



ETHIOPIA GENDER ASSESSMENT

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Ethiopia Gender Assessment

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"There is a traditional belief that men are the head of the house, but they want to be the roof, too."
– Female service non-user

TABLE OF CONTENTS

- List of Acronyms.....v**
- Executive Summary..... vi**
 - Findings.....vi**
- Project Background..... 1**
 - Objective of the Gender Assessment..... 1**
 - United States Government (USG) Gender Imperatives 2**
- Methodology and Limitations 3**
 - Methodology..... 3**
- Findings: Institutional Delivery..... 6**
 - Context..... 6**
 - What is working 6**
 - Perceptions of services..... 10**
 - Barriers 20**
 - Institutional Delivery Recommendations 31**
- Findings: Male Partner Testing 39**
 - What Is Working 39**
 - Perceptions of Services 42**
 - Barriers 44**
 - Opportunity: Men Want to Be Involved but Don’t Know How..... 51**
 - Male Partner Testing Recommendations..... 53**
- Annex A: Scope of Work for Gender Assessment..... 59**
- Annex B: Individuals Interviewed 62**
- Annex C: Documents Reviewed 63**
- Annex D: Focus Group Discussions and Sites 67**
- Annex E: Focus Group Discussion Guides 68**

LIST OF ACRONYMS

ANC	antenatal care
CPMTCT	Community Prevention of Mother-to-Child Transmission
FGD	focus group discussion
FMOH	Federal Ministry of Health
GBV	gender-based violence
GHI	Global Health Initiative
GoE	Government of Ethiopia
HC	health center
HEW	health extension worker
IGWG	Interagency Gender Working Group
IOCC	International Orthodox Christian Charities
IPV	interpersonal violence
MNCH	maternal and newborn child health
MSG	mother support group
MSGM	mother support group mentor
PATH	Program for Appropriate Technology in Health
PEPFAR	President's Emergency Plan for AIDS Relief
PMTCT	prevention of mother-to-child transmission
RHB	regional health bureau
SBA	skilled birth attendant
TBA	traditional birth attendant
UHEP	urban health extension professional
USAID	United States Agency for International Development
WHO	World Health Organization

EXECUTIVE SUMMARY

Gender analysis allows for the examination of how gender dynamics and power affect a given context. The objective of this gender analysis was to identify gender barriers to the uptake of two critical prevention of mother-to-child transmission (PMTCT) services—male partner testing and facility-based delivery—and provide recommendations for addressing those barriers.

The Community PMTCT (CPMTCT) gender assessment team consisted of five members from IntraHealth International and CPMTCT implementing partners: Maryce Ramsey, Senior Gender Equality Advisor, IntraHealth International, Washington, D.C. and Gender Assessment Team Leader; Aynalem Yigzaw, Senior Program Coordinator, IntraHealth International, Ethiopia; Wondemagegn Tekalign, Demand Creation and Community Mobilization Advisor, CPMTCT Project, Pathfinder International; Aynalem Tefera, HIV/AIDS Program Manager, CPMTCT Project, International Orthodox Christian Charities; and, Emiamrew Sisay Ayalew, Consultant. (For Ms. Ramsey's Scope of Work, see Annex A.)

This gender assessment was carried out from May 28 through June 14, 2012, following standard gender assessment procedures: interviews with staff, partners, cooperating agencies, United States Agency for International Development (USAID), and other donors; a review of project and other relevant documents; meetings with project implementers (facility-based providers, Mother Support Group Mentors, Urban Health Extension Professionals [UHEPs] and Religious Fathers), and service users/non-users. Given the service specific focus of the assessment, it was heavily weighted to the latter, which took the form of focus group discussions. These focus groups took place in six different locations in two regions and included site visits to health facilities.

Findings

In every focus group, men and women could knowledgeably discuss both the benefits of facility delivery and the risks of home birth. HIV-positive women in particular are motivated to deliver in the health center in order to have a healthy, HIV-negative baby. Many women reported attending antenatal care (ANC) but not all deliver in a health center. Some go to private clinics, but others still prefer home. Providers perceive that they are delivering a good service of reasonable quality. This is distinctly different than the perception of facility-based delivery services held, to a certain degree, by UHEPs and most certainly by the community. The primary barrier identified to use of facility-based delivery was that disrespect and abuse deter pregnant women from seeking those services. The project must address this barrier at multiple levels through targeted interventions in order to change this negative perception and offer women respectful, high-quality maternity care.

Men and women are aware of the benefits of PMTCT and male partner testing and profess their support for it, even men. But that professed support does not translate into actual couples' testing. Men in particular have a variety of barriers, none of which are unique to this setting. Men are testing, just not necessarily as part of a couple. The dynamics of relationships and the role of trust within those relationships affect testing and disclosure for both men and women. One troubling and oft repeated

belief was that men do not need to test if their partners have already done so, the idea of testing by proxy. Many men did express a desire to be more involved, and the project can best respond by strengthening the role that Religious Fathers play as well as identifying other men and community venues to reach and engage men.

PROJECT BACKGROUND

Since October 2009, IntraHealth International and its partners, Pathfinder International, Program for Appropriate Technology in Health (PATH), and the International Orthodox Christian Charities (IOCC) have been implementing the United States Agency for International Development-funded (USAID-funded), five year, Community Prevention of Mother-to-Child Transmission of HIV (CPMTCT) Project in five regions: Amhara, Tigray, Oromia, SNNPR, and Addis Ababa. In close collaboration with the Federal Ministry of Health (FMOH), HAPCO, Regional Health Bureaus (RHBs), Zonal and Woreda Health Offices, health centers (HCs), and health care providers as well as local organizations and communities, the project continues to successfully achieve the project's four core objectives:

1. To build the capacity of RHBs, zonal and woreda health offices, and community-based organizations to support and manage community-based prevention of mother-to-child transmission (PMTCT)
2. To increase access to maternal and newborn child health (MNCH)/PMTCT services through providing facility and community services; and improving bi-directional linkages/referrals.
3. To increase demand for MNCH/PMTCT services through community outreach
4. To improve the quality of community and facility-based MNCH/PMTCT services.

Poor PMTCT performance in general has led the Government of Ethiopia (GoE) to launch the Accelerated Plan for Scaling-Up PMTCT in Ethiopia. This plan includes demand creation led by health extension workers (HEWs) supervising Health Development Army and Women's Coalition efforts. The purpose is to create demand for at least one HC level antenatal care (ANC) visit, couples' counseling, male partner testing, and institutional delivery.

There have been dramatic improvements in the uptake of services, especially male partner testing and use of a skilled birth attendant (SBA), at CPMTCT sites, but overall coverage is still low. For example, comparing 100 sites with data for Oct-Dec 2010 and Oct-Dec 2011, there was a 101% increase in male partner testing and a 48% in use of a SBA; however, this increase is an increase to only 30% of male partners of ANC clients tested, and in terms of SBA, 20% of ANC clients.

Objective of the Gender Assessment

Given the ongoing low levels of male partner testing and facility-based delivery, the objective of the three-week gender assessment was to identify gender biases and barriers affecting uptake of male partner testing and institutional delivery services.

United States Government (USG) Gender Imperatives

A gender assessment of services offered through the CPMTCT Project is in keeping with several applicable USG mandates and policies including the recent USAID Gender Equality and Female Empowerment Policy which highlights the importance of a gender analysis at both the strategy and project levels in identifying women and men's "differing needs, constraints and opportunities, and the impact of these differences on their lives."¹

By identifying and addressing gender barriers to male partner testing and facility-based delivery, the CPMTCT Project stands ready to contribute to two of the three outcomes identified in the Gender Policy, namely:

- Reduce gender disparities in access to, control over, and benefit from resources, wealth, opportunities, and services—economic, social, political, and cultural
- Reduce gender-based violence and mitigate its harmful effects on individuals and communities so that all people can live healthy and productive lives.²

Further, addressing gender barriers in the CPMTCT Project responds to the Global Health Initiative's first of seven core principles—to focus on women, girls, and gender equality—and the majority of its ten elements for promoting the Women, Girls and Gender Equality Principle.³ Lastly, the President's Emergency Plan for AIDS Relief (PEPFAR) as part of the Global Health Initiative is guided by the initiative's gender requirements as well as its own gender strategy. That strategy emphasizes PEPFAR's commitment to ensuring gender equity in prevention, care, and treatment services. Addressing gender barriers to CPMTCT Project services contributes to three of the five PEPFAR gender strategy focus areas, namely:

- Increasing gender equity in HIV/AIDS programs and services
- Reducing violence and coercion
- Addressing male norms and behaviors.⁴

¹ USAID Gender Equality and Female Empowerment Policy, March 2012. Page 12.

http://transition.usaid.gov/our_work/policy_planning_and_learning/documents/GenderEqualityPolicy.pdf

² USAID Gender Equality and Female Empowerment Policy, March 2012. Page 10

³ Global Health Initiative Supplemental Guidance on Women, Girls, and Gender Equality Principle, <http://www.ghi.gov/resources/guidance/161891.htm>

⁴ A Woman and Girl-Centered Approach to Health and Gender Equity, <http://www.pepfar.gov/strategy/ghi/134852.htm>

METHODOLOGY AND LIMITATIONS

This is a qualitative programmatic assessment, and the findings are not meant to be generalizable to other programs. Given the qualitative assessment methodology used, standard limitations do exist regarding the scope, representativeness, and extent to which generalizations can be made based on the data collected. The contextual depth of analysis that interviews, literature review, focus group discussions (FGDs), and field site visits allow compensates for these limitations. The assessment presents the views and perspectives of an array of stakeholders (approximately 200) allowing for some degree of validation and triangulation. The assessment was reviewed and approved by IntraHealth International's internal Research Review Committee in accord with its human subjects procedures.

