Health Sector
Gender Mainstreaming Manual

Federal Democratic Republic of Ethiopia
Ministry of Health

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FOREWORD

The Federal Ministry of Health (FMOH) of Ethiopia has made great strides in recognizing the important inter-linkage between Gender and Health through the progressive versions of the Health Sector Development Program IV (HSDP IV) and various strategies and guidelines. However, there is always room for improvement and need for adapting to varying priorities and demands.

The Ministry believes that Gender Mainstreaming is an effective strategy for ensuring that policies and decision-making processes take into account, both women and men's separate interests and needs, thus promoting gender equality and equitable health services. This approach also underlines gender equality as an integral part of the health systems' planning, implementation, monitoring, evaluation processes and work practices.

This Guideline is aligned with Ethiopia's overall Growth and Transformation Plan and fosters the Ministry's continued efforts in the reduction of gender inequalities.

To this end, FMOH's Gender Directorate has undertaken a significant step to revise guideline to enhance the strategic direction, coordination, and harmonization of the health sector's efforts in gender mainstreaming. The guideline is developed to enhance the gender knowledge and practical skills of staff to integrate gender into critical health concerns, and strengthen the ability of MOH's program and operations directorates, agencies, Regional Health Bureaus and other critical stakeholders, to adequately address gender issues. Moreover, the Guideline is intended to reinforce the required organizational commitment to ensure the institutionalization of gender mainstreaming across all levels of the health system.

We are indeed grateful to all our partners for their assistance in the development of this Guideline. Also, special thanks to the World Health Organization, Country Office for their support in the revision and printing of this Guideline.

Kesetebirhan Admassu (MD, MPH)
Minister
Ministry of Health

ACRONYMS

AHWO	African Health workforce Observatory
ANC	Antenatal Care
BEmONC	Basic Emergency Obstetrics and Neonatal Care
BPR	Business Process Re-engineering
CARMMA	Campaign for Accelerated Reduction of Maternal Mortality in Africa
CEmONC	Comprehensive Emergency Obstetrics and Neonatal Care
CSA	Central Statistics Authority
EDHS	Ethiopian Demographic and Health Survey
FMoH	Federal Ministry of Health
GoE	Government of Ethiopia
GRB	Gender responsive budgeting
GTP	Growth and transformation plan
HDA	Health development Army
HEP	Health Extension Program
HEW	Health Extension Workers
HIS	Health Information System
HMIS	Health Management Information system
HSDP	Health Sector Development Program
HTP	Harmful Tradition Practice
LLINs	Long lasting Insecticides nets
ICCM	Integrated Community case Management
IMNCI	Integrated Management of Neonatal and Childhood Illness
MDG	Millennium Development Goal
MoWCYA	Ministry of Women, Children and Youth Affairs
MNCH	Maternal, Newborn and Child Health
MOFED	Ministry of Finance and Economic Development
MNH	Maternal and Neonatal Health
HPDP	Health Promotion and Disease Prevention
PCCD	Prevention and control of communicable diseases
PCCD	Prevention and control of communicable disease
PMTCT	Prevention of Mother to Child Transmission (HIV)
RHB	Regional Health Bureau
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
WHO	World Health Organization

PREAMBLE

Cognizant that the health and well-being of women and men, girls and boys, is a key factor in achieving strong social and economic development; the Government of Ethiopia, in line with its national goals and objectives aligned to global commitments, has established a firm commitment to mainstream gender across all line ministries, agencies, and private institutions and communities.

The Federal Ministry of Health has acted on its responsibility for mainstreaming gender in the health sector by establishing a Gender Directorate that is tasked with institutionalizing and implementing a gender mainstreaming process that will support equal access to and utilization of health services among women and men, and boys and girls. To establish standards that can be applied throughout the sector, the Gender Directorate has developed a basic Manual that incorporates current research, relevant findings, local and international contextual analyses, and the inputs of health sector experts and other professionals. Moreover, the guideline is designed in accordance with and to build upon existing national policies and programs that currently provide strategic direction in areas of gender and health.

The Health Sector Development Program (HSDP) provides the fundamental strategic direction for Ethiopia's national health system (1). It was designed and continues to cater to the health needs of the majority of the rural poor, and for the provision of preventive as well as curative services to all segments of the population. The main arm of the health sector is the Health Extension Program, an Ethiopian brand of women's high contribution in community health interventions. Recently the Health Development Army (HDAs) has been established as the key agents to strengthen the achievements of the Health Extension Program in reaching the rural population with health messages and social mobilization to develop community ownership. In addition, there have been considerable efforts for strengthening the health system through the reorganization of a three- tier health system (primary, secondary and tertiary levels). Many health facilities have been built and health professionals of all types have been trained. Nevertheless, there are disparities in the number of beneficiaries of the health services. Since women and girls are an important target group for the provision of health services, it is also possible that gender inequalities may be impacting on both the user and service delivery end. It is therefore, imperative to address gender inequalities that may be impacting on the

achievements of the health system to improve the accessibility and utilization of the health system through the identification of gaps, gender-responsive planning and monitoring and evaluation of progress.

The fourth Health Sector Development Plan (HSDP IV) has highlighted gender mainstreaming as a key strategy for achieving improved health outcomes in the country. The recently designed strategy of the Health Development Army offers opportunities for the coordinated participation of all health workforces from kebele to the federal level for the ultimate capacity building of the health sector. HSDP-IV is situated within and supports the government's overall vision for Ethiopia whereby Ethiopia is set to become a middle-income country soon after the MDG 3 target date of 2015. To do so, the health sector of Ethiopia will have to stretch to attain its objectives of reaching every section of the population with effective health interventions.

Vision of the FMOH

To see healthy, productive, and prosperous Ethiopians

Mission of the FMOH

To reduce mortality, morbidity and disability and improve the health status of the Ethiopian people through providing and regulating a comprehensive package of promotive, preventive, curative and rehabilitative health services via a decentralized and democratized health system.

Historical statement of the Gender Directorate

Gender related activities used to be carried out by the Women's Affairs Department at the Ministry of Health for a long period of time. The office was not included during the initial structural reform of the Ministry i.e. in the first business process reengineering process. However, since 2008, the entity charged with carrying out gender-related activities within the Ministry has acquired not only a new name but has been repositioned and reorganized in the new structure as "The Gender Directorate," which is accountable to the Minister.

Vision of the Directorate

To ensure that all gender-based activities are supported by research, evidence and planning and see that women participate in, benefit from and are empowered by these efforts.

Main Activities of the Directorate

With the mission to ensure that gender is effectively addressed and mainstreamed in all policies and programs implemented by the FMOH, RHBs, Federal Agencies & Hospitals through harmonization between the various units, the Gender Directorate seeks to undertake and/or support the following activities throughout the health sector:

- ensures gender is mainstreamed in all the planning, implementation and monitoring and evaluation of all health programs and at all level of the health system
- ensure that women and men benefit equally from the health policy, programs, and health services
- facilitates that women staff have access to empowerment trainings and professional development opportunities to strengthen their capacities, confidence including participation in the health sector's decision making
- ensures that the health system female workers are accorded equal rights in the recruitment, deployment, salary, and benefits; and follow-up the correct implementation of affirmative action per the 'quota' and the Civil Service Reform and the HR strategy
- develops the networking for coordination with other concerned bodies to facilitate and encourage the role of women in decision making in the health sector
- promotes/ studies, researches on gender gaps/issues that prevail in programming and at institutional level
- contributes to the inclusion of gender consideration in strategies, plans, reports, researches, project proposals, rules and regulations that are developed for the health sector
- evaluates complaints that may be received by the Directorate and ensures that they are adequately addressed; provides recommendations, as needed, to resolve formal grievances in a timely and equitable manner

- provides the necessary support and inputs to strengthen regional capacities and awareness of effective gender mainstreaming strategies, coordinates activities with Regional Health Bureaus and Agencies

- create and raise awareness by preparing and distributing printed materials and through the media for awareness raising on gender and health
- participates in monitoring and evaluation activities and in the analysis of data of the health sector through participation in supportive supervisions, through reviews such as the ARM and facility survey
- creates and strengthens coordinated relationships with governmental and nongovernmental organizations that are involved in gender and health programs and activities

THE STRUCTURE OF THE MANUAL

The Manual is divided into five chapters. The first chapter presents the background, policy context and the rationale for revising the 2002 gender mainstreaming guideline. The second chapter elaborates a conceptual framework for gender mainstreaming. Chapter three provides a situational and contextual analysis of gender and health in Ethiopia, and further identifies points of entry for addressing gender in priority areas in the health sector. Chapter Four, sets out a gender-responsive planning framework for mainstreaming in the context of priority health programs. Chapter Five provides gender responsive Monitoring and Evaluation framework and includes tools for monitoring and evaluation, including indicators and checklists that can be used for mainstreaming gender in the health sector.

CHAPTER ONE: INTRODUCTION

1. Background

The health of an individual is influenced by several determinants of health; these are the biological (sex), social determinants such as gender, the physical environment, socio-cultural and the economic determinants including access and utilization of health services.

Evidence shows that most of the global burden of disease and the bulk of health inequalities are caused by social determinants. Accordingly the most powerful social determinants reflect people's different positions in the social 'ladder' of status, power and resources (10). The Millennium Development Goals (MDGs) recognize this interdependence between health and social conditions.

Gender, as a social factor, is an important determinant of health as it refers to socially constructed norms, behaviors, attributes, relationships and actions that a given society considers appropriate for men and women. Because sex and gender are critical health determinants, they give rise to differential health risks and needs as well as influence the individual to access to and control over resources (2).

Ethiopia, with an estimated population of 86 million, has a predominantly rural (82%) population of whom half (49.5%) are female (projected 2007 Census, CSA). Ethiopia has a high burden of a variety of communicable but preventative diseases largely related to absence of sanitation, hygiene and resource constraints. The health service access and utilization coverage is estimated at 92% with a disproportionate distribution among men and women (3). Maternal Health in particular has long been recognized as an area with serious gap.

In the last two decades, the country has made significant changes in its strategic policy to combat poverty. The recent five year national plan of Ethiopia, 'the Growth and Transformation Plan (GTP) 2010/11- 2014/15, acknowledges that development targets can only be achieved when gender inequalities are properly addressed.

The health sector in particular has made notable gains through the formulation of four consecutive Health Sector Development Programs (HSDP I –IV) since the last 16 years. Initially the priority was for improving coverage to preventive and promotive health services through community

based approaches. Subsequently, strengthening of the health system has been given attention through expansion of infrastructures, training of health professionals, strengthening the logistics and pharmaceutical system, building the health management information system and resource mobilization for priority health programs that target maternal child health, communicable diseases and environmental sanitation.

Building on the achievements of the HSDPs I to III, the current HSDP IV of (2011 to 2015) has incorporated gender as a basic area of focus for the health sector development. The program is aligned to the MDGs (3, 4, 5, 6 and 7) and HSDP IV underlines that the country will not attain its health targets without significant gains in poverty reduction, food security, education and women's empowerment. HSDP IV also recognizes the contributions of the health sector in the achievement of all the MDGs objectives.

Despite many efforts put forth into the health sector, girls as well as boys and women are still vulnerable to gender-based violence, including harmful practices and a higher prevalence of communicable diseases such as malaria, HIV and Tuberculosis. Unintended pregnancies are common among girls and women while most have very little access to information and health care services contributing to the country's high maternal mortality and morbidity, among high prevalence countries in the world (3). Child marriage, a proxy for poor sexual reproductive health, is prevalent in Ethiopia depriving girls of the opportunity for education, whereas, boys and/men are prone to alcohol abuse and injuries, largely due to (road traffic and conflicts. Such complex and socio-culturally interwoven situation of gender differences can be addressed through a gender mainstreaming approach that seeks to ensure equity in health service delivery.

