank God, my son got well without any medication._ —Male participant, group discussion with married men, ages 15–24, Oromia

Few group discussion participants referred to nutritional services. Those who did mostly expressed appreciation for growth monitoring, maternal and/or child nutritional supplements, and therapeutic
feeding. Two men (one from Amhara and one from Tigray) said they liked the general nutrition counseling healthcare providers supplied. There was one complaint from older male group discussion participants in Oromia that Plumpy Nut (a supplement for treating malnutrition) could be found for sale in local shops, suggesting that the health facility was diverting the supply for financial gain.

They admit children with malnutrition to therapeutic treatment. They feed and treat such children until their health condition gets improved. — Male participant, group discussion with married men, ages 25–45, Oromia

When I was pregnant until I reached my third month, they give us flour which the government subsidizes and when I get to the fifth month, they will give me a card that identifies me as a pregnant woman. They train us that the flour has a medicine, and it is only for me because I am pregnant. And during delivery, they will give it again because I breastfeeding the child. During the 9 months of pregnancy, they will give us four times. They will give us 5 kilograms of flour per month. After delivery, when a mother goes to health facility for vaccine, they will give the flour for those mothers who breastfeeding... They will measure the child and if he has a good weight and the mother is also healthy, the flour will not be given. It is not all children and mothers who require the support. — Female participant, group discussion with married women, ages 15–24, SNNPR

Services for malaria testing and treatment were mentioned in a handful of group discussions. Most participants who mentioned malaria services were happy with the quality, although stock-outs of medications (e.g., coartem) seemed common and some (all women) were unhappy about having to purchase medications from private pharmacies. There were also several complaints from women that malaria was diagnosed or ruled out without testing. There were no clear patterns by region.

I have had malaria case and most of the time, I come to the health post for treatment and counseling. The health extension workers in the facility often treated me with care, respect and kindness. They have given me tablets free of charges and in the meantime, I started showing progress. They visited and consulted me at my home. They also facilitated our social groupings of one-to-five (tokko shanne) to help each other through discussions and to contribute money (10 birr) and three kilos of grains annually. — Female participant, group discussion with married women, ages 25–45, Oromia.

Sometimes, they don’t give us medical service well when we go there with having our health insurance card. They would say us that there is no medicine. Then after, we go to private pharmacy and would buy medicine. In addition to this, they became angry with us. They became angered, for example, if we go there because we became sick of malaria and then they examined us and say to us that we have no malaria... But I know that it is malaria. But when they get medical examination by going to a private clinic, they would find it that it is malaria. — Female participant, group discussion with unmarried women, ages 15–24, Amhara
RESULT AREA 3: IMPROVED HOUSEHOLD AND COMMUNITY HEALTH PRACTICES AND HEALTH-SEEKING BEHAVIORS

For Result Area 3, the project aims to increase individual and household-level care-seeking behavior and uptake of healthy practices, and to strengthen the enabling environment for health-seeking behavior, including community engagement in health service oversight.

3.1 DECISION MAKING

Male and female group discussion participants said decision making about seeking health services for themselves or their children was a collaborative process. However, women stated that they often did not have complete autonomy regarding their healthcare, and that men influence women’s decision making in myriad ways.

Male and female group discussion participants described a process for healthcare decision making that included spouses, parents, neighbors, or other community members, and took into account advice from health extension workers or other community groups (such as those led by the Women’s Development Army). Group discussion participants across all four regions (except male participants from Tigray) acknowledged that men were primary, and sometimes sole, decision makers with regard to healthcare for themselves and their families.

“Once, I had unusual swelling on my face and I got advice from the health extension worker to go to the health center. This helped me to decide to go to the health center and get the appropriate medical care. My family also encourages me to visit health providers when I get sick. I also advise my wife to see health workers when she gets sick. When our child falls sick, we make the decision together for her treatment.” —Male participant, group discussion with married men, ages 15–24, Amhara

Group discussion participants shared that women who are financially dependent were not the primary decision makers about healthcare for their family, although they might have more influence in deciding for their children. Married female group discussion participants, ages 15–49, from Oromia and Tigray spoke about a preference for male children, but male and female group discussion participants from all four regions remarked that male and female children were treated equally and taken to health facilities as soon as their families were able to do so.

“Men have culturally gender preferences and biases towards boys, but when it comes to health issues, they care equally for both, and my husband does as well. As a mother and woman, I have natural advantage of tracking my children’s well-being on an everyday basis, and they are close to me. However, at their adolescence ages, girls do have more affiliations towards their mothers, while boys do to their fathers. When I used to take my small children and grandchildren to the health center, I needed someone to aid me, additional food and clothes, and money needed for transportation and medical fees. These things are equally important for both a girl and [a] boy.” —Female participant, group discussion with married women, ages 25–45, Oromia
Unmarried and married female group discussion participants from Amhara, SNNPR, and Tigray said they felt supported in their decision making, although women expressed frustration with their limited autonomy. More young unmarried male respondents aged 15–24 than female group discussion participants from Amhara and SNNPR expressed their displeasure and unhappiness with others’ involvement in their health decisions.

*I also share what she said. Even when I want to go to a health facility today, he says that he can’t take me today. And I get mad. I feel that that is happening because I am dependent on them and because I don’t have money.* —Female participant, group discussion with unmarried women, ages 15–24, Amhara

*If the involvement of people in our healthcare is negative to the extent that we will not benefit from their involvement, we will decide on our own healthcare issues.* —Male participant, group discussion with unmarried men, ages 15–24, Amhara

In all regions, female group discussion participants, ages 15–25 and 25–40, said men (primarily husbands and fathers) influenced their decisions on when and where to access healthcare services. Female participants in both age groups in Amhara, Oromia, and Tigray, as well as women ages 25–40 in SNNPR, cited men as influencing their decisions through discussions or providing advice. Female participants, ages 15–24 and 25–40, in Amhara and Oromia, and women, ages 15–24, in SNNPR and Tigray also spoke about men having full authority to make the “ultimate decision” on matters related to their healthcare. These respondents also frequently cited men as providing other support critical for their access to healthcare services. Across regions, female participants spoke about receiving financial support. In Amhara (women ages 15–24), Oromia (women ages 25–40), and Tigray (women ages 14–25 and 25–40), group discussion participants discussed the importance of men assisting them with transportation or chaperoning them to health facilities.

*As a tradition, the head of the household, which is most [of] the time men, make[s] decision and the rest of the family members adhere to that decision. If our fathers say let’s try tradition medicine, our mothers will try it. The opposite is also true, if our fathers say let’s go to the health center, then we will go to the health center. Such tradition is somehow altering, in some families, father and mother discuss and decide together, but in some families it’s the father that have [sic] the final say when it comes to deciding over whether one family member should go to the health center or not.* —Female participant, group discussion with unmarried women, ages 15–24, Tigray

*As it has been said, majority of women don’t have income of their own, hence our husbands are the ones who pay money for community-based health insurance and also for our medical bill. Hence, they help us to make decision by giving us the money and also by going with us if our disease is severe.* —Female participant, group discussion with married women, ages 25–40, Tigray

Health facility managers and healthcare providers in all four regions described men being engaged in family healthcare in a variety of ways, including visiting healthcare facilities with their partners for the sake of family planning, prenatal and postnatal care, other healthcare services, and child delivery, or for taking children to health facilities due to illness or vaccinations.
3.2 ENABLERS AND CONSTRAINTS TO ACCESSING RMNCAH-N SERVICES

Interviewees and group discussion participants in all four regions reported widespread male opposition to family planning; yet, women were able to access family planning services.

Interviewees and group discussion participants reported that men tended to oppose the use of family planning. Female group discussion participants in both age groups (15–24 and 25–45) in Amhara and Oromia frequently suggested that their husbands’ opposition to family planning required them to access services in secret.

*When I wanted to take long-term contraceptives, he refused to sign for me. The contraceptives women take are not known by their husbands most times.* —Female participant, group discussion with married women, ages 25–45, Amhara

*There are a number of times where staff members try to convince husbands for their wives to use family planning. Mostly, men disagree in family planning and women use it secretly... Especially rural men would like more children and are not interested in family planning.* —Female health facility manager, Oromia

Male group discussion participants cited a number of reasons for opposing family planning. Men in both age groups (15–24 and 25–60) in Amhara and Oromia said their desire for more children precluded the use of family planning. Healthcare providers, health facility managers, and health extension workers in all regions noted that many men opposed family planning for religious reasons. Some interviewees in Amhara, SNNPR, and Tigray also remarked that men were concerned with the potential health risks for their spouses.

*There are some people who are not well aware and still think that their wives will leave them if they don’t have many children. They also think their wife will be infertile if she takes contraceptives. Some religious leaders are perpetuating this way of thinking; they say using contraceptive is a sin and a woman needs to have as many children as possible until God makes her infertile.* —Female health extension worker, Tigray

Some female group discussion participants reported that their husbands were open to and encouraging family planning. Interviewees in Amhara, Oromia, and SNNPR echoed this by citing family planning as one of the main reasons men access healthcare. Interviewees also noted men’s willingness to visit health facilities with their partners to access family planning services.