Methodology

The gender assessment used a qualitative methodology following standard gender assessment practices. Four methods were used to collect information:

1. Key informant interviews

This aspect was quite focused, targeting individuals with specific gender and/or programmatic expertise from USAID, other donors, CPMTCT partners, and cooperating agencies. For a list of individuals and organizations, see Annex B.

2. Literature review of pertinent documents

For a list of documents reviewed, see Annex C. Types of materials reviewed include:

- Literature on male involvement in PMTCT
- Published studies, assessments and surveys on gender in Ethiopia, and basic gender data
- CPMTCT Project documents
- Relevant provider training materials
- Materials on gender programs carried out by other donors, nongovernmental organizations, and cooperating agencies.

3. Focus group discussions

FGDs were conducted with 191 people most affected/potentially affected by the two services of interest, namely, male partner testing and facility-based delivery. In all, 25 FGDs were held in two regions and six sites with:

- Male service users (three FGDs), defined as men who had used male partner testing services
- Male service non-users (four FGDs), defined as men who had not used male partner testing services
- Female service users (five FGDs), defined as women who had delivered recently in a project-supported HC

- Female service non-users (four FGDs), defined as women who had delivered somewhere other than a project-supported HC
- Facility-based providers (four FGDs) based at the six selected HCs
- Religious Fathers (two FGDs) trained and providing demand-creation activities under CPMTCT partner IOCC
- Urban health extension professionals (UHEPs) (two FGDs) assigned to two selected HCs
- Mother Support Group Mentors (MSGMs) (one FGD, which was actually primarily made up of mother support group (MSG) members with only two MSGMs).

For a complete list of FGDs and sites, see Annex D. For FGD guides, see Annex E.

4. Health facility site visits

The gender assessment team toured the targeted health facilities focusing on the delivery services.

Site selection criteria

The selection of informants and project sites was based on purposive sampling in order to maximize the collection of relevant data within the limited time frame. Six sites were selected using the following criteria:

- A list of poor-performing and high-performing HCs in terms of facility-based delivery and male partner testing was generated for each region using project data.
- Urban and peri-urban sites were prioritized based on HIV prevalence.
- Convenience was taken into account in terms of location to maximize time and data collection.

Based on a combination of the above criteria, the following sites were selected:

- Buanbuha, Dessie, Amhara Region
- Segno Gebeya, Dessie, Amhara
- Kombolcha 05, Kombolcha, Amhara
- Legetafo, Legatafo, Ormoia Region
- Bulchana, Sheshamane, Oromia
- Bokushenen, Adama, Oromia.

Gender Assessment Team preparation

All CPMTCT staff, including all of the gender assessment team, received gender training covering: basic gender concepts; values clarification regarding gender; USAID, Global Health Initiative, and PEPFAR gender commitments and requirements; the domains of gender analysis: identification of causes and consequences of low facility-based delivery and male partner testing; application of the gender

domains to those causes and consequences; and the gender continuum framework. In a practical application of gender concepts and gender analysis, the Gender Assessment team pared down detailed thematic interview lists to final FGD guides, which were also vetted for cultural appropriateness. Team assignments for FGD facilitator, note taker and translator were planned in advance, based on experience, skills, and cultural appropriateness and rotated among the Ethiopian members of the team.

Data collection

Data was collected in the form of notes—a primary set taken by the Senior Gender Advisor and a backup set taken by a rotating member of the Gender Assessment team. There was no audio recording. FGDs were conducted in Amharic with simultaneous translation into English. At the end of the gender assessment, the team met to identify preliminary findings from the FGDs for the staff debrief. Subsequently, the Gender Advisor carried out the full analysis by employing a thematic manual analysis of the data and by color coding persistent words, phrases, or concepts within the data according to broad themes. Data categories were grouped, summarized, and integrated with other data from resource materials in order to draw conclusions for the project.

Informed consent

There were two levels of consent for participants: one verbal consent at the time of invitation to participate and the second a verbal consent confirmation at the time of participation. Both were obtained in Amharic. No names or individual identifiers were recorded. Group discussions were closed to participants only and held where others could not overhear.

FINDINGS: INSTITUTIONAL DELIVERY

Context

For the context of gender relations and Ethiopia's national response please see pages 16 through 22 of the May, 2012 USAID/Ethiopia HAPN Gender Assessment.

For the purposes of this assessment, institutional delivery meant delivery in an HC.

What is working

Overall, the team found providers and staff dedicated to the program and to delivering quality services. It is clear that providers are called on to do much with little and are working their best to do so. All of the groups: facility-based providers, UHEPS, MSG Mentors/Members and Religious Fathers are all doing their part to promote and provide HC-based delivery and PMTCT services. It was obvious from the FGDs that there were many dedicated providers.

Most men and women know the benefits of facility-based delivery.

One anticipated barrier was that people might not know the dangers of delivery at home or the benefits to facility-based delivery. That did not, however, appear to be the case. In every focus group, individuals were able to articulate the dangers associated with delivery at home as well as the benefits of institutional delivery. Even the groups of women who delivered at home could articulate the benefits to facility delivery and the risks to home birth. Every group shared an example of either their own experience or someone they knew who had suffered a childbirth-related illness or the illness or loss of a baby in childbirth. These were all groups in urban and peri-urban areas. When groups talked about people who did not know about the benefits of facility-based delivery or the dangers of home birth, it was in regard to those living in the rural areas where some of them had migrated from or to recent migrants from rural areas.

"During the early days due to lack of knowledge, we thought that it was the will of God that some died. But now, all women are aware to deliver in a health facility." – Female service non-user

"During our time we were born at home, but thanks to God our children are educated and go to the health facility." – Religious Father

"Those who have knowledge go to the health facility to deliver. I wish for my wife to deliver at the facility because they are equipped. I don't want her to deliver at home." – Male service non-user

"When we decided to have a baby and she got pregnant we came here [to the health facility]. If she delivered at home, there would be problems like bleeding or death. But if she goes to the health center, she can be treated. If the baby is in the wrong position, she can be referred, and there is follow-up." – Male service user

"We know there is a problem with delivering at home like infection and bleeding." – Female service non-user

"I understand the need for facility delivery." – Female service non-user

"Many of our mothers and sisters are suffering from birth complications at home." – Female service non-user

"Recently a woman delivered twins at home by herself. She lost both babies." – Female service non-user

"We can save our lives if we deliver at the health center. Even our neighbors advise us to deliver at the facility." – Female service user

"At home I could not save my wife and child. There could be bleeding, and it is unclean." – Male service non-user

"There can be a problem with bleeding. If it is at the health center they can care for you. If it is at home you bleed for days." – Female service non-user

"The baby won't get vaccinations with a home delivery. If it is at a health facility, both the mother and baby get vaccinated on time." – Female service non-user

"Everyone prefers the health facility for birth these days. If at home it is a TBA [traditional birth attendant], and there can be unsafe equipment and risk for the mother. So a man does what is expected of him by praying to God and taking her to the facility." – Male service non-user

PMTCT motivates HIV-positive women to deliver in the health center.

In addition to avoidance of poor health outcomes, many expressed a strong motivation for HIV-positive women to deliver in a health facility because through appropriate care they can avoid transmission of HIV to their child. This was, as one would expect, expressed most by groups of female service users who were also members of mother support groups. Even though some expressed dissatisfaction with the services, the possibility of having an HIV-negative baby far outweighed any dissatisfaction they may have felt. And from the groups of MSG members who attended the FGDs with their healthy HIV-negative babies on their laps, it is clearly working.

"Women go to the health facility because she [sic] wants a healthy baby. To be healthy she needs to get tested for HIV and if positive to get treatment." – Religious Father

"She comes for her health and the health of her baby. We tell them the advantages. They ask, 'Is it really possible to get a safe, healthy baby?' We tell them, there is medicine. There is follow-up." – MSGM

"When I started to deliver, I came to the health center. To get an HIV-free baby I came. My family and husband insisted I not come, but I came to get an HIV-free baby." – Female service user

"The neighbors wanted me to stay home. I may not get a free baby at home, so I delivered at the facility." – Female service user

"Since we have follow-up to have a free baby, we take care of everything, so we decide we need to give birth in a health facility. It is important to get an HIV-free baby." – Female service user

"When I was told that I could have an HIV-free baby, I couldn't believe it. They said you need to birth in a health facility. So I went, and I advise others to get this service." – Female service user

"To get a healthy baby you have to visit the health center. For the health of my child, I follow up and use the services." – Female service user

"If we didn't have HIV, we could give birth at home." – Female service user

"We are HIV-positive, so having a healthy baby is a big thing." – Female service user

"What encouraged me was knowing that I could get an HIV-free baby." – Female service user

"Our life has been affected, but we don't want our children to be affected." – Female service user

"We already contracted HIV, but we credit them with getting us an HIV-free child." – Female service user

Some facilities are providing mother-friendly services.

Providers recognize that there may be aspects of home birth that are attractive to mothers. For more on mothers' perspective on home birth see page 13. As one UHEP put it: "How can we bring what is good about birthing at home into the health centers?"

Some are already reporting that they are taking measures to make birthing women more comfortable in the HC by bringing some of the comforts of home into the HC as reflected in the following provider quotes:

"Anyone who wants can come into visit her—this is advantageous because she is closer to them than the health provider."

"The family accompanies, and it is open to the family. This makes them more comfortable. . . . We take care of them, and then they tell their sister. They are afraid and want their family to come with them. Here we discuss with the family."