Furthermore, examining specific illnesses from a gender perspective helps to illustrate the importance of an engendered understanding of health. For instance, malaria is more common among men than among women but the severity of malaria is most intense in pregnant women often leading to death (4). Mental health such as depression may be more intense in women though serious episodes of psychosis requiring medication are more often seen in men (5). An understanding of the gender inequalities in programs and in the access and the utilization of health service are the key to ensuring equitable access to all women and men. Integrating a gender perspective into all aspects of health service delivery will help strengthen the strides made at national level to achieve the MDG goals.

1.1 Policy Provisions relevant to gender mainstreaming

Ethiopia ratified The Convention on the Elimination of All Forms of Violence against Women (CEDAW) in 1979, the Beijing Declaration and Platform for Action of 1995, the International Conference on Population and Development-Plan of Action (ICPD) of 1994 and the MDGS The Ethiopian government is also committed to regional conventions such as 'The Abuja Declaration' (2003) and 'The Maputo Plan of Action' (2006). These conventions and declarations lay-out foundations for governments to address reproductive rights with gender equality goals..

At the national level, the constitution of Ethiopia (1995), under Article 35, guarantees equality between men and women in all spheres of political, social and economic efforts and benefits. Based on the Federal Constitution, the Family Law and The Penal Code were also amended to address discriminatory practices and biases against women. Key policies that reinforce gender equality goals and objectives are: The National Population Policy (1993), the Health Policy (1993), and The National Policy on Ethiopian Women (1993).

In terms of structures to uphold gender equality and women's empowerment goals, the Ethiopian government established a line ministry on Women's Affairs, currently renamed as the Ministry of Women, Children and Youth Affairs (MoWYA). In line with this, Gender directorate has been established in all sector ministries to facilitate the implementation of the gender and women empowerment efforts.

1.2 Rationale for revision of the Manual

The rationale for revising the 2002 Gender Mainstreaming Manual is guided and informed by a decade of historically dynamic changes in the health sector brought about through reforms in the health system. The following are the main reasons for the revision of the 2002 Gender Mainstreaming Manual:

- Improved Health System: with access to health services extending from the community to the highest referral level;
- Changes in the health strategies that have adopted more evidence- based, technologically advanced life- saving interventions;

- Progress in the understanding of the concepts of gender as a key social determinant for health reflected by international commitments, Manual and tools;
- Availability of updated quantitative and qualitative data on the gender determinants of health;
- The need to address gender issues that hinder the access and utilization of service;
- The Business Process Re-engineering reform (2009) giving emphasis to gender and;
- The need to produce a user-friendly guide, aligned to the priorities of the HSDP and the BPR with a clear planning, implementation and monitoring framework to facilitate gender mainstreaming at all levels in the health system.

1.3 Objectives of the Gender Mainstreaming Manual

General Objective

To enhance and ensure effective gender mainstreaming at all levels of the health system for equitable health services.

Specific objectives:

- To enhance knowledge and accountability on gender among the health workforce;
- To provide insight on gender and health situational analysis and interventions to reduce gender inequalities;
- To provide guidance on integrating gender into health program planning and implementation;
- To measure, monitor and evaluate gender mainstreamed health performance processes.

1.4 The development of the manual (Methodology)

The Gender Directorate developed the manual through the collaborative effort of a taskforce drawn from the Gender & Health Technical Working Group that was formed to advice and support the directorate. The following methods were applied to produce the Mainstreaming Manual:

- Desk study and Secondary data review: Relevant publications including global and local research, data, and guideline and toolkit documentation were reviewed. Internal FMoH documentation were carefully reviewed to understand relevant health sector strategies, guidance and performance systems
- Consultative meetings: Consultative meetings with taskforce members and further with a larger group of experts were conducted to enrich the document and;
- Key informant interviews including various staff within the health system were undertaken to inform the drafting of the Guideline;

1.5 Users of the Gender Mainstreaming Manual

The Mainstreaming Manual is designed specifically for use by the health workforce (including decision makers, planners, health providers and admin staffs) across the country's health system to integrate gender issues. It is aimed at generating accountability and a common framework for mainstreaming gender in the health system.

The Manual is also expected to serve as a resource for gender focal officers at all levels of the health system, in their coordination, facilitation, implementation and monitoring functions.
The current Mainstreaming Manual will be instrumental in fostering collaboration with government sector ministries and agencies and development partners.

1.6 Key Principles of gender mainstreaming

The current Gender mainstreaming Manual rests on the following principles that all health staff should incorporate into their professional work and business practices.

- **Equity**: Access to service must be equitable without discrimination and should include efforts to broaden women's equitable participation and share of resources/budget.
- **Human right**: Providers and services must uphold the rights of all persons to the highest attainable standards of health and respect the right of persons seeking health services.
- **Accountability**: Adequate accountability mechanism for monitoring progress should be established in the existing health system.

- **Standardization**: The essence of the Gender Mainstreaming Manual sets the standard for all sectors and programs.
- **Sustainability**: It is critical to uphold the health sector's vision to sustain a balanced approach in preventative and curative services while integrating gender mainstreaming.

CHAPTER TWO:

THE CONCEPTUAL FRAMEWORK FOR GENDER MAINSTREAMING

2.1 Introduction

Gender refers to the socially constructed roles, behaviours, attributes and actions that a given society considers appropriate for men and women. Gender is a social construct reinforced through norms, roles and relations; these concepts refer to what males and females can and should do in a given society and explain what females and males are responsible for in households, communities and in the workplace. The roles assigned by a given society may reflect on the health of an individual with respect to risks and the outcomes.

The concept of health covers a complex human condition in which biological characteristics interact with gender as well as other social determinants that affect disease risk, treatment, and outcomes. Disease patterns are influenced not only by the biological differences between men and women, but also by numerous environmental, social, and behavioural factors.

Substantial international, regional and national commitments to addressing and eliminating disparities in the health of men and women and boys and girls requires that health programmers and professionals at all levels of the health system have the knowledge and skills to respond more effectively to the health needs of men and women. Awareness of the influence of gender on health is a relatively new concept and many health professionals and staff members in the health system have not had access to relevant training (6).

According to the World Health Organization's guideline for gender mainstreaming (7), gender bears two important dimensions as a determinant of health:

i. Addressing gender norms, roles and relations enables better understanding of how socio-cultural identity is constructed (male and female) and the attribution of rights and unequal power relations can affect (among other things) risks and vulnerability, health seeking behavior and ultimately health outcomes.

ii. Gender inequality puts the health of millions of girls and women at risk globally. Addressing gender equality helps to counter the historic burden of inequality and deprivation of the rights faced by women and girls in households, communities, workplaces and health care settings. Addressing gender inequality in health enables the important work to improve the health of women.

Gender norms, roles and relations affect the risk factors or vulnerability of individual to certain health conditions in the following ways:

1) Gender stereotyping, for example, cultural constructs dictates that women bear illness without complaints, often delaying their health-seeking behavior; men on the other hand are expected, even encouraged to practice high risk behaviors (promiscuity, alcohol and substance usage).
2) Gender-based division of labor, for example: in low- income countries, women are exposed to a high level of indoor pollution that damages their health, while men work on construction sites where physical injuries are common
3) Gender-based discrimination occurs where one gender has more power than the other leading to maltreatment and violence. According to the WHO multi-country study on Violence against Women, women are often victims of domestic violence perpetrated by someone close to them while men are victims of violence from unknown persons (8). This could be due to normalized unequal gender relations between women and men, and an accepted low status of women as well as normalized male violence against women.

The sum of all stereotypes, unbalanced division of labor and discriminations has created basis for gender inequality and inequity in health. The recognition of gender inequality and the need to address such avoidable socially created disparities gave rise to the concept of gender mainstreaming.

Figure below summarizes the inter-linkages between the key concepts of gender (norms, roles, and relations), which can increase exposure to risk factors or vulnerability to health conditions due to stereotype and discrimination, also gender-based division of labor.

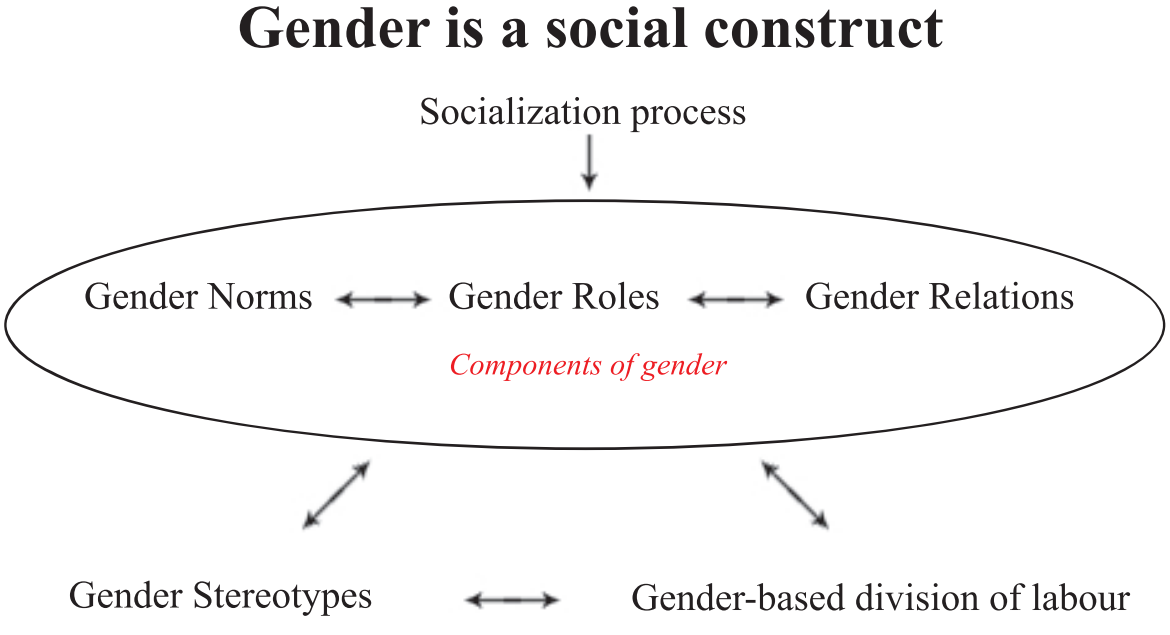

Figure 1: Adopted from WHO gender mainstreaming manual 2010.

Understanding and addressing gender-related causes of ill-health and inequity enables appropriate and adequate policies and programs to be developed in the health sector (7).

2.2 What is gender mainstreaming?

The Beijing Platform for Action, 1995 played a crucial role in highlighting the need for gender equality and for gender mainstreaming. Gender Mainstreaming is a globally accepted strategy for promoting gender equality. Mainstreaming is not an end by itself but a strategy, an approach, a means to achieve the goal of gender equality. Mainstreaming involves ensuring that gender perspectives and attention to the goal of gender equality are central to all activities- policy development, research advocacy/dialogue, legislation, resource allocation, planning, implementation and monitoring of programs and projects.

In the health sector, gender mainstreaming provides a means by which to reduce the harmful effects of gender inequities in health through the integration of gender issues across health sector programs and institutions.

2.3 Why integrate gender in health?

Men and women experience important differences in their health risks, access to health services, and health outcomes, all of which arise from the complex interaction between gender-based inequalities and biological differences between men and women. Health systems and programs that do not account for and respond to these differences and their underlying social inequalities are not positioned to enable either men or women to benefit fully and equitably from investments in health.