*Sometimes, husbands prohibit their wives to take contraceptives. At that time, the women take the contraceptive method in secret. But also, there are some who permit to do so. I, for example, took family planning by consulting my spouse. He suggested to me to take contraceptive method because he wants me to continue my grade 10 education. We have a 5-year-old baby son.* —Female participant, group discussion with married women, ages 15–24, Amhara

*In this woreda, men participate in encouraging their wives to use family planning. They themselves come to health center and consult physicians on how to protect from unplanned pregnancy, use...*
Male and female group discussion participants preferred support in seeking healthcare.

Female group discussion participants reported their husbands and partners accompanied them when accessing health services. Throughout all four regions, health facility managers, healthcare providers, and health extension workers frequently indicated that men visited facilities with their partners for family planning, prenatal and postnatal care, and childbirth.

Many more female group discussion participants stated that they would like their husbands and partners to accompany them while accessing health services. Men’s work schedules were cited as the most common barrier. Women shared they would like another family member to accompany them when their husband is absent.

I want my husband to go with me, especially if our children get sick, as one of us can go to the reception and to the drug store while one of us stays to take care of the sick child. But he usually refuses to go with me, as he is busy with his work. —Female participant, group discussion with married women, ages 15–24, Tigray

I go along with my eldest son when there is long-distance travel to the health center. Even if I wish to [him to] accompany [me]… my husband [sic] when going to the health center for major cases other than delivery, he has often hectic time dealing with on- and off-farm activities. —Female participant, group discussion with married women, ages 25–45, Oromia

Some female group discussion participants expressed a preference for accessing health facilities alone, particularly with regard to family planning.

For family planning services and counseling, I like going alone. However, for ordinary illness and vaccination, I go with my eldest daughter. —Female participant, group discussion with married women ages, 25–45, Oromia

Some regional variation was observed. In Amhara, a few female group discussion participants, ages 15–24 and 25–40, indicated a desire for their husbands/partners to accompany them while accessing health services. In Oromia, female group discussion participants in both age groups most commonly mentioned men already accompanying them or a desire for men to accompany them. In Tigray,
Male group discussion participants and interviewees reported that women accessed healthcare for reproductive health or maternal and child health services.

Male respondents in Oromia, SNNPR, and Tigray stated that women and girls sought services for prenatal care, delivery, post-delivery care, contraception, and related reproductive health services. Healthcare providers said women were responsible, on the whole, for bringing children for preventive and curative health services, although husbands did accompany their wives and children.

Men come with women during delivery. Women come alone for family planning and pregnancy cares. Today, women have better awareness through the Women’s Development Army and do come for family planning. However, there are males who are not convinced and do not want their wives to use family planning. In that case, they come undisclosed and use family planning. —Male healthcare provider, Oromia

In Amhara, male respondents did not mention women seeking family planning services, whereas in Oromia, unmarried male group discussion participants, ages 15–29, distinguished between services accessed by women and young or adolescent girls. Male interviewees in Oromia and SNNPR said adolescent girls were more likely to access these services.

Women come to our facility for delivery service, vaccination, and family planning services, while young girls come to get advice on... STIs and HIV... In addition, girls come for advice for issues related to menstrual cycle, and rarely come to get family planning and tetanus toxoid vaccine. —Male healthcare provider, Oromia

In Oromia, male interviewees suggested that women did not access family planning services due to gaps in knowledge about contraception.

Women who are going to the health center to use family planning service are few. There are gaps in this regard, from healthcare provider’s side, in explaining the side effects of contraceptive methods. For the reason that the community does not understand well about the side effects, they are conveying...
Group discussion participants across all four regions said they possessed knowledge, attitudes, and practices that positively influenced health outcomes. However, infrastructure barriers persisted, and traditional healers and medicines were valued and used.

Group discussion participants shared knowledge and understanding about basic hygiene, malaria transmission, typhoid, giardiasis, and HIV and other STIs. Most participants acknowledged that their increased awareness about health-related matters was due to health education provided by health extension workers.
Health extension workers taught us that a woman should not to give birth at home. Because if we do not take a woman during laboring to health facility, she may face problems. So now, when a woman is in labor, we contact the health facility immediately. —Male participant, group discussion with married men, ages 25–60, Oromia

Most group discussion participants mentioned preventative measures they adopted and practiced on a regular basis, such as toilet construction and proper solid waste disposal techniques; hand and face washing; regular dishwashing; boiling drinking water or using Wuha Agar (an additive for water purification) in water and food preparation; mosquito nets for sleeping; management of standing water for prevention of malaria; and regular visits to health posts for STI and HIV check-ups.

We constructed [a] toilet, we use bed net to protect from mosquitos, I wash my hands before dining, I keep my hygiene and wash my clothes timely. —Male participant, group discussion with unmarried men, ages 15–24, Oromia

There was some regional variation. Group discussion participants in Amhara tended to highlight a lack of knowledge or information and other practical constraints that prevented them from engaging in positive behaviors. Several group discussion participants in Amhara also mentioned specific concerns about potable water—piped water was often far, requiring a 2-hour trip; remote areas had no piped water; piped water systems suffered breakages; and communities mostly used untreated water.

These days, there is no one who drinks water from an untreated source. Tap water is becoming accessible everywhere in our locale, including the countryside. Those [in remote areas] who have no access to tap water are asking for the facility managers in order to have access to it. Everyone is conscious about their health. —Male participant, group discussion with married men, ages 25–60, Amhara

In Oromia and SNNPR, group discussion participants noted that distance from health posts was a significant barrier to accessing RMNCAH-N services, particularly in rural communities. Participants from Tigray did not mention distance from health centers as a factor that affected health-seeking practices. Throughout all regions, male and female group discussion participants highlighted the relationship between lack of information and awareness and community-level health habits.

We are healthy, we drink line water; it is nearby to us. The health post is also close; we use family planning services; we are upbringing our children well. But if we take the whole community, the kebele is vast, the health post is far for others—they should pay around 15–25 birr for motor to reach at health post, but we all are living in [the same] kebele. If we take G-, it is 25 birrs for motor to reach here for vaccination, it is 15–20 birr is required to come from GK- and from D- area it requires 40 birr, to reach [on foot] is tiresome. But for us, we can say we are healthy; we use this and that to be clean because we live near to health facility. I always ask why the health post could not be built in those areas. —Female participant, group discussion with married women, ages 25–45, SNNPR

Group discussion participants expressed continued distrust, and exhibited lack of knowledge and community awareness about “modern” healthcare practices and medicine, which prevented men and women from seeking RMNCAH-N services. Most group discussion participants distinguished
between health issues that could be addressed by medical professionals and those that could only be addressed by traditional medicine or healers.

*Our people do not encourage you to go health center or hospital for some illnesses. If you are sick of gonorrhea and consult somebody, he would ask you, saying, “Are you going to health center for gonorrhea? How can you go to health center?” Rather, they encourage you to visit traditional healers for gonorrhea; they tell you it is only via traditional healers that you can cure.* —Male participant, group discussion with unmarried men, ages 15–24, Oromia

Group discussion respondents noted “evil spirits” and broken bones as conditions that required traditional medicines.

*A young married man would go to Fil Wuha seeking health when he understands that his repeated attempt to get cured through modern medical therapy has failed. This occurs when the sick person considers that the cause of his illness is an evil spirit or Satan. But, it is the power of Allah that can cure him or kill him. The same applies to seeking health through tsebel [holy water].* —Male participant, group discussion with married men, ages 15–24, Amhara

Distances to health posts or health centers, limited availability of ambulance, and health emergencies often led participants to access traditional medicine. Increases in the severity of symptoms, however, prompted participants to access health posts or health centers. Overall, women were more inclined than men to discuss the use of traditional healers or birth attendants.

Male and female group discussion participants from all four regions spoke of different traditional medicines, spiritual practices, or harmful practices prevalent in their woredas. These practices directly affected women (e.g., massaging the abdomen of pregnant women and uvula cutting), children (e.g., teeth extraction), or the whole community (e.g., eye cutting/draining, cauterization, and bloodletting). Respondents also mentioned spiritual practices such as going to *debteras* or “holy waters.” They also described the use of herbal drinks, poultices, and fumigations.

*We have different cultural practices that we think are helpful to lead a healthy life. For instance, it is common to let out contaminated blood from around the arm, called mebat in Amharic, in different conditions. Moreover, there is still a practice of extracting roots of teeth, called geg maswotat in Amharic, when the need arises. With this, staying at home, believing in God for his mercy, instead of visiting health centers is common in our locale.* —Male participant, group discussion with married men, ages 15–24, Amhara

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**Group discussion participants and interviewees noted that many cultural and religious taboos about contraception directly affected girls’ and women’s health by limiting their access to family planning services.**

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2 *Debteras* are spiritual healers who address illnesses by purging evil spirits or demons from the sick person through amulets, potions, smoking, or other means. Holy waters are a spiritual or faith-based treatment in the Christian tradition in Ethiopia, whereby the holy waters help in exorcising demons or causes of illness.
Across regions, group discussion participants and interviewees noted that cultural and religious norms favored large families, making it difficult for women to have autonomy over their fertility and family planning choices. This led to married women either not having access to family planning or accessing these services without the knowledge or consent of their husbands.

