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GENDER ASSESSMENT REPORT

USAID TRANSFORM: PRIMARY HEALTH CARE

March 2022

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ACRONYMS AND ABBREVIATIONS

ANC	Antenatal care
CBHI	Community-based health insurance
CEFM	Child, early, and forced marriage
FGM/C	Female genital mutilation/cutting
GBV	Gender-based violence
HEW	Health extension worker
LMG	Leadership, management, and governance
MELA	Measuring, evaluation, learning, adapting
RFUV	Routine follow-up visit
RMNCH	Reproductive, maternal, newborn, and child health
USAID	United States Agency for International Development

EXECUTIVE SUMMARY

PURPOSE

The purpose of this gender assessment is to identify the United States Agency for International Development (USAID) Transform: Primary Health Care successes and challenges in addressing and responding to the gender gaps and opportunities identified in the Activity's gender analysis (conducted from October 2017 to May 2018) and provide recommendations for future Ministry of Health and USAID programming in Ethiopia.

The overarching question for the gender assessment is:

> ***In what ways have USAID Transform: Primary Health Care interventions addressed gender gaps and opportunities to achieve its intended results?***

This is supplemented by four sub-questions:

1. What systems and processes did USAID Transform: Primary Health Care establish to enable it to address the gender gaps and opportunities identified in the Activity's gender analysis?
2. What interventions, policies, procedures, and initiatives did USAID Transform: Primary Health Care implement individually or with partners to address gender gaps and opportunities identified in the Activity's gender analysis?
3. What remaining gender gaps and opportunities need to be addressed and what new ones have emerged?
4. What successes have potential for sustainability and what is needed to sustain them?

METHODOLOGY

The gender assessment employed a two-phase approach to collect and analyze secondary and primary qualitative data and secondary quantitative data. Because this gender assessment is both retrospective and forward looking in nature, data collection relied mainly on secondary data to tell the USAID Transform: Primary Health Care story and answer the assessment questions. The assessment team collected primary data in Phase 2 to round out secondary data findings and delve deeper into the success stories, challenges, and data gaps that emerged from Phase 1 to more fully answer the assessment questions. Across the two phases, the assessment team used a participatory approach that engaged USAID Transform: Primary Health Care staff, Ministry of Health counterparts, and representatives from USAID.

FINDINGS

The 18 findings from the data, presented below, are organized by the four gender assessment sub-questions to answer the overarching research question. Annex B: Quantitative Findings (see separate document) presents the full findings of the quantitative data.

SUB-QUESTION 1: WHAT SYSTEMS AND PROCESSES DID USAID TRANSFORM: PRIMARY HEALTH CARE ESTABLISH TO ENABLE IT TO ADDRESS THE GENDER GAPS AND OPPORTUNITIES IDENTIFIED IN THE ACTIVITY'S GENDER ANALYSIS?

Finding 1: To integrate gender across the Activity, USAID Transform: Primary Health Care established a gender architecture and developed and annually reviewed a gender strategy to collaborate on, learn from, and support the adaptation or development of new interventions to respond to emerging gender gaps and opportunities across technical teams and result areas.

Finding 2: USAID Transform: Primary Health Care used monitoring and follow-up data to identify gender gaps and adjusted interventions accordingly.

SUB-QUESTION 2: WHAT INTERVENTIONS, POLICIES, PROCEDURES, AND INITIATIVES DID USAID TRANSFORM: PRIMARY HEALTH CARE IMPLEMENT INDIVIDUALLY OR WITH PARTNERS TO ADDRESS GENDER GAPS AND OPPORTUNITIES IDENTIFIED IN THE ACTIVITY'S GENDER ANALYSIS?

Finding 3: USAID Transform: Primary Health Care provided technical and financial support to the Federal Ministry of Health Women, Children and Youth Affairs Directorate and its regional structures to address gender gaps in the health sector and increase gender-based violence (GBV) prevention and response.

Finding 4: USAID Transform: Primary Health Care augmented the Ministry of Health gender and health mainstreaming training with on-site mentoring to enable staff to conduct gender analyses and develop action plans to address gender gaps.

Finding 5: USAID Transform: Primary Health Care supported the Ministry of Health to disseminate and operationalize its Standard Operating Procedure for The Response and Prevention of Sexual Violence in Ethiopia and strengthen a multi-sector response for GBV survivors.

Finding 6: USAID Transform: Primary Health Care built health service providers' capacity in GBV clinical response services and referrals, especially for sexual violence survivors.

Finding 7: USAID Transform: Primary Health Care developed a woman-centered, woman-focused leadership, management, and governance (LMG) training and coaching intervention to fill the gender gap in LMG participation.

Finding 8: USAID Transform: Primary Health Care implemented interventions to increase male engagement in antenatal care, maternal health, and family planning, but monitoring and learning are weak.

Finding 9: USAID Transform: Primary Health Care implemented a variety of awareness-raising interventions to increase women and girls' access to and use of health services and to prevent GBV.

Finding 10: USAID Transform: Primary Health Care supported the Government of Ethiopia to eliminate female genital mutilation/cutting (FGM/C) and child, early, and forced marriage (CEFM) by 2025.

Finding 11: USAID Transform: Primary Health Care added GBV prevention and response sessions to Her Space to respond to new data on gender gaps.

SUB-QUESTION 3: WHAT REMAINING GENDER GAPS AND OPPORTUNITIES NEED TO BE ADDRESSED AND WHAT NEW ONES HAVE EMERGED?

Finding 12: GBV is widespread in Ethiopia, yet lack of knowledge among clients and healthcare workers, a weak multi-sectoral response, and sociocultural norms create gaps in GBV prevention and response in health and other related services.

Finding 13: Engaging men and boys is a gap in reproductive, maternal, newborn, and child health services, especially for women's access to antenatal care and family planning, GBV prevention, and improved respectful care.

Finding 14: Women's leadership in the health sector is critically low, and health extension workers face increased workload demands that could negatively affect their own health and prevent them from exercising their full range of skills.

Finding 15: Gaps exist in the Ministry of Health's gender structure and budget that have implications for potential sustainability.

SUB-QUESTION 4: WHAT SUCCESSES HAVE POTENTIAL FOR SUSTAINABILITY AND WHAT IS NEEDED TO SUSTAIN THEM?

Finding 16: In most regions health posts and health centers demonstrated a positive and statistically significant increase in the availability of GBV services and dedicated services for sexual violence survivors, which is anticipated to continue after the Activity ends.

Finding 17: The addition of on-site gender analysis mentorship and action planning to the Ministry's Gender and Health Mainstreaming Training led to positive, significant changes in the percentage of woreda health offices conducting and using gender analyses for work planning. It is unclear if this will be sustained after the Activity ends.

Finding 18: Community-based health insurance interventions had an unintended positive consequence of empowering female enrollees to seek health care services.

CONCLUSIONS

Overall, the findings show that USAID Transform: Primary Health Care integrated gender in its operations, supported the Ministry of Health's "gender mainstreaming" commitments and efforts at all levels, actively sought to address the gender gaps identified in the Activity's gender analysis across result areas and technical teams, and adapted interventions to address new gender gaps that emerged from the

Activity's monitoring data. Evidence from this research suggests Transform: Primary Health Care contributed to an increase in facilities providing post-GBV services and the number of Woreda Health Offices (WorHOs) conducting gender analysis and integrating gender considerations in their annual plan. Other impacts or outcomes cannot be measured within the scope and methodology of this report, but anecdotes and observations indicate the Activity advanced efforts to promote gender equality and equity across the health system in a number of ways. Going forward, findings show that the Ministry of Health still needs support, especially at the woreda level, to sustain the interventions and support the Activity provided. The following six conclusions present the assessment team's synthesis and interpretation of the significance of the findings:

Conclusion 1: The Activity's gender analysis was an entry point for integrating gender into its operations and interventions and for supporting gender integration across the Activity.

Conclusion 2: USAID Transform: Primary Health Care used collaborating, learning, and adapting to monitor and respond to evidence-based gender gaps over the life of the Activity.

Conclusion 3: USAID Transform: Primary Health Care integrated gender across thematic and result areas rather than implementing gender-specific interventions.

Conclusion 5: The USAID Transform: Primary Health Care GBV landscape analysis provided essential evidence to the Ministry of Health to propel GBV prevention and response interventions and services.

Conclusion 6: The Ministry of Health lacks resources, capacity, and infrastructure to respond to gender gaps and sustain several USAID Transform: Primary Health Care gender-aware interventions without external financial and technical support.

RECOMMENDATIONS

The findings and conclusions demonstrate that USAID Transform: Primary Health Care instituted systems, processes, and resources (human and financial) to address and mitigate gender inequalities and barriers that hindered access to and use of Ethiopia's health system. It did this by integrating gender into its operations, supporting the Ministry of Health to implement and operationalize its gender-related policies and initiatives, and serving as a thought partner and technical arm to adjust interventions and approaches in response to emerging gender gaps. This partnership enabled the Ministry of Health to advance gender mainstreaming in its sector and development programs, advocacy, and capacity-strengthening at all levels of the health care system as outlined in the Health Sector Transformation Plan (2015/16–2019/20), in which gender equality and women's empowerment were cross-cutting and guiding principles.

However, findings and conclusions also show that gender inequality (both access to services and leadership within the health sector) and GBV remain high in Ethiopia. Further, the Ministry of Health still requires external technical and capacity-strengthening support to achieve the gender equality goals and priorities stated in the Health Sector Transformation Plan II (2020/21–2024/25). These include enforcing women's and girls' rights to health care; providing gender-responsive health services to all; and delivering comprehensive, multi-sectoral services to GBV survivors (including CEFM and FGM/C).

The following six recommendations suggest ways in which USAID and the Ministry of Health can build on the Activity's processes, successes, and learning to develop gender transformative interventions that

support the Ministry of Health's efforts to prevent maternal and child deaths, and holistically strengthen health systems to be available and accessible to all:

Recommendation 1: USAID should require gender integration systems and processes in its solicitations.

Recommendation 2: USAID should support the Ministry of Health to implement the adapted Program P curriculum, and USAID and the Ministry should engage men broadly.

Recommendation 3: USAID and the Ministry of Health should include community-level GBV prevention and social norms change interventions.

Recommendation 4: USAID should support the Ministry of Health to strengthen the Ethiopian government's multi-sectoral GBV response.

Recommendation 5: USAID should support the Ministry of Health to scale up interventions piloted or initiated by USAID Transform: Primary Health Care.

Recommendation 6: The Ministry of Health should institute a gender structure and budget for the Women, Children and Youth Affairs Directorate at all levels.

INTRODUCTION

PURPOSE AND ASSESSMENT QUESTIONS

The purpose of this gender assessment is to identify the United States Agency for International Development (USAID) Transform: Primary Health Care successes and challenges in addressing and responding to the gender gaps and opportunities identified in the Activity's gender analysis (conducted from October 2017 to May 2018) and provide recommendations for future Ministry of Health and USAID programming in Ethiopia.

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ACTIVITY BACKGROUND

OVERVIEW

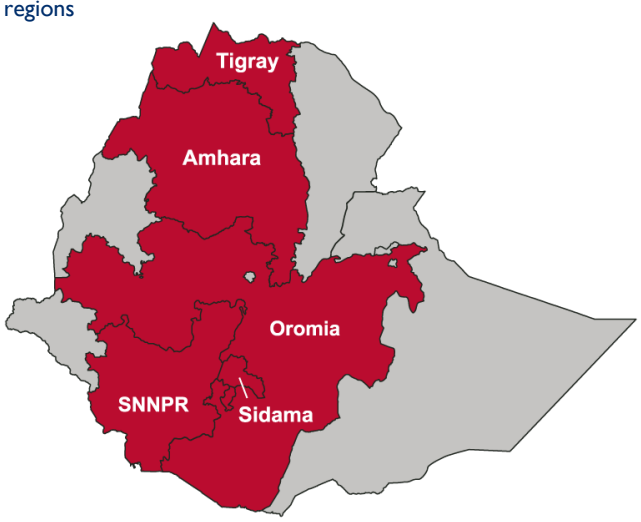
Although Ethiopia reduced its maternal and under-5 mortality rates over the past two decades, inequities persist in access to health care and essential services for all segments of the population (USAID 2020a). To this end, USAID Transform: Primary Health Care (2017–2022)[1] partnered with the Ethiopian government to prevent child and maternal deaths by strengthening the country's health care system (USAID 2020a); (USAID 2020e); (USAID 2020f). USAID Transform: Primary Health Care is one of a

Exhibit 1: USAID Transform Activities

- *Transform: Primary Health Care* focuses on regions.
- *Transform: Health in Developing Regions* supports public sector primary care in pastoral areas.
- *Transform: WASH* addresses access to safe water and improved hygiene.
- *Transform: Measuring, Evaluation, Learning and Adapting* (MELA) collects data and builds an evidence base to determine which models work best.

[1]USAID Transform: Primary Health Care was designed as a five-year Activity. In 2020, USAID granted a nine-month no-cost extension (until September 2022) because of delayed interventions from the impact of the COVID-19 pandemic, and to ensure a smooth transition to the public sector of achievements gained.

Exhibit 2: USAID Transform: Primary Health Care intervention regions

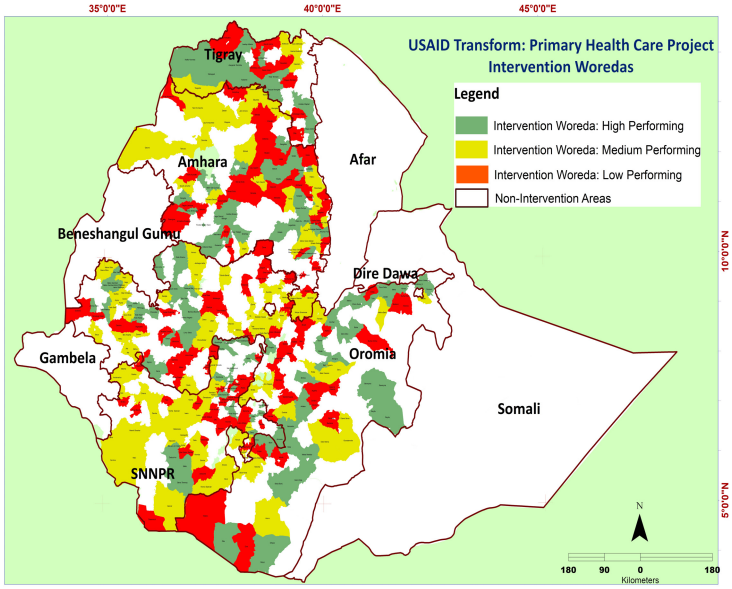


$181 million suite of four Activities listed in Exhibit 1 that USAID/Ethiopia launched in October 2017 (and funded through 2022) to prevent child and maternal deaths in Ethiopia (USAID 2018d); (USAID 2017d).

USAID Transform: Primary Health Care is implemented in Ethiopia's five agrarian regions—Amhara; Oromia; Sidama;[2] Southern Nations, Nationalities, and Peoples; and Tigray (Exhibit 2)—by a consortium led by Pathfinder International and comprised of Abt Associates, EnCompass LLC, Ethiopian Midwives Association, and JSI Research & Training Institute, in collaboration with local government partners and augmented by a pool of local resource partners that contribute a range of local and international experience and innovative thinking through on-demand technical input and innovation.[3]

Within these regions, the Activity worked in a total of 434 woredas, which covered about 56 million people, half the country's population (USAID 2020f; USAID 2019g). Exhibit 3 presents the woredas where the Activity implemented interventions.

Exhibit 3: USAID Transform: Primary Health Care intervention woredas, Year 4

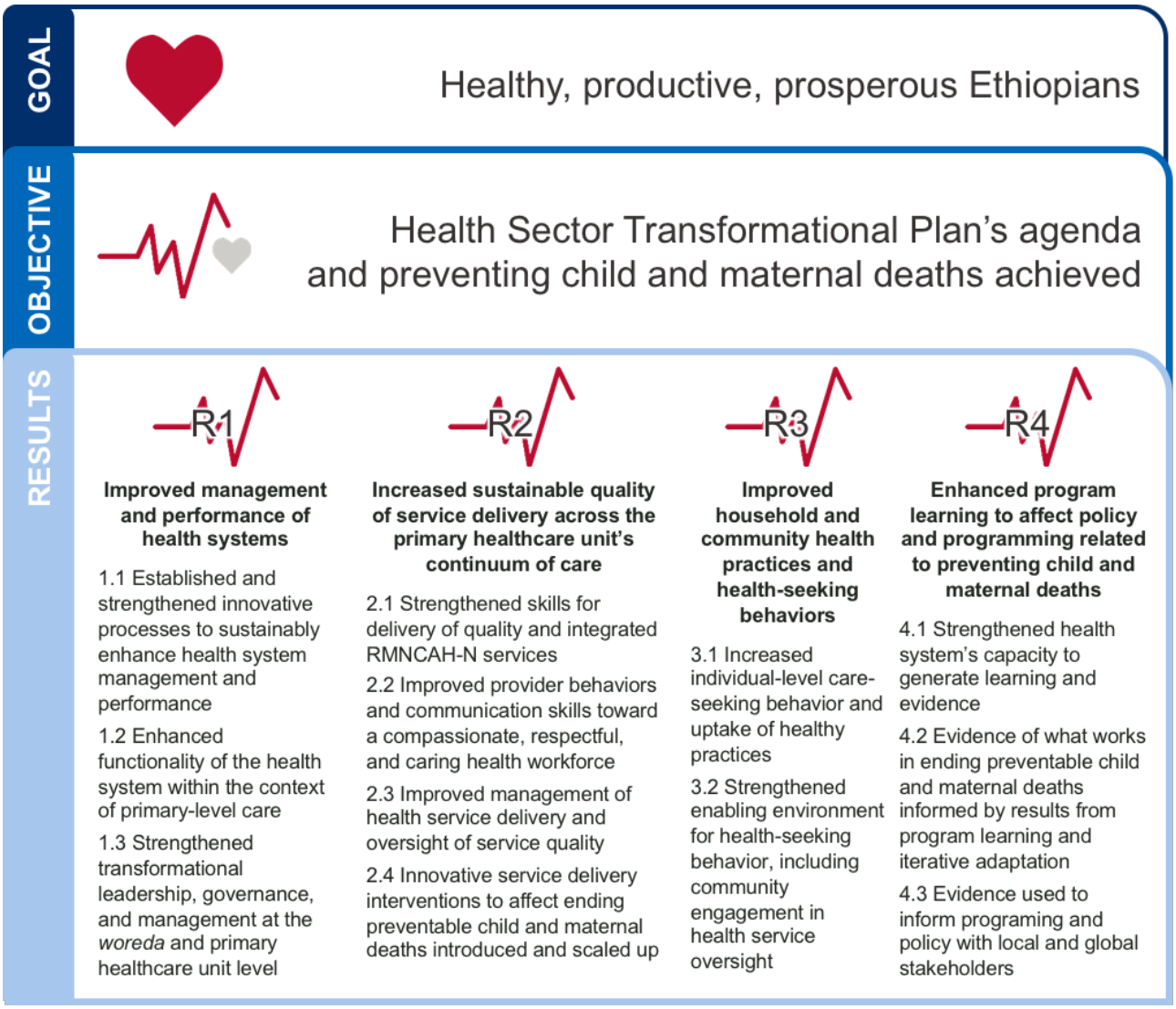


USAID Transform: Primary Health Care contributes to the Ethiopia government's five transformational priority issues under the Health Sector Transformation Plan II (2020/21-2024/25): quality and equity; information revolution; motivated, competent, and compassionate health workforce; health financing; and leadership.[4] The Activity supports these strategic initiatives through phased, adaptive technical assistance to achieve four high-level results and 12 sub-results. As illustrated by the Activity's results framework presented in Exhibit 4, these results make

[2] The Sidama region was added in 2020 when it was transformed from a zone of the Southern Nations, Nationalities, and Peoples' region to an autonomous region in June 2020. This change did not alter USAID Transform: Primary Health Care's work, as it was already working in the Sidama zone.
[3] The Malaria Consortium was engaged in USAID Transform: Primary Health Care through Activity Year 3.
[4] At the time of design, Transform: Primary Health Care aligned with the Health Sector Transformation Plan (2015/16-2019/20), which had four transformational agendas: woreda transformation; quality and equity; caring, respectful, and compassionate health professionals; and information revolution. The Activity adjusted its workplan and activities to align with the updated Health Sector Transformation Plan II when it was published in 2021.

significant contributions to prevent maternal and child deaths, while ensuring sustainable progress toward the Health Sector Transformation Plan with the ultimate goal of healthy, productive, and prosperous Ethiopians (USAID 2018g, 2018f, 2017a, Nd-b, 2017c, 2018b, 2020f, 2020d, 2019g, 2020b, 2020c, 2018d, 2018c, 2017b; Pathfinder International 2017; USAID 2018e, 2019f, 2020e).