Gender mainstreaming in health is needed to transform socially entrenched gender norms and inequalities that ultimately increase health risks for both women and men. Mainstreaming not only assures equity and human rights, but also promotes the utilization of services by more individuals, thereby improving the overall efficiency of health sector programs and investments.

Application of gender mainstreaming in health

Gender mainstreaming is about addressing gender equality throughout the stages of program planning, implementing and monitoring & evaluating. All programs must reflect their concern and how women and men will benefit from the program effort. It includes the participation of men and women, working with health sectors for solving problems, example where the solution is social justice.

Ideally, it is should be applied at the beginning of the program e.g. during 'agenda setting'. It can also be applied to incorporate gender perspectives at any time through a review process, with an 'integration' approach (7).

2.4 The key components of mainstreaming gender in health

2.4.1 Gender analysis

Gender analysis is a fundamental step toward identifying, assessing and informing actions that are essential to address gender inequality.

Gender analysis in health contributes to the understanding of the gender related factors and socio cultural issues with respect to differentials in risk factors and exposures to disease, differences in the severity and frequency of diseases among men, women, boys and girls. It shows the responses of the culture, society and health system to these problems. Some information that will be collected will be about 'who' gets ill, on 'who' has access to and use of health services. It is also possible to understand the health-seeking behaviour, treatment options, experiences in health care settings and the health and social outcomes and consequences of the particular disease.

2.4.2 Gender Audit

It is primarily a process for undertaking reviews of an organization's commitment to implement gender mainstreaming in policies and programs. A Gender Audit aims to assess how well policies have been institutionalized within organizational departments and individuals. Among others, a Gender Audit also reviews; resources allocation, gender balance of staffing, mainstreaming of gender responsive interventions within programs. Such audits are useful to establish baselines, identify critical gaps, challenges, and document good practices and to recommend strategies to address gaps and challenges towards the achievement of gender equality (9 & 10).

As Gender Audits are often undertaken through participatory approaches, they allow for an assessment and re-visiting of the perceptions of staff members on gender issues, thus opening avenues for change in organizational culture.

2.4.3 Gender responsive budgeting in health (GRB)

GRB in health sector looks at the full spectrum of health spending/health financing from a gender perspective to assess how it addresses the different health related priorities, needs and interests of women and men, girls and boys. It is not about allocating separate budgets for women or men, but it is about making the budgeting process gender sensitive.

The GRB in health helps to decide how budget and policies need to be adjusted to achieve maximum impact and where resources need to be reallocated to achieve gender equity in health.

2.5 The two broad approaches to gender mainstreaming

2.5.1 Programmatic gender mainstreaming

Based on principles of equality, participation, and nondiscrimination, programmatic gender mainstreaming examines the way in which gender norms, roles and relations influence behavior and health outcomes among both men and women. It responds to gender and other social biases and promotes equity in health to:

- address how health problems affect women and men differently;
- focus on women's empowerment and women-specific conditions as a way of addressing the historical and ongoing discrimination that women and girls face;
- adopt a broad social equity approach that considers other determinants such as age, socio-economic status, ethnic diversity, and other issues of equity and empowerment that may further lead to health inequities; and provide an evidence base, disaggregated by sex and other social stratifications, to enable evidence-based health planning, policy-making and service delivery.

2.5.2 Institutional gender mainstreaming

In acknowledgement that an institution should have the capacity, and an enabling atmosphere to promote gender equality, gender mainstreaming must also occur at institutional and structural levels. This approach seeks to transform an organization's structure, policies, procedures and its culture to promote gender equity and equal participation at the institutional level, thereby minimizing institutional gender inequalities. Institutional gender mainstreaming addresses issues including:

- Workplace codes of conduct, staff capacity and professional development, general staffing and recruitment regulations. gender parity in team composition and career advancement;
- Mechanisms for equal participation in institutional decision-making, and capacity for promoting gender-awareness, and monitoring gender equity and;

- allocation of adequate financial resources for integration of gender concerns and investing in capacity building of staff to carry out programmatic gender mainstreaming.

2.6 Key terms for gender mainstreaming in health (additional terms are annexed)

Gender equality is the absence of discrimination - on the basis of a person's sex - in providing opportunities, in allocating resources and benefits or in access to services.

Gender equity refers to fairness and justice in the distribution of benefits and responsibilities between women and men. The concept recognizes that women and men have different needs and strengths and that these differences should be identified and addressed to rectify the imbalance between the sexes.

Gender blind means there is no awareness of gender concepts and the impact they have on life experiences and outcomes for girls and boys, men and women.

Gender-sensitivity is the ability to consider gender norms, roles and relations and gender awareness. It includes gender awareness on concepts of equality between women and men, counting and valuing women's work, respecting their views

Gender responsiveness is the potential of policies or programs which explicitly take measures to reduce the harms and discriminatory effects of gender norms, roles and relations

Gender transformative actively seeks to understand the underlying causes of gender inequalities and takes effective action to transform the unequal power relations between men and women, resulting in an improved status of women and gender equality.

CHAPTER THREE

GENDER AND HEALTH SITUATION ANALYSIS

3.1 General Situation

3.1.1 Demographic, socio-cultural and economic situation

The population of Ethiopia has increased steadily over the last three decades, from 42.6 million in 1984 to 53.5 million in 1994 and 73.8 million in 2007 according to the Central Statistics Agency's Census reports. With an annual 2.6 percent population growth rate, the 2007 Census projections estimate a total population of 86 million in 2013, making Ethiopia the second populous country in Africa. The overall sex ratio between male and female is 1:1.02i.e. Males constitute 50.5 percent and females 49.5 percent of the population. The age structure of the country's population reflects a predominantly young population, with 47 percent under 15 years and 4 percent above 65 years of age. Women of reproductive age (15 – 49 years) comprise 23 percent of the total population, and average lifetime fertility is currently at 4.8 children (3). Rural women still have an average of three more births per woman compared to urban women. Average life expectancy at birth is 57 years for men and 60 years for women.

Most of Ethiopia's population resides in the central highlands, at 2,000 meters above sea level. An estimated 82% of the population lives in rural areas making Ethiopia among the least urbanized countries. As socio-economic vulnerabilities, including health status are influenced by residence, emphasis has been made on rural conditions.

Economy

The Ethiopian economy has made significant progress over recent years with its annual economic growth rate reaching double digits. The country's economy is based on agriculture, which accounts for more than 43 percent of GDP (CSA, 2009). 50.1% of the population falls within the age cohort 15 to 60 years, traditionally considered the economically productive segment of the population (National Census, CSA 2007). Women's engagement in the formal sector has increased over the years but mainly concentrated in unpaid labor.

Education

The education level of women and girls corresponds to autonomy in the household and influences access and utilization of health services. According to the EDHS 2011, 52.1 percent of the female population, compared to 38.3 percent of males, has no formal education, while 39.1 percent of females compared to 49.3% of males have some primary education. Significant progress has been made toward achieving parity in primary education while increased gaps are skewed in favor of males at higher levels of education due to higher dropout rate among girls (3).

Decision making

Women's confidence and self-esteem increase when they have greater knowledge, economic assets and income-earning capacity enabling them to participate more in both private and public decision-making. Notable advances have been recorded in Ethiopia in high-level decision-making; with women's representation at 27.8 percent of seats in the house of people's representatives, 15.8 percent at ministerial level and 13% at state minister position. There are also notable advances at household level decision-making in which 13 percent of married women make their own decision on their own health care and 24.9 percent make joint decisions with their husband/partners (3). Despite progress, only 5% (1 of 19) of executive position of decision making are held by women in the health sector. (3).

Harmful traditional practices and gender-based violence

Ethiopia is characterized by a traditional society with patriarchal cultural values and norms that impinge on women's development. Although there has been a decline in recent years, women's low status in society is evident in a number of cultural practices, including harmful traditional practices. Female genital mutilation has the estimated prevalence of 56 percent, reduced from 74 percent in 2005, abduction is estimated at 12.7 percent in 2007 from 23.3 1997, and early marriage is 21.4 in 2007 from 33.1 in 1997 (4).

Physical and sexual violence are still practiced, although trends suggest some decline. Attitudes toward intimate partner violence are a common indicator of women's autonomy and empowerment. According to the EDHS 2011, 68% of women reported that they believed wife-beating was justifiable for certain reasons. While this number remains high, it represents a significant decline from the 81% acceptance rate among women reported in the EDHS 2005(9).

Intimate Partner Violence, estimated as high as 72%, may include physical and psychological abuse, such as spousal control or the threat of physical violence. Gender based violence also impacts women's psychological health. Studies show that women in Ethiopia have a high prevalence of depressive episodes, at 4.8%, also associated with a high lifetime prevalence of intimate partner violence (14). In a joint Population Council/UNFPA survey in 2010, 19 percent of rural female respondents reported rape as their first sexual experience. Fifteen percent of women who experienced sexual violence blamed themselves and few sought medical, legal or psychological assistance. These complex social factors surrounding traditional practices, gender norms, power dynamics within the family and gender-based violence require a complex, systemic health sector response, rather than detached pockets of interventions. The recent escalation of young female trafficking is also another tragic situation that has physical, social and mental health consequences.

3.1.2 Legal and Policy environment

International

Ethiopia has signed its commitment to a number of international conventions, charters and declarations that focus on gender equality and women's health. These include: the Convention on the Elimination of All forms of Discrimination against Women (CEDAW; signed by Ethiopia in 1980 and ratified in 1981); 1987 Safe Motherhood Conference in Nairobi which brought attention the issue of maternal mortality reduction and the 1990 World Summit for Children all underline women's equality, girls' education, family planning, and safe motherhood. Others equally important include, the International Conference on Population and Development (ICPD) Programme of Action which also highlighted gender equality and paved the way for the reproductive rights of women (Cairo, 1994); and the Beijing 1995 Fourth World Conference for Women Platform for Action, which provided a comprehensive agenda for achieving women's rights and empowerment and establishing national level gender mainstreaming objectives. Among key regional commitments, the Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases (2001) calls on governments to coordinate across sectors and at all levels with a gender perspective to address common killer diseases; and the Maputo Plan of Action 2006 is a sexual and reproductive health framework for African countries incorporating the need to address adolescent reproductive health and gender, among other relevant issues.