*After giving birth for two, they do not want to give birth for the third one immediately. One woman in our community said, “I want to wait for 4 or 5 years before I give birth for the next,” and her husband insisted, “No, we should not wait all these years, 3 years is enough to have our next baby, 2 or 3 years is enough for the second baby to breastfeed, then you should give birth.” And she persisted, “I want my second baby to reach 5 or 6 years before I have the next one.” Some do not let their husband know they are taking Depo or an implant for 4 to 6 years. There are also some women who do not mind letting others know.* —Female health extension worker, SNNPR

Group discussion participants spoke of the ways the limited use of contraceptives contributed to a number of other health problems, including child malnutrition and weakened health of mothers.

*The first reason for malnutrition of infants is unwillingness to use family planning and giving birth frequently. A woman gets pregnant and gives birth in a year, while another of her babies is sucking her breast. So, the baby could not get adequately breastfed.* —Female healthcare provider, Amhara

In Amhara, group discussion participants described norms against sex outside of marriage, which encouraged early marriage, adversely affecting the health of young girls because they became burdened with childbearing and child-rearing at young ages. Group discussion participants in Oromia spoke of cultural norms that dictated a woman breastfeed her child for 2 years and not have sexual intercourse with her husband for the duration. These participants mentioned that because Islam allows polygamy, women’s decisions to use contraception without their husbands’ consent or knowledge could result in men marrying other women for the sake of having more children. Health extension workers also mentioned the cultural acceptance of the practice of *jaalaa-jaalttoo*, or having mistresses.

*The majority of the community we live in here are settlers… What we wish them to use is family planning. But, they are unwilling to use family planning. They say it is against Shariah law… They give such reasons as “If I do not give birth, my husband would marry another woman.”* —Female health extension worker, Oromia

*One good thing about the Quran is that it helps people to remain faithful to their partners. Clearly, the Quran does not allow Muslims to use condom for sexual intercourse. It regards sexual practice before marriage or adultery as Haram (sin). But, as an unmarried young people, we use condom irrespective of Islamic religious laws about sexuality.* —Male participant, group discussion with unmarried men, ages 15-24, Amhara

Overall, female group discussion participants were more likely than male participants to discuss cultural norms around contraceptives. Health workers were more likely to raise issues around contraception in interviews than in group discussions.
3.3 CBHI PROGRAM

Male and female group discussion participants across regions said that access to the CBHI influenced women’s ability to independently access healthcare services.

The role of the CBHI was specifically assessed during data collection, predominantly in group discussions, to understand community perceptions of the program and its role in increasing access to healthcare. CBHI is a locally administered insurance program that seeks to expand affordable healthcare coverage across most woredas. Unmarried and married male and female group discussion participants across the four regions and all age groups (except married women ages 25–45 from Amhara) overwhelmingly mentioned financial constraints as barriers to accessing RMNCAH-N services. These participants reported visiting traditional healers or using traditional herbs and medicine as part of their initial response, and visiting the health center only if the health concern persisted or increased in severity.

*I use traditional herbal medicine before going to the health center... People who do not have money do this... There are herbs that have medicinal ingredients, which I myself know about, which could be used to treat health problems like stomach ache... I may also visit the “wise men”... There are herbal roots which are prepared in the form of juice and given to patients... they help to cure the patient.* — Male participant, group discussion with married men, ages 25–45, SNNPR

Unmarried women, ages 15–24, and married women, ages 25–45, in Tigray group discussions said the CBHI improved their ability to take themselves or their children to health centers without requesting financial support from a male head of household, positioning them to be better able to address healthcare needs for themselves and their families.

*Unfortunately, the majority of us, women, don’t have income of our own. We rely on our husband’s money in order to pay for the medical bill. But if we have this card, we don’t have to ask our husbands for money whenever we are sick. In addition, our husbands may not be at home when we get sick, hence having this card will allow us to go to the health center without waiting on our husbands.* — Female participant, group discussion with married women, ages 24–45, Tigray

In Tigray, government representatives, married men and women ages 15–60, and unmarried women ages 15–24 mentioned that women and other family members gained some decision-making power as a result of CBHI membership. In Amhara and SNNPR, the issue of freedom in decision making about health concerns was raised primarily by government representatives and other men in the community. There was no mention of freedom in decision making by any stakeholder of either sex in Oromia.

*Most beneficiary women feel that the introduction of CBHI to their community helps them to avoid endless arguments with their husbands on problems related to financing their medical care... CBHI also provides women with personal experience of freedom and self-confidence, because it enables them to make decisions for accessing medical care without their husbands’ involvement. I consider CBHI in this respect as a program that initiates people to develop a new tradition of self-help, because it*
Male and female group discussion participants across the four regions stated that CBHI contributes to better health-seeking behaviors. They also remarked on implementation challenges, and offered suggestions to strengthen and expand the program.

Across the four regions, married men and women, ages 15–60, and unmarried men and women, ages 15–24, who were users or expected to be users of the CBHI recognized that having the insurance had removed, or would have removed, financial constraints or considerations while seeking or using health services. Government representatives from all four regions, healthcare providers in Amhara and SNNPR, and health facility managers and health extension workers in Amhara also highlighted the benefit of freedom from financial worry. Many group discussion participants who subscribed to the CBHI described health services as “free,” even though the program requires members to pay a fee of 205 birr. They viewed the benefits of healthcare received due to the CBHI as justifying the annual per-family costs of buying into the program. Group discussion participants reported a reduction in borrowing to finance healthcare needs.

I have seen the importance of the system from people who have paid the 205 birr and take advantage of the system. They have family card and it has the picture of each family member. They, practically, get the service for free at the health center. —Female participant, group discussion with married women, ages 25–45, SNNPR

Across the four regions, unmarried young men and women and married group discussion participants, ages 15–60, who subscribed to the CBHI, wanted to subscribe, or had heard about the CBHI noted that the program motivated health seeking for themselves and their families. Many participants commented that without the CBHI, people would delay seeking services, which would have a negative impact on health outcomes.

Both men and women are users of health insurance. Before this time, women couldn’t go quickly and get the treatment… because they thought that they would be asked a higher amount of money; they just stayed in their houses… But now, even though there is no money but health insurance, they wouldn’t stay within house most of the time. They would go quickly and get the treatment. My neighbor had a very small swollen thing under her breast. She stayed many days, saying that she had no money. Then, she went to health center when things got worse. But it was changed to cancer. She went to the hospital in Addis Ababa… and didn’t cure… Had she gone early, in the due time, she...
might have been cured from her problem. —Female participant, group discussion with married women, ages 15–24, Amhara

Despite the perceived benefit of participating in the CBHI, throughout all four regions, many unmarried and married men and women, ages 15–60, in the group discussions had low or no awareness of the scheme. Participants from Oromia seemed to have the least awareness of the program, its benefits, and its shortcomings. Several participants from SNNPR and Tigray mentioned that they had enrolled and paid, but had not seen the program implemented in their woreda. SNNPR government representatives corroborated this by highlighting the importance of rolling out the program to demonstrate it was being governed well. Group discussion participants in Tigray specifically raised the issue of low coverage and high costs of the CBHI.

I already paid 250 birr to get treatment to all my families per annum, but I did not get the service because many people outside our kebele have not been paid yet. —Male participant, group discussion with married men, ages 25–60, Tigray

There should be experience-sharing between the neighbors who are joined in the community-based health insurance and not joined, because the non-users can easily understand the benefit of community health insurance. —Female participant, group discussion with married women, ages 15–24, Tigray

For those who have already contributed, they have started to request the service, and if this does not get a proper response, it will raise the question of lack of good governance, so it has been planned to mobilize to completely collect the community contribution and to deposit to the bank to begin the service. —Female government representative, SNNPR

Male and female group discussion participants in Tigray specifically mentioned increased costs as barriers to joining the CBHI for many community members.

In the past, we used to pay only 142 birr to be a member of community-based insurance, and many people were members. Now, the money to be a member has been raised to 242 birr; hence, people are reluctant to renew their membership. —Female participant, group discussion with married women, ages 25–45, Tigray

Government representatives across all four regions said the CBHI needed to be implemented in several woredas, and initiation of the program needed to be strengthened to improve use. Healthcare providers said insured households tended to use health services more than uninsured households, leading to case overload or abuse of healthcare services.

Suggestions for strengthening the program included actions to improve membership, evaluation of costs and processes for collecting payments, and ensuring members received quality services.