Exhibit 4: USAID Transform: Primary Health Care results framework



Government ownership and sustainability were core principles of USAID Transform: Primary Health Care (USAID 2017a). To this end, the Activity worked at every health system level to support government-owned solutions for lasting change and provide innovative approaches to solving health challenges, while harnessing local knowledge and perspectives (USAID 2017b). The Activity sought to enhance regional health bureau capacity (USAID 2020a; USAID Nd-b; Stones et al. Nd; USAID 2020e; Stones et al. Nd; USAID 2020e) such as skills and knowledge to manage, source, and provide technical assistance to woreda health offices and strengthen woreda health office capacity to support and oversee primary health care units. (USAID 2017a; USAID 2020a; USAID 2018e, 2019g). The Activity also collaborated with other relevant USAID Activities and health system partners, including the Federal

Ministry of Health, to enhance health system functionality and address issues such as health care financing (e.g., community-based health insurance [CBHI]) (L. Messner et al. 2019).

The Activity focused specifically on improving the health system's performance and capacity in delivering quality health services related to the thematic areas listed in Exhibit 5 (responding to COVID-19 was added in 2020). (USAID 2017a, 2018f, 2018g, 2020f, 2018a, 2019g, 2020c, 2020f, 2018d)

Exhibit 5: USAID Transform: Primary Health Care thematic areas

- Adolescent and youth health and development
- Child health and development
- Family planning and reproductive health
- Gender equality
- Health care financing
- Health systems strengthening
- Leadership, management, and governance
- Malaria
- Maternal and newborn health
- Nutrition
- Obstetric fistula
- Program learning
- Quality improvement and assurance
- Responding to COVID-19
- Social and behavior change communication

STRATEGIC APPROACHES

USAID Transform: Primary Health Care used the three strategic approaches below in its work across result areas (USAID 2017a; USAID 2020f, 2018f, 2019g, 2017b, 2018e).

- **Providing phased, focused, and adaptive technical assistance.** Supported the Ethiopian government's strategic initiatives through demand-driven technical, financial, and other resource support to regional health bureaus, woreda health offices, primary hospitals, health centers, and health posts. Provided technical and financial support to the Federal Ministry of Health and Ethiopian Health Insurance Agency (USAID 2020f, 2017c). Conducted regional and national annual woreda strengths and gaps analyses and theory of change exercises to update changes in performance, partners' presence, infrastructure, and service availability in intervention areas (USAID 2019g, 2018e).
- **Harnessing existing mechanisms and investments.** Conducted annual landscape analyses of key partners and government initiatives in target regions, zones, and woredas to minimize duplication of efforts and leverage the work of other partners (USAID 2019g, 2018e). Participated in a variety of networks and working groups—USAID's Gender Champions Network,[5] the National Family Planning Technical Working Group, the Child Health and Development Working Group, the Federal Ministry of Health Adolescent and Youth Health Development and Technical Committees—to enable efficient allocation of resources and avoid duplication of efforts and funding. These platforms helped the Activity share and disseminate workable strategies and test approaches with a wider audience (USAID 2019g, 2018e, 2017c, 2020e, 2018g).
- **Scaling up and sustaining initiatives using the public system.** Strengthened regional health bureaus and zonal health departments' and woreda health offices' management capacity through mentorship, training, and technical assistance (USAID 2019g, 2018e). Built sustainability milestones into its work plans and theory of change analyses to benchmark

[5] USAID Transform: Primary Health Care was an active member of the USAID Gender Champions Network comprised of more than 20 USAID implementing partners that aimed to improve collaboration and avoid duplicating efforts related to gender integration. This network met bimonthly to discuss technical updates, validate studies and tools, exchange relevant gender technical expertise, develop a gender and health toolkit, co-organize learning events, build partnerships, share expertise, and develop relevant resources and abstracts submissions.

progress, interventions' long-term effects, and public sector leadership, management, and ownership (USAID 2019g). Issued grants to respond to the distinct needs of targeted woredas to improve overall performance, contain shocks, and test innovative ideas to address lingering challenges in the health system (USAID 2019g, 2018e).

GENDER INTEGRATION

Over the past 20 years, Ethiopia has significantly improved its health system and its population's health status. However, despite such advancements, Ethiopians have limited access to clean water, sanitation facilities, and quality health services. Some areas have persistent food insecurity. A body of existing research demonstrates that social determinants of health (Exhibit 6) affect women, men, girls, and boys differently (USAID 2018d). According to a range of documents, USAID Transform: Primary Health Care and the Ethiopia Federal Ministry of Health recognized gender equality as a key social determinant of health and that addressing gender gaps and opportunities was crucial in preventing maternal, neonatal, and child deaths (USAID 2018g, Nd-b, 2018b, 2020b, 2018d). To this end, the Activity strove to address gender equality across its four result areas, guided by evidence and participation of all stakeholders by:

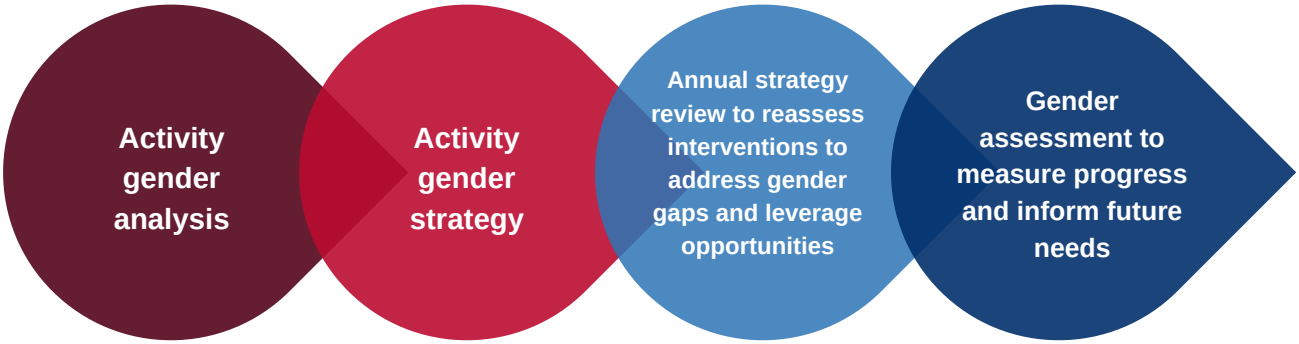
Exhibit 6: Social determinants of health

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

- Critically examining gender norms and dynamics
- Strengthening systems to be gender responsive
- Strategically challenging and changing inequitable health-related gender norms and behaviors
- Tailoring capacity-strengthening training supported by mentorship and coaching to systematically integrate gender into primary health care systems, service delivery, and demand creation

USAID Transform: Primary Health Care describes its gender integration approach as one that addresses identified gender gaps across the four result areas through advocacy, capacity enhancement, mentorship, and on-site follow-up visits (USAID 2020e). Further, the Activity defines this approach as interconnected, mutually reinforcing, gender-transformative, and evidence-based, contributing to preventing maternal, newborn, and child deaths across the four result areas, as illustrated in Exhibit 7 (USAID Nd-b).

Exhibit 7: USAID Transform: Primary Health Care gender integration approach



In 2017, USAID Transform: Primary Health Care, with the Federal Ministry of Health Women, Children and Youth Affairs Directorate, conducted a gender analysis using a collaborative approach that engaged Activity staff and key stakeholders from design to conclusions and recommendations. This participatory process ensured alignment with country priorities; provided relevant, meaningful, and effective gender integration throughout the life of the Activity; served as a capacity-strengthening opportunity for the Federal Ministry of Health; and helped inform federal policy priorities. Based on this gender analysis, the Activity identified key gender gaps and proposed actions to address those gaps (USAID 2018e, 2020e, 2020a, 2019f; Stones et al. Nd) (see Exhibit 8).

Exhibit 8: Activity gender analysis-identified gender gaps by result area and Activity proposed actions

RESULT AREA	GENDER GAPS	PROPOSED ACTIONS
	• Absence of female health workers in leadership positions • Inconsistent application of affirmative action and an enabling environment for female health care providers (e.g., breast-feeding corners and housing in remote health facilities)	• Target federal, regional, and zonal health system leaders to enhance awareness and advocate for more females in health system leadership, appropriate implementation of affirmative actions, and a conducive work environment for female health workers to excel in their jobs. • Strengthen leadership capacity of female health workers through training on leadership, management, and governance (LMG) and coaching to assume leadership positions. • Leverage every interface with health system leaders (e.g., senior alignment meetings, program review meetings) to raise awareness of gender gaps and advocate for a favorable organizational culture and work environment for female workers.
	• Poor provider capacity in gender-responsive service provision • Inconsistent availability of quality primary health care unit GBV responses • Intimate partner violence and male opposition to family planning drive underutilization of reproductive and maternal health services	• Increase availability of quality health services for gender-based violence (GBV) survivors. • Build service providers' capacity to provide gender-responsive health care. • Train and mentor primary health care unit managers and service providers along the continuum of care on attitudes and behaviors that recognize the differential health needs of men, women, boys, and girls. • Support orientation to the Federal Ministry of Health's Standard Operating Procedure for The Response and Prevention of Sexual Violence in Ethiopia to improve a multi-sector coordinated and collaborative GBV response.
	• Gender-related religious and cultural barriers prevent communities from practicing healthy behaviors, namely, male opposition and myths and misconceptions about family planning; limited male engagement in antenatal visits; child, early, and forced marriage (CEFM); female genital mutilation/cutting (FGM/C); and beliefs in traditional medicine.	• Improve health workers' capacity to engage men in reproductive, maternal, newborn, and child health. • Identify a community-level model to engage men in antenatal care and family planning. • Produce gender-aware health care information, education, and communication materials focusing on changing harmful gender norms and values. • Catalyze multi-sector actions to prevent CEFM and FGM/C in "hotspot" woredas by strengthening capacity and supporting joint review meetings.[6]

[6] Per a 2017 UNICEF report, "Child marriage in Ethiopia: A review of the evidence and an analysis of the prevalence of child marriage in hotspot districts," 16 of the 50 hotspot woredas for early marriage are in USAID

RESULT AREA	GENDER GAPS	PROPOSED ACTIONS
	• Evidence gap in health sector GBV prevention and response, male engagement in family planning, and community awareness-raising on gender norms	• Develop technical briefs and oral presentations and publish in scientific journals to document and share evidence-based gender transformative interventions. • Generate new evidence to inform the Federal Ministry of Health's GBV prevention and response at the primary health care level and strengthen the link between women's economic empowerment and CBHI. • Conduct a GBV landscape analysis to assess existing GBV services and referral linkages in selected primary health care units and design a model for GBV response health services.

In 2017, based on the gender analysis, USAID Transform: Primary Health Care identified and compiled key gender-sensitive health indicators to include in the Activity's monitoring and evaluation framework.

DESIGN AND METHODOLOGY

On November 18 and 19, 2020, the assessment team facilitated a gender assessment design meeting on Zoom with 17 USAID Transform: Primary Health Care staff to collaboratively develop research questions, sample, and methods for the Activity's gender assessment. During the meeting, the group articulated the gender assessment purpose, developed a shared vision, identified and prioritized key lines of inquiry, and proposed a sample and methods to meet the Activity's needs. The assessment team developed gender assessment guiding questions and methodology based on the meeting's outputs.

The gender assessment employed a two-phase approach to collect and analyze secondary and primary qualitative data and secondary quantitative data. Because this gender assessment is both retrospective and forward looking in nature, data collection relied mainly on secondary data to tell the USAID Transform: Primary Health Care story and answer the assessment questions. The assessment team collected primary data in Phase 2 to round out secondary data findings and delve deeper into the success stories, challenges, and data gaps that emerged from Phase 1 to more fully answer the assessment questions.

Across the two phases, the assessment team used a participatory approach that engaged USAID Transform: Primary Health Care staff, Ministry of Health counterparts, and representatives from USAID.

Transform: Primary Health Care intervention sites.
https://www.unicef.org/ethiopia/media/1516/file/Child%20marriage%20in%20Ethiopia%20.pdf

PHASE 1: DOCUMENT REVIEW, QUANTITATIVE DATA, AND DRAFT REPORT

DOCUMENT REVIEW

From February 5 to March 12, 2021, the assessment team reviewed 58 documents (see Annex A) using a document review tool (in Word) to code data by the four sub-questions, general background information on the Activity (for the Activity Background section of this report), and other relevant information to identify successes in and challenges to integrating gender into internal (Activity) and external (government and health care centers) practices.

Documents included government publications that discussed the Ministry of Health's gender mainstreaming commitments and activities; USAID Transform: Primary Health Care gender analysis report, gender strategy, and GBV landscape analysis report; quarterly and annual reports; work plans and other Activity reports; external mid-line performance evaluation of the Activity; and research and articles identified via an online search.

From March 24 to April 20, 2021, the assessment team used Dedoose version 8.3.21 (a Web-based application for managing, analyzing, and presenting qualitative and mixed-methods research data) to inductively code the document review tool data and identify themes captured in a data analysis summary document.

SECONDARY QUANTITATIVE DATA ANALYSIS

The assessment team collected statistical data from the Activity's routine follow-up visit (RFUV) survey monitoring data (drawn from its district health information software 2) from January 2017 to December 2020. The assessment team purposively selected and exported these data for 37 indicators from the four regions from household, health post, health center, and primary hospital RFUV surveys (see Exhibit 9) based on their alignment with the Activity's interventions that address gender gaps. The assessment team also drew data from the woreda health office 10.5 indictor, "gender analysis being exercised and results were used to inform woreda based planning," to collect data on the gender analysis mentorship intervention.

Exhibit 9: RFUV indicators analyzed from household, health post, health center, and primary hospital RFUV surveys

HOUSEHOLD RFUV SURVEY	HEALTH POST RFUV SURVEY	HEALTH CENTER RFUV SURVEY	PRIMARY HOSPITAL RFUV SURVEY
• **Family Planning 3.9c**: Proportion of non-pregnant women surveyed who started using family planning for the first time in the past year • **Family Planning 3.10**: Proportion of pregnant and non-pregnant women surveyed who are not current family planning users with	• **Gender 10.01**: Proportion of kebeles with an active health committee or community mobilization team • **Gender 10.02:** Proportion of kebeles having a health steering committee with women representatives • **Gender 10.03**: Proportion of health posts reporting most	• **Maternal and newborn health 5.02**: Proportion of health centers providing women-friendly services • **Gender 10.01**: Proportion of health centers reporting women representatives among the Primary Hospital board • **Gender 10.02**: Proportion of health centers reporting most	• **Gender 10.01**: Proportion of hospitals reporting women representatives among the Primary Hospital board • **Gender 10.02**: Proportion of hospitals reporting most male partners accompany their wives when they come for family planning services

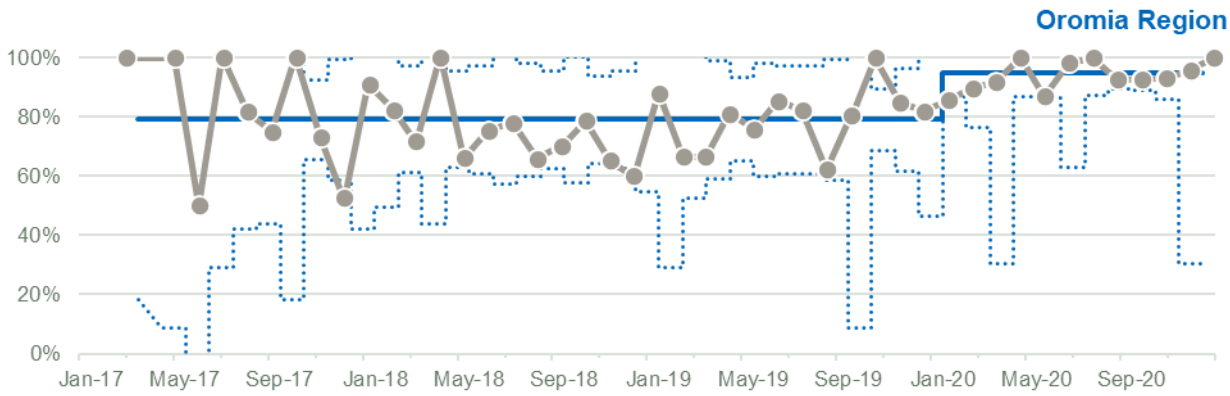
HOUSEHOLD RFUV SURVEY	HEALTH POST RFUV SURVEY	HEALTH CENTER RFUV SURVEY	PRIMARY HOSPITAL RFUV SURVEY
intentions to use family planning in the future • **Maternal and newborn health 4.12**: Number of women who received compassionate, respectful, friendly, and culturally acceptable care during pregnancy, labor, and delivery, and postnatal period of the child at health facilities • **Gender 9.1**: Proportion of women who usually make decisions about their own health care • **Gender 9.2**: Proportion of women who ever used family planning whose husband/partner supports in using family planning • **Gender 9.3:** Proportion of women who attended ANC visit for their last pregnancy • **Gender 9.4:** Proportion of women who attended an ANC visit for their last pregnancy and whose husband accompanied them during the ANC visit • **Gender 9.5:** Proportion of women who gave birth at a health facility for the last child • **Gender 9.6:** Proportion of women who gave birth at a health facility for the last child and their husband accompanied during delivery • **Gender 9.7:** Proportion of women who know any woman or girl who faced violence (rape, beating, etc.) in the past one year • **Gender 9.8:** Proportion of women/girls who faced violence and received a health service in relation to the violence	women in a community are able to make joint decisions with their husband/partner to use family planning services • **Gender 10.04**: Proportion of health posts reporting men coming to health posts accompanying their wives and children for family planning, child health, and other services • **Gender 10.05**: Proportion of health posts reporting having conducted discussion sessions focusing on prevention of violence against women and girls and inform about available health services for victims when health extension workers (HEWs) gather communities and make household visits • **Gender 10.06**: Proportion of health posts providing services such as treatment of minor wounds, emergency contraceptives, and immediate referrals to survivors of sexual violence • **Gender 10.07**: Proportion of health posts providing post-GBV services	male partners accompany their wives when they come for family planning services • **Gender 10.03**: Proportion of health centers reporting that service providers invite/allow male partners during ANC check-ups • **Gender 10.04**: Proportion of health centers reporting male partners (any person a laboring mother wants) allowed to be with her during labor and delivery • **Gender 10.05**: Proportion of health centers reporting there are dedicated/ immediate services available for victims of sexual violence in health facilities • **Gender 10.06**: Proportion of health centers providing post-GBV services • **Gender 10.07**: Proportion of health centers reporting service providers are oriented/trained on *Standard Operating Procedure for The Response and Prevention of Sexual Violence in Ethiopia* • **Gender 10.08**: Proportion of health centers reporting there is a practice of looking at/investigating sex disaggregated data from a gender perspective • **Gender 10.09**: Proportion of health centers reporting having conducted a gender analysis	• **Gender 10.03**: Proportion of hospitals reporting that service providers invite/allow male partners during ANC check-ups • **Gender 10.04**: Proportion of hospitals reporting male partners (any person a laboring mother wants) allowed to be with her during labor and delivery • **Gender 10.05**: Proportion of hospitals reporting there are dedicated/ immediate services available for victims of sexual violence in health facilities • **Gender 10.06**: Proportion of hospitals providing post-GBV services • **Gender 10.07**: Proportion of hospitals reporting service providers are oriented/trained on *Standard Operating Procedure for The Response and Prevention of Sexual Violence in Ethiopia* • **Gender 10.08**: Proportion of hospitals reporting there is a practice of looking at/investigating sex disaggregated data from a gender perspective • **Gender 10.09**: Proportion of hospitals reporting having conducted a gender analysis

The assessment team analyzed and interpreted the data using Excel to produce control charts that corresponded to relevant indicators for each result area in the Activity's performance monitoring plan and gender strategy. A control chart plots an indicator's value on the y-axis and time on the x-axis, and uses specific rules to determine if and when a statistically significant change or "special cause" variation occurs in the indicator's value, or, alternatively, that changes over time in the indicator's value represents "common cause" variation. The assessment team used p-charts, a specific type of control chart that accounts for datasets that include subgroups of unequal size, which was the case in this data set because the number of facilities reporting data each month (subgroup) varied considerably over time.

The assessment team created four control charts for each indicator and calculated the median value for each chart, and the upper and lower control limits, to identify special causes. The assessment team then analyzed the control charts according to special cause rules, which included a single point outside the upper or lower control limits, eight successive points above or below the median, and six or more consecutive points steadily increasing or decreasing.[7] "Special cause variation" indicates statistically significant changes in the performance of a system, which may or may not mean a practically significant change. Using this method, the assessment team identified incidences where performance of the health system increased or decreased over the Activity implementation period.

In the example below (Exhibit 10), the gray line and points represent the indicator values at each data collection event, the solid blue line indicates the mean, and the dotted blue lines represent the upper and lower control limits. In this case, the assessment team identified eight or more points above the mean starting in January 2020, indicating special cause variation. The assessment team then redrew the chart to show this statistically significant change, showing a mean performance of around 79 percent of health centers offering women-friendly services[8] from March 2017 to December 2019 and a mean performance of 95 percent from January 2020 to November 2020.