National

The constitution of Ethiopia, in Article 35, establishes equal rights for women, with specific provisions addressing access to information on family planning (35.8) and right to maternity leave (35.5), freedom from harmful customary practices and oppressive stereotypes and customs that harm women's physical and mental well-being (35.4), and women's equal participation in development (35.6) (Federal Democratic Republic of Ethiopia, 1995). Recent legislation has further reinforced the rights outlined in Article 35:

- Ethiopia's Revised Family Code (2000), establishes an equal age at marriage for girls and boys at eighteen years[1]. It emphasizes that full, mutual consent of both spouses is an essential condition for marriage, and also allows for dissolution of the marriage by mutual consent. The Revised Family Code moves toward establishing spousal equality in household and property administration. While the realization of spousal equality may remain a challenge in the context of entrenched social inequalities and household norms, these provisions in the revised code are essential to supporting women's empowerment and ability to make healthcare decisions for themselves and their families. More than 70 percent of women have sole or joint decision-making power about their own health or household purchases (3).
- Ethiopia's comprehensive Criminal Code of 2004, which repealed the 1957 Penal Code, has made significant advancements in criminalizing acts of sexual and gender-based violence, including domestic violence, trafficking for prostitution and harmful traditional practices such as abduction, female genital mutilation and forced labor. It has also reduced restrictions on the advertisement of contraception and expanded the instances in which abortion is allowable to include cases of incest and rape.[2]
- The revised Federal Civil Servants proclamation No. 515/2007 supports women's constitutional rights to equal employment opportunities, including in promotion, deployment, training and the creation of violence-free working environments.
- The National Population Policy (1993) supports the promotion of family planning in order to harmonize the rate of population growth with economic development. It links high

[1] *Under the previous family code, minimum age of marriage was 15 for girls, and 18 for boys.*
[2] *Under the 1957 Penal Code, rape or incest justified mitigation of punishment for performing abortion.*
[2] *Under the 1957 Penal Code, rape or incest justified mitigation of punishment for performing abortion.*
[3] *It is evidenced that modern contraceptives prevent about one-third of all maternal deaths; and similar proportion of*

fertility to women's low social, economic, and political status, and links high fertility rates to higher rates of maternal mortality and poor maternal health[3]

- The National Policy on Ethiopian Women (1993) focuses on institutionalizing the political and socio-economic rights of women by strengthening education and employment opportunities and encouraging women's social, economic and political participation. It outlines strategic actions to address women's reproductive health and family planning needs, as well as key priorities including the eradication of harmful traditional practices and gender-based violence.
- The National Education and Training Policy (1994) acknowledges that women's education delays marriage and first birth, increases family planning use, improves partner communication and advances women's status in the community.
- The Development and Social Welfare Policy (1996) puts special emphasis on gender issues and the elimination of discrimination against women in the formal employment sector, general working conditions, and access to healthcare services. It also promotes conditions that enable low income women to reduce their work load.
- The Agricultural Development Led Industrialization Strategy (ADLI) was first formulated in 1992, and further elaborated and implemented since 2000. Among other priorities, the strategy focuses on improving national food security, increasing food supplies to meet domestic demand, commercialization of agricultural products, the improving farmers' access to external markets and promoting the participation of women. These strategic packages have implications for women because of their responsibilities for catering to the food needs of the household, as consumers and also as producers of agricultural products.
- The Natural Resource and Environmental Policy (1997) address the control of hazardous material and air pollution, including indoor pollution and toxins that particularly affect the health of women and children. The Government of Ethiopia further advanced this commitment to women, health, and the environment by signing the Libreville Declaration of Health and Environment in 2003 and conducting an assessment in 2010 that led to strategic interventions for the reduction of indoor pollution in particular.

[3] *It is evidenced that modern contraceptives prevent about one-third of all maternal deaths; and similar proportion of maternal disabilities that result from birth complications (UNFPA/PATH, Outlook, 2008).*

- The National Health Policy (1993) underlines the provision of "comprehensive and integrated primary health care in a decentralized and equitable fashion", as one of its main objectives. The policy has given special consideration to reproductive health, including maternal and child health. This has enabled the formulation of additional strategies such as the National Reproductive Health and Adolescent Reproductive Health Strategies (2006-2015) which are elaborated further with guidelines and packages.
- The GoE has also developed various implementation guidelines and packages to translate the various policies into action.

3.2. Gender and Health Program level response

The HSDP covers four consecutive cycles, covering 18 years, to span through the end of the MDGs in 2015. The main features of the current HSDP IV is the inclusion of gender as a key cross cutting issue in the health system.

HSDP IV (2011/15), which is inextricably linked to the Government of Ethiopia's National Growth and Transformation Plan (GTP), is a key pillar responding to the GTP goal '*Social development enhancement and ensuring quality service'*. This fourth generation health strategy builds on the recommendation that emphasize the implementation of gender mainstreaming in addition to focus on deepening engagement and active participation of local communities, particularly women.

The government has initiated a scale up strategy which is designed to adapt and scale up new health related technologies and best practices involved in health extension packages in a short period of time. The pillar of the strategy is establishing a health development army (HDA) and building their implementation capacity. The Health development army (HDA) is a community level group of 25-30 households (women) organized in a "1 to 5" networks in each group. The "1 to 5" network is established between one model woman as a leader of the network and five women as members of the network. The woman is elected as "a model" because of her implementation status of the 16 HEP; she is responsible to provide trainings to the network members, lead group discussions in the network and monitor the implementation of the agreed plan in the women's house. HDA is seen as an effective approach to build household's capacity and improve knowledge, skill and attitude in the implementation of health extension packages.

It is believed that strengthening the capacity of health workers, HEWs, and members of the HDA would lead to effective utilization of the HDA for promotion of optimal adolescent, maternal and child feeding practices, among other health promotion practices. The HSDP IV also gives consideration to the need for gender sensitive messages, for empowering women and for their involvement and participation in different boards at community & health facility level committees. Also a distinct highlight of HSDP IV is a focus on gender mainstreaming at all levels and components of the health system; through the health reform process (Business Process Re-Engineering), the health sector has underlined the importance of gender mainstreaming at all institutional levels.

3.3. Institutional Capacity for Gender Mainstreaming in the Health Sector

Organizational Policy/Strategy Gender Mainstreaming manual	A health sector gender mainstreaming guideline was developed in 2002 and a gender analysis tool in 2008 by the FMoH. However, these tools have not been fully operationalized, calling for *the development of operational strategy*.
Human Resource; staffing levels, recruitment and female staff progression policy	Sex disaggregated data on overall staff and various levels of representation in both service delivery and decision-making positions are available in the ministry. However, *a comprehensive and systematic strategy to promote and empower female staff is required*.
Staff awareness and training opportunities for gender sensitivity and integration	Annual work-plans are formulated targeting building staff awareness and for trainings on gender without integration into the health system planning, implementation and monitoring mechanisms.
Gender mainstreaming structure and mechanisms	Gender is part of the health system structure; however, adequate number of trained staff to coordinate the implementation, or monitor gender mainstreaming activities are limited in capacity.
Budget & Resource allocation	Gender Responsive Budgeting is a fairly new concept in the health sector with limited or no application. *A systematic process is desirable to evaluate budget allocations in program interventions within the workplace.*

3.4 Mainstreaming gender across health sector in the priorities of the health sector's service delivery and quality of care

A gender analysis of the Ethiopian health sector requires consideration of socio-cultural barriers that inhibit or negatively affect *access*, *utilization* and *quality* of health care. This focus is captured in the HSDP-IV strategic theme of *Health Service Delivery and Quality of Care*, which addresses core services that include *Maternal, Newborn, Child, and Adolescent Health; Nutrition; Prevention and Control of Diseases; the Health Extension Program; and Hygiene and Environmental Health.* The focus on health service delivery is also the first of six building blocks of health systems outlined by the World Health Organization: **service delivery, the health workforce, health information systems, medical products, vaccines & technology, health financing, and leadership and governance** (19). These building blocks are reflected in HSDP priorities, and may provide a framework for developing a more systematic and coherent approach to analyzing and mainstreaming gender throughout Ethiopia's health sector.

3.4.1 Health service delivery and quality of Care

a. Maternal, newborn, child, and adolescent health:

Maternal morbidity and mortality (676/100,000) continues to pose a major public health challenge in Ethiopia, although there is significant progress in reproductive health and a general increase in health service coverage. In recent years, the health sector has made major advances in addressing maternal and newborn health including: the 2011/15 Road Map for Accelerating the Reduction of Maternal and Newborn Morbidity and Mortality in Ethiopia, FMOH August 2011 (17); Conducting of a national baseline census type of survey on EmONC (18), *task-shifting* strategies (2008) to address the limited number of professionals for obstetric care; Expansion of the provision of BEmONC and CEmONC; commitment of resources to long-term contraceptives; and inclusion of life-saving drugs in the national drug list, as well as Ethiopia's endorsement of CARRMA (2009).

Despite notable gains in maternal health care, the causes for maternal mortality continue to be major concern. Obstructed labor (22%), ruptured uterus (13%), sepsis (12%), hemorrhage (10%) and hypertension (9%) are the most common direct obstetric complications attributed to maternal mortality (21). Limited access to skilled obstetric care that is capable of responding to these complications effectively is a major contributor to death during childbirth.

Key socio-cultural determinants, and in particular those that relate to values on gender and their implications on health-seeking behavior, also impact maternal and child health.

Ethiopia's young population poses both an opportunity and a special challenge with respect to the reproductive health of young girls and their unborn children. A young population not only reflects increased childbearing by women of reproductive age, but also increased burdens to care for young children, disproportionately felt among women and older girls as a result of gendered household norms. Ethiopian women experience their first sexual encounter earlier than men, with the median age of first sexual encounter being 16.5 years for rural women compared to 21 for rural men (3). Younger age of marriage for girls has significant implications on education, as it often results in failure to complete secondary education, lost economic opportunities and negative reproductive health outcomes. Age at marriage thus correlates with potential vulnerability to reproductive and other health complications such as infection, fistula, HIV/AIDS and even death as a result of being physically unready for childbirth and a lack of power to make and follow up on informed health decisions.

Gender and Health key indicators

MR: 676/100,000 live births

Contraceptive Prevalence Rate: 29%

Unmet need for family planning: 25%

Skilled Birth Attendance: 10%

Teenage pregnancy: 29% girls < 19 years

Breastfeeding women: 52%

Source: EDHS 2011

Literacy and years of schooling are also key influences on women's reproductive health, affecting fertility choices, health-seeking behavior and vulnerability to HTPs and gender-based violence. Moreover, there is a stark difference in utilization of antenatal and skilled birth attendance between women with only primary versus those with secondary education (22). Furthermore, a strong correlation exists between women's empowerment and health, as measured in the EDHS by household decision-making and women's reported acceptance of wife-beating in some circumstances. With increased empowerment, women's health-seeking behavior and reproductive health choices increase.

Among rural women, access to maternal health facilities and services tends to be limited, and their empowerment to access those health services appears to be a larger barrier. The "*Three Delays* (delay in deciding to seek care, delay in reaching care in time and delay in receiving adequate

treatment; UNFPA 2002) experienced by women tend to be aggravated by women's limited education and decision-making capacity. In recognition of these problems the government is investing in increasing the number of health facilities, improvement of infrastructures including roads and means of transport such as ambulances. Access to and utilization of skilled birth attendance, an important factor in curtailing maternal deaths, is significantly lower among younger rural women, at 4% compared to 49% among urban women. Women with nine years of education are more likely to deliver at a health facility than uneducated women, 7% compared to 78% (22). Fertility, as another key factor affecting maternal mortality and women's reproductive and economic well-being, has yet to be rigorously analyzed, including high disparity between desired fertility (3 children) compared to the current rate of 4.8 children (3). Female genital mutilation, a common practice, poses a distinct maternal health problem as it often leads to permanent damage of reproductive health organs and increases likelihood of complications during childbirth. Women as well as men contribute to the continuation of this harmful practice, with nearly 30% of women accepting the practice for their daughters as a matter of family honor. In regions such as Afar where infibulation, one of the most invasive and harmful forms of the practice, is performed 42% of women believe that it should be continued. These entrenched social norms underline the need to target women and communities in behavior change and social mobilization strategies.

Neonatal mortality at 37 per 1000 LB, (3) and morbidity are closely interlinked to mothers' health and health-seeking behavior. There is an inverse relation between a child's risk of death and a mother's education level. Under-five mortality is five times higher among uneducated women compared to a mother with more than secondary education. Women's empowerment, measured by decision-making and attitude to wife-beating (3) is also inversely related to child mortality.

b. Nutrition

Under-nutrition is endemic among Ethiopian women and children because of low dietary intake, inequitable distribution of food within the household, improper food storage and preparation, dietary taboos and infectious diseases (23).According to a recent study, women's empowerment is a key determinant of women's nutrition levels (24). Furthermore, women's educational attainment, employment status, and financial empowerment within the household serve as

important factors in women's nutrition. Studies also indicate that household economic status, a woman's employment status, age, marital status and decision-making power over her income are important determinants of chronic energy deficiency among women of reproductive age (25).