The insurance scheme should be implemented in all woredas, and there needs to be awareness so that beneficiaries would get a chance to be served at a nearby health institution. The other thing is all necessary preconditions need to be fulfilled. For instance, medicine and medical equipment need to be supplied. Further, the level of awareness and commitment of kebele managers is decisive. Kebele managers used to collect taxes and other revenue without receipts, which they find it difficult to apply for community insurance membership fee as result of which they lack motivation. So, this also needs to
be improved. According to the health sector guideline, there are exempted services that grant women charge-free services. In [the CBHI], there is no such distinction. — Male government representative, Oromia

The service providers have an evaluation that the clients are abusing the health insurance, visiting the health center for no reason other than that they think that they have already paid for the service. — Male government representative, Amhara

RESULT AREA 4: ENHANCED PROGRAM LEARNING TO IMPACT POLICY AND PROGRAMMING RELATED TO PREVENTING CHILD AND MATERNAL DEATHS

For Result Area 4, specific information was collected on the factors that support or hinder health facility managers from collecting and using sex- and age-disaggregated data. Where possible, research efforts also sought to identify relevant research gaps, as well as recommendations for potential interventions or areas where expanded programming is needed.

4.1 COLLECTION AND USE OF DATA

27 Interviewees reported that data collection systems support managers in monitoring and evaluation, and decision making on service delivery.

Government representatives and health facility managers shared that data collection processes included both health facility data collection systems (health management information system) and outreach through health extension workers, sometimes referred to as the Community Health Information System. Interviewees said these data collection systems supported health facility managers to collect sex- and age-disaggregated data. Respondents discussed other ways of obtaining sex-disaggregated data, including checklists and registers, community meetings, home visits, or individual phone calls to households.

We do have different mechanisms to collect data on health service users. This is through the health management information system. Community Health Information System, registers, tally sheets, a suggestion box posted on the shelf of the office, female and male cards, and from routine reporting of data from the health center and health posts. — Male government representative, SNNPR

Health facility managers and government representatives from all four regions reported that disaggregated data collected through these methods were used for monitoring and evaluating health services and programs, and for making decisions about service delivery. Interviewees said data were disaggregated by the type of medical services provided, supplying richer information for use in improving services and service coverage.

Generally, in our data compilation and reporting system, we list out each activity on sex, age, and types of services we have been offering. This reporting system then can show the distribution in sex, as
Health facility managers and government representatives reported data gaps, and that collection of sex- and age-disaggregated data varied based on health areas, populations, and health management information system capabilities.

Interviewees also acknowledged gaps in data collection and a lack of processes around data generation, management, analysis, dissemination, and use. These respondents indicated that although data were collected and disaggregated by sex in some health areas (e.g., HIV), this was not universal.

We collect data from the people we serve. There is a problem in data collection. Lack of awareness in using the data and we do not know where it goes [sic]. Lack of awareness that data has [sic] impact on the life of a person. We collect the data, but we do not use it [sic]. Even the data is [sic] transferred to the federal level, it does [sic] not have any value. —Female health facility manager, Oromia

In brief, the collection of data on HIV/AIDS is disaggregated on the basis of sex and age of clients, while the data on non-communicable diseases are disaggregated mainly on the age of the persons treated. Also, the collection of disaggregated data on family planning services (contraceptive use and condom use) involves the sex category of individuals, while the collection of data on nutrition involves both the age and sex of children treated. —Male government representative, Amhara

Two government representatives from Tigray explained that they had requested disaggregated data from the woreda health office and did not receive them.

We always ask them to prepare plans using sex-disaggregated data. Despite some improvements, there is still a problem when it comes to sending sex-disaggregated data. —Female government representative, Tigray

4.2 RESPONDENTS’ RECOMMENDATIONS FOR EXPANDED PROGRAMMING

Interviewees across the four regions consistently highlighted three areas where expanded programming is needed: (1) gender-based violence prevention and response; (2) male engagement in family planning; and (3) community sensitization to gender inequality.

Government representatives and at least one healthcare provider voiced a gap in knowledge, skills, and programmatic actions or resources available to address the issue of violence against women and
girls in the community. They said they were unable to address gender-based violence adequately at the community level, not only due to sociocultural norms and barriers, but also due to a gap in knowledge, skills, programmatic actions, and resources (medical and legal) available to providers. A government representative explained that she felt she was unable to provide the right care to survivors of harassment because she lacked legal knowledge background.

As I said earlier, lot of harassment cases are brought to our office and none of us have a law educational background. I need to take law courses in order to satisfy the people I am serving. In order to confront the judges whenever they commit injustice, I need to know about the details of the legal system of the country. —Female government representative, Tigray

Interviewees recommended interventions such as primary prevention through the promotion of community awareness and prevention campaigns, and secondary prevention through survivors’ physical, mental, and reproductive healthcare, as well as capacity building of health staff to provide referrals to social, economic, or legal support. A female government official in Oromia described community mobilization as a method for preventing gender-based violence and harassment against females, noting that she saw rates of gender-based violence increasing in communities.

I want to eliminate or reduce gender-based violence that exists within the community by creating a big community mobilization, because I think harassment that is committed against females is now increasing again from previous times, which harms females physically and psychologically. —Female government representative, Oromia

Several respondents—including health extension workers, health facility managers, healthcare providers, and female group discussion participants—discussed the need to increase male engagement in family planning and healthcare conversations and education. These respondents’ recommendations focused on increasing men’s awareness of family planning methods and benefits to broadly boost men’s understanding, participation, and involvement in family planning and healthcare.

More awareness and education should be given for men both in rural and urban areas to let them engage with women in the health facilities about family planning, child health, maternal healthcare, etc. Most of the time, rural men refuse to allow women to use family planning. There is a need to create awareness among men. —Male healthcare provider, Oromia

Two health facility managers discussed different entry points to engage men in conversations on family planning, including reaching male partners of pregnant women during antenatal appointments, advising men who enter the health center for outpatient services on family planning, and using health extension workers to consult with and encourage men to engage in family planning. A male health facility manager in Amhara suggested that men, as well as kebele officials, should engage in family planning.

[N]ot only mothers, but also men and kebele officials, are supposed to take part in conferences on family planning and related issues. In practice, however, we see that the role of men and kebele officials is not significant. This is the area that we need to focus on in the future through assistance
from kebele and woreda officials, together with health workers. I also suggest that health extension workers’ outreach programs should be strengthened in ways targeting [sic] not only mothers, but also husbands or men. —Male health facility manager, Amhara

Mostly female respondents from group discussions and interviews raised the need for increased male engagement in family planning in the community.

Some health facility managers, healthcare providers, and health extension workers from all four regions conveyed the need for greater efforts to raise awareness and create sensitization on gender inequality—namely, early marriage, female genital mutilation, and education.

In our locale, the influence of the community’s tradition is extremely high. We are facing pronounced challenges due to it. Hence, there is a need to establish an integrated program where stakeholders participate and that works on the issue of awareness creation in order to get rid of the influences of the tradition. I want females to grow in education, not only to the level of the primary or the secondary level, but to the higher level, too. In order to realize such aspiration, there needs be a rule in the law that protects the female from early marriage and other obstacles. —Male government representative, Amhara

Most of us [healthcare providers] have an awareness gap on gender that considers it a women’s issue, but gender is an issue for… men and women. In order to achieve equality among both sexes, all of us should give emphasis on gender issues. The gap isn’t only at the community level; there is also gap among public servants—there is negative attitude in our own homes. Our attitude towards equality has a gap. Since there is a gap on attitude, we have to work hard on behavioral change through promotion of key messages on gender issues. —Male government representative, Tigray
CONCLUSIONS

In May 2018, the Transform: Primary Health Care project gender team held a data consultation meeting with project staff, partners, and other key stakeholders to validate and interpret the gender analysis findings, and jointly develop conclusions and recommendations to address the gender gaps and opportunities identified in the project gender analysis.

Overall, the findings show that the Government of Ethiopia and other key stakeholders recognize gender disparities in the health sector, from the facility to the community level, and have made strides in addressing those inequalities. Efforts have been made to strengthen health systems by improving service delivery across the continuum of care, and creating awareness among women about healthy practices and the importance of health services. However, more needs to be done to engage and create awareness among men, especially around family planning, as well as to improve the collection, understanding, and use of sex disaggregated data for health program decision making. In addition, traditional, harmful gender norms and practices persist at levels that impede the availability of and access to quality health services for all Ethiopians, and the full participation and advancement of women in leadership in the health sector.

These conclusions are organized below by the project’s four result areas that address both the supply and demand sides of the health sector for a holistic strengthening of health systems.