Exhibit 10: Proportion of health centers offering women-friendly services in Oromia Region



[7] A guide to creating and interpreting run and control charts. https://www.england.nhs.uk/improvement-hub/wp-content/uploads/sites/44/2017/11/A-guide-to-creating-and-interpreting-run-and-control-charts.pdf

[8] Per the health center RFUV checklist criteria, women-friendly services referred to the presence of a coffee ceremony, respecting preferred delivery position, allowing a labor companion, administering labor pain management, allowing fluid intake during labor, and ambulation.

The assessment team also exported participant data from the Activity's district health information software 2 system for interventions detailed in the findings section below and presented the relevant data by sex, region, and year.

DATA ANALYSIS AND INTERPRETATION

On April 28 and 29, 2021 the assessment team triangulated the qualitative and quantitative data during an internal data analysis and interpretation session using Zoom and Miro. Guided by the assessment questions, during the session the team discussed the significance of and interrelationships between the emerging themes and identified data gaps and sources for missing data.

Following the data analysis and interpretation session, the assessment team created emerging findings and drafted an assessment report with background and findings.

DATA CONSULTATION AND PHASE 2 DESIGN MEETING

On June 15, 2021, the assessment team facilitated an online data consultation and Phase 2 design meeting with USAID Transform: Primary Health Care technical area leads. The purpose of the session was to obtain feedback on Phase 1 emerging themes for sub-questions 1 and 2 and input on additional data sources and methodologies to fill gaps and round out the Activity's gender integration "story" for sub-questions 1, 2, and 4 in Phase 2. The assessment team submitted the final Phase 2 design to an internal Institutional Review Board and received approval on August 30, 2021 (IRB no. EC-008-2021).

PHASE 2: DOCUMENT REVIEW, STRUCTURED INTERVIEWS, AND DRAFT REPORT

DOCUMENT REVIEW

In August 2021, after the data consultation and Phase 2 design meeting, the assessment team reviewed an additional 24 documents (see Annex A) to augment and fill gaps in the emerging findings and coded the data using the Phase 1 process.

STRUCTURED INTERVIEWS

After the data consultation and Phase 2 design meeting, the assessment team developed structured key informant interview guides to obtain specific information on interventions, fill gaps in the emerging findings, and capture perceptions of interventions and what Ministry of Health entities at federal, regional, and woreda levels did differently as a result. These tools drew from participatory, appreciative evaluation methods. The interview guides were structured and tailored to the unique information needed from each key informant. However, all key informants were asked about remaining gender gaps (including gender implications of the coronavirus and the crisis in Tigray), sustainability of the Activity's gender transformative interventions; and descriptions of the interventions (e.g., content, participants, application).

The assessment team conducted 24 interviews in September and October 2021. Because of connectivity issues and lower coronavirus infection rates in rural areas, the assessment team conducted interviews

with regional health bureaus and woreda health offices in person. The assessment team conducted interviews with respondents in Addis Ababa over Zoom.

RECRUITMENT AND SAMPLE

Because of the participatory approach and the internal nature of this assessment, most targeted interviewees were already aware of the assessment and their potential role as interviewees. Activity staff participated in both design meetings—Phase 1 and Phase 2—and contributed to the assessment design, sample, and lines of inquiry. The Ministry of Health had been engaging since the procurement process and had worked closely with the data collectors over the previous four years. The assessment team formally reached out to Ministry of Health interview respondents through a recruitment letter and Activity technical staff through a recruitment email. The assessment team used a recruitment script when interviewing woreda health office, regional health bureau, and Federal Ministry of Health staff.

Exhibit 11: USAID Transform Primary Health Care key informants

1. Adolescent and Youth Health Advisor
2. Family Planning Advisor
3. Health System Strengthening Advisor
4. Leadership, Management, and Governance Advisor
5. Maternal and Child Health Advisor
6. Quality Improvement Advisor
7. Regional Gender Officer, Amhara
8. Regional Gender Officer, Oromia,
9. Regional Gender Officer, SNNPR
10. Regional Gender Officer, Tigray (if possible)
11. Reproductive Health Advisor
12. Senior Gender Advisor
13. Senior Monitoring and Evaluation Advisor
14. Social and Behavior Change Communication Advisor
15. Technical Director, Family Planning, Reproductive Health, and Gender
16. Former Technical Director, Family Planning, Reproductive Health, and Gender

The assessment team identified key informants in collaboration with Pathfinder International using a purposeful sample based on who could provide the missing data. Primary respondents were 16 Activity technical advisors (listed in Exhibit 11) who could provide details on how specific interventions were developed or designed to address the gender gaps in the Activity's gender analysis, what interventions had potential for sustainability, and what gender gaps and opportunities remained to be addressed (including implications of the COVID-19 pandemic and the crisis in Tigray). The assessment team identified three Ministry of Health "champions" in each region except Tigray: one from the regional health bureau and one each from woreda health offices in two learning woredas where all USAID Transform: Primary Health Care interventions were implemented. The team also interviewed the Federal Ministry of Health Women, Children, and Youth Affairs Directorate Executive Director with whom the Activity worked closely, for a total of 10 interviews with Ministry of Health representatives.[9] Because of the ongoing crisis in Tigray, the assessment team did not collect data in that region. "Champions" were identified as those who could describe USAID Transform: Primary Health Care's interventions in their region or woreda, what was done differently as a result of the interventions, potential for sustainability, and remaining gender gaps. No interviews were conducted with health facilities or community members.

[9] Because Sidama only recently separated from SNNP region, and the Activity considers SNNP and Sidama one region for other interventions and research efforts at the time of this assessment, the team considered the two regions together. Therefore, the sample included 1 regional health bureau and 2 *woreda* health office champions in its sample to represent SNNP and Sidama regions.

DATA COLLECTION PROCESS

Two U.S.-based assessment team members (one female, one male) conducted interviews with the USAID Transform: Primary Health Care technical advisors, and three of the Activity's four regional gender officers conducted interviews with Ministry of Health "gender champions" in their respective regions (i.e., Amhara, Oromia, and SNNP) and with the Federal Ministry of Health Women, Children and Youth Affairs Directorate Executive Director. Regional gender officers were selected as interviewers because of their existing rapport with respondents and a solid understanding of the Activity's context that enabled them to ask relevant probing questions to obtain missing information. All data collectors completed and submitted a signed conflict of interest statement; participated in a data collection training on data quality control and management, evaluation ethics, and interview techniques; and engaged in an orientation to review these concepts and requirements prior to conducting interviews. The issue of potential bias of USAID Transform: Primary Health Care staff collecting data was covered in the orientation to increase data collectors' self-awareness to avoid asking leading questions and mitigate bias as much as possible.

At the start of each interview, data collectors read a standard informed consent and confidentiality statement in the local language and provided respondents with a copy of the study information sheet and informed consent statement, via e-mail for Zoom interviews and hard copy for face-to-face interviews. Interview respondents were asked for oral consent to participate and permission to audio-record the conversations. No financial incentives or compensation was provided. Data collectors completed 24 of the targeted 26 interviews in September and October 2021. The team was unable to reach the Gender Officer in Tigray (because of the ongoing conflict in the region) nor the former Technical Director (because of scheduling conflicts).

DATA ANALYSIS AND REPORT WRITING

The assessment team coded and analyzed all interview data in Dedoose Version 8.3.21, which were triangulated with the Phase 1 draft findings to augment existing information and fill data gaps.

The assessment team developed this draft report to share at a data consultation meeting December 21, 2021 with more than 38 USAID Transform: Primary Health Care staff. During the data consultation meeting, participants validated the draft findings and conclusions and jointly developed recommendations that responded to the overarching assessment question and sub-questions.

After the data consultation meeting, the assessment team finalized the draft assessment report and submitted it to Pathfinder International in January 2022 for review and feedback. The assessment team will incorporate Pathfinder International's feedback to create a final report and will coordinate with Pathfinder International to plan and deliver a dissemination meeting for USAID, the Ministry of Health, and other external stakeholders.

LIMITATIONS

- Because of the crisis in Tigray, it was impossible to reach individuals via telephone and internet. Therefore, the assessment team was unable to collect primary data from the Tigray region, even remotely.
- In June 2020, the Sidama zone of the SNNP region became its own region. USAID Transform: Primary Health Care has a zonal level cluster office in Sidama, but it was not possible to

disaggregate quantitative data by this new region the Activity's information system (DHIS2) does not differentiate between Sidama and SNNPR as it was established before Sidama's formation.

- EnCompass conducted this gender assessment and is the USAID Transform: Primary Health Care gender partner, so there may be some unintended bias to the data collection and analysis, although steps were taken to mitigate this.
- Due to time and budgetary constraints, this study did not conduct interviews with community members or health facility representatives. The study relied on data and observations from RFUV surveys, project progress reports, external evaluations, and other secondary sources to indicate interventions and potential changes at these levels.
- USAID Transform: Primary Health Care RFUV data used for the quantitative analysis was collected by Activity staff, not an external party. The Activity also conducted random visits to mitigate potential bias from facilities performing above average because they anticipated and prepared for the routine visits. The assessment team plotted values for both the random and RFUV data to determine if there were any statistically significant differences, but there were no significant differences in almost all cases, indicating the reliability of the RFUV data based on the random visit findings. Because of the COVID-19 pandemic, data collection for several RFUV indicators was interrupted or inconsistent from April–December 2020. There may have been significant changes not observed in the analysis because of a lack of data. The COVID-19 pandemic's effect on some indicators is also unclear, as the situation continues to develop. Due to the small number of primary hospitals in each region, results at the primary hospital level were often inconsistent, and it is difficult to determine significant change with a small sample using this methodology.

FINDINGS

The analyzed data—qualitative (primary and secondary) collected in Phases 1 and 2, and quantitative—are presented as findings below. They are organized by the four gender assessment sub-questions (Exhibit 12) and answer the overarching question: In what ways have USAID Transform: Primary Health Care interventions addressed gender gaps and opportunities to achieve its intended results?

Given the small, purposeful sample, respondents referenced in the quotes are referred to as either USAID Transform: Primary Health Care or Ministry of Health interview respondent. The latter is inclusive of regional health bureaus, woreda health offices, and the Federal Ministry of Health Women, Children and Youth Affairs Directorate.

Annex B: Quantitative Findings presents the full findings of the quantitative data.

Exhibit 12: Gender assessment sub-questions

1. What systems and processes did USAID Transform: Primary Health Care establish to enable it to address the gender gaps and opportunities identified in the Activity's gender analysis?
2. What interventions, policies, procedures, and initiatives did USAID Transform: Primary Health Care implement individually or with partners to address gender gaps and opportunities identified in the Activity's gender analysis?
3. What remaining gender gaps and opportunities need to be addressed and what new ones have emerged?
4. What successes have potential for sustainability and what is needed to sustain them?

SUB-QUESTION 1: WHAT SYSTEMS AND PROCESSES DID USAID TRANSFORM: PRIMARY HEALTH CARE ESTABLISH TO ENABLE IT TO ADDRESS THE GENDER GAPS AND OPPORTUNITIES IDENTIFIED IN THE ACTIVITY'S GENDER ANALYSIS?

FINDING 1: To integrate gender across the Activity, USAID Transform: Primary Health Care established a gender architecture and developed and annually reviewed a gender strategy to collaborate on, learn from, and support the adaptation or development of new interventions to respond to emerging gender gaps and opportunities across technical teams and result areas.

The documents reviewed illustrate the Activity's commitment to gender integration from conception to lead and support gender integration across result areas. This included hiring a full-time Senior Gender Advisor based in Addis Ababa and four gender officers in each of the Activity's four regional offices; conducting a gender integration training for all technical staff; developing a gender strategy; and holding annual gender strategy review meetings (USAID 2018g, Nd-b, 2018b, 2020b, 2018d). The Activity used the Interagency Gender Working Group Gender Integration Continuum[10] as a guiding framework for integrating gender and advocating for and building capacity of technical teams to implement norms change and transformative approaches (United States Agency for International Development Nd-b). For

[10] Programmatic Guidance: IGWG. https://www.igwg.org/training/programmatic-guidance/

instance, in Year 2, the Activity conducted a gender integration training for all technical staff (which included the Gender Integration Continuum) to ensure that all technical teams were able to develop and implement "gender-aware (and ideally gender-transformative) interventions."[11] The Activity's "gender team"[12] trained and strengthened technical leads' capacity to identify gender needs and opportunities and adapt their interventions to be gender-responsive (USAID Nd-b, 2017a, 2018g).

Documents reviewed indicated that in 2018 the Activity used the gender analysis findings to develop a gender strategy that provided guidance for evidenced-based, gender-transformative interventions to address existing gender gaps and opportunities identified by the 2018 Activity gender analysis across its four result areas. The gender strategy articulated a shared vision for gender transformation in the Activity's interventions (see Exhibit 13) (USAID 2020b, 2017b). Developed jointly with technical teams, the gender strategy identified interventions for each result area to address gender gaps, listed resources to support implementation of the interventions, and provided indicators for measuring progress on closing the gender analysis gender gaps and leveraging opportunities. The Activity monitored gender strategy implementation and evaluated progress through relevant performance management plan indicators and through the gender strategy intervention-specific indicators linked to the monitoring and evaluation platform, and collected indicator data by cluster-level staff through standard RFUVs (USAID 2020b).

Exhibit 13: USAID Transform: Primary Health Care Gender Strategy Vision

> By 2021, USAID Transform: Primary Health Care achieved gender and health transformational agendas through responsiveness to gender-based violence (GBV), and gender and health needs, with a focus on reproductive, maternal, newborn, child, and adolescent health and nutrition.

According to documents reviewed, USAID Transform: Primary Health Care used the gender strategy to promote women's leadership in the health system; create gender-responsive work environments; and enhance institutional capacity to conduct gender analyses for better health outcomes (USAID 2020b, 2021b). The Activity also used the gender strategy to guide collaboration with thematic technical leaders and Federal Ministry of Health structures to respond to gender gaps and leverage opportunities in health care management and quality service delivery (USAID Nd-b). USAID Transform: Primary Health Care interview respondents spoke spontaneously about how the Activity's "gender team" supported the technical teams.

> *"You know we have started working with [the Senior Gender Advisor] and her team since the start, you know, starting from the gender analysis findings…since that meeting we were working with [her], we were working with the gender team."* —USAID Transform: Primary Health Care interview respondent

Documents reviewed and USAID Transform: Primary Health Care interview respondents described how the Activity held annual strategy review meetings during theory of change and work planning processes in 2019 and 2020. Technical leads, regional gender officers, regional technical coordinators, the monitoring and evaluation advisor, senior technical advisors, and thematic area leads participated to collaborate on, learn from, and adapt interventions or develop new ones to respond to emerging gender needs, gaps, and opportunities. During these review meetings, staff reflected on gender integration

[11] The Activity drew these terms from the USAID Interagency Gender Working Group Gender Integration Continuum: https://www.igwg.org/wp-content/uploads/2017/05/Gender-Continuum-PowerPoint_final.pdf
[12] The Activity referred to the "gender team" as the Addis Ababa-based Senior Gender Advisor, four regional gender officers, and a U.S.-based team of experts that supported the in-country team.

successes, reviewed achievements against performance management plan indicators, mapped progress toward the gender strategy objectives, refined interventions and indicators for the following year, and determined priority interventions for the coming year to build on successes to achieve greater gender and health transformation across interventions. Result area teams identified priorities for modifying or expanding current interventions or creating and implementing new ones for the following year (USAID 2020b, Nd-b).

> *"Transform [sic] used the gender strategy to inform interventions such as the male engagement work, fostering of female leadership in the health sector, the GBV prevention and management work, etc. The strategy was presented to staff, donor, and partners at different venues and was informing the planning process for Transform [sic]."* – USAID Transform: Primary Health Care interview respondent

> *"Feeding into the annual theory of change .... Revising major assumptions and activities [sic] to align with the finding and recommendation of the strategy, and accordingly the intervention was either changed or proposed corresponding to the finding. For example, the comprehensive GBV response was designed following the finding that indicated limited knowledge and attitudes to GBV response"* – USAID Transform: Primary Health Care interview respondent

Documents reviewed showed that at the end of Activity Year 4, because of the COVID-19 pandemic, in lieu of a gender strategy review session, the Activity administered an online survey to gather feedback from the technical leads on the use of the gender strategy, successful gender integration interventions in their technical area, and what enabled their teams to implement the strategy successfully. The top three survey responses to the question, "what enabled the Activity to be successful," were: previous knowledge of gender integration, integrating gender in Activity Year 4 work planning, and support from government stakeholders. Training in gender integration also received many responses (USAID 2020b, Nd-b).

FINDING 2: USAID Transform: Primary Health Care used monitoring and follow-up data to identify gender gaps, and adjusted interventions accordingly.

USAID Transform: Primary Health Care interview respondents said they used random and routine follow-up visits with monitoring/supervision checklists—which included "gender questions" (i.e., a set of gender-related indicators)—to monitor implementation at community, health post, health center, and hospital levels. Activity staff were able to access the data through the internal district health information software 2 to track performance. However, several interview respondents mentioned that they got updates through quarterly reports and internal quarterly review meetings rather than through the software. Examples of how the Activity used these data included adjusting the gender balance of trainees for future workshops based on maternal and child health training attendance data; developing a new LMG training for women only based on LMG training follow-up data that showed a very low number of female participants (see Finding 7); strengthening health providers capacity in clinical GBV services based on monitoring data that identified gaps in GBV response services (see Finding 6); and adding on-site gender analysis mentoring and action planning in response to RFUV data that showed low performance of facilities conducting gender analyses (see Finding 4).

> *"In 2019, there was a big gap in terms of the gender analysis at the woreda and health center was not going as planned. This was identified by the MEL [monitoring, evaluation, and learning] team and we were able to adjust our approach so that there would be more of a focus on gender analysis by strengthening our follow-up visits and technical support."* – USAID Transform: Primary Health Care interview respondent

> *"We have gender-related indicators. People can access these indicators and see where there is low performance."* – USAID Transform: Primary Health Care interview respondent

Annex B presents a summary of gender-related RFUV data for each region.

SUB-QUESTION 2: WHAT INTERVENTIONS, POLICIES, PROCEDURES, AND INITIATIVES DID USAID TRANSFORM: PRIMARY HEALTH CARE IMPLEMENT INDIVIDUALLY OR WITH PARTNERS TO ADDRESS GENDER GAPS AND OPPORTUNITIES IDENTIFIED IN THE ACTIVITY'S GENDER ANALYSIS?

FINDING 3: USAID Transform: Primary Health Care provided technical and financial support to the Federal Ministry of Health Women, Children and Youth Affairs Directorate and its regional structures to address gender gaps in the health sector and increase GBV prevention and response.

Documents reviewed show that USAID Transform: Primary Health Care's technical and financial support ranged from strategic planning to organizational strengthening to gender mainstreaming. This support included compiling findings from a women in health care leadership analysis, preparing a five-year strategic plan results framework, designing annual review and planning meetings and a gender audit, and developing the maternal and women's health section of the *Ethiopian Primary Health Care Clinical Guideline* (USAID 2020e) (USAID 2020f).

According to quarterly and annual reports and USAID Transform Primary Health Care interview respondents, the Activity provided critical and substantive technical and financial support to the Women, Children and Youth Affairs Directorate and its regional structures from 2018 to 2020 as a member of the Federal Ministry of Health gender and health technical working group (USAID 2020e). The USAID Transform: Primary Health Care Senior Gender Advisor was also a member of the gender and health technical working group core team that helped develop the Directorate's *Strategic Plan for Action on Health Response to Gender Based Violence/Sexual Violence 2020/21–2025/26* and in 2020 was awarded a certificate of appreciation by the Directorate (Ethiopia Ministry of Health Women Children and Youth Directorate 2020), (USAID 2020e).

> *"So the gender team, the project [sic] gender team highly closely working with the Ministry Gender Department [sic], and they are doing a fine job in addressing these gender issues at various levels, even at regional level there be a smooth relationship."* —Transform Primary Health Care interview respondent

> *"We are working with [USAID: Transform Primary Health Care] not as a partner, but as one of the government structures; so, I appreciate it well."* – Ministry of Health interview respondent

Documents reviewed showed that in 2018, the Activity conducted a GBV landscape analysis for the Activity and the Ministry of Health to understand the health system's existing GBV services, assess what

GBV prevention and response services were available and their existing scope, and ascertain the current GBV referral pathways within and outside the primary health care continuum (USAID 2019a, 2019b, 2019c, Nd-a, 2019d, 2019e, 2021b). According to documents reviewed, the GBV landscape analysis was the first of its kind in Ethiopia (USAID Nd-b, 2021b; Ghelani Nd; USAID 2019a, 2019b, 2019c, Nd-a, 2019d, 2019e). The Federal Ministry of Health used the findings to introduce management of GBV survivors to the health system, inform the national GBV strategic action plan (2020–2025), and revise its gender mainstreaming manual and community engagement guide (USAID 2020e, 2020f).