Many instances of under nutrition result from deficiencies in protein, low caloric intake, and lack of micronutrients such as Vitamin A, iron and iodine. Malnutrition is a contributing factor in 50-60% of instances of childhood mortality. For pregnant women, malnutrition and anemia are highly associated with maternal mortality. Because of chronic malnutrition, stunted growth is prevalent among young women. This may further lead to a smaller-sized pelvis in young women leading to complications during child birth, as well as giving birth to smaller babies.

Gender and Health key indicators

Anemia: (women) 17%

Iodinated salt: 20%

Maternal/girls malnutrition:

<5 stunting 44%

Source: EDHS 2011

Ensuring food security is an important target under MDG 1, the goal for the Eradication of Poverty and Hunger. It is also an important factor in realizing MDG 4 and MDG 5, addressing child and maternal health, and for MDG 2 on universal education (MOFED, MDG report, 2010). Nutrition is also a key priority in the delivery of Ethiopia's Health Extension Program.

Despite national decline in prevalence of malnutrition among under-five children, current figures show 29% underweight, 44% stunting and 9% wasting. Increase in exclusive breastfeeding is noted from 49% to 52% and complementary feeding is now 51%, from 44%. Despite progress in these indicators, malnutrition continues to be a public challenge, hence, underlining the need for addressing gender inequality in nutrition interventions (3).

c. Prevention and Control of Communicable diseases

i. HIV/AIDS

> ***Gender and Health key indicators***
>
> *HIV prevalence among women in adult population: 1.9% compared to male of 1%*
>
> *Comprehensive Knowledge on HIV among female: 19% compared to 32% of men*
>
> *Source: EDHS 2011*
>
> *PMTCT coverage is at 42.9%*
>
> *Source: APR of FMOH, 2012/13*

HIV/AIDS is profoundly influenced by gender relations adding to biological vulnerabilities among women, HIV transmission among women is triggered by lack of knowledge, economic factors and limited control and decision-making. After years of outreach and awareness-raising activities, more men, women, and young people demonstrate general awareness about HIV/AIDS and its transmission. However significant variation is noted among women's (19%) and men's (32%) comprehensive knowledge of the disease transmission and prevention methods. Among adults, HIV prevalence is higher among females (1.9%) compared to males (1.1%). In general, HIV prevalence among younger female (6.8%) and male (6.3%) age cohorts under 19 years was found to be high (3), suggesting early sexual debut among women as increasing risk of contracting HIV and other sexually transmitted diseases.

High HIV prevalence among female commercial sex workers (25.3%) highlights another dimension of gender vulnerability. While the 2011 EDHS do not indicate specific reasons for higher prevalence among females, there appears to be a correlation with number of sexual partners and condom use. In other words, HIV prevalence was highest among the 1 percent of women compared to 4 percent of men that had two or more sexual partners in the past 12 months. However, regional data in sub-Saharan Africa does corroborate women's low status, limited negotiation, and sexual violence as key determinants for higher HIV infection among women.

Prevention of Mother-to-Child Transmission (PMTCT) also presents a critical area for addressing the intersections of HIV, gender and maternal and child health, particularly in light of the low uptake of PMTCT services (25.5% in 2011/12 FMOH), compared to a high uptake of antiretroviral treatment (86%) among adults (HAPCO, 2011/12). This low uptake of PMTCT is reflective of more general gender disparities in health-seeking behavior influenced by women's limited decision-making capacity, limited access to health information and or lack of education, among other socio-cultural determinants.

ii. *Tuberculosis*

Tuberculosis (TB) is among the top ten causes of morbidity, hospital admission and mortality for both sexes (27). The main interventions have been to increase case detection, and increase TB treatment for improved cure rate. With efforts to raise awareness and health service interventions focusing on improved laboratories, plus the introduction of directly observed treatment (DOT), all three of the above parameters have increased. TB detection and TB treatment success rate have reached HSDP-IV target levels, while the TB cure rate is below the target (HSDP-IV report). Because of lack of sex disaggregated data on TB prevalence, it is difficult to comprehensively assess the prevalence and impact of the disease specific to either male or female populations. TB prevalence is typically associated with poverty, malnutrition and overcrowding, and more recently with HIV. Both men and women are equally vulnerable in their young and productive ages of 20-30 years. However, gender disparities in health-seeking behavior contribute to differences in vulnerabilities. A study in Southern Ethiopia showed that more women than men were identified and treated at a *community based service delivery level* (26). Global research, on the other hand, shows that due to gender-based barriers in diagnosis and treatment, tuberculin positive women tend to progress faster to active TB than men of the same age (11).

iii. *Malaria*

As a sub-Saharan country with high incidence of malaria, Ethiopia is implementing the WHO-recommended three-pronged approach of early diagnosis, effective treatment, selective vector control and epidemic prevention and control. National efforts have been successful, with Ethiopia having the third highest rate of ITN distribution in sub-Saharan Africa (3.5% in 2005 to 100% in 2009/2010). While the disease was the number one cause of morbidity and mortality in 2005, recent reports show a reduction to 48 percent for morbidity, 54 percent reduction in hospital admission and 55 percent in mortality (FMOH, Health Indicator, 2011). Despite this progress, gender disparities remain in disease vulnerability. Pregnancy, for example, reduces women's immunity to malaria, thus increasing pregnant women's vulnerability causing serious illness, anemia or even death. A gap also remains in the ability to recognize symptoms of malaria or engage in effective disease prevention. According to the 2012 National Malaria Indicator Survey, only 68.2 % of women in endemic areas, when questioned, knew that bed nets helped prevent mosquito bites and 64.2% of pregnant women utilized ITNs (28).

iv. Health Extension Program (HEP)

The Health Extension Program has been the top priority of the health sector since its launch in 2006. It is a community-based program with the basic and essential promotive, preventive and selected high-impact curative services. Targeting households, its objectives are to improve access and equity in the universal coverage of primary health care through community ownership, with families enabled to address and improve their own health circumstances.

The HEP package consists of sixteen packages of: maternal and child health, nutrition, common communicable diseases (HIV/AIDS, TB and malaria), hygiene and sanitation, environmental health, health education and communication strategies; and more recently has expanded to include clean and safe delivery, Integrated Community Case Management(ICCM), and Family planning including implants insertion.

The main agents of the program are Health Extension Workers (HEWs), who are all female and possess at least a 10^{th} grade education. HEWs are selected by the community, and trained and deployed by the government. By its design, the program recognizes women's traditional role as care providers and as health care seekers. It uses a culturally acceptable approach to facilitate health services access through women health providers to every household.

The Health Development Army

Health development army (HDA) is a community level group of 25-30 households (women) organized in a "1 to 5" network. The "1 to 5" network is led by model woman with five women under her leadership. The HDA approach currently supports increase in knowledge, skills and health-seeking behavior of households in the implementation of health extension packages. The approach facilitates horizontal and vertical support and monitoring activities, which help, identify bottlenecks and gaps and provide solutions as early as possible.

The HEWs are assisted by the HDA, in the dissemination of health promotion and disease prevention messages and in social mobilization activities. HEWs provide technical support and supervision services to the HDA. Further strengthening of capacity of the HDAs is however warranted.

Hygiene and Environmental Health

HSDP endorsement of the MDGs brought further attention to key environmental concerns, including the relevance of clean water in the reduction of child mortality (MDG 4), and maternal mortality (MDG 5) (8). Much has been achieved through the efforts of the HEWs through health education and community mobilization in both rural and urban localities. Since 2005, the HSDP has set targets for both full coverage of latrines and access to safe water, but recent data show that achievements are below the targets at 62percent latrine coverage and 42 percent access to safe water (3). The gap noted are the main reasons for the high rate of infectious and communicable diseases such as diarrhea, which is responsible for about 33 % of deaths in children under 5 years of age (23). Nevertheless, the improvement in both maintaining and improving upon current achievements has important gender equality implications with broader social, economic and security implications. Women and girls are the main providers of household water supply and sanitation and bear primary responsibility for maintaining a clean home environment as well as care givers for the sick and elderly family members. Collecting water is a labor-intensive activity that competes with their time and opportunities for education and income generation. It also exposes them to gender-based violence (23).

Exposure to indoor pollution is associated with a number of illnesses, particularly respiratory disorders and eye diseases in women and children, who traditionally spend more time inside the home (29). Data collected on indoor air pollution from the homes of Addis Ababa in 2007 revealed the existence of high levels of pollution, largely as a result of the burning of solid biomass fuels and kerosene for cooking (30). The joint Federal Ministry of Health and Federal Environmental Protection Authority Situation Analysis and Needs Assessment (SANA) report on health and environment inter-linkages (31) established a context and basis for addressing indoor air quality issues in Ethiopia. The survey identified indoor pollution as one of the main environmental health issues that required urgent intervention. Through the collaborative efforts of the Federal Ministry of Health, Regional Health Bureaus, the Environmental Protection Authority, the Ministry of Water and Energy and some NGOs initiatives are underway to develop, test and disseminate improved and efficient cook-stoves, thereby reducing the amount of air pollutants released during food preparation. The intervention is promoted for household use through the Health Extension Programme (HEP), as part of the health package for the promotion of healthy living conditions.

3.4.2. Human resources

Ethiopia has taken steps toward promoting gender parity in the health workforce, and has focused significantly on improving availability and quality of maternal health care and other health services most directly impacting on women. Strengthened gender integration within health sector human resources includes promoting equal participation and opportunities for both women and men working in the health sector and expanding awareness and best practices for gender integration and equity among both male and female health sector workers. Relevant interventions include the training and deployment of a new cadre of female Health Extension Workers (HEWs); the Accelerated training of Health Officers (HOs) with Master's degree training (MSc) in Integrated Emergency Obstetric and Surgery (IESO) skills; and the more recently, the Accelerated Midwifery training. In response to the critical lack of skilled providers, competency based in-service training in BEmONC is under implementation. As short term solution to fill the gap for emergency maternal care, a six-month on-site training in emergency obstetrics is being implemented at regional facilities through the collaboration of FMOH, Ethiopian Society of Obstetricians & Gynecologists (ESOG) and WHO and under the ownership of the RHBs. Both initiatives provide opportunities for promoting and strengthening women's health care at the primary and intermediate levels of service delivery.

According to the AHWO, Human Resource for Health study (32), the high level health workers like physicians and specialists are predominantly male with women accounting for 17.6% and 17.8% of the workforce. The number of female is much higher for midlevel health providers: 49% for nurses, 71% for midwives and 99.5% for HEWs. However, many facilities do not have the required number of trained staff for the key maternal services.. Most striking is the huge gap in the proportion of number of midwives to reproductive age population ratio at 1 per 8,208(FMOH, Health Indicator, 2012). WHO recommends 1 midwife per 100 expected deliveries or for 5000 reproductive age population (21). Furthermore, women often express religious and cultural preferences for female health professionals that hinder service utilization among women where no female providers are available.

3.4.3. Health Information System & Research

Strategic information in the health sector has been strengthened in the last two decades. It has grown in its scope and capacity to show the strength and weakness of health system performance in general.

Tools and instruments for data collection (registers, formats etc.) at different levels of health structure are in position. Recently, electronic data collection is made available up to health facility level, which has contributed to the availability of timely, complete and reliable data.