"She can sleep in or birth in any way she wants."

Women report the use of ANC/follow-up and testing even if they do not deliver in the facility.

It might be expected that a "non-user" in terms of one health service—facility-based delivery in this case—might be a non-user of all health services or even all pregnancy-related services, but that was not the case. In fact, a surprising number of women who participated in the female non-users FGD were actually service users. They reported using ANC services, especially vaccinations and also HIV testing. This aligns with the findings from a study looking at barriers to facility delivery in rural Ethiopia: "The dominant perception of a 'normal' birth precludes many mothers from engaging with health facilities for routine deliveries. A paradoxical situation has developed in which increasing numbers of women who have the ability to access health facilities and utilise other MNCH services, still do not give birth there. Nigussie et al.⁵ suggest that prenatal visits to a health facility are a strong predictor of safe delivery service utilisation. This was not reflected in our study. The situation in South Wollo underlines that having services in place does not automatically result in mothers who are able to utilise them doing so. Mothers, as health service consumers, are selecting specific MNCH services rather than complying

⁵ Nigussie, M., Marian, D. H., & Mitike, G. (2004). Assessment of safe delivery service utilisation among women of childbearing age in north Gondar Zone, north west Ethiopia. *Ethiopian Journal of Health Development*, 18(3), 145–152.

with the whole continuum-of-care package.”⁶ For more on the perception of a “normal” birth as a barrier, see page 28.

“I was in ANC follow-up here.” – Female service non-user

“The vaccinations were here. I gave birth at home.” – Female service non-user

“As far as testing, we accept.” – Female service non-user

“We got vaccinations with our babies, but we didn’t know to deliver there.” – Female service non-user

“I gave birth in the rural area. Now I am following ANC.” – Female service non-user

Women have many birthing options—public as well as private—and are using them.

UHEPs, because of their work tracking pregnant women in the community, are able to tell where pregnant women in their catchment deliver, whether at home, in the HC, hospital, or private facility. UHEPs reported that many women are giving birth in a health facility but not necessarily the HC. Some women are opting for a private facility. Providers also pointed out that women avail themselves of other opportunities. Some do so because they are not happy with the quality of the public services, or they think the quality at the private facilities is better. The important thing is that women deliver assisted by an SBA—whether in a public or private facility—as stated in the last provider quote below.

“They prefer private clinics.” – Facility-based provider

“Women who have some source of income do not come here because services are better at private.” – UHEP

“Women go to private clinics to deliver. What can we do?” – Facility-based provider

“There are three private clinics. They get their vaccines from us but deliver in the private.” – Facility-based provider

“They want a doctor, a gynecologist, so they go to the private clinic.” – Facility-based provider

“When they come for their 45th day appointment, they say they went to the private clinic because they prefer a doctor over a nurse.” – Facility-based provider

“To work here is humanitarian for health workers. We cannot limit a client’s preference. If a woman wants to go somewhere else she can—that is our guideline. We tell them to use a health facility for delivery and HIV services. They can go anywhere.” – Facility-based provider

“[Our delivery is low here] because people have alternatives for testing/delivery. They go with their preference. If wealthy, they go to a better facility. Not because of our service. There are three health centers around. But for delivery they want to go to other place. What we advise is not to give birth at home but to go to their preference. They attend ANC here but deliver elsewhere. We cannot limit their choice. We just tell them to use a facility.” – Facility-based provider

⁶ [Bedford J, Gandhi M, Admassu M, Girma A.](#) 'A Normal Delivery Takes Place at Home': A Qualitative Study of the Location of Childbirth in Rural Ethiopia. [Matern Child Health J](#). 2012 Feb 23 . [Epub ahead of print]

Perceptions of services

Given the nearly universal understanding of the benefits to institutional delivery and the risks of home birth, one would expect better usage of these services than exists. Why are women still overwhelmingly giving birth at home? The first area we examine is perceptions of the services: what are the different views, experiences, observations, insights, and opinions of the groups?

Health center-based providers

Overall, many of the HC-based providers are happy with the quality of services that they provide, especially given the limitations within which they work.

Health Center-Based Providers' Perspectives

"The approach to the client is important. If the approach is not good they won't come. Our client flow is good because of our approach."

"Our numbers are high because our ANC counseling is strongly working on educating women."

"Previously it was not acceptable to birth at the facility because they want to be seen by doctors and gynecologists. But they are coming now."

"If we approach her as family and friend and touch her—if I had been with my family, I would be treated this way. It is all about the approach."

"Anyone that wants to can come into visit her—this is advantageous because she is closer to them than the health provider."

"She can sleep in or birth in any way she wants."

"For the HIV-positive mothers, they get prophylaxis, and everything is so convenient."

"[Women go to private facilities] because they think if there is a complication, they will get better support and better professionals. It is not because of the service we provide but because they want better professionals."

"The attitude of the health workers who provide services has also improved. If there is a good service, the community will come. But if it is not a good approach, they won't."

"What attracts them is quality of care, so we provide."

"The family accompanies her. This makes them more comfortable than going to the hospital. It is free. We take care of them, and then they tell their sister. Here we discuss things with the family."

"The pregnant woman reads your face and knows how you feel. They feel comfortable. They say what they face in the health facility."

"Satisfaction is there to some extent. But we cannot say that we are 100% satisfied. There are materials gaps. People do not come on time and with complications. We may not get sufficient supplies in the delivery room. But people are committed, and we maintain procedure."

"It starts with washing materials. We do not discriminate. We clean everything. We start with hygiene. We assume that each who comes is our mother or sister. If very poor we contribute ourselves to refer her. We give them our clothes."

"There is only one person in the labor ward. There could be four deliveries in a day. There is no allowance for the person that spends time. Instead of referral, we decided to save lives."

"The technical part isn't recognized by the community. The midwife and others have a nice approach. The community doesn't know the technical side—what attracts them is our approach."

"From our perspective, we think the services are good."

"Our service is friendly for ANC and delivery. If there is a problem, we refer them. They give us feedback that our services are good and better than others."

"If they come here it is based on their interest and not because they have no other options."

"The women are low-income and have no idea what we provide. Once they come, we tell them the value of institutional delivery. They have no idea of our services before they come. The health center is working in a collaborative way. We do our best to attract them and counsel them."

"We are the best, and we are satisfied."

"We follow the checklist and partograph. We keep them six hours."

"I would like to talk about the poor. Some come alone with no support. We treat her and follow her status. After birth we bring her Mirinda [a local soft drink]. If she has no one to accompany her, we take her home."

"We are giving good service—the community says so. We have a good reputation with the community."

HC-based providers did express dissatisfaction with materials gaps, the physical structure, and poor or no ambulance service. The lack of a separate waiting room for delivering mothers was noted by providers as a gap in several facilities whether there was insufficient room for before or after delivery or both (for more on this, see section, "There is no space before and after labor" beginning on page 19). One center lacked water, another lacked toilets, and yet another had problems with electricity. They noted problems with either an insufficient number of delivery couches or the quality of the couch, or with the procedure for changing the sheets. There were materials gaps such as a lack of silk in the delivery room, sheets, and gloves. A few places mentioned a gap in necessary medicine (TT/prophylaxis). One facility noted a lack of equipment (ultrasound) and proper training (in PMTCT and antiretroviral) that was leading them to refer cases. However, this seemed to be more about who had been trained and the number trained rather than no one being trained. They also pointed out that as success increased in terms of the number of women delivering in their facilities, their human capacity remained the same and was strained by the increased demand. Some did not have access to an ambulance, or the service was poor. In one center that was not served by an ambulance, it affected their ability to refer cases, and, in the opinion of the providers, it created less confidence in the women.

Urban health extension professionals

The providers in the Urban Health Extension Program have a unique viewpoint on the program and the services, given their position based in the HC while carrying out extensive community outreach. UHEPs serve as the link between the facility and pregnant women and their families. It is their job to follow up

with pregnant women and to encourage them to come for ANC and to deliver in the HC. Through UHEPs' work going house to house in their assigned catchment area, they follow the pregnant women through ANC and know where each woman delivers—whether at the HC, public hospital, or a private facility. It is telling, then, that their perspective of the delivery services and of the quality of services overall is much less sanguine than that of the facility-based providers actually carrying out the services of interest. Neither of the groups of UHEPs was from the HC identified as low performing in terms of facility-based delivery.

UHEPs' Perspectives

"The service is not attractive. The providers just want to relieve their obligation, not make the services attractive."

"We tell the women what the problems of delivery at home are, but maybe we should tell the providers what the problems are. The women come and wait for a day. They have their card, but no one checks it. They do the tests twice. They take the blood twice. I believe that people don't want to come here because when the providers don't tell them anything, the women think they don't know anything. The main thing is the provider approach. Good treatment will bring clients back. That is the main thing."

"They say, 'The service isn't good.' 'We don't want to go to that facility.' 'We prefer private and NGOs [nongovernmental organizations].' They think they won't be treated properly. The clients are not satisfied with the treatment of the providers. Any mistreatment of clients will affect the whole community."

"They don't like the health center because they don't treat them properly. The service is poor compared to the private facility. Most women resist to come to the health center. I know a woman who has two cards—one at the health center and one at the private."

"We need to convince the woman's mind (on what she needs to do). The same needs to be done at the facility. The service providers should give proper service. I can convince and bring her, but if she gets poor service she will prefer to go home to deliver. The TBA gets paid, so she is happy to support the pregnant woman. So the women prefer the TBA. . . . Better services here would convince women to deliver at the health facility. . . . Whenever we go to a new place, we must be humble and respect her: the same should happen at the health center."