The document review and Ministry of Health and USAID Transform: Primary Health Care interview respondents described how the Activity also provided financial and technical support to the Ministry of Health to establish day care centers at regional health bureaus. As part of its efforts to empower women and bring them into leadership positions, the Ministry sought to establish day care centers in regional health bureaus to create a conducive work environment for female staff returning from maternity leave by creating more stability at their workplaces and enabling them to breastfeed their infants exclusively for the first six months (USAID 2020e, 2019f). Ministry of Health interview respondents said that the Directorate facilitated the purchase of items for the day care centers, and the Ministry conducted an assessment to understand "the desirability of the service" and learned that many women wanted day care centers. Ministry of Health interview respondents said that USAID Transform: Primary Health Care provided financial (sub-grant) and technical support. The Ministry used grant funds to procure supplies for the day care center based on the Ministry of Health's standard.

However, Ministry of Health respondents said that despite being able to purchase materials, where the regional health bureau had a room shortage, the Ministry had not built day care center rooms as promised because of a shifting budget to respond to the current national political instability and COVID-19. So, at the time of the interviews, the purchased materials were in storage and renovations were on hold. Additionally, in regions where the day care centers were established, women were not willing to bring their infants because of COVID-19.

> *"Besides, related to day care particularly, it curbs problems related to breastfeeding. It also minimizes the pressure on working mothers and improves their performance. So, the day care has a big contribution to ensure the right of the mother as well as the child."* – Ministry of Health interview respondent

> *"…the establishment of the day care center is one of the greatest success [sic] at regional level. It has been our long ambition to establish the center, and finally we become successful through the support we got from [USAID Transform: Primary Health Care]."* – Ministry of Health interview respondent

> *"There has been a proclamation to create [day care centers], but there are challenges to do this at a regional level. We have only established one at the regional level, but this needs to be expanded. There needs to be available services for breastfeeding, [and] for other forms of day care. Otherwise, mothers will drop out of the health workforce because they cannot come to the offices. The care of babies and work performance of mothers would both suffer without this day care service support."* – USAID Transform: Primary Health Care interview respondent

The documents reviewed and Ministry of Health interview respondents listed other ways in which the Activity supported the Directorate's GBV prevention and response efforts from 2017 through 2020, such as developing the *Workplace Harassment Prevention and Response Manual*, distributing GBV-related job aids and data capturing tools, developing GBV prevention and response manuals, strengthening

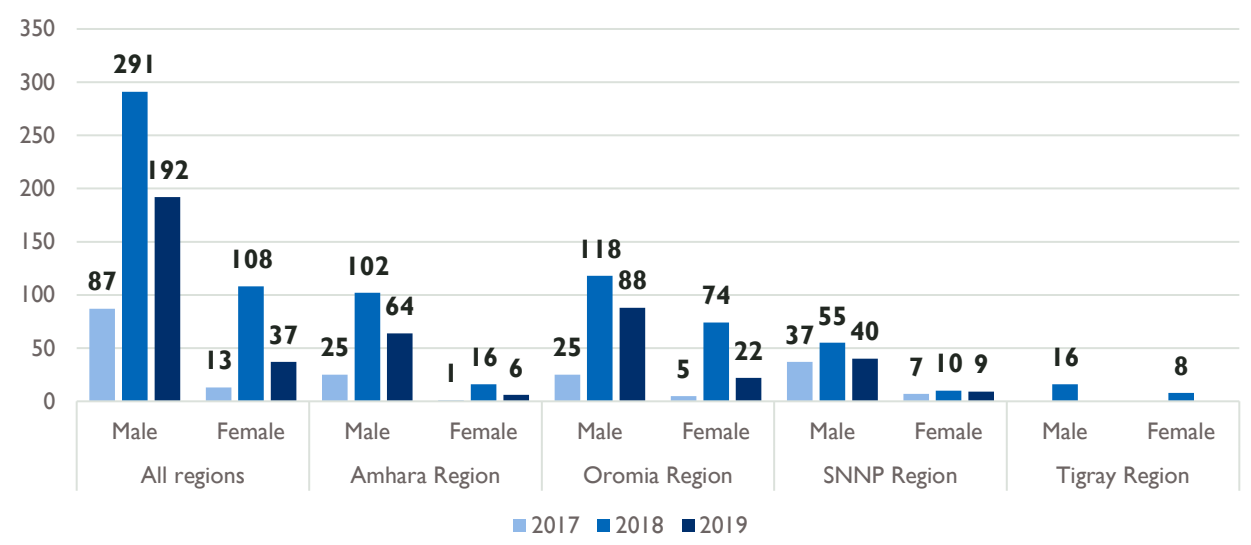
availability of primary health care GBV services and trained professionals, and developing and costing a five-year health sector GBV prevention and response action plan (USAID 2020e, 2020f).

FINDING 4: USAID Transform: Primary Health Care augmented the Ministry of Health gender and health mainstreaming training with on-site mentoring to enable staff to conduct gender analyses and develop action plans to address gender gaps.

According Ministry of Health and USAID Transform: Primary Health Care interview respondents, prior to USAID Transform: Primary Health Care, the Ministry of Health had developed a generic (i.e., for all health workers) *Gender and Health Mainstreaming Manual and Training Manual* and a cascade approach for a standard, five-day basic training on gender gaps and gender analysis.

Documents reviewed and Ministry of Health and USAID Transform: Primary Health Care interview respondents stated that the training covered basic gender concepts such as: gender and sex, gender roles, gender mainstreaming, gender analysis, gender budgeting, gender audit, and national and international policies and conventions.[13] The Activity used the Ministry's manual to train 628 (483 male, 145 female) health center directors, case team leaders, woreda gender officers/focal persons, and reproductive, maternal, newborn, and child health (RMNCH) officers (see Exhibit 14). At the end of the training, participants developed a plan (with targets, responsible persons, and budget) to conduct a gender analysis using the World Health Organization gender analysis matrix[14] adapted to the local context (USAID 2018g, 2017c, 2018c, 2018b, 2019f).

Exhibit 14: Gender and health training participants by sex: 2017–2019



However, Transform: Primary Health Care interview respondents and the document review reported that the Activity's RFUV data showed that most trainees did not implement their action plans and

[13] A Ministry of Health interview respondent remarked that the *Gender and Health Mainstreaming Manual* was currently being revised by the Ministry of Health (with support from USAID Transform: Primary Health Care) to add missing topics, such as responding to GBV.

[14] The WHO Gender Analysis Matrix (GAM): https://www.who.int/gender/mainstreaming/GMH_Participant_GenderAnalysisMatrix.pdf

conduct gender analyses in their respective facilities and woreda health offices after the training because of limited structural capacity, accountability, resources, time, and buy-in for gender analysis or gender integration. In response, in Year 4, the Activity pivoted resources to the woreda health offices to provide more focused support for on-site gender analysis mentorship and action planning to help staff who completed the training conduct a simple gender analysis and apply the findings to woreda-based planning (USAID 2018g, 2017c, 2018c, 2018b, 2019f). The document review and Ministry of Health interview respondents indicated that following the gender analyses, some facilities assigned a gender focal person to coordinate gender interventions and certain woredas began including gender indicators in their annual plans (USAID 2020b, 2020a).

Ministry of Health respondents spoke highly of the gender analysis training and mentoring, which enabled them to start integrating gender in their plans for the first time. They said that the gender analysis helped them understand different gender-based problems and needs (e.g., who is benefiting from their services and who is not) and develop an activity plan that was shared with different departments and monitored quarterly. These interview respondents said that the gender analyses explored women's leadership, empowerment, health service utilization, planning, and budgeting to improve gender equality and service utilization. Some examples of gender analysis findings and subsequent action items from WorHO annual plans are found in Exhibit 15 below (USAID 2020a, 2020e):

Exhibit 15: Woreda-level gender analysis findings and action planning

GENDER ANALYSIS FINDINGS	ACTIONS INTEGRATED IN THE WOREDA-BASED PLAN
Limited women in health care leadership and management	Commitments to make 50 percent of management positions held by women and bring qualified women to health center manager positions
Gaps in implementing affirmative action in employment, promotion, and access to educational opportunities	Review Federal Ministry of Health guidance and follow-up on affirmative action implementation
Limited number of service providers providing gender-responsive health services	Prepare list of trained persons and trainers pool at woreda level and organize training workshops
Charging fees to GBV survivors for health services	Ensure GBV services are delivered free of charge during integrated supportive supervision visits
Weak multi-sector collaboration platforms	Establish and/or revitalize existing platforms and take deliberate action to make gender needs standout

Some Ministry of Health respondents said they used the gender analysis findings to support female staff to take leadership positions in health centers and facilities.

> *"…gender analysis training was one of the major capacity building activities that we got from [USAID Transform: Primary Health Care]. The training enabled us to see every activity from a gender point of view and address equity of health service, both for males and females. For example, during gender analysis, we found that a husband with two wives, one CBHI card was only provided as one family while one of the wives couldn't access the card whenever she wants. Taking this into account … we allowed a separate card for the two wives so that they can use it whenever they want to get a health service."* – Ministry of Health interview respondent

> *"We have never done [gender analysis] before, except the one which we did in [USAID Transform: Primary Health Care's] presence … The actual incorporation of gender specific activities in the woreda-based plan is a change, which came in connection with the gender analysis. It is after the conduction of*

> woreda-*level gender analysis that we started to incorporate gender activities in the woreda base plan…"* – Ministry of Health interview respondent

These respondents also said the gender analysis mentoring sessions enabled them to identify gender gaps at different health facility levels, which they included in their annual work plans. They said that the gender analysis mentorship was "very relevant" and that every six months, before preparing the annual work plan, woredas conducted gender analyses using a checklist.

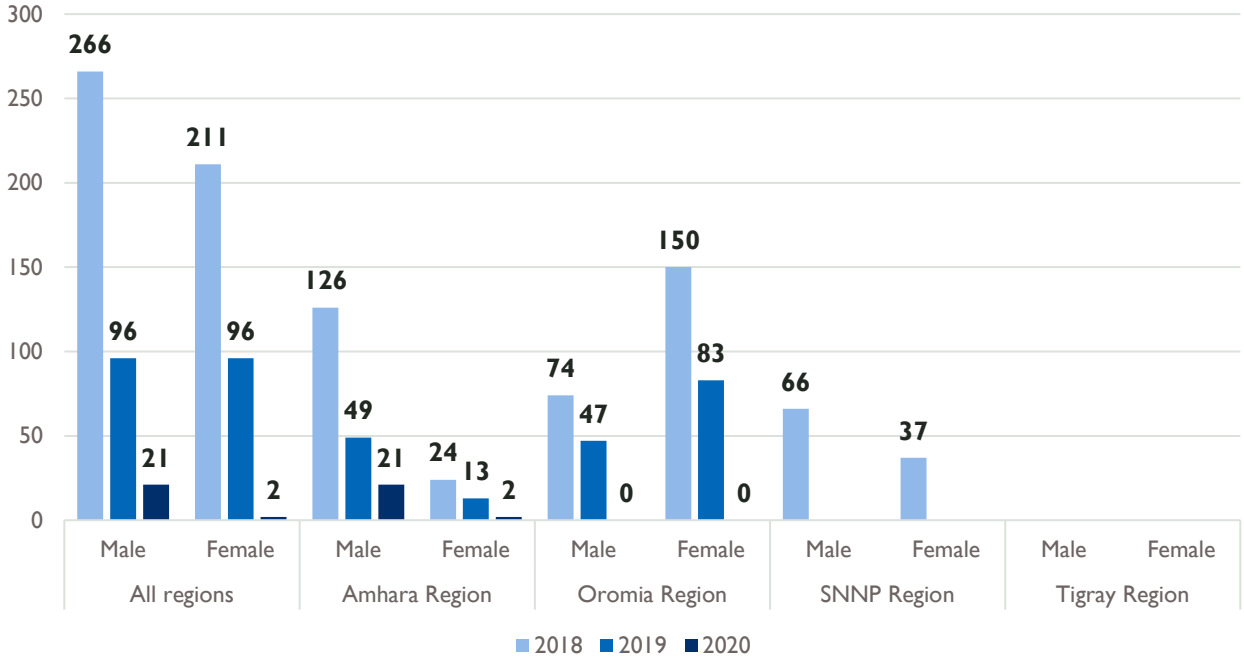
FINDING 5: USAID Transform: Primary Health Care supported the Ministry of Health to disseminate and operationalize its *Standard Operating Procedure for The Response and Prevention of Sexual Violence in Ethiopia* and strengthen a multi-sector response for GBV survivors.

The 2017/2018 USAID Transform: Primary Health Care gender analysis showed that while Ethiopia had laws and policies to prevent and respond to GBV, there was poor implementation and enforcement. For instance, GBV services, especially for sexual violence survivors, were extremely limited or overwhelmed by the number of cases and limited capacity and staff, especially for men and boys in rural areas (USAID 2018d).

According to the document review and Ministry of Health interview respondents, in Activity Year 1, the Activity participated in the SNNP regional health bureau and Federal Ministry of Health Women, Children and Youth Affairs Directorate regional launch of the Standard Operating Procedure for The Response and Prevention of Sexual Violence in Ethiopia manual (Standard Operating Procedure). The Activity helped disseminate the manual, which standardized national preventive, protective, and service amenities for preventing and eliminating of all forms of sexual violence, and described multi-sectoral mechanisms to support women and children (USAID 2017c). Ministry of Health interview respondents said the manual included what GBV is and its definition, who the perpetrators are, how to prevent GBV, multi-sectoral collaboration, and who should do what—task and responsibility—in each sector (e.g., health, justice, women and children affairs, education).

In Activity Years 2, 3, and 4, RFUV data and Ministry of Health interview respondents indicated that the Activity provided per diem and other support to the Federal Ministry of Health to roll out the *Standard Operating Procedure*. According to the document review and Activity monitoring data, from 2018 to 2020, in collaboration with regional health bureaus and zonal health offices, the Activity provided three-day orientation sessions to 692 (383 male, 309 female) woreda and zonal health office representatives from primary hospitals, labor and social affairs, justice, police, religious organizations (Orthodox, Muslim, and Protestant), social security, and women and children affairs offices in three regions (see Exhibit 16) (USAID 2020c, 2020d). The orientation covered GBV prevention and response roles and mandates, standard referral formats and procedures, and available services for sexual violence survivors. At the end of the orientation, participants developed action plans to standardize existing efforts in their respective woredas (USAID 2018c, 2018g, 2018e).

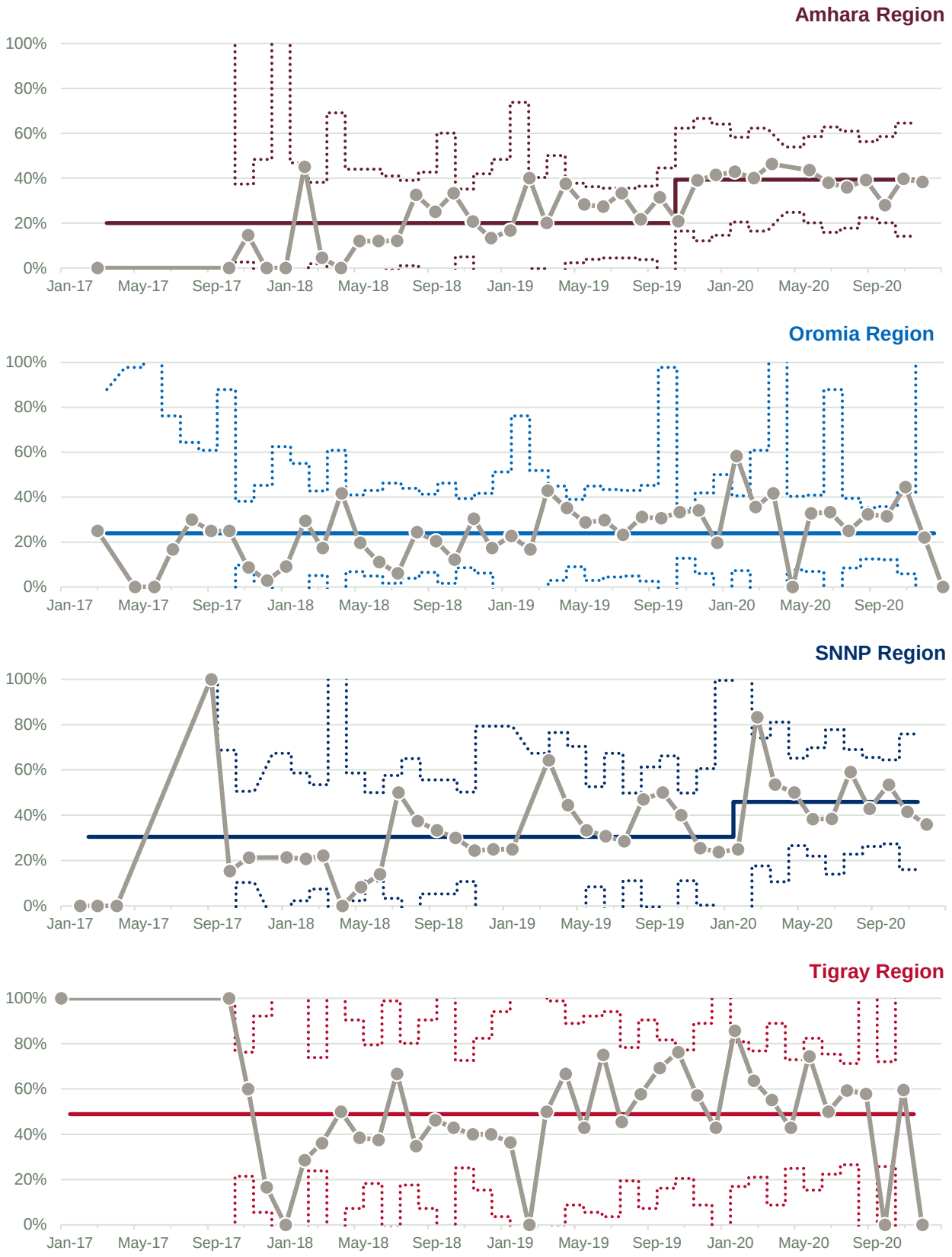
Exhibit 16: Total *Standard Operating Procedure* orientation participants from 2018–2020



According to an Activity quarterly report and Ministry of Health interview respondents, the orientation focused on each sector's roles and responsibilities to improve coordination based on standard referral formats and to address existing communication gaps in GBV prevention and referral paths for GBV survivors (USAID 2018g), as well as how to work collaboratively on GBV prevention and response, create a common understanding of service provision principles, and provide services to GBV survivors and maintain confidentiality. A Ministry of Health interview respondent mentioned that, after the orientation in one region, the sectors agreed to establish one-stop centers in three different places to provide all services a GBV survivor needs in one place, and this region planned to scale up the centers to other locations.

Analysis of RFUV data (Illustrated in Exhibit 17) showed a statistically significant increase in November 2019 in the percentage of health centers with service providers trained on the *Standard Operating Procedure* in Amhara and SNNP regions September 2018 and February 2020 (Annex B). Oromia and Tigray regions showed no statistically significant changes, but there appeared to be an upward trend across the years in both regions before a decline in 2020. At the primary hospital level, there was a statistically significant increase from 21 percent to 45 percent in Amhara region around February 2020 in the percentage of hospitals with service providers trained on the *Standard Operating Procedure*. Similarly, there was a positive, statistically significant increase around February 2020 in Tigray region. However, in Oromia and SNNP regions, results fluctuated over the years with an average of 45 percent and 60 percent, respectively, of facilities with trained providers. See Finding 3 in Annex B for additional analysis and findings.

Exhibit 17: Percentage of health centers reporting service providers are oriented/trained on the *Standard Operating Procedure*



Ministry of Health interview respondents remarked that the *Standard Operating Procedure* orientations were critical and cascaded to different stakeholders. According to these respondents, these orientations improved health workers' reporting on GBV survivors (children and women), and the health, police, women, children and youth affairs, and justice sectors worked more closely in a one-stop center, which improved referral and follow-up for GBV cases. According to an Activity annual report, orientation participants demonstrated a 63 percent increase in knowledge of their roles and responsibilities and developed referral pathways for GBV survivors, which resulted in 86 health facilities with improved GBV clinical and referral services (USAID 2019f).