Key sex and age disaggregated indicators are being applied at the service delivery level, but data are not fully disaggregated in the Health Management Information System (HMIS). Furthermore, few additional indicators need to be developed and applied to monitor gender mainstreaming at service delivery points, necessitating their incorporation in the information system.

Operational research is needed on gender relevant issues to inform policy makers and program managers on gender perspectives in health. It is also important to disseminate the findings and establish a mechanism for sharing experiences and feeding the next health sector planning process.

3. 4.4. Medical Products, Vaccines & Technology

Since the first HSDP, the government has been committed to ensuring community access to essential medicines that are safe, effective, affordable and of assured quality with the practice of rational drug prescription and use. However, weaknesses in the logistics system cause interruptions in regular provision of services. Important equipment for maternal health services, including emergency care are lacking or malfunctioning, and essential drugs/supplies, including life-saving drugs and oxygen are in some cases not available (21).

3.4.5. Health Financing

Limited steps have been taken to mainstream gender into health care finance and budgeting processes. Notably, support for women as beneficiaries of maternal and child health services has been addressed, but systematic integration of gendered social and economic factors into health sector financing has not taken place.

a) Health care financing: The FMOH has adopted a health care financing strategy that focuses mainly on improving the efficiency of allocation and utilization of public sector health resources. Health insurance schemes and regulation of revenue retention by facilities, as well as fee waivers for maternal primary health care, have been endorsed and are in use. A proclamation on Health Care Financing allows maternal fee waivers, which has been applied at primary health care level. However, these practices need to be implemented uniformly throughout the country to ensure that they benefit all women who need them.

b) Budgeting: the National Health Account has been increasing and the majority of the budget is allocated for programs that benefit women (33). In support of national harmonization and alignment principles, the FMOH is currently leading a sector-pooled fund through the MDG Performance Package Fund that gives high priority to maternal health (MDG5). Budget allocations for gender-based violence programs and for broader gender training and integration including the establishment of gender offices to implement, monitor, and evaluate gender mainstreaming, are minimal.

3.4.6. Leadership and Governance

HSDP is implemented as a single strategic plan framework for coordinating health sector actions, 'One-Plan-One-Budget-One-Report' (33). There are opportunities for gender responsiveness in the planning, resource allocation, implementation and performance monitoring and evaluation issues for accountability at each level. One recent strategic operation to facilitate gender mainstreaming is the introduction of the HDA networking approach at all levels of the health system structure from the federal to the kebele level. It is a performance improvement strategy that is focused on the identification and solving gaps in attitude, inputs, skill, knowledge and management in a coordinated and participatory manner. The organizational aspect of the HDAs is guided, monitored and supported through the networking under the Case Team Forum, the Transformation Forum, the Directorates' Forum, the Council's Form, the Executive Forum and the Joint Steering Committee. The implementation of a networking strategy is led by a manual with clear job descriptions for each level.

a) Gender mainstreaming and women empowerment

As has been addressed in the HSDP IV and the GTP, the Government of Ethiopia has expressed its commitment to gender mainstreaming in all its sectoral programs, including the health sector, so that women and men participate and benefit equally from its service outlets. It mandates gender-sensitive planning, including gender assessments and identification of measures to fill gender gaps in all areas and at all levels. Gender mainstreaming incorporates the concerns and experiences of both women and men as integral dimensions in the design, implementation, monitoring and evaluation of health sector programmes. These dimensions are addressed through: a) promoting gender equality and the empowerment of women; b) increasing the use of health services by women; c) enhancing equal opportunities in the participation of economic and social development including health. The establishment of the Gender Directorate within the FMOH is the commitment of the government to address gender issues in the health sector.

b) Infrastructure

The HSDP-IV has prioritized infrastructure improvements, with a focus on the construction of district level hospitals to expand the availability of quality curative services at primary health care level. Challenges include the inadequacy of facilities with respect to a lack of water, electricity, and the means of communication for referral purposes (21). The EMONC Needs Assessment survey showed that there was a correlation between the utilization of the facilities and the quality of the infrastructure. Reasons for lack of utilization ranges between lack of transport facilities in rural areas and traffic jam in urban areas, and women's perception of lack of privacy, the 'unfriendliness' of the facility environment.

Most of the maternal health services delivering facilities providing CEmONC do not have well designed facility for modern blood bank services.

In addition, the health architectural design does not seem to give consideration to the needs of adolescents (boys and girls) for privacy, as well as for clients who are disabled e.g. unconscious, weak and laboring mothers.

SUMMARY RESULTS OF GENDER AND HEALTH SITUATION ANALYSIS: Key issues

S/ No	Areas	Gender influences on health outcomes
	SOCIO-DEMOGRAPHIC COMPONENT	
1.	**Demography**	The *Life expectancy* of men is less than that of women owing to genetic and social determinants: Need for ***gender analysis*** to inform implications on f health issues affecting male and females, different age-groups and social categories.
2.	**Socio-cultural norms**	**Gender-based violence including harmful traditional practices such as early marriage, female genital mutilation and** abduction; **delay in health seeking behavior**; and persistence of traditional or alternative means treatments. *Discriminatory socio-cultural and economic norms and practices:* girls'/women's disproportionate burden of domestic chores; low self-esteem and decision-making, lower literacy, low number of girls in high-schools, high dropout rate for girls and higher unemployment among women.
	COMPONENTS OF HEALTH SYSTEM	
1.	**Health service delivery and Quality of care**	
1.1	Maternal, newborn, Child and adolescent health	**Unmet need for family planning; teenage pregnancy; persistently low coverage of skilled delivery; limited skill for newborn care; paucity of knowledge about the danger signs** in pregnancy, post-natal period; lack of awareness on when to seek MNH care; **low male involvement** in utilization of FP/RH services, limited **youth-friendly services** and low utilization; health facilities unfriendly for women; lack of care for fistula and uterine prolapse surgeries; deficient MNH/RH services for emergency settings/displaced people; limited integration of **GBV** awareness and response in MNH programs and services
1.2	**Nutrition**	Malnutrition: **protein-energy malnutrition** (PEM), vitamin and mineral deficiency, especially for females; **breast feeding and child feeding practices**; poor knowledge of healthy nutrition; non-availability of space for lactating women in workplace

S/ No	Areas	Gender influences on health outcomes
1.3	**PCCD**	
1.3.1	*HIV/AIDS*	**Limited knowledge among women and girls of HIV risk factors**; age difference between partners; low economic independence and lack of decision-making among women to practice safer sex; high prevalence of **GBV**; low voluntary counseling and testing among women; low **PMTCT uptake**; fear of stigma and abandonment to disclose HIV status;
1.3.2	*Tuberculosis*	**Low TB detection and treatment rates** among women, poor compliance with treatment protocols, and adherence to alternate treatments and **MDR TB**
1.3.3	*Malaria*	**Low utilization of mosquito nets**; exposure to mosquito bites while engaged in household chores and; lack of knowledge of symptoms of malaria.
1.4	Health extension program	**Multiple assignments/tasks as a result of demands from other sectors and time constraints**, limit capacity; inadequate technical support; insufficient **knowledge of gender and health issues**; limited skills for clean and safe delivery, neonatal resuscitation, proper use of contraceptive implants; and lack of expertise in using equipment.
1.4.1	Hygiene & Environmental sanitation	**Limited clean water supply**; women and girls bear responsibility for water collection, which is time consuming, labor intensive, and increases risk of exposure to infectious disease; inadequate number of and access to latrines, with night time use being particularly dangerous for girls and women; school absenteeism and dropout during menses.
2.	**Medical products, vaccines and technology**	
2.1	Logistic and supplies	Gaps in the availability of medical **equipment,** essential drugs and supplies for obstetric and maternal care (**emergency contraceptives, diagnostic kits including VDRL and HIV testing)**; scarcity of blood transfusion and blood products.

3.	**Leadership and governance**	
3.1	Policy, strategies & guidelines	**HIV policy does not address post-exposure prophylaxis for rape**; limited cross-sectoral networking and collaboration on gender and health; lack of mechanism and knowledge to facilitate gender responsive planning; lack of tools for gender integration, monitoring, and evaluation in planning and programs
3.2	Health infrastructure	Limited **water supply; electricity; transportation**, communication to support health facilities and access and; Limited infrastructure for blood bank.
3.3	Service Operation/implementation	Inconsistent/weak **referral linkages between public health units**; MNCH services not opened 24 hours days a week and; problems with **lack of sensitivity and behavior of providers toward patients.**
4.	**HMIS**	
4.1	Strategic information: M& E ; research	Lack of **sex and age disaggregated data** indicators and disease prevalence; limited **research** on issues relevant to gender disparities in health and; **absence of baseline and monitoring documentation of gender analysis.**
5.	**Human resource**	
5.1	Human resource development	Gender sensitive issues are inadequately addressed in health care training at all levels; **low number of maternal newborn health service providers including midwives**, OBGYNs, IESOs and anesthetics.
6.	**Finance**	
6.1	Health care financing	**User fee waived for maternal health limited to primary health care level**; unequal implementation of health care financing for maternal health programs and; coverage requires local registration.
6.2	Health budget	**Minimal budget allocation for gender mainstreaming activities, For (training, IEC, advocacy)**
6.3	Health insurance	Coverage for gender-based violence is limited; in most places only legal residents are eligible for coverage.

CHAPTER FOUR:

INTEGRATING GENDER ISSUES IN THE HEALTH SYSTEM

Integrating gender into the health system logically follows from the earlier chapter on Situational Analysis. This chapter aims at indicating gender responsive interventions in the context of the priority programs and institutional gender mainstreaming. For programming, the focuses are mainly under the six building blocks. The first section, it mains focuses on **Health Service Delivery and Quality of Care: Maternal and Newborn health, Child Health, Nutrition, Communicable Diseases and the Health Extension Program**. It also provides key inputs gender responsive interventions that need to be considered through the other five "building blocks"; in the last section.it highlights key institutional enabling factors for the successful implementation of the integration of gender issues in the health system.

The Health Sector Development Program (HSDP) uses the HEP and more recently the HDAs (the Health Development Army); both are women-focused approaches that serve to reach the community and are opportunities to implement gender mainstreaming as a cross-cutting priority issues. However, a rigorous, systematic and an integrated approach to mainstreaming gender needs further strengthening in the planning, implementation and monitoring of all the activities of the health system. It is therefore the intent of the current and following chapter to guide mainstreaming of gender-responsive interventions within the health system toward increased efficiency and equitable health services for both men and women. **This approach fosters interventions that reduce hindrances toward access, utilization and benefits from health services.**

The institutionalization of gender mainstreaming in the health system requires the integration of gender specific interventions in the current HSDP IV annual plans and in the next generations' health sector development programs. It calls for increased organizational accountability, resources (both human and financial), technical capacity and a strong monitoring and evaluation mechanism.

The Gender Directorate/department/process, at all levels of the health system as the hub for coordinating and facilitating gender mainstreaming in the health sector, needs to strengthen its capacity to facilitate the planning and monitoring of gender mainstreaming efforts in the health

system in collaboration with the other Directorates and the respective core processes. This implies that gender mainstreaming needs to be integrated into the existing woreda based health sector plans and monitoring and evaluation. It is important to underline here that gender mainstreaming efforts should be made within existing systems and work practices in the health sector .e.g. HIS, ISS, performance review and evaluation and operational research.

4.1. Key gender issues and gender responsive interventions

As stated at the beginning of this chapter, the purpose of this chapter is to identify and propose key gender responsive interventions that are directed at the gender issues that were identified in the previous chapter. They deal with both programmatic as well as institutional aspects of gender mainstreaming.