RESULT AREA 1: IMPROVED MANAGEMENT AND PERFORMANCE OF HEALTH SYSTEMS

In the first result area, management and performance of health systems was examined in the light of gender policies pertaining to human resources for health, specifically:

- Affirmative action policies
- Family leave policies
- Workplace sexual harassment policies
- Gender differences in access to strategic resources, such as training, supervision, administrative and organizational support, and formal and informal networking
- Policies or practices to address gendered vulnerabilities to violence experienced by health workers
- Gender differences in measuring or rewarding work

Findings show that policies and standard operating procedures are in place, but poor implementation and understanding of these policies and procedures impede their effectiveness. In addition, there is a lack of accountability to ensure that managers and providers apply the policies and procedures equally and consistently (e.g., implementation of paternity and maternity leave policies). The affirmative action policy is widely known, but appears to be implemented in different ways across regions, and a workplace harassment policy does not exist. Although some affirmative
actions for the workforce might be effective in getting more women workers into the health sector, the findings reveal that proper socialization of the policy in the communities and among stakeholders is necessary for sustainability and to avoid misinterpretations.

In many ways, the work environment is not conducive to female service providers. While job responsibilities may be distributed equally between men and women, they often cause undue burden for female health workers. Findings reveal that work assignments do not account for gendered vulnerabilities to sexual harassment or women health workers’ reproductive and childcare roles. For example, female health workers were assigned night duty or required to travel long distances without accommodations for breastfeeding or safe housing at health facilities.

Women continue working as healthcare providers, but there are minimal numbers of females in leadership positions and no strategy that impels females into leadership positions. Family and community support play a critical role in supporting females in leadership positions, but the proportion of females in management and leadership is still inadequate.

RESULT AREA 2: INCREASED SUSTAINABLE QUALITY OF SERVICE DELIVERY ACROSS THE CONTINUUM OF CARE

CRC professionals and service delivery are a high-priority issue in the Government of Ethiopia’s Health Sector Transformation Policy. The Health Sector Transformation Policy identifies four characteristics of CRC health professionals:

1. Consider patients as human beings with complex psychological, social, and economic needs, and provide person-centered care with empathy
2. Have effective communication with healthcare teams, and interactions with patients and other health professionals over time and across settings
3. Have respect for and facilitate patients’ and families’ participation in decisions and care
4. Take pride in the health profession they are in, get satisfaction by serving the people and the country, and hold CRC to be a critical requirement in achieving high-quality health services and ensuring equity

Findings show that the language of “caring, respectful, and compassionate services,” or CRC, is well known and used by providers. However, there is unevenness in CRC across regions, with some facilities being better than others at providing it. Overall, there seems to be an increasing uptake of health services. However, many health workers are still not providing CRC services, especially in rural areas and to CBHI users, and some are less attentive to males and unmarried females. CRC matters for the uptake of services; in places where it is absent, clients notice.

Other dimensions of quality of care that emerged from the data were related to infrastructure and cleanliness of facilities, and timely and efficient access to health services. Health extension workers were often preferred because of the counseling and follow-up they provide through their community outreach, especially with respect to family planning.
Users of the CBHI are happy with the scheme overall, and it has increased women’s access and use of services. Mothers are receiving good care in health facilities and maternal health services have improved over time. Nonetheless, poor quality of service delivery continues in the form of long waiting times, unavailability of drugs and supplies, and shortage of health workers. Health providers’ attitudes (influenced by gender norms) also affect quality of care, such as longer waiting times for women because health providers believe men are busy, and providers not always upholding clients’ rights to confidentiality and privacy.

RESULT AREA 3: IMPROVED HOUSEHOLD AND COMMUNITY HEALTH PRACTICES AND HEALTH-SEEKING BEHAVIORS

Findings show that women do not have complete autonomy regarding healthcare, and that although men and women often make healthcare decisions jointly, it is ultimately the decision of the man. However, the CBHI enables women to independently access healthcare services despite quality-related challenges.

Both males and females prefer to be supported and accompanied when seeking healthcare, except when related to HIV and other STIs, and family planning. Men are perceived to be busier than women, which serves as a reason for not accompanying their female partners to the health facility, as well as for not seeking services for themselves.

There is widespread male opposition to family planning due to the gender role expectation to have more children, misconceptions about family planning, and religious reasons. Women are hesitant about accessing family planning services due to fear of side effects, and competing traditional and religious practices, taboos, and beliefs that directly impede contraception use among women.

RESULT AREA 4: ENHANCED PROGRAM LEARNING TO IMPACT POLICY AND PROGRAMMING RELATED TO PREVENTING CHILD AND MATERNAL DEATHS

Sex-disaggregated data, as well as capacities to understand and use them for programming, are essential to preventing childhood and maternal deaths.

Findings show that data collection systems support managers in service delivery monitoring, evaluating, and decision making; yet, data gaps and lack of processes around data generation, management, analysis, dissemination, and use exist. Not all data are disaggregated by sex, and even fewer are disaggregated by age. Some of this is due to limitations of the health management information system itself.

The findings also identified three areas where more learning and focus are needed:

1. Preventing and improving response to gender-based violence: More attention and focus are needed in understanding and addressing the sociocultural norms that allow abuse of and violence against women, and prevent redress to survivors of violence. Findings highlighted
gaps in knowledge, skills, and programmatic actions, and lack of available medical and legal resources as impediments to community health services’ response to gender-based violence.

2. **Enhancing male engagement:** More attention and focus are needed in shifting sociocultural expectations and norms that affect men’s limited health seeking and support for meeting the health needs of their partners and children, as well as their negative attitudes and beliefs toward family planning.

3. **Addressing harmful practices:** More attention and focus are needed in eliminating harmful practices negatively affecting girls and women, such as early and forced marriage, and female genital mutilation and cutting.

4. **Understanding the pay gap:** More attention and focus are needed with regard to developing a comprehensive understanding of the extent to which a pay gap likely exists between women and men in the healthcare professions.

**RECOMMENDATIONS**

This section provides recommendations for the Transform: Primary Health Care project to work with and support its partners to build on what is working, and improve areas that are impeding achievement of outcomes intended by the project and government. These recommendations were developed collaboratively with project staff and will be used to develop activities for the project’s gender strategy.

**RESULT AREA 1: IMPROVED MANAGEMENT AND PERFORMANCE OF HEALTH SYSTEMS**

**POLICY IMPLEMENTATION**

1. Every 6 months, the Transform: Primary Health Care project should support the Ministry of Health, regional health boards, *woreda* health centers, and project partners to ensure the ongoing availability, awareness creation, and implementation of guidelines, standards, and procedures across regions related to affirmative action, sexual harassment, and standard operating procedures.

2. As soon as possible, the Transform: Primary Health Care project should advocate to the Ministry of Health, regional health boards, *woreda* health centers, and project partners to raise awareness of maternity and paternity leave policies, and ensure they are being implemented according to the standards.

**ENABLING ENVIRONMENT**

3. In project year 3, the Transform: Primary Health Care project should advocate to the Ministry of Health, regional health boards, and *woreda* health centers to establish private,
secure places at facilities for women to breastfeed; and establish childcare centers inside or near health facilities or provide discounts to staff to use nearby childcare centers.

4. As soon as possible, the Transform: Primary Health Care project should advocate to government and health workers to provide secure housing in the health facilities for providers on night duty, especially those located in remote areas.

WOMEN’S LEADERSHIP AND RETENTION

5. The Transform: Primary Health Care project should immediately work with health facilities, *woreda* health office, and partners to develop a strategy that supports women in leadership positions and creates an enabling environment for female healthcare workers. This includes targeting female healthcare workers through the project’s leadership, management, and governance activities.

6. As soon as possible, the Transform: Primary Health Care project should work with the Ministry of Health, regional health boards, health facilities, families, community members, and partners to strengthen community members’ awareness and support to female healthcare providers to continue in their professions.

RESULT AREA 2: INCREASED SUSTAINABLE QUALITY OF SERVICE DELIVERY ACROSS THE CONTINUUM OF CARE

CRC SERVICES

7. In project year 3, the Transform: Primary Healthcare project should advocate to the Ministry of Health and the Ministry of Education to integrate CRC services and client rights in the pre-service health medical ethics trainings.

8. In project year 3, the Transform: Primary Healthcare project, *woreda* health offices, and health facilities should ensure that periodic follow-up visits and mentorship for health facilities at all levels are occurring. This could include random checks by “mystery clients.”

9. In project year 3, the Transform: Primary Healthcare project, *woreda* health offices, and regional health bureaus should monitor CRC services and ethics by using the community scorecard, conducting random checks (perhaps through “mystery clients”), and conducting “whole-site” and “on-site” trainings.

CBHI PROGRAM

10. The Transform: Primary Healthcare project and regional health boards should advocate to, and sensitize officials and health workers on the CBHI purpose, participation, and service policies to increase enrollment and improve implementation.

11. The Transform: Primary Healthcare project and regional health boards should ensure timely reimbursement of CBHI medical expenses through Ministry of Health’s guidelines.
12. The Transform: Primary Healthcare project and regional health boards should support universal enrollment to decrease bias among service providers.
13. The Transform: Primary Healthcare project and regional health boards should work with the health facilities to improve availability of drugs, services, and equipment (e.g., laboratory and x-ray equipment).
14. The Transform: Primary Healthcare project quality improvement team should work with health facilities to identify the bottlenecks that are causing longer waiting times, and act on removing them.