> *"The Standard Operating Procedure orientation is crucial to work with different sectors. It clearly states every one's mandate on how to strength linkage with other sectors and documentation at health facility level. The most appreciated part on the Standard Operating Procedure is how to keep medico-legal documentation and referral linkage with other sectors/concerned bodies."* – Ministry of Health interview respondent

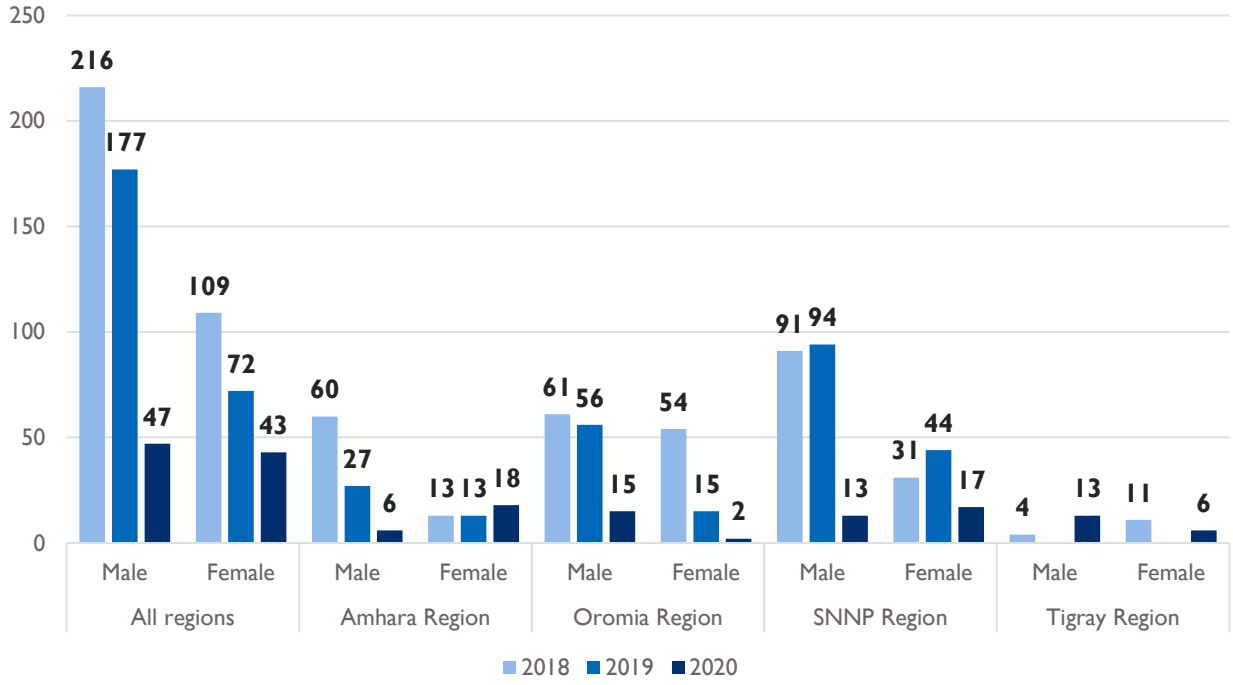
> *"Well, the orientation helped us to understand what standards are expected to be met by different stakeholders that [sic] are involved in gender-based violence prevention. Clients with gender-based violence are receiving priority in our health facilities. The health facilities provide a medical certificate when they are asked by police or justice office. The coordination among the different stakeholders is not adequate and we meet once in a quarter during council meeting and reports will be shared."* – Ministry of Health interview respondent

In addition to the orientation sessions, Ministry of Health interview respondents said that USAID Transform: Primary Health Care helped translate the *Standard Operating Procedure* into other languages to make it accessible.

FINDING 6: USAID Transform: Primary Health Care built health service providers' capacity in GBV clinical response services and referrals, especially for sexual violence survivors.

The document review and Ministry of Health and USAID Transform: Primary Health Care interview respondents mentioned that the Activity trained health service providers in Amhara, SNNP, and Oromia regions on clinical standards for managing sexual violence survivors. The training—held in Activity Years 2, 3, and 4 with male and female service providers—covered how to complete patient charts, take medical histories, conduct post-GBV exams, prescribe medications, and improve clinical, counseling and psychosocial support skills to manage and refer GBV cases (USAID 2018f, USAID 2019f). Activity participant data (Exhibit 18) shows that the Activity trained 664 individuals (440 male, 224 female) in all regions from 2018 to 2020.

Exhibit 18: Total individuals trained in health response to sexual violence survivors by sex 2018–2020



The document review showed that the Activity also facilitated a training of trainers for 15 medical doctors and emergency officers from primary hospitals and university training centers in Oromia region on clinical skills, management, and referral (e.g., psycho-social and legal services) for survivors of sexual violence. This effort aimed to start up and strengthen existing regional health board efforts to increase the number of one-stop centers and their ability to provide services to GBV survivors. Participants developed action plans to identify the remaining gaps in service provision and roll out the training to other service providers (USAID 2018c, 2018e).

The document review also indicated that the Activity trained service providers from 15 health centers and two primary hospitals in the SNNP region on GBV prevention and response for internally displaced persons in recognition of women's and girls' increased vulnerability to GBV during crisis. After the training, participants improved their clinical services and referrals for sexual and physical violence survivors (USAID 2019f). This was corroborated by Ministry of Health interview respondents.

> *"USAID Transform: Primary Health Care provided intensive training on health response to survivors of GBV/ [sexual violence] for health workers ... This was great work and there were changes brought after the provision of the training. At least rape, sexual assault, and the like, cases were not given focus, identified, and given appropriate treatment service by health centers. From the trained persons, there are resigned ones due to different reasons, and some are still working in the health centers, but I remember a time when at least an opportunity was created for the health workers … to have know-how on identifying the GBV cases and be capable of providing health care and services."* – Ministry of Health interview respondent

Following these events, facilities designed quality improvement interventions and standardized staff skills, and encouraged ownership using wall charts, data tacking sheets, and woreda transformation tracking tools to measure progress (USAID 2020a).

The Activity gender strategy stated that USAID Transform: Primary Health Care built on the GBV response training for health service providers by hosting workshops for government officials from various sectors involved in GBV response to improve multi-sectoral collaboration for better provision of comprehensive, timely GBV response services, including effective referrals. According to the Activity gender strategy, these workshops facilitated a common understanding of each sector's roles in GBV response and referrals, provided time for participants to outline specific roles and responsibilities of each sector, and developed a common understanding and improved communication to better manage GBV response services among different actors (USAID 2020b).

FINDING 7: USAID Transform: Primary Health Care developed a woman-centered, woman-focused LMG training and coaching intervention to fill the gender gap in LMG participation.

The 2017/2018 USAID Transform: Primary Health Care gender analysis found a general absence of female health workers in leadership positions, and that female health workers encountered challenges to advancement, leadership, and retention (USAID 2019g, Nd-b). For instance, a USAID Transform: Primary Health Care interview respondent for this assessment said that less than 2 percent of health care facilities were led by a woman.

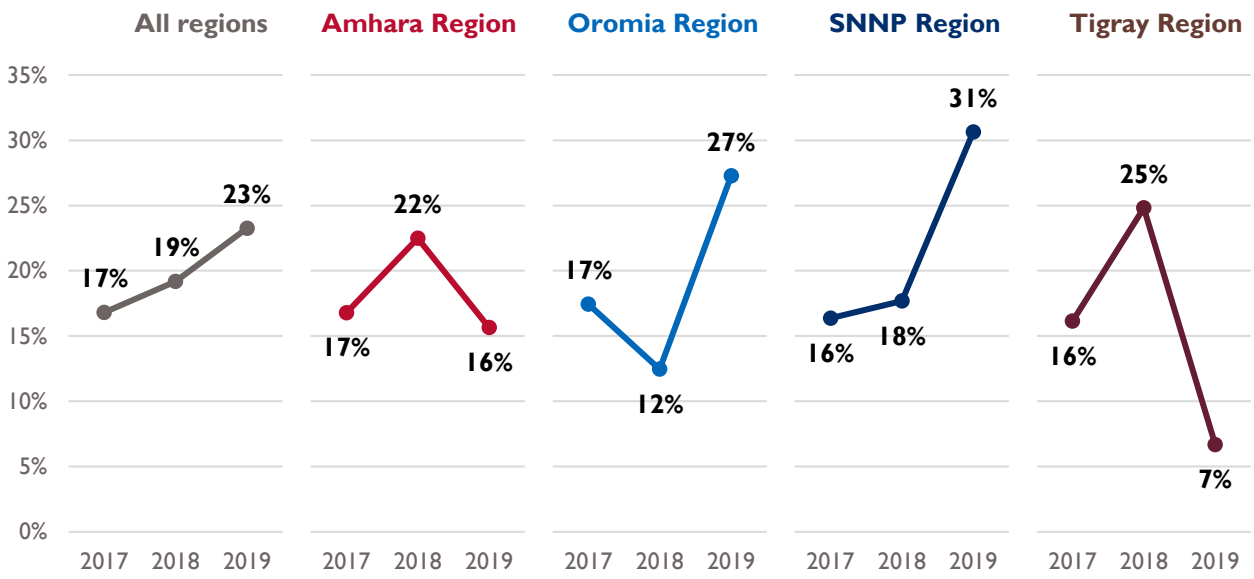
To address this gap, USAID Transform: Primary Health Care interview respondents stated that the Activity initially implemented a mixed-sex LMG training program for health workers that aimed to reach at least 50:50 (male:female) participation. However, despite calls, invitation letters, and advocacy that clearly stated that a least 50 percent of participants should be women, after two years, very few participants were female.

In response, according to USAID Transform: Primary Health Care interview respondents and documents reviewed, in 2019 the Activity randomly collected data from intervention sites on how many women were leading woreda health offices and how many women were heads of primary health care units to identify ways to understand the gender gap and engage more women in LMG training. The Activity found that none of the woreda health offices in Oromia and Tigray regions were led by women. In response, the Activity developed a new woman-centered, woman-focused LMG training that was followed by face-to-face coaching sessions (via phone after COVID-19 arrived) (USAID 2019g, 2017b).

USAID Transform: Primary Health Care interview respondents said that they conducted three training sessions; one each in Amhara, Oromia, and SNNP regions (budget limitations precluded a Tigray training) culminating in a total of 78 female health workers trained. After the training, the Activity provided close coaching and follow-up so the participants could attain leadership positions (USAID 2019g).

USAID Transform: Primary Health Care's participant data show that the percentage of women trained in LMG increased slightly over time. In 2017, all regions reported that 16–17 percent of LMG training participants were female, while the average percentage of female participants across all regions rose to 23 percent in 2019. However, there were discrepancies between regions. Only in SNNP region did the average percentage of women increase each year, rising to the highest percentage of women trained in LMG among all the regions, at 31 percent of participants. Percentages of female LMG participants fell over time in Amhara and Tigray, dropping to 16 and 7 percent, respectively, as illustrated in Exhibit 19. Despite the Activity's efforts and the introduction of the women-only cohort in Amhara, female participants in LMG training remained low.

Exhibit 19: Percentage of female LMG participants 2017–2019



However, USAID Transform: Primary Health Care and Ministry of Health interview respondents and documents reviewed reported that of the 78 participants in the women-only LMG cohort, 18 (23 percent) were promoted to leadership positions such as zonal health department vice head, woreda team leader, deputy woreda health office head, and primary health care unit director and vice director. Female health workers were also added to the health center management board. Those not promoted continued to work on their leadership projects to strengthen and improve their problem solving, work climate, leadership, and resource mobilization skills (USAID 2020e).

> *"Also using the grant fund, we have organized joint LMG training and training of trainers training. This is believed to have played a positive role in bringing women to leadership positions, and in empowering them."* – Ministry of Health interview respondent

> *"After the training, we developed an action plan, and now in almost all health centers, there is at least one woman at the management level, and there are some female health center directors, which there were not before." – USAID Transform: Primary Health Care interview respondent*

The document review and USAID Transform: Primary Health Care and Ministry of Health interview respondents remarked that the Activity also advocated to regional health bureaus to place these female graduates in leadership and management positions, and targeted federal, regional, and zonal health system leaders to advocate for more women in leadership positions, appropriate implementation of affirmative action policies, and work environments conducive for female health workers to excel in their jobs. Due to this advocacy, for example, Oromia regional health bureau management decided that all zone and woreda health office deputy head positions should be filled by competent female leaders (USAID 2020e, 2019g).

> *"We provided leadership, management, and governance training for women to improve their capacity in these areas. Additionally, advocacy is done at the woreda, zone, and regional level so women can acquire more leadership positions."* – USAID Transform: Primary Health Care interview respondent

> *"The other big success was that in providing the training…we saw at first that most of the leadership of the centers were males. After the training, we developed an action plan, and now in almost all health centers there is at least one woman at the management level, and there are some female health center directors, which there were not before."* – USAID Transform: Primary Health Care interview respondent

One component of the LMG interventions spontaneously mentioned by several USAID Transform: Primary Health Care and Ministry of Health respondents was the focus on increasing the number of women on health center governance boards. These respondents said that RFUV data consistently showed that women were not part of the health center governing board even though health center memorandums of understanding stipulated that at least one board representative must be a woman. In response, Activity staff consistently reminded facility managers of this through visits, advocacy, technical support, and grants. Over time, respondents said the number of women participating on health center governing boards improved.

> *"So, we try to integrate the importance of gender in the health center or primary health care unit governing boards, and we try to provide technical support for the Ministry [of Health], the regional health bureaus, and primary care units. So, they ensure at least minimum of two women members or health care providers should be the part of the governing boards for each primary health care unit."* – USAID Transform: Primary Health Care interview respondent

> *"We even mobilized budget to empower women [sic] board members by developing a sub-grant proposal and accomplished an activity related to empowerment of women in general and female board members in particular. This could not be done without USAID Transform: Primary Health Care's support and appropriate guidance. This is what we can mention it as one success, which was not known before but can sustain. There is a condition where we have put what we have to do in a plan."* – Ministry of Health interview respondent

Analysis of RFUV data found generally positive results in women's participation in kebele health steering committees, health center boards, and hospital boards. Statistically significant changes were small overall, but in most cases, the overall average of facilities reporting women on the board were high, in excess of 87 percent, with hospitals in SNNP and Tigray regions consistently reporting 100 percent of facilities with female board representatives in the latter half of the Activity. For the full analysis, see Annex B Finding 4.

An Activity work plan stated that in 2020, the Activity's women's leadership program was scaled by the Federal Ministry of Health, regional health bureaus, the International Institute of Primary Health Care, and the Ethiopia Health Workforce Improvement Program (USAID 2020f). USAID Transform: Primary Health Care interview respondents said that the LMG program was incorporated into the Ministry of Health Leadership Program. They also said that the Health Sector Transformation Plan II (2020/21–2024/25) includes a target stating that 50 percent of health leadership positions should be occupied by women, which requires confident, talented, and competent female health leaders. However, USAID Transform: Primary Health Care and Ministry of Health interview respondents did not think the woman-only LMG program would continue after the Activity ended. They said that this training should get more support and the government should own that kind of program.

> *"This [women's leadership] remains an important area so that women are represented at different levels of leadership. Although there are commitments from the government around women's leadership, there is more need for behavioral change at the woreda and committee level. A clear strategy and*

accountability is [sic] still needed to ensure that women are integrated into leadership roles." – USAID Transform: Primary Health Care interview respondent

The undertakings will continue. But the support that Transform: Primary Health Care provides would cease. For instance, Transform[sic] align their programs with our plan in areas of capacity building, expansion works, gap analysis through gender analysis, and leadership, management, and governance…Covering all these with budget from the government would not be easy. There is wide array of issues to be taken up, for instance, gender issues in relation to people at old age, children, and people with disability. So, without the support of Transform [sic], it will inevitably negatively impact our undertakings ahead. We were working together on gender issues and Transform's [sic] involvement would help us achieve more." – Ministry of Health interview respondent

FINDING 8: USAID Transform: Primary Health Care implemented interventions to increase male engagement in antenatal care, maternal health, and family planning, but monitoring and learning are weak.

The Transform: Primary Health Care gender analysis found that men resisted family planning and were not engaged in antenatal care (ANC), maternal health, and parenting. The analysis also showed a need to expand men's awareness of family planning methods and associated benefits; boost men's understanding, participation, and involvement in family planning; and raise men's awareness of GBV, especially CEFM and FGM/C (USAID 2018d).

In response to this gap, an Activity annual report and its gender strategy showed that from 2017 to 2020 the Activity developed evidence-based, transformative male engagement interventions in its four regions to mitigate barriers, leverage opportunities, and meet expressed needs, such as including fathers in family planning counseling services (USAID 2020a), male-inclusive social and behavior change communication, and CBHI promotional fliers that emphasized joint decision-making between husbands and wives and encouraging both to discuss and enroll in the program (L. Messner, Dustin Smith, Heran Ababe Tadesse, Diana Santillán 2020; USAID 2021b).

The document review and USAID Transform: Primary Health Care interview respondents stated that the Activity identified Program P as an evidence-based, community-based male engagement program that increases men's awareness and involvement in family planning, pregnancy, and early childhood development and could be adapted to the Ethiopian context to increase male engagement (see full curriculum in Annex C) (USAID 2021a).[15] The Activity conducted formative research in SNNP and Oromia regions and used the findings to adapt the curriculum to Ethiopia. The Activity was unable to pilot the intervention because of the COVID-19 pandemic, but handed over the adapted curriculum, the formative research report, the adaptation process, and the implementation guidelines to the Ministry of Health for future programming (USAID 2021a).

"It [Program P curriculum] wasn't implemented and hence unable to draw the lesson around the significance of engaging men in ANC and family planning, which would have been the first kind in Ethiopia." – USAID Transform: Primary Health Care interview respondent

Exhibit 20 presents document review, participant data, and Ministry of Health interview respondent descriptions of these and other interventions (L. Messner et al., 2020; USAID 2021b, 2018g, 2019f, Nd-

[15] Promundo Program P: https://promundoglobal.org/programs/program-p/

b; Stones et al. Nd; USAID 2020e, 2020a; "USAID Transform: Primary Health Care Report on Training: Male Engagement in SRH" 2021).

Exhibit 20: Interventions to increase male engagement as clients, partners, and change agents in primary health care services

INTERVENTION	DESCRIPTION
Health extension worker orientation	Integrated a one-hour orientation session on male engagement approaches in maternal and reproductive health into two-day primary health care unit review meetings with health care managers, service providers, and health extension workers in specific catchment areas to review team performance, identify gaps, and coordinate responses.
Male engagement training for service providers	Trained service providers from Amhara and Tigray regions on male engagement approaches and strategies to engage men. The training was cascaded to health workers through a Transform: Primary Health Care grant, which increased outreach to engage men in ANC, family planning, and delivery. In Activity Years 2, 3, and 4, trained 157 service providers, the majority of whom were female midwives in Oromia (Activity Year 1), SNNP (Activity Year 2), and Tigray regions (Activity Year 4).
Male religious leader outreach	Included key messages on maternal and reproductive health and gender equality in two-day capacity-strengthening workshops for religious leaders to explore inequitable gender norms as they link with negative RMNCH outcomes and to influence community members.
Male engagement workshop for agricultural extension workers, woreda agriculture office experts, and woreda health office staff	Conducted a male engagement workshop in Amhara, Oromia, Tigray, and SNNP regions to build knowledge and skills to promote appropriate health and gender equitable behaviors. Participants developed a male engagement plan of action for their respective woreda health offices.
Male-inclusive social and behavior change communication	• Redesigned immunization diplomas to include language and messages appropriate for both mothers and fathers. • Modified CBHI promotional fliers to include women's economic contributions and roles in decision-making, emphasize joint decisions between husbands and wives, and encourage men and women to discuss and enroll in the program. • Revised family folders on child health to address both mothers and fathers, not mothers only. • Modified posters on patient rights and responsibilities from general patient rights that addressed men only, and rights related to RMNCH that addressed women only, to address both men and women.
Male engagement curriculum	Conducted formative research in selected woredas in Oromia and SNNP regions. Used the findings to adapt the Program P curriculum, which includes 11 participatory, small-group dialogue sessions on fatherhood, caregiving, pregnancy, delivery, family planning, and gender-based violence for new or expectant fathers; six sessions include the men's partners. Translated the curriculum to Amharic and Afan Oromo.
Male engagement promoters training	• Organized a male engagement training and action planning, in collaboration with SNNP regional office, for 53 (31 male, 22 female) regional, zonal, and woreda health office staff from selected nine woredas and 11 zones. • Collaborated with the Amhara regional health bureau to conduct a three-day training for 23 (17 male, 6 female) woreda health office reproductive health officers on male engagement in sexual and reproductive health.

When speaking about these interventions, Ministry of Health respondents shared how the Activity helped them engage men by providing male engagement orientation, grant funds to organize woreda-level workshops, and mobilize communities in kebeles.

> *"We received the training on male engagement last year, and then we cascaded the training to health workers through grant fund. The training was very interesting and gave us knowledge on the strategies that can be used to involve males in maternal and child health issues…After the training, we started encouraging male involvement during monthly pregnant women conferences, antenatal care, family planning, and delivery."* – Ministry of Health interview respondent.

> "*The male engagement initiatives have been a good start to engage men and boys in family planning, antenatal care, and delivery in a different way. The [curriculum] was well-developed; it was a good initiative that can be cascaded all over the different regions. Because of COVID-19, and the different security issues, we couldn't conduct as expected. I hope when things are back to normal it is our first priority.* – Ministry of Health interview respondent.