Table 1: indicates a set of programmatic interventions for community and health facilities level that range from primary health care service to comprehensive specialized health care provision.. They are designed to address gender issues that have been identified as bottlenecks for the achievement of the efforts of the health system for the majority of the population. *Component: Health service delivery and quality of care*: MNCH/ adolescent health, Child health and Nutrition: Priorities: focus for action against high unmet need for FP, low skilled attendance, low PMTCT and low TB and cure rates.

Table 2: describes the enabling inputs that are needed in the important building blocks of the health system for the implementation and monitoring of the gender responsive interventions in the above priority programs.

Table 3: describes the key issues related to institutional accountability.

Table 1: Key Gender Interventions for Priority Programs at Community and Facility Level:

Priority Programs	*Key gender issues*	*Level of implementation of interventions*	
		Community Level	*Health facility Service Levels*
Health Service Delivery and Quality of Care **MNCH**	• The prevalence of child marriage, FGM/C, other HTPs that affect RH and acts of physical and sexual violence; • Low male utilization of family planning/RH services • Lack of knowledge about the danger signs of pregnancy, • Limited youth- friendly services and low utilization; • Health facilities are not women-friendly; • Deficient MNCH/RH services for emergency settings/displaced people; limitation for maternal health program covering GBV • Limited integration of GBV awareness and response in MNCH programmes	• Referring and reporting cases of gender based violence including child marriage, FGM/C and abduction and maternal death • Strengthen HDA and social mobilization to raise awareness on prevention of the HTP • Strengthen IEC/BCC on HTPs and against acts of physical and sexual violence; • Promote community dialogues for improved FP use & against practice of HTPs that affect women/girls; • Promote male involvement in family planning and skilled delivery • Promote Focused ANC and birth preparedness plan; • Coordinate community-based social mobilization interventions for facility based delivery including referral linkages for mothers through cost coverage and transportation;	• Establishing a unit for counseling, managing and caring for HTPs and Sexual violence; • Ensure birthing environment through adaptation of safe cultural practices; • Ensure functional 24 hours life-saving health services for mothers & newborn including water, electricity, equipment, emergency/maternal drugs and blood for transfusion services; • Male are involved in the safe motherhood program and youth-friendly services focusing on adolescent girls; • Availability of skilled health providers for maternal care for BEmONC and emergency specialists for CEmONC services at HC and Hospital Respectively; • Ensure maternal and newborn outcomes are recorded and documented; • Strengthen health center-health post linkage and referral system • Promote health providers awareness and attitude to provide gender sensitive and responsive services.
Nutrition	• Protein –energy malnutrition (PEM), vitamin and mineral deficiency among female due to differential preference for boys/men;	• Promote community based nutrition and healthy feeding practicesfor pregnant women and children	• Treatment of diseases associated with malnutrition;

Priority Programs	*Key gender issues*	*Level of implementation of interventions*	
		Community Level	*Health facility Service Levels*
Communicable Diseases **HIV/AIDs**	● Limited knowledge on HIV risks among female and high economic dependency for women to practice safer sex; ● High prevalence of GBV; low coverage of VCT among women including PMTCT uptake; fear of stigma and abandonment to disclose HIV status.	● Promote focused IEC/BCC on gender responsive messages using HDA ● Promote male involvement for HIV prevention (GBV) and PMTCT service ● Promote the utilization of LLINs for pregnant women and under -five children ● Promote Environmental management for vector control through social mobilization and health development army	● Strengthen availability of trained health provider for HTC; ● Promote availability of ARV drugs and prophylaxis in case of GBV ● Strengthen the diagnostic and treatment interventions for GBV ● Promote and strengthen male involvement and partner testing &treatment for PMTCT programs; ● Expand availability of Youth-friendly services with focus on adolescent girls
Malaria	● Low utilization of malaria bed-nets; exposure to mosquito bites while engaged in household chores, lack of knowledge on signs of malaria, lack of knowledge on prevention measures	● Increase the distribution and use of LLINs for pregnant women and children.	● Early diagnosis and prompt malaria treatment
TB	● drop out (Low cure rate) and initiation of treatment for TB due to delay in accessing care ● poor compliance to treatment protocol, belief in alternate treatment, MDR TB	● Promote screening of women for TB in case of cough lasting more than two weeks ● Use HDA and social mobilization to promote compliance with treatment for TB and other infections	● Establish measures to help women and men access DOTs through identification, treatment and link per the TB treatment guideline
Hygiene & Sanitation, Environmental health	○ Limitation in clean water supply; time consuming and labor intensive for women and young girls, related to infectious disease ○ Scantiness of safe latrine in terms to night time uses and privacy that may be dangerous for girls and women (for example possibility to predispose them to violence and rape); also identified as a cause for absenteeism and school dropout during menses, ○ Indoor air pollution	● Increase awareness on household after treatment (boiling, sand filtration,) ● Improved hand washing practices ● Strengthen participation of women in community based hygiene, sanitation and environmental health efforts ● Awareness on hygiene, sanitation and on proper waste disposal at community through mobilizing Health development army ● Promote latrine utilization ● Strengthen availability of cooking alternatives to decrease indoor pollution	● Improve use of Infection prevention standards and practices in health facilities ● Improve proper solid and liquid waste management in and around the health facilities

Table 2: Gender responsive interventions in the health system building blocks

Thematic area	Human Resource	Finance	HIS	Medical products, vaccine and technology	Leadership &Governance
MNCH	● Strengthen clean and safe delivery by HEWs in the worst case scenario ○ Strengthen Health workers positive attitude and skills in MNCH ○ Promote training on gender based violence for health providers at all level ○ Promote Health workers retention ○ Support task-shifting for CEmONC	○ Apply Gender budgeting to integrate MNCH in key budgeting processes + in Pooled Funding mechanisms ● Promote waiver for all maternal health services ● Strengthen community & social Insurance	● -Strengthen data collection, use and reporting on sex and age disaggregated data ● Strengthen operational research on key gender determinants for programming	○ Availability of essential commodities, equipment, supplies and drugs with particular emphasis on availability of drugs for maternal care ● Apply gender sensitive assessment in procurement, distribution & monitoring processes	● Strengthen functional ● 24 hours life-saving services including staffing, the availability of blood transfusion ● Strengthen expansion ● Of functional infrastructure ● Strengthen functioning ● Referral system and transport

Thematic area	Human Resource	Finance	HIS/	Medical products, vaccine and technology	Leadership & Governance
Hygiene+ Sanitation	Staff Training integrates a gender sensitive approach focusing at the community and facility levels	Promote Community based cost sharing mechanisms to improve sanitation with focus on reducing women's workload and promoting their participation	Strengthen Community level information Document and dissemination of good practices.	Promote use of energy conserving and low pollution stoves	Ensure availability of potable water supply Community based water source.
Health Extension Program	IEC materials and messages to be gender responsive for both male and female and for those who cannot read and write s. HEWs need training for social mobilization and for coordinating of linkages. Capacity building for HDAs and social mobilization teams	Promotion of maternal cost coverage through community resource mobilization	• Strengthen the documentation of Family folders	Health education on the appropriate use of essential medicines and contraceptives.	Include the key gender issues in the IRT and HDA Direct IEC/BCC messages on HTPs including child marriage, FGM/C and other forms of gender based -violence.

Table 3: Institutional Accountability

The following table below illustrates the key interventions that need to be integrated into the Health system to strengthen gender mainstreaming. A detailed checklist is illustrated in the Annex 1 Chapter 5 for measuring accountability in planning and review processes in the health sector:

Organizational Commitment	Budget and Financial Resource	Human Resource	Organizational Culture	Knowledge Management and M&E
• Institutionalize the Gender Mainstreaming Guideline into the Health system's planning, monitoring and evaluation systems; • Ensure Management endorsement that apply for gender mainstreaming checklist in the M/E system of HSDP	• Ensure allocation of resources for gender mainstreaming within Program and within the Workplace; • Institute a systematic process of budget review in terms of allocation of resources to address gender inequality.	• Institute Workplace policy to mainstream gender within the organization e.g. through training, gender audits; • Institute a human resource policy and strategy to promote female staff development; • Strengthen the capacity of the Gender Directorate & offices to guide and facilitate gender mainstreaming within Program & in the Workplace.	• Promote a gender sensitive culture within the organization through innovative approaches that can impact positively • Institute gender sensitive communication messages through audio-visual and print materials	• Institute a rigorous M&E system within the health system aligned to the HSDP through HMIS and/or other monitoring mechanisms – • Ensure reporting on gender mainstreaming in national, regional, zonal and woreda consultative processes e.g. ARM,JRM, MTR and key technical consultations.

CHAPTER FIVE:

Gender Responsive Monitoring and Evaluation

5.1. Introduction

A monitoring and evaluation will follow the Health sector M&E framework from mapping of gender interventions discussed in the earlier chapters. A Gender Responsive framework for undertaking monitoring and evaluation work at both the program and institutional level is illustrated in the following paragraphs. These include indicators at service delivery level and at institutional level across all levels of the health system. It is expected that the M&E framework described will be used to measure changes and results attributed to interventions inherent in the health system's program management cycle including the effective, efficient and equitable budgeting allocation and utilization.

5.2. Key Service Delivery gender responsive indicators

Service delivery level indicators largely capture output level indicators that need to be monitored regularly through the health system's routine data collection and reporting timeframe. Outcome indicators (see annexed key gender related indicators) will be monitored through the health sector's M&E framework mechanism and supplemented through research and assessments. Process indicators were critical in monitoring the implementation of the gender mainstreaming guideline. For instance, where the planned gender responsive interventions focus on improving women's access to health care, the process indicators would track the implementation of special interventions such as fee waivers and free transportation of obstetric referral cases at hospital level. In addition, qualitative data will be important for the monitoring of gender responsive interventions denoting the changes in the attitude of health providers.

The sources for monitoring the health service delivery indicators are the Health Information System (HIS), surveys/assessments and administrative Reports. The HIS offers a comprehensive reporting system aligned to the HSDP strategic themes and objectives as well as performance measures. Key principles of the HIS are to foster *simplification, integration, standardization* and *institutionalization.* These principles are applicable for the integration of gender responsive indicators. Though the existing HIS is generally gender sensitive, some performance monitoring

indicators require disaggregation of data elements by sex to better analyze gender relations while there is need for integrating additional indicators to foster gender responsive interventions. All M/E routine process should integrate gender:

- Routine data collection and aggregation
- Integrated supportive Supervision
- Performance monitoring and quality improvement including JRM, ARM
- Evaluation / Operational research

The table below illustrates key gender responsive indicators that need to be extensively discussed and internalized for integration into the health monitoring system, among decision-makers and lead managers at Federal and Regional levels. Ownership, commitment and action will be critical in effecting a regular monitoring and reporting mechanism in the health system.