"The service in the facility needs major improvement. They are not doing their job properly."

"I want to second the previous comment. Women come with their card, and no one helps them in a timely way. A woman came after strong pains; she came to the health center, and she was mistreated. She told the community, and they believe they will be mistreated. So they go to the private facility... Unless women are treated well; not only by the health provider; it starts with the guard and the woman who gives the card. All should be convinced."

"She had her health card but could not get in. I brought her and paid for her transport. The health provider left. She did not get the service, and I wasted my time and money."

"If a woman came here and got good services, she would be happy and explain to her family and come regularly."

"Doctors in private clinics do proper investigation and proper care. So private clinics give better care."

"Women who have some source of income do not come here because services are better at a private clinic."

Community women and men

Positive perceptions of home birth

Perception of services actually has two aspects for community members that must be weighed against one another: the perception of facility-based delivery versus the perception of home birth. Although many report an understanding of the benefits of facility birth and the risks of home birth, this does not mean there were not individuals in some groups who expressed positive feelings regarding home birth. This was especially true for women who had birthed at home and had no problems. But they also expressed benefits to birthing at home in terms of physical comfort and psychological support.

"We birthed at home and nothing happened." – Female service user

"In my case, there were two people, two TBAs I worked with. They assisted me: two supported my back. They gave me hot drinks. Traditional drinks. – Female service non-user

"I understand the need for facility delivery. But there is nothing as good as delivery at home." – Female service non-user

"If we have no HIV, we can birth at home." – Female service user

"For me, I prefer coffee ceremony and to stay home." – Female service non-user

"The neighbors and my friends were there. They are there to give me care and support. People arrange everything. They warm the house. They get charcoal. I told my husband I would be OK with their support. You don't suffer when you deliver at home. There is no stretcher or couch. You don't need to move. There is no problem especially if you have a TBA. At the health center there is a process: register, get your card. You go from room to room. Home is the safest place to deliver. You have warm drinks and massage. Your mother is there with you and Saint Mary. I had all three children at home. If the TBA can bring a blade to cut the umbilical cord; if she can bring gloves to prevent HIV, then home delivery is preferable." – Female service non-user

"A lot of women prefer to deliver at home. They want the TBA to massage their abdomen. This is our weakness as women." – Female service non-user

"So at home . . . there is a coffee ceremony. In another corner, they are praying to Mother Mary to support you. So everyone is supporting you." – Female service non-user

"I gave birth at home and faced no problems." – Female service non-user

Positive perceptions of facility services

However, the perspectives on the quality of services provided at the HCs became much less positive as the conversations moved away from the facility (facility-based providers) and closer to the community (UHEP) with the conversations with male and female service users and non-users, the actual communities where clients are drawn from, being less and least favorable, respectively. In the two sites with high numbers of facility-based deliveries, the comments from the female service users and male service users were much more positive than those of the female non-service users and male non-service users in those two places. The comments of active mother support group members were the most

positive of all. However, when asked whether they were happy with the delivery services they received and if so to share what they liked, the women's comments were more often about the kinds of services provided, the fact that they were free, and the positive health outcomes they experienced as a result of the services rather than about the manner in which the services were delivered.

Female Service Users' Perspectives

"I was always happy with the services provided at the center. I like the approach of the doctors and their interaction—in urban areas there are a lot of clients, so they don't give you a lot of time. Their facial expressions are inviting."

"In some places we hear they beat and insult pregnant women, but here they encourage us to move around. They are nice and kind and follow us."

"They are collaborative and they educate us. They tell us what we don't know."

"I was happy. They treated me well. I am HIV-positive. I had an HIV-positive baby, but now the baby is free. I am happy."

"They treated us during labor, and we are happy."

"Everybody likes the health center. They treat everybody."

"It saves our lives."

"It is really good."

"I was sick, and the provider saved me."

"They gave me glucose because I am not strong enough to push."

"The placenta would not come out, and they took it out."

"Some women who don't come to the health center complain about bad service, but it is only that they don't want to come."

"There was good service. The attendants provided good support."

"Those who come during vaccinations are newly trained, and no one wants to come. They are students. No one wants the students."

"The service at the health center is nice. The doctors are nice, and we have never faced a problem."

"This center delivers the best service. It is clean."

"It's nice. They respect the appointments."

"They treat us well. When it is beyond their capacity they refer. If they can handle it, they treat us like parents. It is the best facility."

"There is a lack of care in delivery—some follow up and take care, but some do not."

"My labor was prolonged. The one who should refer me wasn't here, so I waited a long time to be referred."

"People tell us there is a problem here—that they are not treated properly—but for me I was fine."

Negative perceptions of facility services

However, in total, there were many more negative comments from male and female service non-users. It is important to reiterate that for the purposes of this assessment, "non-user" only refers to whether a man has used male partner testing services or a woman has delivered in the HC. They could have used the HC for other services, or a man or woman might have brought a family member or friend to the center to deliver. So "non-user" does not necessarily mean that they are not familiar with the HC.

Community Perspectives: Male and Female Non-Users

"When we see how the HEWs, doctors, and nurses treat clients, we feel like that person is our own family, but others do not care. We come here to be saved. We are all different in our appearance. Providers are the same. We come to be saved, and there are some who are cruel, and some don't even provide first aid until someone comes to make them." – Male service user

"Out of 20 providers, maybe only three or four are good in terms of communication. They don't follow up. They insult the women in labor. Sometimes the family will quarrel with the providers." – Male service user

"The nature of health service providers is different than other civil servants: they are life savers. Pregnant women deserve care, protection, affection, and respect. The service provider can be friendly and talk like a family member. Service providers need to understand it is not just medical care." – Male service user

"It is hard to deliver at home because we are alone—no family here because of the job. We would like to use the facility but they are not friendly." – Female service non-user

"It is still better for the health of the baby to be at a facility, even if they mistreat you." – Female service non-user who delivered a sick baby at home

"Most people in the city know they should go to the health facility for services, but the problem is getting service." – Male service non-user

"When I delivered, there were nice service providers who encouraged me and were with me every minute. These days I went with my friend, and there was much that was disappointing—rough words, insults, no respect for those that accompany. Some things we saw not only discouraged from delivery but from all health services. We waited for eight hours, but then we were referred. We asked if we should go earlier, but they said they are service providers and we are not. We want the care and passion. If we can get that at the health facility, why would we go to the hospital?" – Female service non-user

"The health center service providers should give priority to pregnant women. They should have a sense of urgency for pregnant women. Education should not be limited to the community but also be for the provider. The doctor gives responsibility to the nurses, and the nurses don't care. They seem fed up with what they do on a daily basis. We understand that they might have a huge client flow to treat, but they must have a feeling for the woman." – Female service non-user

"The cleaner, the guard, the service provider—all abuse her (the pregnant woman)." – Male service user

"Usually pregnant women are accompanied by other women. If she is treated well—not insulted, not physically punished—then other women will see and come." – Male service user

It isn't always clear which of these comments are "just" referring to poor service and which are examples

of mistreatment and abuse. In one focus group of female non-service users organized at a parish, the women had many stories of mistreatment of pregnant women by providers to tell, and yet it was clear that they were trying to be fair and evenhanded by pointing out that not all providers mistreat or that it was primarily younger, less-experienced providers.

Female Service Non-Users' Perspectives

"The providers need an ethical approach. We want a good approach from health providers."

"There is mistreatment of delivering women."

"Some are kind, but some do not have ethics."

"They are mistreated. Providers are not friendly so many women just pray to God and Mary to deliver at home. Only when there is a complication and bleeding will they call an ambulance and go to the facility. There is mistreatment."

"Not all but a few are bad. The few need to be advised: not just public (providers) but private also."

"There is no need to cover. Maybe only 10% are not good. We don't need to cover for anyone."

"There are behavioral problems at the health center which need close follow-up."

"There are a lot of problems that we cannot mention. I prefer to deliver at home. You have to see into the problems deeply and try to solve."

"There are challenges at the facility with the providers."

Others comments such as the story below are clearer about mistreatment as well as the impact on services:

Two Women's Stories

"I delivered three babies at home. I pray not to go to the health center because there is mistreatment there during delivery. It would be better if providers treat pregnant women with care and respect. When I see providers mistreating pregnant women, I pray not to go. Even the female providers mistreat women. I follow antenatal care, but I prefer to deliver at home."
– Female service non-user

"I was living at home without any family. I am a newcomer here, and I am separated from my husband. The labor came at midnight. The neighbors took me to the health center. I was disappointed with the providers. They mistreated me. They threw me away. They took me to the street outside the compound. I had no money to get home. They didn't even wait for the day even. I tried to commit suicide. They refused to provide me the service because I did not have money. They look at your appearance before they give services. If you have no money, they refuse you service. Everything they say about the facility is a lie. They do not help you." – Female service non-user

There are a few important caveats when talking about mistreatment in HCs and the examples the women shared, and those are that the women were:

- Sometimes referring to public hospitals as well as HCs
- Rarely referring to a nongovernmental organization clinic
- Sometimes, as in the woman’s story above, referring to things that had happened in the more distant past (three years ago).