> *"The changes we are now seeing in the* woredas *on male engagement is the result of the training provided, and most* woredas *are currently taking the initiative and providing orientation to different stakeholders on male engagement using grant fund." – Ministry of Health interview respondent*

A USAID Transform: Primary Health Care annual and quarterly report stated that the Activity built male engagement capacity through platforms such as during primary health care unit performance review meetings and by responding to specific requests from woreda health offices and health facilities to enhance their staff capacity to engage men (USAID 2019f).

Despite these efforts, USAID Transform: Primary Health Care documents from 2020 show that the Activity identified the need for monitoring and learning activities around male engagement, and that the indicator on husbands accompanying their wives for ANC and family planning showed little progress (USAID 2020b, 2020e).

According to the Activity Year 5 work plan, the Federal Ministry of Health Women, Children and Youth Affairs Directorate and regional health bureaus planned to scale up male engagement in 2021 based on lessons on the feasibility of the approach (USAID 2020f). Both Ministry of Health and USAID Transform: Primary Health Care interview respondents said that male engagement remained a critical area to address in the Ethiopia health sector but had mixed responses as to whether or not the Activity's work would continue.

> *"As I said earlier, education, training, and community awareness are important to increase male's involvement and GBV case management, thus this will be continued. However, as the regional government is not budgeted, and no person assigned for gender position, we need more support from NGOs."* – Ministry of Health interview respondent

> *"The success that we saw in male engagement on family planning is very encouraging. As I mentioned earlier, the achievement of [NAME] kebele in mobilizing husbands for improving their engagement in long-acting family planning has shown significant change in long-acting family planning utilization in that kebele. We are now planning to scale up this to other kebeles." – Ministry of Health interview respondent*

FINDING 9: USAID Transform: Primary Health Care implemented a variety of awareness-raising interventions to increase women and girls' access to and use of health services and to prevent GBV.

According to a USAID Transform: Primary Health Care report, the Activity gender analysis, and GBV landscape analysis, many women, particularly married women, did not access health services because of lack of awareness of available services (among other reasons). In response, in 2019 the Activity introduced health post "open house" events for community members to visit health posts at which health extension workers provided education on and demonstrated availability of services at the facility (USAID Nd-b). According to the Activity gender strategy, health post open house events provided an opportunity for women to go to facilities and see what maternal and child health services were available. (USAID 2020b).

According to the Activity's gender strategy, the Activity held sensitization workshops in 2019 for community and religious leaders to improve health-seeking behaviors for reproductive and maternal health services. After the workshops, communities formed village-level committees to prevent CEFM and FGM/C, which facilitated leaders to be more involved in health affairs, promoting women's control over health decisions for themselves and their families, preventing other forms of GBV, and promoting reproductive, maternal, newborn, and child health services. Activity staff recommended ongoing follow-up on community- and district-level health committees to address gender gaps in these committees (USAID 2020b).

According to the document review, in Activity Years 1, 2, and 3, USAID Transform: Primary Health Care supported the Ministry of Health in various ways to prevent GBV across technical sectors and regions:

- To commemorate 16 Days of Activism against Gender-based Violence in 2017, the Activity collaborated with the Oromia regional health bureau and the Ministry of Health Women, Children and Youth Affairs Directorate to organize a field visit to a primary hospital that started comprehensive one-stop services for GBV survivors (USAID 2018g). Abba Gedaa (elders) blessed the event and expressed their stand against GBV, and the event concluded with participants raising their hands and promising to stand with women and girls experiencing GBV (USAID 2018b).
- To commemorate International Disability Day in 2017, the Activity collaborated with the Ethiopian National Disability Action Network on a panel discussion to emphasize that GBV is a serious public health concern, and the importance of a responsive health care system for disability and GBV (USAID 2018b).
- The Activity provided technical assistance to the Federal Ministry of Health Women, Children and Youth Affairs Directorate in 2017 to develop a concept note, Strengthening Health Sector Role in the Prevention and Response of Female Genital Mutilation, which the Directorate presented at a World Health Organization consultation meeting on FGM response in South Africa (USAID 2017c).
- The Activity adapted a child health curriculum in 2019 to emphasize norms change communication about gender inequality, GBV, pregnancy, and parenting to improve child health, and advocated to the Ministry of Health to integrate the curriculum more broadly within the health system (USAID Nd-b).

Analysis of Activity RFUV data showed a large, statistically significant increase from January 2017 to December 2020 in the percentage of health posts conducting discussion sessions and awareness-raising interventions focusing on GBV prevention in Amhara (52 percent to 64 percent) and Oromia (53

percent to 68 percent) regions, and rates remained consistent in SNNP and Tigray regions. In SNNP and Tigray regions, there were no statistically significant changes, with an average of 63 percent and 75 percent of health posts, respectively, conducting discussion sessions focusing on GBV prevention over the four years of the Activity. Despite these increases, analysis of Activity household RFUV survey data did not find any change in the percentage of women experiencing GBV who sought or received GBV services or care at a health facility. For full analysis and results, see Annex B Finding 2.

FINDING 10: USAID Transform: Primary Health Care supported the Government of Ethiopia to eliminate FGM/C and CEFM by 2025.

The USAID Transform: Primary Health Care gender analysis found that more attention and focus were needed to eliminate GBV against girls and women, such as CEFM and FGM/C. To this end, according to documents reviewed, in Activity Year 2, the Activity supported the Government of Ethiopia's efforts to eliminate FGM/C and CEFM by providing tailored support to woredas with high FGM/C and CEFM prevalence (USAID 2018g, 2018b). For example, the Activity held a review meeting and refresher training in 25 hot spots with woreda Women, Children and Youth Affairs Directorate offices and key community and sector representatives from priority kebeles. The meeting and refresher training assessed the functionality of harmful traditional practices committees and increased stakeholders' familiarity with the existing FGM/C and CEFM elimination strategy. A total of 200 participants (100 male, 100 female) attended four sessions and discussed current challenges, and each woreda developed an action plan to address the challenges, established or strengthened harmful traditional practices committees, held high-level discussions with religious leaders, and identified fistula cases and clandestine CEFM practices (USAID 2018b).

Activity quarterly and annual reports showed that USAID Transform: Primary Health Care convened action planning meetings, re-vitalized GBV committees, disseminated research findings on the status of FGM/C and CEFM, and increased awareness of policies and laws in rural kebeles to intensify the Ethiopian government's efforts to eliminate FGM/C and CEFM by 2025. According to these reports, these interventions contributed to the cancellation of arranged marriages in Amhara, Oromia, and Tigray regions, and strengthened prevention coordination among woreda-level stakeholders (USAID 2018g, 2019f).

FINDING 11: USAID Transform: Primary Health Care added GBV prevention and response sessions to Her Space to respond to new data on gender gaps.

USAID Transform: Primary Health Care interview respondents stated that the Activity implemented Her Space with adolescent girls to address their fears of accessing health facilities for family planning and other sexual needs; increase their knowledge of services available to them (e.g., youth-friendly health centers); understand their bodies; and impart life skills (e.g., how to open bank accounts and save and "grow" their money).[16] In 2018, the Activity conducted a GBV landscape analysis, which found that young married and unmarried female GBV survivors often did not seek services because of fear of stigma or lack of awareness of available services.

In response to this gender gap, starting in 2018 the Activity added sessions on GBV (e.g., CEFM) prevention and response to the Her Space curriculum. These additions included girls visiting police

[16] According to interviews with Transform: Primary Health Care staff, Her Space was implemented by Pathfinder International before 2017 under another Activity, and was discontinued. Her Space resumed in 2018 under Transform: Primary Health Care at the request of the Minister of Health.

stations; learning what services were available should they experience GBV; and imparting the importance of informing police, mentors, and teachers when they see signs of CEFM or other forms of GBV (USAID 2018f, 2020b; Pathfinder International 2020). USAID Transform: Primary Health Care interview respondents and the document review described how Her Space also engaged boys to serve as allies for GBV prevention (Pathfinder International 2020; USAID 2018f, 2018g, 2018b, 2018c, 2020a, 2019f). Documents reviewed and Transform: Primary Health Care staff interview respondents indicated that as a result of these additions, girls understood they could seek help when CEFM and other forms of GBV occurred (Pathfinder International 2020; USAID 2018f, 2018g, 2018b, 2018c, 2020a, 2019f). These documents and respondents also indicated that as a result of these additions, girls understood they could seek help when CEFM and other forms of GBV occurred (USAID Nd-b).

> *"…because they [Her Space participants] were visiting the police stations they were encouraged, whenever they feel not comfortable in the community, go to school, being harassed, or have kind of gender-based violence, even in the families, if they feel that their parents are planning to give them away, they can come in the police station to report them. This…empowers the girls so whenever they think something is going on wrongly, they ran to the police station and informed them of the situation."* – Transform: Primary Health Care staff interview respondent

> *"The Her Space session was really helping to empower [girls] to say no for [sic] early marriages and react whenever they are facing gender-based violence in schools or on the way to schools…and in bringing their brothers into the household chores. Even the Her Space sessions encouraged the boys, the brothers of these girls, to prevent … gender-based violence and harassment in the schools for other girls who are not their sisters."* – Transform: Primary Health Care staff interview respondent

Her Space Success Story
Nitsuh Mitiku, a Her Space mentor in the Mesobo kebele in Amhara region, found one of her mentees, 13-year-old Belaynesh Adane, crying the morning of the fourth session. The girl said that her parents agreed to give her away for marriage without her consent. Nitsuh shared this with the school director and together they spoke to Belaynesh's parents. If the parents still wanted to proceed with the marriage, Nitsuh and the school director agreed that they would take the matter to the police. They visited Belaynesh's home and discussed the marriage proposal versus opportunities Belaynesh would have if she continued her education. They spent hours discussing the ramifications of early marriage (from legal to physical and psychological). Ultimately, the parents gave their blessing for Belaynesh to continue her education and participation Her Space (USAID 2019f).

According to Activity reports, Her Space experienced challenges that included mentor attrition, and COVID-19 data indicated an increase in GBV (including CEFM) and other barriers to healthy reproductive health outcomes, which presented significant implications for girls' day-to-day lives and their future outcomes. (USAID 2019f; Pathfinder International 2020).

Regarding sustainability, interview respondents reported that the Her Space manual and mentor manual are the Ministry of Health's and that the Ministry included Her Space in its annual plans, but not yet in the Ministry budget, although one respondent indicated that Oromia budgeted for it in its annual plan (Pathfinder International 2020).

SUB-QUESTION 3: WHAT REMAINING GENDER GAPS AND OPPORTUNITIES NEED TO BE ADDRESSED AND WHAT NEW ONES HAVE EMERGED?

FINDING 12: GBV is widespread in Ethiopia, yet lack of knowledge among clients and healthcare workers, a weak multi-sectoral response, and sociocultural norms create gaps in GBV prevention and response in health and other related services.

When Ministry of Health and USAID Transform: Primary Health Care interview respondents were asked "reflecting on the Ethiopia in 2021, what are the top three gender gaps in health services that need to be addressed in the next five years?" more than half spontaneously mentioned responding to GBV and preventing CEFM and FGM/C. Many of these respondents spoke of the increase in GBV, especially sexual violence and CFEM, which have been exacerbated during the COVID-19 pandemic and recent conflict.

A recent UN Women gender assessment found that most women in Ethiopia view GBV as a widespread and frequent problem (UN Women 2020). UN and Ethiopia government documents showed that GBV remains prevalent in Ethiopia "under the veil of traditional values and practices" (United Nations Office of Drugs and Crime 2020; Ethiopia Ministry of Health Women Children and Youth Directorate 2020). This is exacerbated by sociocultural norms that stigmatize survivors, normalize violence within partnerships, and inhibit women's, men's, boys', and girls' access to comprehensive GBV care and treatment (USAID 2019a). An Ethiopian government study found that the most dominant GBV norms or "traditions" in Ethiopia are CEFM and FGM/C. *Abusuma* (forced union between cousins) persists and some families marry their daughters young to avoid stigma such as the label, *haftuu* (unwanted) (Ethiopia Ministry of Women, Children and Youth 2020).

Ministry of Health and USAID Transform: Primary Health Care interview respondents stated that much work remains to strengthen the government's multi-sectoral GBV response (e.g., improving referral linkage with other sectors on GBV case management), quality services, creating safe spaces (e.g., shelters) for GBV survivors, and establishing more one-stop shops that provide health, legal, and psychosocial services to GBV survivors.

> *"The priority for me is GBV and sexual violence, including use of sexual violence as a weapon in conflict settings. We need to ensure that health services can cater for the surge in sexual violence that came as a result of the COVID pandemic, as well as conflict."* – USAID Transform: Primary Health Care interview respondent

> *"…due to COVID-19 and emerging of war, safety and security issue has been compromised, and rape, physical violence, and killing has been increasing in our area…To this end, strengthening multi-sectorial collaboration and closely working with security which can decrease GBV is necessary. From the health sector perspective, we do both on prevention and treatment. Other sectors have their own duties. So, if we strengthen our collaboration, I believe that we can bring change."* – Ministry of Health interview respondent

> *"It would be helpful to have a one-stop shop approach (health, legal, psychosocial services) all in one place so that women would not drop out of the GBV response system. This has been started in two places in the region, and five others have been identified to build this out. Doing more on this would also be important."* – USAID Transform: Primary Health Care interview respondent

The USAID Transform: Primary Health Care GBV landscape analysis found that healthcare workers were aware of gaps in service delivery for GBV survivors, and desire additional resources, training, and guidance to deliver quality care. While basic services existed, resource constraints, knowledge gaps among clients and healthcare workers, and weak multi-sectoral referral links created disjointed and incomplete pathways of care for GBV survivors (USAID 2019a).

According to Ethiopia Ministry of Health Women, Children and Youth Affairs Directorate documents, the health sector made some progress in responding to GBV but gaps remain in scaling services to reach the desired target, systematic information gathering on performance, health services institutional capacity, health infrastructure to provide a comprehensive health response, comprehensive and multi-sectorial coordinated service for GBV survivors, and encouraging survivors to seek health care. (Ethiopia Ministry of Health Women Children and Youth Directorate 2020). And four main challenges remain:

1. Limited coordinated, survivor-friendly community response programs for GBV survivors through health extension workers and the health development army.
2. Weakly bonded integrated and harmonized survivor-centered actions across the health system pillars.
3. Under-prioritized holistic, inter-sectoral approach to improve health care services for GBV survivors despite a conducive legal and policy framework.
4. Fear, stigma, dissatisfaction, or lack of awareness of the availability of services, and more is needed to make health facilities friendly to GBV survivors. (Ethiopia Ministry of Health Women Children and Youth Directorate 2020).

Further, workplace harassment guidance was drafted based on an Ethiopia Ministry of Health Women, Children and Youth Directorate rapid assessment, but the recommended reporting mechanism is still in progress (Ethiopia Ministry of Health Women Children and Youth Directorate 2020).

Two other recent studies found that GBV response in Ethiopia needs continued programmatic support and interventions that increased advocacy and access to helplines and shelters; provided economic alternatives to women affected by GBV; identified high-risk individuals; and strengthened the link between social and national health system, family laws and police investigations (UN Women 2020; Gebrewahd, Gebremeskel, and Tadesse 2020).

FINDING 13: Engaging men and boys is a gap in RMNCH services, especially for women's access to ANC and family planning, GBV prevention, and improved respectful care.

When Ministry of Health and USAID Transform: Primary Health Care interview respondents were asked what they thought were the top three gender gaps in health services that need to be addressed in the next five years many spontaneously mentioned engaging men and boys in ANC, family planning, GBV prevention, and respectful care.

> *"The first one being the male engagement. As part of the RMNCH services, especially on antenatal care and family planning…So, engaging male even, like if they are able to accompany their female partners to go to the facilities to do a follow up would be critical...Because as the decision makers are the males…men engagement in the family planning and in maternal health services will be one of the critical areas to be considered."* – USAID Transform: Primary Health Care interview respondent

> *"…there should be some kinds of boys' engagement activities…Because, boys are the ones who are harassing the girls. Boys are one performing different kinds of gender-based violence, boys are the ones who are just thinking and planning to marry very young adolescent girls. If you are able to change their minds, and feelings attitudes and values. I think this can be really easily addressed."* – USAID Transform: Primary Health Care interview respondent

> *"Thus, we need to work more on male engagement, the participation of men, and supportive husbands on sexual reproductive health is crucial."* – Ministry of Health interview respondent

The USAID Transform: MELA mid-term evaluation found that the proportion of women who received four or more ANC visits declined significantly from 57 percent at baseline to 52 percent at mid-term. The evaluation posited that the decline could be associated with changes in partner involvement, maternal and child health messaging, distance to health facility, and available transportation (USAID 2020c).

A 2019, USAID Transform: Primary Health Care quarterly report illustrated that during an orientation on adolescent maternal, infant, and young child nutrition in four regions, fathers consistently stated that they were not targeted, were unaware of the importance of the agenda, and believed that fathers can do a lot in their families and communities if awareness efforts target both parents (USAID 2019f). The USAID Transform: MELA mid-term evaluation found that women accompanied by their spouses to ANC clinics were 1.5 times more likely to have four or more ANC visits than women whose spouses did not accompany them. The evaluation showed a decline in spouses accompanying women to at least one ANC visit for their last birth from 62 percent at baseline to 49 percent at mid-term. Males accompanying their wives/partners during at least one ANC visit declined in all the four regions, with Oromia region showing a 25 percentage point decline (USAID 2020c).

The Transform: Primary Health Care gender analysis showed widespread male opposition to family planning because of the gender role expectation to have more children, misconceptions about family planning, and religious beliefs (USAID 2019f, 2018d). Activity RFUV data (see Annex B) showed that the proportion of women who ever used family planning whose husband or partner supported family planning use was relatively consistent in Amhara, Oromia, and SNNP regions. In Tigray region, there was a statistically significant decrease from March 2019 onwards (see Annex B).

Analysis of Activity routine follow-up household-level RFUV survey data for this assessment (see Annex B) also showed no statistically significant change in male partners accompanying women for family planning visits, ANC visits, or labor and delivery from January 2017 to December 2020. Rates of male accompaniment during family planning were the lowest (26 percent to 53 percent of facilities), slightly higher during ANC visits (53 percent to 71 percent of women reporting), and highest during labor and delivery (87 percent to 93 percent of women reporting). This is consistent with the USAID Transform: Primary Health Care male engagement in family planning and ANC formative research that found that men typically did not attend family planning or ANC visits and were much more likely to attend during delivery or a health emergency (USAID 2021a). In some regions, there were modest statistically significant increases in the percentage of health centers or hospitals permitting male partners during ANC visits and labor and delivery, but most showed no significant change in these indicators. For full analysis and results, see Annex B Finding 9.

Another research study showed that, if working to their potential, the Women's Development Army could influence changes in certain patriarchal norms and promote gender equality. These included convincing husbands to cease requiring heavy work by their later-stage pregnant wives; encouraging

husbands to transport and accompany their wives to a health facility for delivery; assisting women during their maternity waiting area stay; promoting healthy eating during pregnancy; and discussing antenatal and postnatal care benefits. It also showed that key to reducing access barriers due to traditional gender roles and relations was to increase attention to men's health in the Health Extension Program by actively soliciting men's involvement in RMNCH. For example, allowing men to stay at maternity waiting areas that are currently only for women in their last stages of pregnancy. Another example was including men in educational conferences on pregnancy (e.g., pregnant woman and midwife fora) to ensure that pregnant women access appropriate care, and to support by men in how to engage and care for their wives and partners during pregnancy (Bergen et al. 2020).

FINDING 14: Women's leadership in the health sector is critically low and health extension workers face increased workload demands that could negatively affect their own health and prevent them from exercising their full range of skills.

When Ministry of Health and USAID Transform: Primary Health Care interview respondents were asked what they thought were the top three gender gaps in health services that need to be addressed in the next five years several spontaneously mentioned increasing women's leadership and empowerment. Ministry of Health respondents said that there are "plenty" of female professionals in the health system but not in leadership and management positions. They said that the federal Ministry of Health is in the process of developing a women's empowerment training manual that they will use to prioritize bringing women into decision-making and leadership positions.

> *"At regional level, the number of women in leadership positions is minimal. So, working aggressively on women who are in leadership, as well as those who are coming to leadership, is crucial to bring about change."* – Ministry of Health interview respondent

USAID Transform: Primary Health Care interview respondents emphasized the need for women's representation at different levels of leadership at all health sector levels. They said that although there are government commitments to women's leadership, more behavior change is needed at woreda and community levels. They spoke of the need for coaching, capacity-strengthening, and a women-only, women-centered leadership program.