Table 1: List of indicators in HMIS, or surveys to be disaggregated by sex at all levels

SN	SUBJECT AREA	PRIORITY INTERVENTIONS	PERFORMANCE INDICATORS	Source
1	**Health service delivery and quality of care**			
1.1.	Maternal, newborn and child health			
	Family planning	Promote male involvement in FP	Proportion of male using modern family planning methods	EDHS
		Adolescent friendly health services responding to the SRH needs of adolescent girls and boys	Proportion of facilities with AYFS	Administrative report
			Users of adolescent service disaggregated by sex & age	Gender specific study
	Maternal health care	Health response to Gender based violence	Proportion of health care facilities providing services for victims of GBV	Facility survey
		Community level assistance for institutional delivery	Proportion of women who gave birth at health facilities supported by community	HEP survey
		Establishment/Adaptation of women friendly services	Proportion of health facilities providing mother friendly services	Facility Survey
1.2.	**Nutrition**			
	Breast feeding and nutrition	Promotion of breastfeeding practices at workplace	Proportion of work place in health system with breastfeeding corners	Activity report and facility survey
		Promote the use of iodized salt particularly for adolescent and pregnant girls/women	Proportion of new cases of goiter among girls and pregnant women	
		Promote treatment of severe malnutrition	Proportion of children treated for severe malnutrition disaggregated by sex	
1.3.	**Communicable diseases**			
	HIV/AIDS	Provision of ARV drugs for prophylaxis in cases of GBV	Proportion of GBV victims received ARV drug prophylaxis (disaggregated by sex)	HMIS/Facility record survey

		Adolescent friendly health services responding to the HIV of adolescent girls and boys	Proportion of facilities with AYFS integrating HIV prevention, treatment, care and support	Admin report
	Tuberculosis	Promote early diagnosis of TB among women	Newly diagnosed smear positive TB patients (disaggregated by sex)	
		Promote treatment compliance among women	TB cure rate (disaggregated by sex)	HMIS
	Malaria	Improve awareness on the dangers of malaria in pregnancy	Malaria morbidity and mortality rate (disaggregated by age and sex)	MIS
1.4	Hygiene &Environmental health			
	Hygiene and sanitation	Improve use and disposal of female menstrual pads	Proportion of households with appropriate waste disposal *	HEP survey
		Safe outdoor latrines for female night use	Proportion of households with indoor or well illuminated latrine	HMIS
		Availability of treated drinking water	Proportion of household with safe, clean and treated drinking water *	Household survey
	Environmental health	Environment friendly cooking stoves and fuels	Proportion of households with improved stoves	
		Participation of men and women in community based environmental sanitation	Proportion of 'kebeles' with female members in environment committees	House hold Survey
1.5	IEC/BCC	Gender responsive messages addressing both men and women	Proportion of gender responsive messages transmitted to the households	
		Developed Materials with:	Proportion of IEC/BCC including community dialogue/conversations organized that promote the elimination of HTPs and GBV	Household Survey
		messages channeling to women		
		targeting men for FP messages		Facility survey
		distributed to ensure access of rural women to IEC		

1.6	Community ownership	Promote the inclusion of gender issues in knowledge at household level	Proportion of household who mention the key gender issues that affect the health of the household	
		Participation of women	Proportion of kebeles with women centered Health development army	KAP Surveys
		As members of the Health Development Army at the community level	Proportion of health facilities that have women representatives among the board members	Administrative report
		As members of the health insurance scheme leads		Facility and community report or survey
		As board members of health facilities		Administrative reports
1.7	Gender Mainstreaming	**Gender analysis**	Proportion of health facilities undertaking gender analysis;	Administrative reports
		Gender Audits	Proportion of health facilities undertaking gender audit;	Administrative reports
		Gender based budgeting	Proportion of health facilities undertaking gender budgeting.	Administrative reports

5.3 Key interventions for institutional gender mainstreaming and deliverables

The list of deliverables are for monitoring institutional gender mainstreaming.. The concept of "building blocks", as backbone of the health system, discussed in earlier chapters has been used to frame key interventions and deliverables to be monitored at all levels. This section also builds on the key interventions illustrated under table 2 and 3 on "**Gender Responsive interventions in the Building Blocks**" and "**Institutional Accountability**", respectively. While Federal level directorates and agencies are expected to coordinate and facilitate the use of the institutional monitoring framework, as with the service delivery monitoring indicators, ownership, commitment and action are critical for effective monitoring and evaluation.

The table below illustrates key monitoring interventions with the deliverables for the activities to be used by directorates leading the "building blocks of the health system of Ethiopia". It should be noted that the deliverables may be interpreted as linked to service delivery and management indicators. However, monitoring processes will need to be implemented in tandem with the directorates accountable for **Health Service Delivery and Quality of Care**, namely the

- Agrarian Directorate (the focal point for Communicable Diseases including HIV/AIDS, Malaria and TB),
- Urban Directorate (the focal point for Maternal, Newborn and Child Health and Nutrition),
- Pastoralist Directorate (the focal point for Hygiene & Sanitation) and the Directorate of Medical Services.

As with table 1, the key interventions and deliverables for each process at all level so that they serve as guides for application and to enable tracking the status of mainstreaming at the Federal level – to be cascaded at Regional, Zonal and Woreda level of the health-system.

Supervisory check list to monitor institutional gender mainstreaming

S/No	Supervision themes for respective units	Yes	No
	Policy, Plan, Monitoring and Evaluation Units		
1	Is gender equity addressed in the health policy, strategic and normative documents?		
2	Have gender analysis been undertaken for the health sector annual planning?		
3	Does the planning process include men and women in the target population?		
4	Has the gender unit been consulted?		
5	Have gender focal points from partner agencies collaborated?		
6	Do awareness-raising briefings on gender conducted for decision- makers/planners?		
7	Is budget allocated for gender mainstreaming activities during planning?		
8	Are sex- disaggregated data used for allocation of resources to implement gender responsive interventions		
9	Are gender issues included in the checklists for supportive supervision?		
10	Do the M/E tools and formats incorporate gender?		
11	Is gender considered in researches?		
	Gender Unit		
1	Is there a focal person assigned? Is there a gender officer (trained in gender)?		
2	Is there adequate budget for facilitating gender mainstreaming?		
3	Are there stakeholders assisting the unit?		
4	Are there educational and training opportunities on gender and health, and gender mainstreaming?		
5	Are there strategies for multi-sectorial linkages and for networking? Including GBV		
6	Are there tools developed for training, supervision, implementation and auditing for gender mainstreaming guideline etc.		
7	Does performance auditing address the status of gender integration?		
8	Is there inter-sectorial collaboration to advance gender mainstreaming in the activities of other units within the health system?		
	Health promotion and disease prevention Units		
1	Are all staffs trained on gender mainstreaming on programs?		
2	Have the relevant gender issues been identified?		
3	Have plans been designed to address gender issues in the priority programs?		
4	Are gender- responsive interventions and indicators selected?		
	Are there tools/formats for monitoring and evaluation that include gender?		
6	Are gender issues included in the checklists for supportive supervision of programs?		
	Financial Utilization and Mobilization		
1	Are the finance staffs aware of concept of gender budgeting?		
2	Is consideration given to gender issues in resource mobilization and budget allocation for health?		
3	Are considerations given to gender gaps in the designs of health care financing schemes and insurances?		
4	Are the budget and resources allocated to the various areas adequate for them to address gender issues?		
5	Is there a monitoring and evaluation system in place to track that budgets have being utilized as planned?		
6	Are there continuous medical supplies and logistics for the provision of gender responsive health care?		
7	Is there continuous medical supply for emergency maternal care including contraceptives?		
8	Is gender a criterion in donor funded programs\projects?		

9	Are gender issues given consideration in the mobilization proposals/projects?		
	Public relation and communication Units		
1	Are the recognized gender gaps given consideration when designing PR materials?		
2	Is there a section on gender in the periodic publication of the health sector?		
3	Is publicity accorded to the gender related activities in the health sector?		
4	Do the communication strategies of programs incorporate gender?		
	Human Resource		
1	Is there a sex disaggregated database with the number of staff by education level, position and year of service?		
2	Is there a format for keeping record of male/female employee's promotion and training experiences?		
3	Are managers and staff familiar with gender issues in HR according to the Civil Service legislation?		
4	Are the enough staffs recruited and deployed for the implementation of gender responsive interventions?		
	General Service		
1	Are all the general service staffs oriented on gender issues?		
2	Are there opportunities to supplement the skill and income for general staff?		
3	Do staff have cleaning attires and awareness on the proper utilization?		
	Health infrastructure		
1	Are gender issues given consideration with respect to infrastructure? (availability of water, electricity and means of communication)		
2	Are the health infra-structures organized to suit women friendly services? (privacy, indoor toilet in labor and delivery units, adequate and ventilated space)		
	Internal audit		
1	Are the audit staffs adequately trained on gender issues and auditing approaches?		
2	Are the auditing tools revised to include auditing of the gender dimensions of health?		
	Medico legal		
1	Is gender mainstreaming integrated in priorities of the legal unit?		
2	Are gender issues included in the training of staff?		
3	Does the unit have the capacity to address gender related problems?		
4	Do the official agreements maintain gender equality in the work place?		
5	Do the medical ethics integrate gender equality and equity? (Stigma and discrimination of PLHIV and disabilities…)		
6	Does the office consider work-place gender related disparities/abuses/harassments as deserving actions?		
	ANTI-CORRUPTION		
1	Are the staffs aware on gender related corruptions and misuse of authority?		
2	Does the office consider work-place gender based violence related disparities?		

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ANNEX 1: OUTCOME INDICATORS

Priority program	Outcome Indicator	Definition	Source
Maternal Newborn Health	Contraceptive acceptor rate	The proportion of women of reproductive age (15-49 years) who are not pregnant who are accepting a modern contraceptive method (new and repeat acceptors).	HMIS
	Adolescent fertility rate	The number of births occurring in a given year per 1000 women in the age 15-21 years by marital and educational status and residence	
	Antenatal care coverage – fourth visits	The percentage of women that received antenatal care at least four or more times during pregnancy. (by age, social class, residence, urban/rural)	HMIS
	ANC Syphilis Screening	Prevalence of syphilis among pregnant women	HMIS
	Births attended by skilled health personnel	Proportion of births attended by skilled health personnel.	HMIS
	Abortion care	Proportion women that received safe abortion services and emergency post abortion care	HMIS
	Maternal death (institutional and community level)	The proportion of female deaths from any cause related to or aggravated by pregnancy or its management (in institutional and community level)	Facility reports Community reports
Child health	Newborn death (institutional and community level	The proportion of newborn deaths disaggregated by sex, by maternal age, maternal outcome, ANC follow-up, (institutional and community level)	Facility reports Community reports
	Exclusive breast feeding rate	Percentage of children <6months who are on exclusive breast feeding (disaggregated by maternal age, social class, educational level, residence)	HMIS
	Fully Immunized	% age of infants at year 1, who have been immunized with BCG, third doses of (DPT & Polio), and measles disaggregated by sex	HMIS

	Infant mortality rate	The number of registered deaths among infants below one year of age per 1000 live births in a given year	HMIS
HIV/AIDs	Prevention of mother to child transmission testing rate ART	Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy Percentage of HIV-infected pregnant women who received antiretroviral medicines to reduce the risk of mother-to-child transmission, among the estimated number of HIV-infected pregnant women.	HMIS Facility registers
	Risk factors among HIV – infected women	The age range of HIV- infected women by marital status, age range of partners, educational status, residence	HMIS Survey report
TB	TB Case detection (All forms)	Case detection rate of new smear positive pulmonary TB patients	HMIS
Malaria	Cases of malaria	Morbidity attributed to malaria disaggregated by age and sex Morbidity rate among pregnant women	HMIS
Nutrition	<5 Children stunted by sex Children 10-15 years stunted	Proportion of children <5 with height- for- age less than- 2SD form the median of WHO/NCHIS reference Proportion of teenagers stunted disaggregated by sex	HMIS Survey report
Gender based violence	Prevalence of domestic violence	Number of cases of domestic violence reported by age of victims, by residence	Community Survey Police reports

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Alemayehu Bogale	FMOH- Gender Directorate
Amsale Eshetu	FMOH- Gender Directorate
Fikir Melesse (Dr.)	WHO-CO
Helen Amdemikael	Futures Group/HPP
Tesfayenesh Lemma	Ministry of Women, Children and Youth Affair
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W/o Yamerot Andualem
Director, Gender Directorate