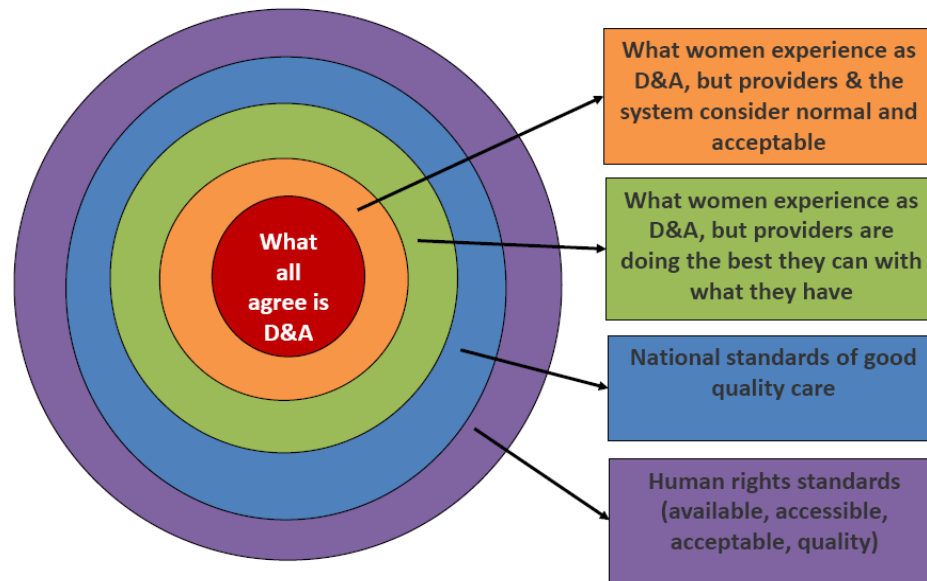
The most horrific stories of abuse were in regard to public hospitals. These most egregious examples of poor service and abuse, including those which ended in death, have been excluded.

However, no matter the source of their perception, it is a very real barrier to seeking services, especially among groups of non-service users. While we may distinguish a HC from a public hospital from a nongovernmental organization clinic, in the minds of the public, and especially non-service users, public hospitals and HCs, in particular, are the same.

The issues regarding how to distinguish abuse and mistreatment from “just” poor quality care as well as categorizing types of abuse and mistreatment have recently begun to be addressed through the USAID Translating Research into Action (TRAction) Project. The imprecision of defining what constitutes mistreatment and whether what one woman considers mistreatment would be seen as mistreatment by other women or providers is reflected in the following graphic taken from the Heshima Project:⁷

⁷ The Heshima Project: Promoting Dignified and Respectful Care During Childbirth in Kenya, Nancy Termini, Population Council on behalf of Tim Abuya (PC) and the TRAction Project Kenya, May 10th 2012; National Press Club, Washington DC

Defining inhumane treatment and abusive care



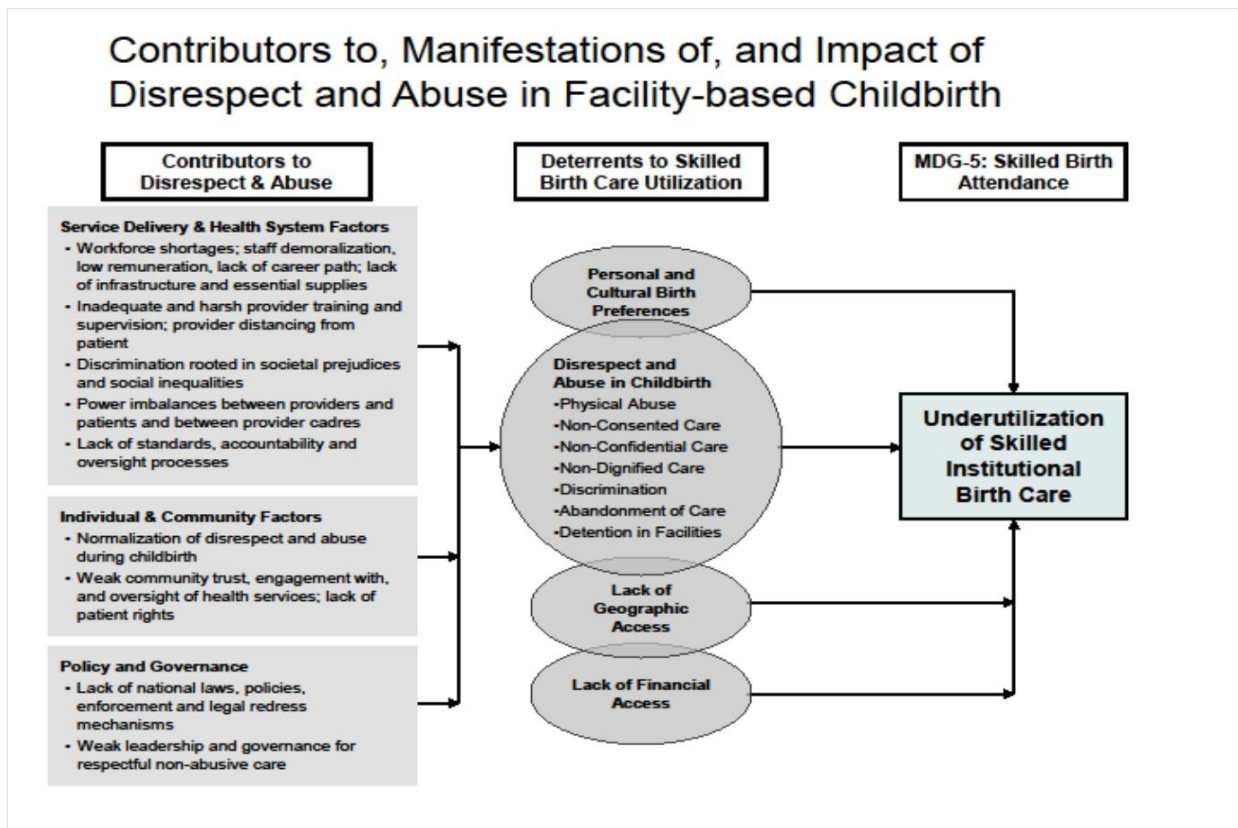
Earlier work under TRAction and the Harvard School of Public Health, the landscape analysis, “Exploring Evidence for Disrespect and Abuse in Facility-Based Childbirth”⁸ reviewed evidence “with regard to the definition, scope, contributors, and impact” of facility-based disrespect and abuse in childbirth, concluding that:

Disrespect and abuse in facility-based childbirth often acts as a deterrent to current and/or future utilization of facility-based childbirth services. Multiple studies highlight the connection between disrespectful and abusive facility-based childbirth care as described by women users and a decision by women users not to use facility-based childbirth services. One of the key strategies for achieving MDG 5 is to increase skilled birth coverage for improved maternal health outcomes. The negative effect of disrespect and abuse in childbirth on skilled care utilization constitutes an important barrier to increasing skilled care utilization and improving maternal health outcomes as defined by MDG 5.⁹

⁸ Bowser, D., and K. Hill. 2010. Exploring Evidence for Disrespect and Abuse in Facility-based Childbirth: Report of a Landscape Analysis. Bethesda, MD: USAID-TRAction Project, University Research Corporation, LLC, and Harvard School of Public Health.

⁹ *Ibid*, page 24.

The paper provided an important framework for looking at the issue of mistreatment and abuse in childbirth which is useful for helping understand the types of mistreatment that were shared in the FGDs.¹⁰



The center part of this framework—“Deterrents to Skilled Birth Care Utilization”—has four types of deterrents listed, each of which arose during the assessment. Disrespect and abuse in childbirth was the gender barrier which was most prominent in this assessment and, therefore, will be examined first. However, each of the other deterrents listed above also came up during the assessment and will be covered later.

As noted in the report, the seven categories of disrespect in the center—physical abuse, non-consented clinical care, non-confidential care, non-dignified care (including verbal abuse), discrimination based on specific patient attributes, abandonment of care, and detention in facilities—are “not mutually exclusive but rather overlap along a continuum.”

¹⁰ Disrespect and Abuse in Facility-Based Childbirth, presentation by Diana Bowser, Sc.D., M.P.H. Harvard School of Public Health, Kathleen Hill, M.D., USAID TRAction Project, May 2012.

In order to sort the FGD examples of mistreatment into the categories, a summary of the examples for each category that the landscape report identified is shown below:¹¹

Results of types of abuse

Category	Summary of Examples
Physical Abuse	Being beaten, threatened with beating, slapped, rough treatment, pinched, tied down, forceful pushing on the abdomen, pulling a baby out by force, painful stitching without anesthesia, withholding of available pain medication when requested
Non-Consented Care	Absence of patient information and communication processes or informed consent for common obstetric procedures including cesarean sections, episiotomies, hysterectomies, blood transfusions, sterilization, and augmentation of labor
Non-Confidential Care	Physical lack of privacy (delivering in public view, lack of curtains), lack of privacy related to sensitive patient information such as HIV status, age, marital status and medical history as well as publically divulging any of this sensitive information
Non-Dignified Care	Verbal abuse, intentional humiliation, blaming, scolding, shouting, and intimidation
Discrimination	Discriminatory behavior, including non-dignified care and withholding care, targeted at individual women based on race, ethnicity, age, language, HIV/AIDS status, traditional beliefs/preferences, economic status, educational level, and marital status
Abandonment of Care	Being left alone, unattended, denied evidence-based care, withholding of moral support and encouragement during and after childbirth
Detention in Facilities	Being held in a health facility after childbirth, sometimes with the newborn child, for failure to pay

Barriers

Disrespect and abuse deter women from seeking services

By the close of the last FGD, the gender assessment team had heard examples of disrespect and abuse fitting each category and usually many for each category. The categories and some examples are listed below:

Category of Disrespect/Abuse	Example Heard in FGD
Physical abuse	"Her suffering is my suffering. Sometimes they beat women at the hospital." – Male service user