> *"A clear strategy and accountability is still needed to ensure that women are integrated into leadership roles."* – USAID Transform: Primary Health Care interview respondent

> *"A very important gender gap in our country is—especially with the health system—women leaders is very minimal, especially at the primary health care unit level and the district health office level. We should work to improve this low number."* – USAID Transform: Primary Health Care interview respondent

Recent research showed that nearly all of Ethiopia's maternal, newborn, and child health community-level workforce are women: midwives, HEWs, and Women Development Army members. Women are recruited for these positions to addresses the gender imbalance in the formal health workforce and to address pregnant women's hesitancy to use health services dominated by male health workers (Bergen et al. 2020). A 2019 study found that employing women as HEWs was intentional to address gender inequality through the health extension program (Jackson, Kilsby, and Hailemariam 2019). HEWs are widely credited with improved health service access in rural Ethiopia. However, they have little access to training (Bergen et al. 2020). A 2019 study recommended that future research explore limitations of the HEW program and identify ways in which the federal Ministry of Health could encourage women in

decision-making roles in the health sector, such as greater respect for community health workers' voices as knowledge-holders of the gender inequality that encounter in their daily lives (Jackson, Kilsby, and Hailemariam 2019).

FINDING 15: Gaps exist in the Ministry of Health's gender structure and budget, that have implications for potential sustainability.

When Ministry of Health interview respondents were asked "reflecting on the Ethiopia in 2021, what are the top three gender gaps in health services that need to be addressed in the next five years?" many spoke of structural and budget gaps, especially at "lower levels." They described a need for a "gender structure" and "report chain" at regional, zonal, and woreda levels not only at the regional level. They said that there was a human resources gap at the regional health bureau advisor level and wished for a gender advisor to be assigned at the regional health bureau. They also mentioned the need for formally assigning a responsible gender focal point at the woreda health office level and gave the example of the quality improvement advisors. These respondents stated that they did not think "gender-related activities" would progress at the required level otherwise, except in some active woreda health offices; many others have not been integrating and "doing gender" in their work. In other words, they believed that if the structure was appropriately functional down to the lower level more could be done.

> *"Instead of saying 'gender focal,' the structure should formally assign and put by labeling 'gender officer' in the woreda health office. Even a similar position is necessary at the zonal health department."* – Ministry of Health interview respondent

> *"If the structure continues as it is, the gender program will be weakened."* – Ministry of Health interview respondent

When speaking of gender structures, these same respondents said there was no gender-specific budgeting to implement activities, and as one interview respondent put it, "A structure without budget cannot function as expected." They stated that although there was sub-grant or other budget support from partners for follow-up, performance review meetings, and strengthening programs, there was a budget gap for sustaining gender activities started with partner support. As a result, they explained, "gender has many issues left undone, so it should have separate budget allocation for appropriate gender mainstreaming."

> *"The other is gender specific budgeting is important. When the woreda health office makes 11 percent budget allocation, there is no gender specific budget allocation. For instance, for HIV mainstreaming 2 percent budget is allocated."* – Ministry of Health interview respondent

> *"We do gender related activities by begging or developing proposal. It has no its own regular budget allocation."* – Ministry of Health interview respondent

> *"Therefore, a work should be done on the three issues, such as human structure up to lower level, gender-specific budget allocation, and evaluation of multi-sectorial collaboration, and making it functional. If we do all these, more outputs can be achieved from what have already been achieved."* – Ministry of Health interview respondent

Other gaps spontaneously mentioned by Ministry of Health respondents were:

- Leadership and political commitment

- Continuous performance monitoring of gender activities
- Multi-sectoral collaboration
- Gender audits and gender analyses
- Daycare services for employees at zone and woreda levels
- Needs of women living with disability and other marginalized people

SUB-QUESTION 4: WHAT SUCCESSES HAVE POTENTIAL FOR SUSTAINABILITY AND WHAT IS NEEDED TO SUSTAIN THEM?

FINDING 16: In most regions, health posts and health centers demonstrated a positive and statistically significant increase in the availability of GBV services and dedicated services for sexual violence survivors, which is anticipated to continue after the Activity ends.

Documents reviewed showed that USAID Transform: Primary Health Care follow-up data found an increasing trend in health centers providing GBV services across the regions from 2017 to 2020 (USAID 2020e, 2020f). Documents show that during supportive follow-up visits, Activity staff observed that health center providers had an increased knowledge of clinical services for GBV survivors, had started capturing data on the number of GBV clinical services provided, and had begun discussing ways the health center could engage in GBV prevention (USAID 2020b). Ministry of Health interview respondents also mentioned an increase in the number of facilities providing clinical services to GBV survivors and that health workers were conducting follow-ups on GBV, reviewing patient charts, and following up on specific registrations provided.

> *"We see changes from time to time. GBV registers was provided to health facilities. Before they did not have the registers, they just recorded in routine registrations, and we were not able to find data on GBV before. However, now all victims are recorded."* – Ministry of Health interview respondent

> *"Before this, GBV clients were getting services like any other client, but now health workers in all…health centers have taken the training and started to provide services, and this process was very good, which pushed us to work and strengthened our follow up. This is great and we had not heard and seen this before, and this is what I want to say a good deed."* – Ministry of Health interview respondent

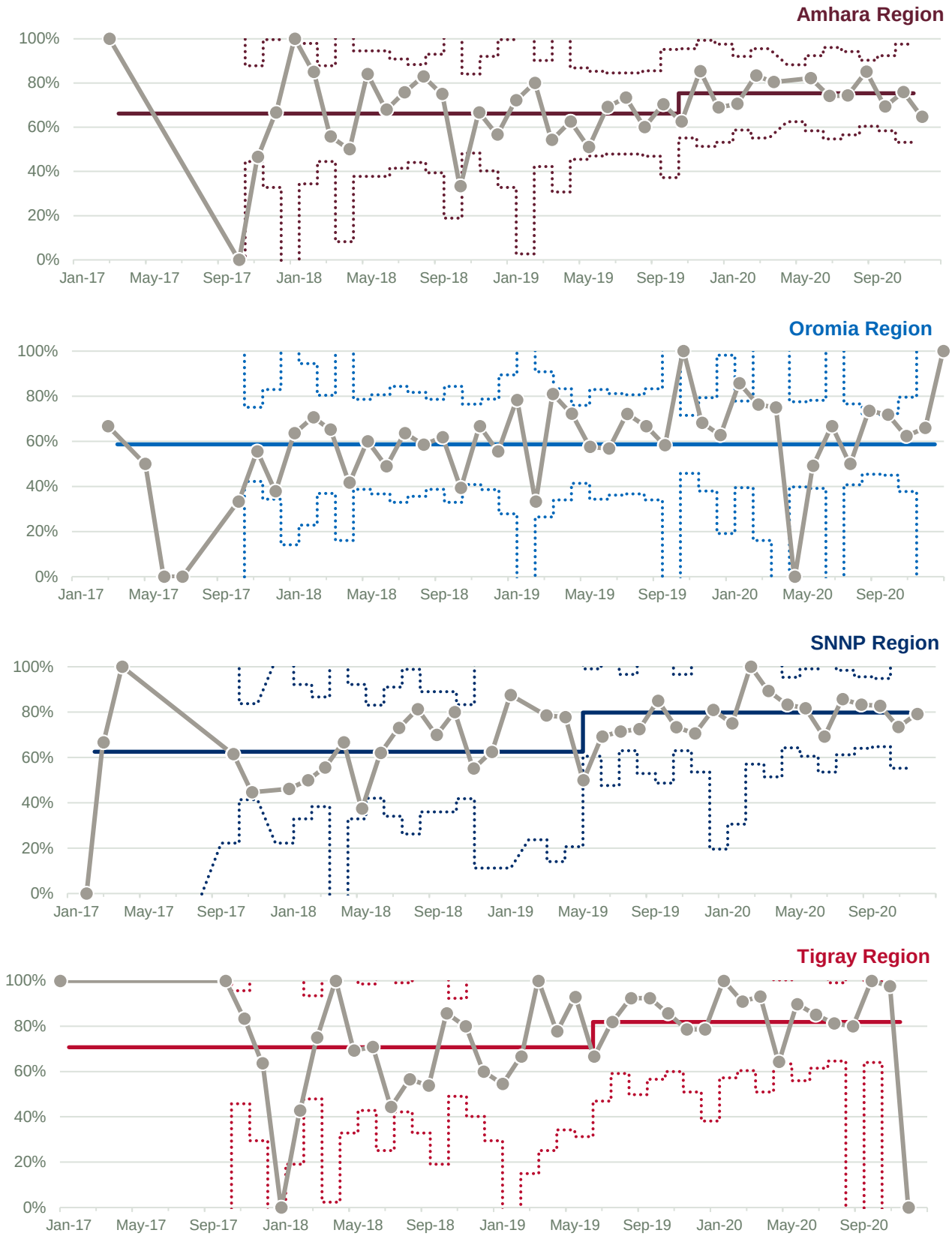
> *"One success to mention, for example, on September a GBV survivor came to [NAME] health center and she was provided with health response service by the focal. Other than this, since we established good multi-sectorial collaboration with other sectors, after taking the training, the survivor could be linked to justice office, and the perpetrator could be punished with five to ten years imprisonment…There are other cases other than sexual violence. There were physical violence cases who got health services and reported to us and got legal services."* Ministry of Health interview respondent

Random follow-up visit data in the reviewed documents showed an increase in the percentage of health centers offering GBV response services from 64 percent to 81 percent from 2018 to 2019 (USAID 2020b). Specific services included immediate provision of emergency contraceptives and HIV post-exposure prophylaxis, psychosocial counseling, and referral for legal services with appropriate documentation (USAID 2018g). In 2020, USAID Transform: Primary Health Care reported that 85

percent of health centers in implementation areas had an immediate/dedicated service available to GBV survivors by March 2020, and 320 women and girls accessed the service (USAID 2020f, 2020e).

Analysis of Activity RFUV data (see Annex B) showed, in most instances, an increase in the availability of GBV services in most regions of over 10 percentage points between 2017 and 2020. At both the health post and health center level, there were positive, statistically significant increases in the availability of dedicated or immediate services for sexual violence survivors in all four regions. Similarly, there was a positive, statistically significant increase in the percentage of health posts and health centers providing GBV services in Amhara, SNNP, and Tigray regions. Results at the primary hospital level were more inconsistent, which could be a result of the smaller sample size. Most of the shifts occurred in mid- to late-2019, corresponding with the months following the Activity's GBV landscape analysis reports and additional *Standard Operating Procedure* orientation, dissemination, and job aids. Exhibit 21 below shows results for the percentage of health centers providing post-GBV services. See Annex B Finding 1 for full analysis and results.

Exhibit 21: Percentage of health centers providing post-GBV services



According to the Activity's gender strategy, going into Activity Year 5, Activity staff saw the need to strengthen the sustainability of its GBV response work and the importance of getting local government partner buy-in and ownership to establish supportive systems and structures at all health system levels. Activity staff members also mentioned the importance of educating others at facilities and in communities, and continuing to support health centers to institutionalize the capture of GBV service data in the health management information system to better support woreda-based planning (USAID 2020b). Ministry of Health interview respondents also said that more work is needed to strengthen the multi-sectoral response and quality of services, although they also said that the Activity's support for GBV response was notable.

> *"A lot of work remains uncovered, particularly in strengthening the multi-sectoral [GBV] response and continuing the quality of service. There has been progress, but more is still needed."* – USAID Transform: Primary Health Care interview respondent

> *"One the most important support we received is on GBV, because GBV activity requires multi-sectoral response and health sector alone can't solve the problem. The orientation helped us to have good understanding on the standards of service, and roles and responsibility of different stakeholder in the GBV prevention and response. We have started to have quarterly review meeting with different sectors, but it is not consistent due to lack of commitment and shortage of budget."* – Ministry of Health interview respondent

> *"But as a region, the improvement in GBV services and gap filling trainings are areas where we worked better, and no partner has supported like USAID Transform: Primary Health Care."* – Ministry of Health interview respondent

Ministry of Health and USAID Transform: Primary Health Care interview respondents said they expect GBV response services to continue after the Activity ends. The Ministry has plans to establish one-stop services in six referral hospitals and provide training in GBV services for primary hospitals. The community has started to ask about GBV as a health issue, and the *Standard Operating Procedure* has made GBV response mandatory across sectors. However, Ministry of Health interview respondents said there are challenges to implementing the *Standard Operating Procedure*, especially establishing one-stop centers in hospitals because of a lack of stakeholder commitment, awareness of the need, and supplies to furnish the centers.

> *"Since turnover is high in USAID Transform: Primary Health Care intervention areas, the regional health bureau has been filling this gap. So, by doing all these, the regional health bureau will sustain GBV services."* – Ministry of Health interview respondent

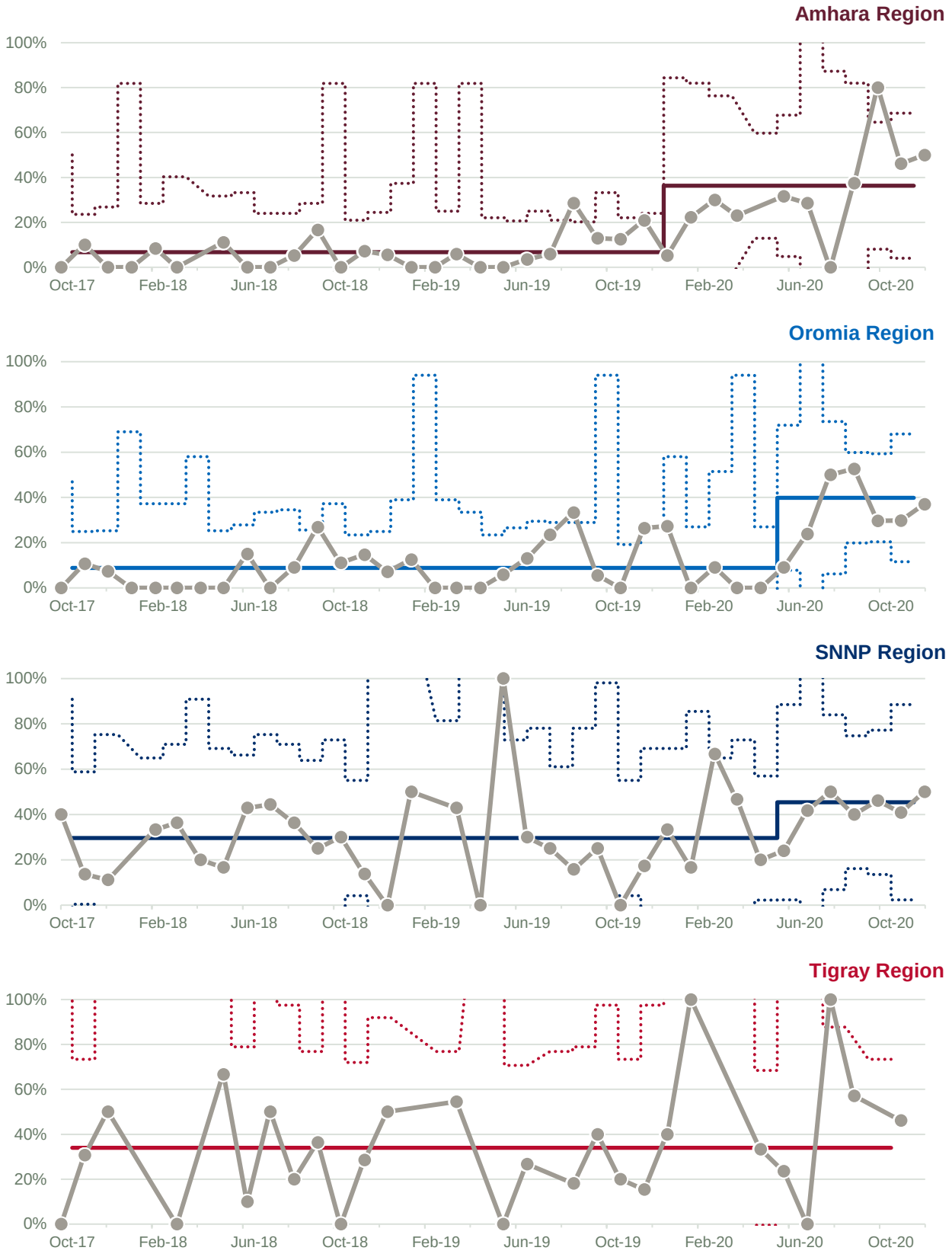
> *"I will say that the provision of GBV services can continue. The system has already been owned by the public sector, there are already trained persons, and the regional health bureau has provided support and training for this. The bureau is already working to make this service more culturally sensitive."* – USAID Transform: Primary Health Care interview respondent

> *"Services provided on GBV by health centers will sustain. Free service provision to survivors has been formally started through official letter written from higher level…We can also sustain multi-sectorial collaboration on GBV."* – Ministry of Health interview respondent

FINDING 17: The addition of on-site gender analysis mentorship and action planning to the Ministry's Gender and Health Mainstreaming Training led to positive, significant changes in the percentage of woreda health offices conducting and using gender analyses for work planning. It is unclear if this will be sustained after the Activity ends.

According to documents reviewed, the proportion of woredas conducting gender analyses to inform woreda-based planning increased over time (USAID 2020b, 2020a). Analysis of RFUV data (see Exhibit 22 and Annex B) showed that in 2019, when the Activity added on-site gender analysis mentorship and action planning to the Ministry's gender and health mainstreaming training and pivoted resources to the woreda health offices, there were statistically significant increases in the percentage of woreda health offices conducting gender analyses in Amhara, Oromia, and SNNP regions. Results fluctuated in Tigray region.

Exhibit 22: Percentage of woreda health offices that conducted a gender analysis and used findings to inform woreda-based planning



The reviewed documents reported that, as of September 2020, 43 percent of Activity intervention woredas had conducted a gender analysis and integrated gender-responsive actions into their woreda-based plan, and that there was a four-fold increase in health centers and woreda health offices conducting gender analyses in Activity Years 3 and 4 (USAID 2020b, 2020a). The Activity Year 5 work plan reported a significant increase in the number of people trained in gender analysis (USAID 2020f). Ministry of Health and USAID Transform: Primary Health Care interview respondents shared that health center-level gender analyses changed men's attitudes by identifying women's needs and raising them to the level of action plans. At the health post level, gender analysis was adopted by health center leaders and workers, and in almost all health centers there is at least one woman at the management level, which was not the case not before.

> *"Health facilities have started include gender issues in their routine activities as the result of the capacity building training and gender analysis mentorship support provided for the facilities."* – Ministry of Health interview respondent

> *"The capacity building training that we received is very good. As a result, we started to integrate gender in our plan and in each thematic area. The mentoring and orientation that we received on gender analysis helped us to see gender from different perspective like empowerment, service utilization, planning and budgeting. The changes can be seen after some time but there are promising changes."* – Ministry of Health interview respondent

> *"The greatest success from the [gender and health mainstreaming] training was around the gender analysis…we saw that it was adopted by health center leaders and workers at the health centers. We saw that after the training these people could do this analysis on selected health topics. For example, they would analyze some of their targets and look at what led them to reach or not reach their targets. They were able to identify places where they need supplies, identify key issues for men and women, etc. Health centers would develop action plans*. – USAID Transform: Primary Health Care interview respondent

> Exhibit 23 presents some examples of how woredas used/applied the gender analysis findings captured in the reviewed documents (USAID 2018g, 2019f).

Exhibit 23: Woreda-level gender analysis in action

1. After a gender analysis training, Abrhajira Health Center providers in **Amhara region** analyzed health management information system data and found that more men than women were diagnosed and treated for malaria and, using the gender analysis matrix, found that men in their area:
   - Work daily at a commercial farm located far from the health center.
   - Were more likely to sleep outdoors than women and therefore less likely to use insecticide-treated nets.
   - Had poor knowledge about malaria transmission and prevention because they came from malaria-free areas, and health extension workers focused on women.

   Based on these findings, the participants developed an action plan focused on targeting malaria prevention information and outreach to daily laborers working at the commercial farm.

2. In **SNNP region**, Abeshgie woreda gender analysis helped health care managers reflect on affirmative action in job promotion and educational opportunities. As a result, the managers agreed to reserve three out of six allocated educational opportunities for female employees. In the same primary health care unit, service providers from Hole health center identified strong community perceptions against unmarried girls using contraceptives. After thorough analysis, they agreed to hold health education sessions and community meetings over a six-week period focused on exploring the lives of unmarried girls and their access to contraceptives.

3. The Jare health center's gender analysis in **Oromia region** revealed that female health workers returning from maternal leave experience challenges breastfeeding their babies. Negotiation with health center management resulted in breastfeeding women receiving an additional two hours of rest time during the day, and staff who cover their work were given certificates of recognition.

The document review indicated that, looking to Activity Year 5, the Activity gender strategy recognized that many government officials still did not have adequate knowledge about gender analysis and integration and many woredas required continued support (USAID 2020b, 2020a). Yet, Ministry of Health respondents stated that they plan to continue conducting facility-level gender analyses and gender integration after USAID Transform: Primary Health Care ends.

> *"We will continue to implement gender analysis and provide awareness creation to health workers on gender integration. We carry out planning every year and we will include the activities in our plan and allocate budget."* – Ministry of Health interview respondent

> *"Besides, there was no gender focal at office level and there was no know-how about gender. We could start this, and even we had not incorporated this in our monitoring and evaluation, but which was corrected since the 2012 Ethiopian Calendar budget year. This can be considered as a success, which was not seen but could be seen with the organization's effort, specially to improve performance of facilities from quality perspective. So, these are big successes. This is what we sustain now onwards whether partners support us or not."* – Ministry of Health interview respondent

FINDING 18: CBHI interventions had an unintended positive consequence of empowering female enrollees to seek health care services.