RESULT AREA 3: IMPROVED HOUSEHOLD AND COMMUNITY HEALTH PRACTICES AND HEALTH-SEEKING BEHAVIORS

15. In project year 3, the Transform: Primary Healthcare project should work with the government and partners to engage religious and traditional leaders to promote gender equality in using RMNCH-N services. This could be achieved by identifying key influencers in the communities who hold understandings of scripture that promote positive social change and social justice, and have used their faith to advocate toward such ends.
16. In project year 3, the Transform: Primary Healthcare project should work with the government and partners to engage men and boys at community and facility levels to increase acceptance and use of RMNCH-N services for themselves and their families.
17. In project year 3, the Transform: Primary Healthcare project should work with the government and partners to promote CBHI enrollment and renewal to enable women to independently access universal health services.
18. In project year 3, the Transform: Primary Healthcare project should work with the government and partners to improve the quality of client and couple counseling on family planning to address myths and misconceptions that deter use of family planning.
19. In project year 3, the Transform: Primary Healthcare project should work with the government and partners to bring gender sensitivity into healthcare practice to dismantle barriers to better health practices and health-seeking behaviors in the communities. For example, gender sensitization of health providers and workers would improve the understanding that longer wait times affect not just men and their health (who fail to access healthcare or accompany their families because that removes them from paid work), but also women and their health (who also work, but whose work is largely unpaid care and domestic work).

RESULT AREA 4: ENHANCED PROGRAM LEARNING TO IMPACT POLICY AND PROGRAMMING RELATED TO PREVENTING CHILD AND MATERNAL DEATHS

20. In project year 3, the Transform: Primary Healthcare project should conduct ethnographic studies to gain deeper insight into gender-based violence, and gender norms and roles related to masculinity and RMNCH-N services.
21. In project year 3, the Transform: Primary Healthcare project should advocate to the government to update the health management information system so that it requires sex- and age-disaggregated data. Additionally, the project should advocate for the government to collect sex-disaggregated data on healthcare providers’ salaries, in order to identify and address outstanding pay gaps.

22. In project year 3, the Transform: Primary Healthcare project should advocate to the government to provide standard operating procedures and trainings to health facility managers so they are better prepared to use data to monitor and evaluate performance, and inform programming.

23. In project year 3, the Transform: Primary Healthcare project should hold gender synchronized community dialogues with special emphasis on the constructive engagement of men and boys (Greene & Levack 2010). These will help sensitize communities to gender equality and positive health-seeking behaviors, bringing in traditional and religious leaders to promote the messages.
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ANNEXES

ANNEX 1: TRANSFORM: PRIMARY HEALTH CARE PROJECT
RESULTS FRAMEWORK

Healthy, productive, prosperous Ethiopians

Health Sector Transformational Plan’s agenda and preventing child and maternal deaths achieved

RESULTS

- **R1**: Improved management and performance of health systems
  1.1 Established and strengthened innovative processes to sustainably enhance health system management and performance
  1.2 Enhanced functionality of the health system within the context of primary-level care
  1.3 Strengthened transformational leadership, governance, and management at the woreda and primary healthcare unit level

- **R2**: Increased sustainable quality of service delivery across the primary healthcare unit’s continuum of care
  2.1 Strengthened skills for delivery of quality and integrated RMNCAH-N services
  2.2 Improved provider behaviors and communication skills toward a compassionate, respectful, and caring health workforce
  2.3 Improved management of health service delivery and oversight of service quality
  2.4 Innovative service delivery interventions to affect ending preventable child and maternal deaths introduced and scaled up

- **R3**: Improved household and community health practices and health-seeking behaviors
  3.1 Increased individual-level care-seeking behavior and uptake of healthy practices
  3.2 Strengthened enabling environment for health-seeking behavior, including community engagement in health service oversight

- **R4**: Enhanced program learning to affect policy and programming related to preventing child and maternal deaths
  4.1 Strengthened health system’s capacity to generate learning and evidence
  4.2 Evidence of what works in ending preventable child and maternal deaths informed by results from program learning and iterative adaptation
  4.3 Evidence used to inform programming and policy with local and global stakeholders
### ANNEX 2: GENDER ANALYSIS RESEARCH QUESTIONS

**TRANSFORM: Primary Health Care Project Gender Analysis Design**

**Overarching Question:** What gender gaps and opportunities does the project need to address to achieve its intended results?

**RESULT 1: Improved management and performance of health systems**

<table>
<thead>
<tr>
<th>Key Question</th>
<th>Sub-Question</th>
<th>Data Source</th>
</tr>
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</table>
| 1.           | What supports or hinders gender equality in health systems management and performance at the primary healthcare level? | • Document review  
• In-depth interviews with male and female managers and providers  
• In-depth interviews with government officials |
| a.           | To what extent do policies support gender equality at the workplace (e.g., affirmative action, sexual harassment policies, maternity leave, flexible work schedules, etc.)? |                                                                                                         |
| b.           | What organizational culture factors either encourage or discourage men and women to excel in performance and leadership (e.g., opportunities for training, capacity building, and advancement; supportive or discriminatory environments, etc.)? | • In-depth interviews with male and female managers and providers |
| c.           | What external factors (beyond organizational culture) support or hinder men and women from holding leadership positions and being effective leaders (e.g., family responsibilities or attitudes, community norms, etc.)? | • In-depth interviews with male and female managers and providers |
| d.           | What opportunities and challenges exist to increasing the number of female health providers? | • In-depth interviews with male and female managers and providers |
| e.           | What indicators should be included in key performance indicators to measure gender equality in health system management? | • In-depth interviews with male and female managers and providers  
• In-depth interviews with government officials |
### RESULT 2: Increased sustainable quality of service delivery across the continuum of care

<table>
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<tr>
<th>Key Question</th>
<th>Sub-Question</th>
<th>Data Source</th>
</tr>
</thead>
</table>
| 2. What supports or hinders the quality of RMNCAH-N service delivery? | a. Which health providers’ attitudes and behaviors positively or negatively affect the provision of CRC? | • Document review  
• In-depth interviews with male and female managers and providers  
• In-depth interviews with health extension workers  
• Focus groups with women  
• Focus groups with men |
| | b. What are women’s and men’s perspectives of the quality of care they receive? | • In-depth interviews with health extension workers  
• Focus groups with women  
• Focus groups with men |

### RESULT 3: Improved household and community health practices and health-seeking behaviors

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<th>Key Question</th>
<th>Sub-Question</th>
<th>Data Source</th>
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| 3. What supports or hinders women and men from seeking RMNCAH-N services? | a. What decision-making power do women and men have regarding seeking health services for themselves or their children? | • Document review  
• In-depth interviews with health extension workers  
• Focus groups with women  
• Focus groups with men |
| | b. What supports or hinders women’s and men’s access to RMNCAH-N services? | • Document review  
• In-depth interviews with health extension workers  
• Focus groups with women  
• Focus groups with men |
| | c. To what extent are RMNCAH-N services perceived as friendly to women and men? | • Focus groups with women  
• Focus groups with men |
### TRANSFORM: Primary Health Care Project Gender Analysis Design

**Overarching Question:** What gender gaps and opportunities does the project need to address to achieve its intended results?

| d. In what ways do women want their husbands/partners to participate in RMNCAH-N services? | • Focus groups with women |
| e. In what ways do men want their wives/partners to participate in RMNCAH-N services? | • Focus groups with men |

#### 4. What gender norms and dynamics support or hinder household and community health and nutrition practices?

| a. What attitudes and roles positively or negatively affect women’s and men’s RMNCAH-N practices at the community level? | • Document review |
| • Focus groups with women |
| • Focus groups with men |

### RESULT 4: Enhanced program learning to impact policy and programming related to ending preventable child and maternal deaths

<table>
<thead>
<tr>
<th>Key Question</th>
<th>Sub-Question</th>
<th>Data Source</th>
</tr>
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<tbody>
<tr>
<td>5. What supports or hinders managers from collecting and using sex- and age-disaggregated data for reporting and learning?</td>
<td></td>
<td>• In-depth interviews with male and female managers</td>
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<td></td>
<td></td>
<td>• In-depth interviews with government officials</td>
</tr>
<tr>
<td>6. What research studies on gender norms and dynamics are needed to inform policy and programming to preventing child and maternal deaths?</td>
<td>What relevant research gaps exist related to gender norms and dynamics in Ethiopia to improve RMNCAH-N?</td>
<td>• Document review</td>
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<tr>
<td></td>
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<td>• Analysis of primary data</td>
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<tr>
<td></td>
<td>What pilot interventions are needed to test gender-transformative approaches for the improvement of RMNCHAH-N?</td>
<td>• Document review</td>
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<tr>
<td></td>
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<td>• Analysis of primary data</td>
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ANNEX 3: DATA COLLECTION TOOLS

KEY INFORMANT INTERVIEWS

This introductory script remained the same for each of the four stakeholder groups interviewed—healthcare providers, health facility managers, health extension workers, and government representatives. The table following the introductory language indicates which questions were asked of each group.