¹¹ *Ibid.*

Category of Disrespect/Abuse	Example Heard in FGD
Non-consented care	<p>"I send women here, and they complain that the providers don't tell them what they are doing. They say that the providers treat them but give them no information on what they are doing." – UHEP</p> <p>"The health providers don't tell them about the baby or the health situations they face." – UHEP</p>
Non-confidential care	<p>"One of the problems is we don't have special waiting rooms, and they are exposed to people." – Health provider</p> <p>"I went and was surrounded by six providers. I said, 'Who are these people? I only want one person.' So five went out, and only 1 stayed. They shouldn't see your private parts." – Female service user</p> <p>None of the delivery rooms have any privacy barriers or curtains. The issue of being exposed is of particular concern to religious women. See the discussion on religion on page 20-21.</p>
Non-dignified care	<p>"There is mistreatment in the facility. They shout at us, and we don't like it." – Female service user</p> <p>"The woman may tell you something you didn't ask, and some mistreat her and say, 'I didn't ask that.'" – Health provider</p> <p>"They insult the women in labor." – Female service user</p> <p>"...they said they are service providers and we are not." – Female service non-user who accompanied a friend to deliver and questioned a late referral</p> <p>"Is it you who prescribe, or is it me?" – Male service non-user describing an interaction with a provider</p>
Discrimination	<p>"I had one provider who knows all my problems. When I came (to the health center) I heard that woman talk about my HIV status, so I went home and changed my mind. I decided to go to the hospital because I had money. I got the service and medicine. I told them my status, and they treated me correctly." – Mother support group member</p> <p>"They judge us on our physical appearance. If we look poor, they treat us differently." – Female service non-user</p> <p>"The covered their noses during delivery." – Female service non-user who accompanied another woman to deliver</p> <p>"There are a few providers who do not accept my status." – Female service user</p> <p>"I think that there is unequal treatment between the health facilities. People mistreat you because you are HIV-positive." – Female service user</p> <p>"In the hospital they mistreat women who have HIV." – Female service user</p> <p>There were many expressions of how the public HCs are for those who cannot afford to go to a private facility for better service.</p>
Abandonment of care	<p>"We took a family member to the hospital at night. They said she wasn't in labor. She was left in the delivery room and came to us and said she didn't want to be alone. The service providers were sleeping." – Male service user</p> <p>"My brother's wife went to the health center. They put her on the couch, and there was no provider with her. When we looked for the providers, they were watching TV. We took her to the hospital, and she delivered there." – Female service non-user</p> <p>"I planned to deliver at the health center. My labor was prolonged, and I was referred to the hospital. But the one who should have referred me wasn't here, so I waited a long time to be referred." – Female service user</p> <p>"I see both sides. The service provider—some are careless and relax while the woman suffers. They have no skills and are not competent." – Male service non-user</p>
Detention in facilities	<p>"She delivered at 2a.m., and when we went to bring her home they asked for 400 br. They said we can't take her unless we pay the 400br. We raised the money from the community. But those without family suffer in these cases." – Male service user</p>

There is no space for before and after labor

None of the six HCs the team visited had sufficient rooms for labor and delivery, although one was in the process of building additional rooms. The lack of adequate space affected the quality of the birthing experience in ways ranging from inconvenience to safety. Among the ways that it was reported that women are affected:

- Women are sent home in contradiction to the six hours recommended in the partograph.

"There are two rooms: If three people come we discharge the first one even if it is less than six hours." – Health provider

"They sent me home just after delivery since there is no waiting area." – Female service user

"We know it is a new center, so they will improve. I only stayed an hour after delivery, but there was no postnatal place. I wanted to stay the night, but they sent me home. I don't want to complain for that." – Female service user

In one site the provider reported that four women had delivered the previous night/early morning and that all had been discharged before six hours in order to make room for the next one. It was unclear why the last one was also discharged early.

"If a woman comes in and is told that there is no bed and space for her then others won't come." – Male service user

- A lack of space causes the pregnant mother physical and emotional discomfort.

"If she is first stage of labor, she is sent back home. If she is second stage labor, she has to stay in the waiting room. There is no place to lie down until she is ready to deliver." – Health provider

"If someone else comes in, we discharge the first. They don't want to hear another woman's labor." – Health provider

Providers and women reported that in the small space they had to limit who could accompany the woman in labor.

"My friends were waiting outside, so I went home to save them from the cold since there was no place for them to wait." – Female service user

In at least one center there was only one room and one bed meaning that the woman labored and delivered on the bed and then had to get up for the bed to be cleaned before being able to rest after delivery.

The last quote above regarding friends waiting outside echoes research carried out in Ethiopia looking at barriers to facility-based delivery in rural Ethiopia. That study found: "Health facilities did not permit relatives or neighbours to accompany a mother into the delivery unit. Consequently, many mothers perceived they were 'alone' during labour, despite the presence of attending health professionals."¹²

¹² [Bedford J, Gandhi M, Admassu M, Girma A.](#) 'A Normal Delivery Takes Place at Home': A Qualitative Study of the Location of Childbirth in Rural Ethiopia. [Matern Child Health J.](#) 2012 Feb 23 . [Epub ahead of print]

- Prevents bonding between mother and baby

“When a woman gives birth, after delivering, she needs to go to another room, but here there is no room. She wants her baby with her but can’t unless there is someone to help her because there is no place for the baby.” – Female service user

- Pregnant women, before, during and after labor have no privacy

For some women, especially the religious, exposing their naked body to anyone other than their husband is wrong. It was not clear whether this meant being naked in front of anyone, whether male or female, or just any other man including a male provider. It may be as the Bedford, et al., study found that the sense of being exposed is related to the position that they give labor in: “The position of delivery was also key. Rather than allowing mothers to deliver in a kneeling position, health facilities instructed them to lie down, often with their legs in stirrups. Such physical exposure was deemed by mothers to be highly problematic.”¹³

The following quotes are all from the FGD with Religious Fathers. As illustrated in the last quote, the religious fathers work to counteract this.

“One of my religious daughters wanted to go to a health center, and her mother said, ‘No. Why should my daughter’s body be exposed to someone else?’”

“Husbands don’t want to expose their wife’s body to others.”

“There is an awareness that a woman’s body shouldn’t be exposed to any other than a husband.”

“When they give birth (at home) they believe that they have Saint Mary with them to keep them safe. If they go to the health center, she won’t be there.”

“We counsel them that skills and knowledge to deliver babies is given by God. Science and technology is given by God, so we have to use them.” – FDG with Religious Fathers

Although the issue was raised most often in regard to religion, this does not mean that other laboring women are comfortable being naked in front of anyone else either or of laboring with their legs in stirrups. The places where there is only one room means that everyone—the laboring mother, other laboring mothers, their accompanying family, providers, etc.—are all in the same space with no privacy curtains to divide the room to shield the mother. The only sheets mentioned were rubber sheets to protect the laboring couches. It is unclear if the laboring mothers are able or allowed to cover themselves while in labor. Lack of privacy is not just an issue for religious women. It is also a type of abuse falling under the category of non-confidential care.

¹³ Bedford, et al., 2012.

Laboring women are being sent home

Many FGDs reported that women in labor go to the facility and are sent home and either give birth at home or on the road. Many women reported their fear of “giving birth on the road.” This fear is exacerbated (or perhaps originates) from their’s and other’s experiences with doing exactly as everyone (health workers, family members, religious fathers, the media, etc.) have told them to do—going to the HC when in labor—only to be sent home. And given that many of these women are going against cultural traditions dictating home birth, are primarily from very poor circumstances where fees for transport are difficult to come by, or where the only transport may be via being carried on a bed, being sent home after having overcome such high barriers ensures that she will not return for the actual delivery.

The issue of sending women home in early labor who then give birth at home has been found in other studies including the one by Bedford et al., in Ethiopia: “In contrast to many interviewees who spoke favourably of health facility deliveries, a number discussed their dissatisfaction with services received and their lack of confidence in health professionals dealing with their case. Several mothers who presented during early stage labour were sent away with instructions to return when they were in true labour, and then stayed at home for their delivery.”¹⁴

“I took my wife to the facility to deliver, and they said to go home because it was not time yet. So the woman escapes the facility and goes back home to deliver. So when they come back home from the health facility, she says, ‘It is better to die at home and trust God.’” – Male service user

“The worst problem I faced is when a woman comes here and then is sent back home to deliver. This affects the whole community.” – UHEP

“When we go to the health center, they send us home because delivery isn’t yet.” – Female service non-user

“If your labor is behind, they push you back home.” – Female service user

“There is mistreatment of delivering women. They tell women they are not close to deliver and send them home. and they deliver on the road.” – Female service non-user

“I went with a woman to the health center. We had already paid for glucose and gloves. An older provider told us that the time is not arrived so go home. So I took the card of the woman, and I explained to a young provider that the older one told us to go home, and the young one helped us.” – Female service non-user

“When a pregnant woman comes to the facility, they tell her it isn’t her time, but she is in labor. They send her home, and she delivers without support.” – Male service non-user

What is unclear from some of the stories about women being sent home and especially women being sent home and then giving birth on the road, is whether the woman is being sent back home because she is in early labor and there is no place for her to wait (see barrier regarding lack of space above); the

¹⁴ Bedford, et al., *op cit*.

woman is unclear where in labor she is and has come too early; or, the provider has misjudged the stage of labor and sends her home incorrectly. In some ways it does not matter because once sent home she does not come back or gives birth on the way. Given the transportation problems, it is understandable that a woman, even if she is in early labor, might end up giving birth on the way home.