According to documents reviewed and routine follow-up data, USAID Transform: Primary Health Care facilitated CBHI training workshops and CBHI interface meetings to improve CBHI enrollment and renewal rates, and targeted Women's Development Armies and other women's associations to share gender-specific CBHI orientations (USAID 2020b). The Activity gender analysis found that CBHI influenced women's ability to independently access health care services (USAID 2020b, 2018d) and

reduced financial constraints for married and unmarried men and women seeking health services (Messner et al. 2019).

The Transform: MELA mid-term evaluation found that CBHI facilitated more widespread and immediate health-seeking behavior among women, that women who registered were more likely to access family planning and maternal health services than those who had not registered, and that membership positively increased the odds of delivery through a skilled birth attendant more than six-fold, positively contributed to women's use of family planning and some maternal health services, and made an important contribution to improved service utilization. The evaluation also showed that even if maternal health services are free, CBHI enrollment empowered women to seek out health care services and contributed to improved health care-seeking behavior among community members (USAID 2020c). The Activity's 2021 learning assessment found a significant difference between insured and non-insured women of child-bearing age in the use of modern family planning, and that insured women seek health services more often that those who are uninsured (USAID 2021b).

Ministry of Health interview respondents said that community mobilization related to CBHI resulted in men supporting women's use of health care services, which the Ministry of Health has continued.

CONCLUSIONS

Overall, the findings show that USAID Transform: Primary Health Care integrated gender in its operations, supported the Ministry of Health's "gender mainstreaming" commitments and efforts at all levels, actively sought to address the gender gaps identified in the Activity's gender analysis across result areas and technical teams, and adapted interventions to address new gender gaps that emerged from the Activity's monitoring data. Evidence from this research suggests Transform: Primary Health Care contributed to an increase in facilities providing post-GBV services and the number of WorHOs conducting gender analysis and integrating gender considerations in their annual plan. Other impacts or outcomes cannot be measured within the scope and methodology of this report, but anecdotes and observations indicate the Activity advanced efforts to promote gender equality and equity across the health system in a number of ways. The findings also show that going forward, the Ministry of Health still needs support, especially at the woreda level, to sustain the interventions and support the Activity provided.

The following conclusions present the assessment team's synthesis and interpretation of the significance of the findings.

Conclusion 1: The Activity's Gender analysis was an entry point for Integrating gender into its operations and interventions and for supporting gender integration across the Activity.

Findings show that USAID Transform: Primary Health Care committed itself to gender integration by establishing systems and processes and that its "gender team" enabled the Activity to institutionalize gender across result and technical areas. These actions—supported by Federal Ministry of Health buy-in and commitment—started during Activity development by establishing a dedicated team of gender experts to serve as resources at all levels of implementation—international, national, regional, woreda—instead of the standard sole "Gender Advisor" who is often marginalized and/or overwhelmed. This team of gender experts—based in Addis Ababa and each region—provided "real time" technical assistance with support from a dedicated headquarters team. Findings also show that the Activity used the gender analysis to develop an Activity-wide gender strategy with indicators to ensure that interventions took gender gaps into account. The gender strategy was a living document that the Activity revisited and revised annually to ensure responsiveness to changing gender gaps. The Activity's "gender team" trained technical staff in gender integration and provided technical assistance to ensure interventions were at least gender aware (and, ideally, gender transformative). These efforts translated into buy-in and capacity improvements across the Activity team.

Conclusion 2: USAID Transform: Primary Health Care used collaborating, learning, and adapting to monitor and respond to evidence-based gender gaps over the life of the Activity.

Findings show that although it did not name it as such, USAID Transform: Primary Health Care used a collaborating, learning, and adapting approach to promulgate gender integration over the life of the Activity. This included annual gender strategy reviews that aligned with the Activity's theory of change process to adjust interventions and routine monitoring and follow-up data collection and analysis to identify gender gaps. The Activity used these to inform annual work planning to collaborate on, learn from, and adapt interventions or develop new ones to respond to emerging gender gaps and

opportunities across technical and result areas. Findings show several instances when the Activity modified its interventions based on emerging data on gender gaps, in collaboration with the Ministry of Health and with its full support. Most notably, the Activity created a new, female-only LMG for Ministry of Health staff in response to data that showed very low numbers of female participants and added on-site gender analysis mentorship and action planning to the Ministry of Health's gender and health mainstreaming training in response to RFUV data showing few facilities conducting gender analyses. In addition to the Activity Year 1 gender analysis and resultant gender strategy, the Activity conducted other research over the years to understand further emerging gender gaps and develop interventions in response to those gaps, such as a GBV landscape analysis and formative research to adapt an evidence-based community male engagement program to Ethiopia (implementation of which was halted due to COVID-19). This collaborating, learning, and adapting approach to gender integration enabled the Activity to be nimble and responsive to changing gender gaps and alert to interventions that were not closing gender gaps as anticipated and to unintended negative consequences (such as the absence of female participants in LMG workshops).

Conclusion 3: USAID Transform: Primary Health Care integrated gender across thematic and result areas rather than implementing gender-specific interventions.

The findings show that USAID Transform: Primary Health Care took a comprehensive approach to gender equality, integrating it across thematic and result areas rather than in isolation. Specific thematic areas described in the findings in which gender was notably integrated were adolescent and youth health and development; family planning and reproductive health; health care financing; LMG; and social and behavior change communication. For example, the Activity developed evidence-based, transformative male engagement interventions to mitigate barriers, leverage opportunities, and meet expressed needs across thematic areas, such as including fathers in family planning counseling services, producing male-inclusive social and behavior change communication products, and developing CBHI promotional fliers that emphasized joint decision-making between men and women. The Activity also implemented awareness-raising interventions to increase women and girls' access to and use of health services, change harmful traditional practices (e.g., CEFM and FGM/C), and prevent GBV. Findings show that this integration was reinforced and supported by the Ministry of Health at all levels.

Conclusion 4: The Activity's technical and financial support to the Federal Ministry of Health strengthened ability, buy-in, and standards for addressing gender gaps.

Findings show that the Federal Ministry of Health (through the Women, Children and Youth Directorate) was committed to gender integration and established several initiatives and interventions, such as a gender and health training and the *Standard Operating Procedure for The Response and Prevention of Sexual Violence in Ethiopia*. USAID Transform: Primary Health Care provided a range of technical and financial support to the Federal Ministry of Health to roll out and operationalize these commitments at all levels and built capacity in identifying and responding to gender gaps. At local levels, this included building health service providers' expertise and procedures in GBV clinical response services and referrals; strengthening efforts to eliminate FGM/C and CEFM; building buy-in and capacity for female staff to serve in leadership positions; and building woreda health office staff expertise to conduct gender analyses and use the results to develop action plans to address gender gaps. At the federal level, the Activity's support enabled the Ministry to establish and operationalize gender mainstreaming and GBV

prevention and response frameworks, standards, and services. Findings show that the Activity's technical and financial support enabled the Ministry to broaden its reach and build its expertise in ways it could not have without USAID Transform: Primary Health Care's assistance and engagement as a thought partner that acted as an extension of the Ministry itself.

Conclusion 5: The USAID Transform: Primary Health Care GBV landscape analysis provided essential evidence to the Ministry of Health to propel GBV prevention and response interventions and services.

Findings show that the 2019 GBV landscape analysis provided critical data the Women, Children and Youth Directorate needed to introduce management of GBV survivors to the health system; develop and disseminate guidance notes, strategic action plans, job aids, manuals, and community engagement guides; and establish and/or strengthen GBV prevention interventions and response services. This extended to interventions such as Her Space, which added sessions on where and how to seek services and help for CEFM and other forms of GBV, and engaged boys as partners and champions to prevent GBV. Findings show that the GBV landscape analysis also spurred the Ministry to roll out the *Standard Operating Procedure* to clarify health staff responsibilities to improve coordination, use standard referral formats, improve communication and referral paths for GBV survivors across sectors, and strengthen existing regional health board efforts to increase the number and ability of one-stop centers to provide services to GBV survivors. Findings show that the Ministry engaged USAID Transform: Primary Health Care to train health center and primary hospital staff in GBV prevention and response for internally displaced people, and mobilized community leaders and members to counter CEFM and FGM/C.

Conclusion 6: The Ministry of Health lacks resources, capacity, and infrastructure to respond to gender gaps and sustain several USAID Transform: Primary Health Care gender-aware interventions without external financial and technical support.

Findings show that although USAID Transform: Primary Health Care contributed to strengthening the Ministry of Health's capacity, continued support is needed for the Ministry to respond to existing and future gender gaps. Findings indicate that the Ministry lacks a functional gender structure and budget at all levels, and capacity, infrastructure, and coordination to respond to gender gaps without outside technical and financial support. In particular, it needs ongoing support in providing basic GBV services or referrals to survivors, establishing women's leadership within Ministry bodies, providing equitable working environments for health extension workers, and engaging men and boys.

The *Standard Operating Procedure* made GBV response mandatory across sectors, and findings show that the Ministry plans to continue GBV response services after the Activity ends (e.g., establishing one-stop services in six referral hospitals and providing training in GBV services for primary hospitals). However, the findings also indicate that the Ministry faces challenges in implementing the *Standard Operating Procedure*, especially in establishing one-stop centers in hospitals, because of lack of stakeholder commitment, awareness of need, and supplies to furnish the centers. The extent to which the Ministry can maintain the momentum catalyzed by USAID Transform: Primary Health Care for GBV response services after the Activity's technical and financial support ends is unclear.

Findings indicate that male engagement remains a critical area to address in the Ethiopia health sector, especially in relation to women's access to ANC and family planning, GBV prevention, and providing

respectful care. Findings show that husbands accompanying their wives for ANC and family planning showed little progress. The findings are unclear as to whether the Ministry is able to continue or strengthen male engagement interventions, especially since the adapted Program P curriculum was not piloted because of the COVID-19 pandemic, and capacity was not built for the Ministry to implement the curriculum itself.

Findings show that USAID Transform: Primary Health Care's on-site mentorship and action planning following the Ministry's gender and health mainstreaming training resulted in a four-fold increase in health centers and woreda health offices conducting gender analyses. However, findings indicate that many government officials do not have adequate knowledge about gender analysis and gender integration, and many woreda health offices require continued support. The findings are unclear as to whether the Ministry of Health will continue conducting gender analyses after the Activity (and therefore on-site mentorship) ends.

Lastly, the revised Her Space manual and mentor manual (which now includes GBV prevention and response) are the property of the Ministry of Health, and Her Space is included in the Ministry's annual plans, but at the time of data collection, was not yet in the Ministry's budget. Also, although the standard LMG program was incorporated into the Ministry of Health Leadership Program, and the *Health Sector Transformation Plan II (2020/21–2024/25)* includes a target of 50 percent health leadership positions occupied by women, findings show that the woman-only LMG program would not continue after the Activity ends.

RECOMMENDATIONS

The findings and conclusions demonstrate that USAID Transform: Primary Health Care instituted systems, processes, and human and financial resources to address and mitigate gender inequalities and barriers that hinder access to and use of Ethiopia's health system. It did this by institutionalizing gender into its operations, supporting the Ministry of Health to implement and operationalize its gender-related policies and initiatives, and serving as a thought partner and technical arm to adjust interventions and approaches in response to emerging gender gaps. This partnership enabled the Ministry of Health to advance gender mainstreaming in its sector and development programs and its advocacy and capacity-strengthening activities at all levels of the health care system, as outlined the *Health Sector Transformation Plan (2015/16–2019/20)*, in which gender equality and women's empowerment were cross cutting and a guiding principle.

However, findings and conclusions also show that gender inequality (both in access to services and in leadership within the health sector) and GBV remain high in Ethiopia. Furthermore, the Ministry of Health still requires external technical and capacity-strengthening support to achieve the gender equality goals and priorities stated in the *Health Sector Transformation Plan II (2020/21–2024/25)*. These include enforcing women's and girls' rights to health; providing gender-responsive health services to all; and delivering comprehensive, multi-sectoral services to GBV survivors (including CEFM and FGM/C).

The assessment team jointly developed recommendations with USAID Transform: Primary Health Care technical staff from all thematic areas. The recommendations—organized by the four research sub-questions in Exhibit 24—suggest ways in which USAID and the Ministry of Health can build on the Activity's processes, successes, and learning to develop gender transformative interventions that support the Ministry of Health's efforts to prevent maternal and child deaths and holistically strengthen health systems to be available and accessible to all.

Exhibit 24: Gender assessment sub-questions

1. What systems and processes did USAID Transform: Primary Health Care establish to enable it to address the gender gaps and opportunities identified in the project's gender analysis?
2. What interventions, policies, procedures, and initiatives did USAID Transform: Primary Health Care implement individually or with partners to address gender gaps and opportunities identified in the project's gender analysis?
3. What remaining gender gaps and opportunities need to be addressed and what new ones have emerged?
4. What successes have potential for sustainability and what is needed to sustain them?

ESTABLISH SYSTEMS AND PROCESSES

RECOMMENDATION 1: USAID SHOULD REQUIRE GENDER INTEGRATION SYSTEMS AND PROCESSES IN ITS SOLICITATIONS.

Findings and conclusions show that USAID Transform: Primary Health Care took a comprehensive approach to gender equality by integrating gender across thematic and result areas. This approach included a gender architecture (i.e., dedicated team of gender experts at multiple levels) and framework: gender analysis, gender strategy and reviews, targeted research for deep dives into gender gaps, and gender assessment. This approach went beyond a token gender advisor and conducting mandatory gender analysis and writing gender strategy reports that "sit on a shelf" to establishing a team of gender

experts that supported and guided technical teams to actively use the gender analysis and gender strategy to inform interventions. This collaborating, learning, and adapting approach promulgated gender integration across the Activity.

USAID should build on this model by requiring adequate and robust gender staffing in its solicitations and stating that implementers must establish systems and processes for gender integration that are dynamic and applied across technical teams. This will enable implementers to achieve gender transformative interventions and solutions and identify and address emerging gender gaps and unintended harmful consequences of interventions over the life of the Activity.

ADDRESS REMAINING GENDER GAPS

RECOMMENDATION 2: USAID SHOULD SUPPORT THE MINISTRY OF HEALTH TO IMPLEMENT THE ADAPTED PROGRAM P CURRICULUM, AND USAID AND THE MINISTRY SHOULD ENGAGE MEN BROADLY.

Findings and conclusions show that male engagement remains a critical area to address in the Ethiopian health sector, that male engagement interventions were well-received by the Ministry of Health, and there was excitement and enthusiasm for the Ethiopia-specific, evidence-based Program P. Given that USAID Transform: Primary Health Care was unable to pilot the Ethiopia-specific Program P curriculum because of COVID-19 and security issues, USAID should support the Ministry to pilot and modify the curriculum based on the pilot and build capacity to scale-up and "own" the curriculum. Furthermore, USAID and the Ministry of Health should go beyond engaging men as supportive partners who accompany women to ANC visits and boost women's access to and use of family planning and delivery to engaging men as clients and advocates to achieve a gender transformative health response. When men are engaged as clients, services address men's prevention and health care needs in a way that extends the same range of services women receive. Engaging men as partners makes them central to supporting women's health as equitable and supportive intimate partners. In working with men as agents of positive change, they are actively involved in promoting gender equality, including prevent GBV, to improve men's and women's health, and as an end in itself.

RECOMMENDATION 3: USAID AND THE MINISTRY OF HEALTH SHOULD INCLUDE COMMUNITY-LEVEL GBV PREVENTION AND SOCIAL NORMS CHANGE INTERVENTIONS.

Findings and conclusions show that gender inequity and GBV (including physical and sexual violence, CEFM, FGM/C, *abusuma,* and others) remain prevalent in Ethiopia. Traditional values and practices and social norms stigmatize individuals (e.g., *haftuu* and stigma and abuse of obstetric fistula and GBV survivors) and normalize violence within partnerships. These fuel harmful practices and beliefs that inhibit women's, men's, boys', and girls' access to and use of equitable services, including comprehensive GBV care and treatment. The Ministry of Health made policy and institutional commitments to mainstream gender and prevent and respond to GBV. However, work is needed to address the local context and driving factors of gender inequities and social exclusion. USAID and the Ministry of Health should implement interventions that link social norms to health system services and GBV response. USAID should invest in community-based activities that transform harmful gender norms that negatively affect access and use of health services or support positive gender norms that positively affect access and use of health services (e.g., male engagement, women's leadership), that targets specific groups at risk. This should include supporting the Ministry of Health to create youth-response services that take

into account the unique and different health needs of boys and girls, and services in which boys and girls feel welcomed. This could include conducting a gender analysis that focuses on the differential health-related gender needs of boys and girls in different age groups, geographies, ethnicities, races, etc.

RECOMMENDATION 4: USAID SHOULD SUPPORT THE MINISTRY OF HEALTH TO STRENGTHEN THE ETHIOPIAN GOVERNMENT'S MULTI-SECTORAL GBV RESPONSE.

Findings and conclusions demonstrate that the Ethiopian government developed policies and standards to improve the health system's GBV response, but the lack of human and financial resources, capacity, infrastructure, and coordination to operationalize these policies and standards hindered primary health care providers and HEWs from providing many basic GBV services or referrals to survivors. Recently, the Women, Children and Youth Affairs Directorate developed the *Strategic Plan for Action on Health Response to Gender Based Violence/Sexual Violence 2020/21–2025/26*. The Directorate has the vision and plan, but is under-resourced to do all the capacity-strengthening, dissemination, and support needed to increase knowledge, attitudes, and behaviors around GBV prevention and response across the health system. Therefore, USAID should support the Directorate to implement this plan to operationalize a clear, multi-sectoral referral pathway for GBV survivors; make rape kits available in all health facilities; improve GBV case management referral linkages with other sectors; institute a coordinated service for GBV survivors that encourages survivors to seek health care; create safe, accessible spaces (e.g., hotlines and shelters) for GBV survivors; continue revising the health management information system to include key indicators on GBV response services and build capacity to analyze and use the data to make decisions; implement the workplace harassment guidance and reporting mechanism; and establish more "one-stop centers" that provide health, legal, and psychosocial services to GBV survivors in one place.

SCALE AND SUSTAIN SUCCESSES

RECOMMENDATION 5: USAID SHOULD SUPPORT THE MINISTRY OF HEALTH TO SCALE UP INTERVENTIONS PILOTED OR INITIATED BY USAID TRANSFORM: PRIMARY HEALTH CARE.

Findings and conclusions show that USAID Transform: Primary Health Care helped the Ministry of Health augment its gender mainstreaming initiatives by identifying gender gaps within the initiatives and developing and piloting modifications to close those gaps. Each of these proved successful and demonstrated results. However, they were implemented on a small scale, and the Ministry requires technical assistance and financial and human resources to fully operationalize and scale these interventions. Therefore, USAID should support the Ministry of Health to:

- Deliver the Ministry of Health gender and health mainstreaming training to woredas that were not trained and provide on-site mentoring to enable staff to conduct gender analyses and develop action plans to address gender gaps.

- Scale-up the women-only LMG workshops in support of the Ministry's *Health Sector Transformation Plan II (2020/21–2024/25)*, which targets increasing women to 50 percent of health leadership positions and building the Ministry's capacity to sustain the training without donor support. This should include supporting the Ministry to roll out the women's empowerment training manual it is developing, which prioritizes placing women in decision-making and leadership positions. It should also be expanded to HEWs to increase their decision-

making and leadership roles in the health sector, given their reach and on-the-ground knowledge and expertise.

- Support the Ministry of Health to scale up childcare centers to regional health bureaus that have not yet built or created them and ensure the Ministry can sustain these centers on its own.

RECOMMENDATION 6: THE MINISTRY OF HEALTH SHOULD INSTITUTE A GENDER STRUCTURE AND BUDGET FOR THE WOMEN, CHILDREN AND YOUTH AFFAIRS DIRECTORATE AT ALL LEVELS.

Findings and conclusions show that there are insufficient Ministry of Health staff dedicated to gender integration at regional and woreda levels and that the existing Ministry of Health gender structure is hindered by budget issues at the federal level. This may be exacerbated by challenges the Ethiopian government faces in handing over mechanisms when there is staff turnover, which negatively impacts staff at regional and woreda levels. The Ministry of Health should allocate adequate human and financial resources to the Women, Children and Youth Affairs Directorate so it can implement its gender mainstreaming and GBV response strategies and plans. This includes establishing a gender advisor position in each regional health bureau and woreda health office (similar to the Ministry's quality improvement advisors).

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ANNEX B: QUANTITATIVE FINDINGS

See separate document with the full quantitative findings.

ANNEX C: FATHERS: INVOLVED, RESPONSIBLE, HEALTHY CURRICULUM

See separate document of the Fathers: Involved, Responsible, Healthy Curriculum, an adaptation of Promundo's Program P.