INTERVIEW GUIDE

Date:

Location (Ministry/Unit/Department, Kebele, Woreda, Region):

Interview #:

Interviewer:

Notetaker:

INTRODUCTION

Thank you very much for setting aside time to talk with me today.

Project Introduction: The Transform: Primary Health Care project is a 5-year, USAID-funded project that works with the Federal Ministry of Health to contribute to ending preventable child and maternal deaths, and improving engagement with the Government of Ethiopia on the implementation of its new Health Sector Transformation Plan. Transform: Primary Health Care project focuses primarily in the areas of maternal, newborn, and child health; family planning and reproductive health; and malaria within Ethiopia’s four major regions of Amhara, Oromia, SNNPR, and Tigray.

Research Introduction: The Transform: Primary Health Care project is conducting a gender analysis to identify potential opportunities, barriers, factors, and conditions that men, women, boys, and girls experience related to healthcare. Your Ministry/Unit/Department works in one of the woredas where the project is being implemented, so we have come here to learn more about your work and the people you serve. This study is not an assessment of your work. We will share the findings among partners to guide activities for the remaining 4 years of the project. We will share the final report with you.

Benefits: We hope to learn what is enabling or hindering access, use, and retention of health services so that we can support the Federal Ministry of Health to contribute to ending preventable child and maternal deaths in Ethiopia.

Voluntary Participation: Taking part in the interview is voluntary. You do not have to participate in the interview if you do not want to. If you do not want to take part in the interview, this will not
have any negative effects for you. It also does not affect your relationship with the Federal Ministry of Health, USAID, or the Transform: Primary Health Care project. You can also change your mind at any time, and stop taking part in the interview at any time if you are uncomfortable.

Confidentiality: Before we begin, I want to let you know that we will keep all the information or examples you give us during this conversation private. We will not share any information about you or anything you tell us with anyone who is not on our team. In the report we will write, we will not mention the names of the facility or your name. This way, nothing you tell us will be connected to you in the report.

Risks: We do not want anyone to be uncomfortable during our conversation, so if there is a question you do not wish to answer, you do not need to answer that question.

Interview Time Frame and Procedure: The conversation will take about 60 minutes. We will ask you several questions during this time frame, and my colleague will be taking notes.

Permission to Record: If you don’t mind, I would like to take notes and audio-record you during our conversation. This is so we can have record of what you say and so that we can listen again to what you said after our conversation. Once the gender analysis is completed, at some point we will delete the audio-recording and destroy the notes, and in the meantime, no one outside of our team will have access to them.

Contact Information and Contact Sheet: All the information I just gave you is summarized in an information sheet that I will now give you. The information sheet also has my contact data so that you can contact me if you have any questions about this research study in the future. It also has the contact data for someone you can contact if you have complaints about our team or the study.

BEGIN RECORDING

Before we begin, do you have any questions?

Note to interviewer: When you’ve reached 45 minutes, inform the interviewee about how many questions remain and check that you can complete the questions in the 15 minutes remaining, or ask for additional time.

INTERVIEW QUESTIONS

In the following table, any questions that were addressed to more than one group are presented as originally addressed to healthcare providers. The questions were modified as needed for informants from the other three groups.

<table>
<thead>
<tr>
<th>Question</th>
<th>Healthcare Providers</th>
<th>Government Representatives</th>
<th>Facility Managers</th>
<th>Health Extension Workers</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Tell us about your time at this facility. How long have you been a provider? How long have you worked here?</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Question</td>
<td>Healthcare Providers</td>
<td>Government Representatives</td>
<td>Facility Managers</td>
<td>Health Extension Workers</td>
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<td>------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>2. During this time, reflect on any opportunities you have had to advance in your career. What has supported you? What other types of support would you have liked? [Probe for examples of access to training, promotions, professional development, etc.]</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>3. Please describe a time when you received support from others working in healthcare to excel in your work and lead others. What did you appreciate the most about that support? Who was involved?</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>4. In what ways have your family and community been supportive of your work? Describe some ways that they have encouraged you to take up your profession and stay in it, even during difficult times.</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>5. What specific policies provide opportunities for staff to advance in this facility? How are they implemented? Please describe any differences between female and male staff that you may be aware of. [Probe for examples of equal pay, flexible schedules, maternity leave, sexual harassment policies, etc.]</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>6. [If not already mentioned, ask:] What sexual harassment policies exist? How are they implemented? [If policies exist, but are not implemented, probe for ways in which they have failed to implement them and any examples of sexual harassment cases.]</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>7. What sort of support or resources have helped women to become healthcare providers in this facility or woreda? What other kinds of support would help them to become health providers?</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>8. What else would help to recruit, retain, and support female healthcare providers?</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>9. What do you think would be some of the best ways to measure if men and women are being treated equally in this healthcare facility?</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>10. Let’s talk now about the community you serve. What motivates community members to visit your facility? For what reasons do women and girls come to the facility? How do providers make them feel respected and cared for when they come? [Probe for specific examples/stories.]</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>11. For what reasons do men and boys come to the facility? How do providers make them feel respected and cared for when they come? [Probe for specific examples/stories.]</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Question</td>
<td>Healthcare Providers</td>
<td>Government Representatives</td>
<td>Facility Managers</td>
<td>Health Extension Workers</td>
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</tr>
<tr>
<td>12. Who is not coming to the facility that you wish would? What needs to change so that they can come and continue to visit on a regular basis?</td>
<td>×</td>
<td>×</td>
<td>×</td>
<td>×</td>
</tr>
<tr>
<td>13. Imagine a woman visits your facility. What do you see as the most important reasons why the woman will feel satisfied with the care she received?</td>
<td>×</td>
<td>×</td>
<td>×</td>
<td>×</td>
</tr>
<tr>
<td>[Probe for examples/stories; these could relate to payment, the attitudes of providers, medicine, privacy, whether she is accepted as a patient, and other issues.]</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Imagine a man visits your facility. What do you see as the most important reasons why the man will feel satisfied with the care he received?</td>
<td>×</td>
<td>×</td>
<td>×</td>
<td>×</td>
</tr>
<tr>
<td>[Probe for examples/stories; these could relate to payment, the attitudes of providers, medicine, privacy, whether he is accepted as a patient, and other issues.]</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. How are men engaged in family planning and maternal, newborn, and child healthcare at the facility? What needs to happen for them to be more engaged?</td>
<td>×</td>
<td>×</td>
<td>×</td>
<td>×</td>
</tr>
<tr>
<td>16. How would you define quality of care? What enables you to provide quality of care?</td>
<td>×</td>
<td>×</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. What support do you receive that allows you to provide quality of care? What more do you need to be able to deliver the care and services that your clients seek?</td>
<td>×</td>
<td>×</td>
<td></td>
<td></td>
</tr>
<tr>
<td>[Probe for examples, such as consent policies and practices, processes for adolescents or unmarried women, etc.]</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>18. What other policies do you think would support equal treatment of female and male staff?</td>
<td></td>
<td>×</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19. In what ways does your ministry/unit/department monitor equal treatment of female and male healthcare staff in terms of things like work schedules, pay, promotions, or access to opportunities for training and development? How is this information used?</td>
<td></td>
<td>×</td>
<td></td>
<td></td>
</tr>
<tr>
<td>[Probe for examples of any specific indicators, such as keeping data on work schedules, promotions, or access to opportunities for training and development, etc.]</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20. What do you think would be some of the best ways to measure if female and male staff are being treated equally in the health system? How could this information support your ministry/unit/department’s work?</td>
<td></td>
<td>×</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Question</td>
<td>Healthcare Providers</td>
<td>Government Representatives</td>
<td>Facility Managers</td>
<td>Health Extension Workers</td>
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</tr>
<tr>
<td>21. How does your ministry, unit, or department make decisions about what health issues to prioritize for funding in your region? [Probe to see if/how the different needs of women/girls, men/boys are taken into account.]</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22. How is the Community Based Health Insurance program progressing? What do you think needs to be in place for the program to reach the people who need it? [Probe for ways to assess if women are accessing the funds and how to support them to do so.]</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>23. Please describe how your ministry, unit, or department collects and uses health data. How do you get information about specific groups that access the health system? [Probe for different ways they disaggregate and use the data.]</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>24. What other information and support would you need to better understand the community members that you serve and who may be missing?</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25. What are some other actions that managers could take to ensure that career advancement opportunities are available to both female and male staff?</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>26. In what ways has your healthcare facility monitored fair treatment between female and male staff in terms of things like work schedules, pay, promotions, or access to opportunities for training and development? What specific indicators [or signposts, measures, assessments] have been used? How has the information been used? [Ask to see records and/or the health center’s reform guidelines and scoring, if they exist.] How do you, as a manager, know if women and men are being treated fairly?</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>27. Who are the most active members on the health board? How many women and how many men are on the health board? [These should be asked in this order.]</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>28. Please describe how you or your facility collects and uses data. How do you get information about specific groups that come to your facility? For example, ‘underweight for age’ is usually collected only for children under 5. Does your facility record ‘underweight for age’ for girls and boys separately? Are there other examples from your facility? [Probe for different ways they disaggregate and use the data.]</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Question</td>
<td>Healthcare Providers</td>
<td>Government Representatives</td>
<td>Facility Managers</td>
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<tr>
<td>29. What support would you and your facility need to better understand</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>the community members that you serve and who may be missing?</td>
<td></td>
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</tr>
<tr>
<td>30. How does the facility get feedback from clients or community</td>
<td>X</td>
<td></td>
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</tr>
<tr>
<td>members? How is this feedback used? How does your facility respond to</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>this feedback?</td>
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</tr>
<tr>
<td>31. Who are you not reaching that you wish you would? What needs to</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>change so that you can reach them?</td>
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</tr>
<tr>
<td>32. What do you think about men working as health extension workers?</td>
<td>X</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>33. Reflecting on all you told us so far, if I had the magical power</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>to grant you three wishes to enable you and your facility to reach</td>
<td></td>
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<td></td>
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<tr>
<td>more people in the community who need your services, what would your</td>
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</tr>
<tr>
<td>three wishes be?</td>
<td></td>
<td></td>
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<tr>
<td>34. Is there anything else that you want to tell us but didn’t, because</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>we didn’t ask the right question?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>35. What questions do you have for us?</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