Tied up in this problem is the idea that setting a delivery date is an exact science, so women come on that date whether they are in labor, or they ignore signs of labor because it is not the due date that they expected. Many women, including ones who participate regularly in ANC services, told stories of giving birth at home because they did not realize that they were in labor (primarily primigravidas) or that their labor was too strong and fast to be able to get to the HC. In fact a surprising number of women who participated in the non-users group reported that they had gone for ANC and follow-up at the HC but that they had delivered at home before they could get to the HC. It is possible that this is true and quite possible that transportation may play a role in this, and it is also possible that with so many knowing the importance of facility delivery that those who deliver at home may use excuses for the decision especially when questioned by health personnel.

“I use ANC follow-up here at the center, but my labor was strong, and I gave birth at home. Some women give birth on the road.” – Female service non-user

“I had an appointment, but the labor came before the scheduled time.” – Female service non-user

“I have ANC here. Before the ambulance could come, I gave birth at home.” – Female service non-user

“If the labor is urgent and acute and if the time is short, we prefer to deliver at home. We don’t want to deliver on the way.” – Female service non-user

“We know that institutional birth is better, but my labor was strong. We can’t help if the labor is high.” – Female service non-user

“Similar to what she said. I did not know the labor pains, and I gave birth at home.” – Female service non-user

“My wife delivered at home because the service providers don’t know when delivery will happen, so many women prefer to wait at home, and then they deliver at home.” – Male service non-user

“Most have good follow-up but don’t know the time of delivery. One gave birth at home.” – Female service user

“There is a TBA in my community, and she knew the exact date for my delivery, and the health provider didn’t.” – Female service non-user

Referrals create a lack of trust in community

Many FGDs raised the issue of referrals for laboring women. There were issues with the timeliness of referrals, the need for referrals and the frustration that time had been wasted going to the HC if the woman was just going to be referred. Without investigating each case of referral, it is hard to know which were appropriate and which were not and, even if found to be appropriate, the woman and her family could still be frustrated because they do not understand the reasons for the referral. There also seem to be times when referral is an easy way out, as suggested by the first provider quote. Since

referral leads to incurring expenses, husbands may be particularly worried about this. (See discussion on free services on page 26 and husbands encouraging home birth on page 28.)

This issue was also identified in the study by Bedford, et al. "For many, the possibility of onwards referral and lack of immediate treatment was a general deterrent against health facility attendance. It was not uncommon for staff at health facilities to lack the skills and resources to manage the late presentation of severe obstetric complications for which onwards referral becomes necessary. This contributed to a negative image of health facilities, especially in cases where the mother or child did not survive."¹⁵

"There is only one person in the labor ward. There could be four deliveries in a day. There is no allowance for the person that spends time. Instead of referral, we decided to save lives." – Health facility provider

"Private hospital gives timely service. If you go to a health center, there is a high chance that you will be referred to another facility. She can follow up at the health center but deliver at the hospital." – Male service user

"The facility lacks drugs and other things—they refer if they lack. If they had materials we would not have to be referred." – Female service user

"Mothers who come to the health center for delivery should get proper treatment. They refer many cases. If one of the ladies is mistreated, others will not come." – Male service user

"One woman who was dying, they did not assist her but referred. They called her brother, and he quarreled with the facility." – Male service user

Not all know that services are free (and some services are not)

The government policy is that delivery services are free. In some places, people did not know about this relatively new policy. There was clearly confusion about what aspects of delivery were free. In one place the entire focus group of female non-service users laughed at the facilitator when he told them that the delivery services were free at the HC, and they responded this way:

"Nothing is free. Card, gloves, delivery, drugs. They prescribe drugs not found at the facility and then send us to a pharmacy where they have a share." – Female service non-user

There was a clear disconnect between the providers who said the services were free and the communities' perceptions and experiences. It was unclear whether the communities' experiences with paying for services/supplies were before or after the policy change. The confusion could stem from community members not distinguishing between services being free and other things related to delivery services such as medicines not being free.

"We are providing free service starting from the card to delivery." – Facility-based provider

¹⁵ Bedford, J. et al., *op cit*.

"The medicines and delivery are free. This encourages them to come to us because it is free. If a woman comes with a complicated case, I advise them to save money for referral." – UHEP

"In our community, there is a problem in all of the health centers. They say no woman should die at home, but they don't allow her in without money." – Male service user

"They might have gloves and sheets, but still they ask us to buy." – Female service non-user

"There are problems with delivering at the health center. They ask a lot of questions of laboring women and ask for money. They ask, 'Who is responsible for this woman?' The system we have does not work for the poor. They should provide the services and ask for payment after." – Female service non-user

"Tradition and fear of payments (asked by providers) for drugs discourage women from going to the facility, so they decide to face the challenges at home. We tell Allah that we cannot afford to go to the health center, and we are in his hands." – Male service non-user

"We tell them it [delivery] is free. A woman was asked for a pregnancy test. She searched for money for the test, but she couldn't find so she didn't come to the facility. Sometimes it isn't clear what is free and what is not." – UHEP

On the other side, it is important to note that the team did hear from MSGMs and Mothers that as a result of participating in the program the pregnant mothers were engaging in birth preparedness, including saving for unexpected costs, such as referral and transportation.

Women fear HIV testing so avoid ANC and delivery at the health center

There are a variety of reasons why pregnant women may fear HIV testing: they fear knowing their status; they fear a positive result; they fear having to disclose a positive result; they fear for the baby's health; they fear asking their partner to test; and mainly they fear their partner's potential reaction. For more on this, see the male partner testing barrier in the section, "Women and men fear the impact of testing and disclosure on their relationships."

Whatever the genesis of this fear, it leads some women to avoid delivering in a HC where they think that they will be confronted with an HIV test. It is interesting that the quotes regarding this are all from service non-users.

It is my understanding that people don't like to go to the health center for delivery because they are afraid of HIV testing. So when they ask, 'Why don't you test for HIV?' they say they don't want to do that. I myself am afraid of testing." – Female service non-user

"I had my first baby at a health facility. Now the rule is that you should bring your partner to test, so the women drop the service. Some do not get the vaccinations, and they give birth at home." – Female service non-user

"Some people do not have ANC follow-up. They do not want to test/are not willing to test, so they give birth at home." – Female service non-user

"There is a man who is a teacher and is on ART [antiretroviral therapy] who told his wife not to be tested. I asked her to be tested, but she took her card (and left) to the kebele. When she came to deliver, she left when she saw me. I said, 'I will deliver.' She asked the father of the baby to come. The wife had prolonged labor, and her husband had her transferred to a

private facility so she wouldn't be tested." – MSG Mentor

"The women don't have the courage to invite their partners to test with them. There are women who deliver with no ANC or follow-up. The reason for not going to the health center is fear of HIV testing. So they say, 'I'll go tomorrow.'" – Male service non-user

"Most prefer not to come to the center. People will know your status, and you will be stigmatized." – Female service user

"Most are not willing for HIV testing. People are not willing to test so don't go to the health center (to deliver)." – Female service non-users

Tied up in this is the belief that those experiencing a "normal" birth, including being HIV-negative, can safely give birth at home, and that those at risk from home births are HIV-positive mothers. Correspondingly, a few women mentioned that they and others preferred not to give birth in a health facility because the community would assume that they are HIV-positive, and they would be stigmatized. (See HAPN Gender Assessment, Page 25.) Others expressed a fear of delivering at the HC because they were afraid of HIV "contamination" if they birthed there.

As noted in the Warren study: "Many recognize there are benefits of medical care during pregnancy but due to distances and poverty women will forgo accessing ANC—especially if they have had a normal pregnancy in the past. Just over half of the women (nine) attended ANC at the local health facility or with a TBA and perceived that because there were no problems during pregnancy: the decision was therefore made to give birth at home. The remaining eight did not attend any health care during pregnancy. Some attended ANC up to three times and were told everything was fine. 'She was not sick during her pregnancy, she used to take antenatal care' (Husband, South Gondar) and '...they told her (at the facility) that her pregnancy was normal (free) and made her go home' (Husband, Oromiya)."¹⁶

Mothers, husbands, and community encourage home birth

When asked who made the decision on where a woman would birth, many women would say that they did:

"I am responsible for my baby and myself so I have to decide for myself." – Female service user

As noted earlier, what seems to empower women and HIV-positive women in particular to be willing to go against tradition and family is the desire to have a healthy, HIV-free baby.

"The women are afraid, so we tell them to test for the sake of the baby. The women are convinced this way. The idea does not convince men." – UHEP

"When I started to deliver, I came to the health center. To get an HIV-free baby I came. My family and husband insisted I not

¹⁶Charlotte Warren, Tekle-Ab Mekbib, "Reviewing maternal mortality in rural Ethiopia: using the verbal autopsy approach", December 2009, Volume 3, Number 3 Ethiopian Journal of Reproductive Health. Page 10.

come, but I came to get an HIV-free baby.” – Female service user

“The neighbors wanted me to stay home. I may not get a free baby at home, so I delivered at the facility.” – Female service user

Although every group, including groups with male service and non-service users, could talk about the risks of home birth and the benefits of delivery, there are still those who want women to birth at home and influence them to do so.

Even many of the women who said that they made the decision for themselves would then talk about strong influencers such as their mothers, neighbors, and husbands, or they would say outright that these others made the decision for them.