**PARTICIPATORY GROUP DISCUSSIONS**

This script and questions represent the full data collection tool for married women aged 25–45. The introductory language remained the same for each group and questions in this tool were modified as needed for each of the other five groups—married women aged 15–24, unmarried women aged 15–24, married men aged 15–24, married men aged 25–60, and unmarried men aged 15–24. In each case, the “paving stones” activity was modified to inquire about the factors that support or hinder community members (of the same sex and age group) in accessing healthcare services. Question 10 was not asked of unmarried women or men.

**INTERVIEW GUIDE**

Date:

Location: *(Kebele, Woreda, Region)*

Number of participants:

Facilitator:

Notetaker:

INTRODUCTION

Thank you very much for setting aside time to join us today.
Project Introduction: The Transform Primary Health Care project is a 5-year, USAID-funded project that works with the Federal Ministry of Health to contribute to ending preventable child and maternal deaths, and improving engagement with the Government of Ethiopia on the implementation of its new Health Sector Transformation Plan. Transform Primary Health Care project focuses primarily in the areas of maternal, newborn, and child health; family planning and reproductive health; and malaria within Ethiopia’s four major regions of Amhara, Oromia, SNNPR, and Tigray.

Research Introduction: The Transform Primary Health Care project is conducting a gender analysis to identify potential opportunities, barriers, factors, and conditions that men, women, boys, and girls experience related to healthcare. Your community is in one of the woredas where the project works, so we have come here to learn more about your perspectives and experiences. This study is not an assessment of your community or anyone in it. We will share the findings among partners to guide activities for the remaining 4 years of the project.

Benefits: We hope to learn what is enabling or hindering access, use, and retention of health services so that we can support the Federal Ministry of Health to contribute to ending preventable child and maternal deaths in Ethiopia.

Voluntary Participation: Taking part in the discussion is voluntary. You do not have to participate in the discussion if you do not want to. If you do not want to take part in the discussion, this will not have any negative effects for you. You can also change your mind at any time, and stop taking part in the discussion at any time if you are uncomfortable.

Confidentiality: Before we begin, I want to let you know that we will keep all the information or examples you give us during this discussion private and ask that you do the same. We will not share any information about any of you or anything you tell us with anyone who is not on our team. In the report we will write, we will not mention your names. This way, nothing you tell us will be connected to you in the report.

Risks: We do not want anyone to be uncomfortable during our conversation, so if there is a question you do not wish to answer, you do not need to answer that question.

Discussion Time Frame and Procedure: The discussion will take about 90 minutes. We will ask you several questions during this time frame, and my colleague will be taking notes.

Permission to Record: If you don’t mind, I would like to take notes and audio-record you during our conversation. This is so we can have a record of what you say and so that we can listen again to what you said after our conversation. Once the gender analysis is completed, at some point we will delete the audio-recording and destroy the notes, and in the meantime, no one outside of our team will have access to them.

Contact Information and Contact Sheet: All the information I just gave you is summarized in an information sheet that I will now give you. The information sheet also has my contact data so that you can contact me if you have any questions about this research study in the future. It also has the contact data for someone you can contact if you have complaints about our team or the study.
BEGIN RECORDING

Before we begin, do you have any questions?

Note to facilitator: When you’ve reached 60 minutes, inform the group about how many questions remain and check that you can complete the questions in the 30 minutes remaining, or ask for additional time.

We’d like to start off by asking each of you to introduce yourselves to the group. Please only give your first name. You can also give a nickname or pseudonym if you prefer to do so.

Notetaker should note names on tags for participants, and then should write down the name with a corresponding number in the notes. Notetaker should use the assigned numbers to track who says what during the discussion.

After introductions and name tags are complete, facilitator begins with the following questions:

INTERVIEW QUESTIONS

Married Women 25-45, Participatory Group Discussion

1. Now we would like to begin with a few questions. What sorts of things do you and other people in your community do to take care of your health and avoid getting sick?

[If respondents are hesitant, begin to probe about healthy foods, special diets, clean drinking water, handwashing, and other health behaviors and health-seeking practices and cultural norms.]

2. What do you and other people in your community do when someone is not feeling well or falls ill? Where do you go? Who do you talk to?

[Probe for examples/stories.]

Paving Stones Activity

3. What health centers, health posts, hospitals, or healthcare service providers exist in your community? Draw a map of your community and where these exist.

[If not mentioned, ask about other relevant service providers, such as the traditional healers, traditional birth attendants, or members of the Women’s Development Army.]

4. What are some reasons why a young married woman in this community might go to a health center or health post, see a doctor, nurse, or midwife, or visit a Health Extension Worker?

5. So, let’s say that a young married woman in your kebele has to go to the health center because [insert one of the reasons provided in the previous question]. We will pretend that the path between the married young woman and the health center is paved with factors that support her journey. What are some of the things that support her in going to the health center?

[If the group has a hard time getting started, you can probe by asking, “Think about the times when you wanted to go to a health center or health post, see a doctor, nurse, or midwife, or visit a health
extension worker, or you thought about doing that, but you needed some help or support to get there. What support did you need?

[You can also suggest some ideas, such as having a neighbor to go with, being nearby the health center, friendliness of services, family support, having time, incentives provided, etc.]

6. If not mentioned: What do you know about the Community Health Insurance Program?

[Probe: How does it help/support young women like you? If they do not know about CHIP, note it here and move on.]

7. Who helps to make decisions about healthcare in your community and when to receive treatment? How do they help make these decisions?

[Draw pictures of people mentioned on the path to the health center.]

[Probe with the following: How do young married women feel about having others involved in their healthcare?]

8. Who goes with married young women like you to see the doctor or other healthcare providers? Why is that? Who would you like to go with you, but doesn’t?

[Probe with: When would a young woman go alone?]

9. When the discussion seems to be wrapping up, do a quick review of the paving stones, reading each one out aloud. Then ask:] What factors are missing? Or very important things that need to be in place to help the young married woman get to the health center that we haven’t talked about?

[If a barrier is mentioned, ask: What needs to change for this barrier to disappear or to overcome it? Add the answer as a paving stone.]

10. How would this look different if the married young woman were considering bringing her child to the health facility? What would be the most important factors? Are there other factors when it comes to children?

11. Now let’s share which of these paving stones your community already has and which ones your community needs. For example, does your community have [read a paving stone]?

12. Point out the largest of the remaining paving stones among those without a checkmark [name it; do not assume participants can read it]. What needs to change for this paving stone to exist in your community?

13. Point out one of the smallest paving stones [again, name it]. What needs to change for this paving stone to exist in your community?

Continue in this manner to check each unmarked stone as to its significance to the participants. Make adjustments in the drawing as necessary.

Next we’re going to ask a few questions about what happens at the health facilities.
Set aside the flipchart paper and save it for reference when you prepare the transcript. Also, please get a clear photo of the drawing.

Healthcare Experiences

14. Think about times when you went to a health facility and received the care, support, and treatment you needed. What made that experience a positive one? What does “good” healthcare look like for young married women in your community?

[If not mentioned, probe for (a) factors related to the health outcome (got well, medicine was given, delivery was successful, etc.); (b) factors related to personal treatment by the health facility workers (caring, respectful, and compassionate care); and (c) factors related to facility management (wait times, cleanliness, hours open, etc.).]

15. How friendly or welcoming are the healthcare services here towards young married women like yourselves? Please give examples of what makes a health center friendly or welcoming.

16. If I had the magical power to grant you three wishes to make health centers and health posts more inviting for people like you, what would your three wishes be?

17. What questions do you have for us?