“Most women prefer to birth at home with their mothers.” – *Male service non-user*

“If it is her first pregnancy, then traditionally they birth at their mother’s home.” – Facility-based provider

“Around 50% prefer to be supported by their mothers during pregnancy—even educated women. But the mother can’t protect her from health hazards. So the mother can accompany her to the health center so she can have both.” – *Male service non-user*

“Our mothers encouraged home deliveries. I delivered at home and had a retained placenta.” – *Female service non-user*

“Your mother is there (at home) with you and Saint Mary.” – *Female service non-user*

“Women give birth at home because of religious beliefs. It is up to God. God will watch us. It is up to God.” – *Female service non-user*

For the female influencers, especially mothers and mothers-in-law, the preference for home delivery appeared to be related to tradition and customs.

For some women, it was clearly their husbands making the decisions:

“Most women cannot convince men (to let them deliver in a health center). My husband refused to let me go.” – *Female service non-user*

“Most time the husband decides whether to go to health center if she is sick. We are under the influence of our culture.” – *Female service non-user*

“But it (deciding together) only works if he is educated and aware. Otherwise, he may decide for the woman.” – *Female service non-user*

For male partners the decision to deliver at home appeared to be related to expenses. This corresponds with findings from the Warren study: “Women interviewed during the larger safe motherhood survey

describe how some husbands refuse to let their wives attend ANC or seek care at a health facility when complications occur—mainly due to the expense. Many women survive by luck.¹⁷

See discussion of free services in the section, “Not all know that services are free and some are not,” page 26.

“There are a lot of men who never ask the woman if she is vaccinated or attend follow-up. They don’t want to encounter costs.” (The whole group agreed with this.) “They say, ‘I didn’t ask her to get pregnant.’” – Female service non-user

“All husbands want their wives to be safe, but there is a financial problem, so all decisions are based on economics. He knows she should go but tells her to deliver at home.” – Female service non-user

“If she has no money, she will give birth at home. Mainly it is the decision of the man.” – Female service user

“People want to go to the health facility for delivery but tradition and the fear of payments for drugs discourage women...” – *Male service non-user*

“If when they feel the labor pains they come directly to the health center, they have no expenses. There are no expenses in the health center.” – Male service user

Transportation remains an issue—ambulance, distance, and cost

Transportation and geography remain barriers to women accessing the health facility for delivery, although it is clearly less of one than in the rural areas. The government’s effort to provide an ambulance to each woreda does appear to be having an effect. But the team heard problems with the implementation of this program. A few HCs reported that the ambulances do not come to their facility. Current practice dictates that a woman should go for delivery in her assigned catchment area where her ANC card/records are. This can present problems. For some women their closest HC may not be the one in their catchment, or it may not be served by an ambulance, or the road may be so poor that transport is too difficult for the vehicle or the laboring woman. For some, even a small cost for transportation can be a barrier.

“Ambulance services are not effective. When called, they don’t come. I’ve never heard of an ambulance coming to the community to take a laboring woman to the health facility.” – Male service user

“There are transport issues. The ambulance does not come here. If there is a referral, there is the issue of transport. It creates less confidence in women.” – Facility-based provider

“The ambulance is not used properly. Currently it is not used to give priority for pregnant women.” – UHEP

“Most people here have come from difficult and rural areas. They bring the women by carrying them. So transport is a big problem. When pregnant women face a problem, they carry them. This contributes to home delivery.” – Female service user

“The ambulance shortage is a big problem.” – Female service user

¹⁷ Warren, et al., *op cit*, page 9.

"Because the ambulance didn't come they carried me using a traditional bed." – Female service non-user

"The problem is that those in the catchment area are expected to come to this center. If she wants to go to another health center, she will be turned away. This site is not good. If they go to another health center, they will be told this is not your place. For a pregnant woman to come here is far, and the transport is bad. Even if she has money, the transport cannot get here." – UHEP

Cumbersome facility processes exist

The length of time to get service, the various steps in the process, and possession of a health card were the issues mentioned the most.

"A relative had follow-up here for ANC. They could not find her card, so she could not get services, so she gave birth at home." – Female service non-user

"Here in the clinic it is a long process. There is one case. It took one day here and then one day to refer to the hospital. The woman said, 'They played on me. It is better to have gone to the hospital or private clinic in the first place.'" – UHEP

"At the health center there is a process: register, get your card. You go from room to room." – Female service non-user

"If we lose our cards and go for delivery, they turn you back to get the card." – Female service non-user

Institutional Delivery Recommendations

Recommendation 1: Address mistreatment of laboring women

The issue of "mistreatment" was the barrier most often heard of although not directly asked for. It constituted the largest barrier to facility-based delivery more so than the other three barriers identified by the Bowser study: personal and cultural birth preferences; lack of geographic access; and lack of financial access. The findings of this gender assessment very closely match the Bowser review which found that:

Growing evidence for the negative impact of disrespect and abuse in facility-based childbirth on skilled birth care utilization across a range of countries is reviewed including recent qualitative and quantitative studies that suggest disrespect and abuse may sometimes act as more powerful deterrents to skilled birth care utilization than other more commonly recognized deterrents such as geographic and financial obstacles.¹⁸

The Bowser study found many contributors to disrespect and abuse of pregnant women, ranging across the various rings of the socio-ecological model, with the following appearing to be the most relevant to the CPMTCT Project assessment findings:

- Normalization of disrespect and abuse during childbirth

¹⁸ Bowser, 2010, page 3.

- Lack of community engagement and oversight
- Lack of autonomy and empowerment
- Bioethics principles relevant to respect and non-abuse in childbirth
- Lack of leadership and governance for respect and non-abuse in childbirth
- Lack of standards and leadership/supervision for respect and non-abuse in childbirth
- Lack of accountability mechanisms at the care site
- Provider prejudice
- Provider demoralization related to weak health systems, shortages of human resources, and professional development opportunities¹⁹

In looking at interventions that had been used to address disrespect and abuse of pregnant women, the study identified nine overlapping categories of programs/tools:

- Quality improvement interventions
- Caring behavior interventions
- Humanization of childbirth
- Health workers as change agents
- Accountability mechanisms
- Human rights interventions
- Legal approaches
- HIV/AIDS stigma reduction interventions
- Tools for measurement.²⁰

The CPMTCT Project can draw on these resources and others to implement some/all of the following recommendations. To successfully mitigate the issue of disrespect and abuse, there will need to be interventions at several levels addressing the underlying contributors and targeting providers, clients, and the community. Fortunately, many of the structures or processes are already in place to which this issue can be added or integrated.

Use the issue to ground provider training in ethics and gender

The Gender Assessment Team did not review any gender training curricula used for the various cadres of providers nor did it find any gender training materials used for training health cadres under the CPMTCT Project. The training materials for PMTCT for UHEPs were reviewed, but neither gender nor disrespect/abuse in childbirth was addressed. The project will need to consider how to integrate this issue into existing training materials for all health cadres of CPMTCT staff: facility-based providers who deliver babies, UHEPs, and MSGMs. The team did note the following recommendation in the recent HAPN Gender Assessment: "The gender training curriculum used for health system staff could be made less abstract, passive and informational and oriented toward values clarification, reflection and

¹⁹ *Ibid.*

²⁰ *Ibid.*

application of the concepts to their work”²¹ because it had found that “...the gender training curriculum used in the health system is quite abstract and removed from its practical applications.”²² Addressing the issue of disrespect and abuse would provide a practical application of gender and ethics to a concrete gender issue affecting maternal health. There are existing materials being used by the White Ribbon Alliance and Health Policy Project’s Respectful Maternity Care work that could be drawn from.

Integrate respectful maternity care into the quality improvement process and tools

The CPMTCT Project has a strong focus on quality improvement backed up with supportive supervision as reflected in its intermediate Result (IR) 4. However, the approach does not appear to capture disrespect and abuse as issues affecting the quality of facility-based delivery—or indeed any service being offered in the HC. A review of the materials used for quality improvement reveals they are in keeping with the finding of the Bowser study: “In general, maternal health care standards in most settings prioritize evidence-based clinical care standards and include relatively little emphasis on standards of respectful and non-abusive birth care such as dignified interpersonal care, information and consent, privacy, non-abandonment of care and right to protection from physical abuse. In many facility service settings, there is very weak leadership and supervision for even basic standards of clinical care, much less standards of respectful care.”²³ The Bowser study included a review of nine categories of programs and tools, and there are several that are promising for use in Ethiopia, particularly the tools used by Family Care International in its Skilled Care Initiative. What all of the promising programs that seemed most applicable had in common were interventions with providers, clients, and the community. The CPMTCT Project is in an advantageous position of having already been addressing clinical care standards, so it is well-placed to add standards for respectful care.

Current supervisory checklists/tools do not capture anything other than clinical standards of care. The only opportunity for possibly raising the issue comes in the supportive supervisory tool for demand creation and community mobilization, which asks the HEWs: “Do you have any idea how we can increase the: # of pregnant women going to HC for ANC visits? # of women delivering at health facilities?” It is unclear if this process has ever uncovered the issue of disrespect and abuse, but it would be more apt to if the tools directly addressed the issue rather than left it for staff to identify. This is particularly important given the normalization of disrespect and abuse.

Strengthen client/community feedback loop on quality

The CPMTCT Project has a strong community component with a focus on demand creation. But it does not appear that the communities’ perspectives on service quality are making it back to the facility. The project needs to take advantage of existing cadres of staff and structures to get community and client feedback on quality. These include: facility-based service delivery providers; UHEPs; MSGMs; MSG members; Religious Fathers; and Woreda Advisory Committees. In particular, the CPMTCT Project needs to ensure that pregnant women’s feedback informs the services, as the women are most impacted by

²¹ USAID/ Ethiopia HAPN Gender Assessment, DevTech Systems, Inc. March 2012, Page 31.

²² *Ibid*, Page 39.

²³ Bowser 2010, page 20.

poor quality services and most likely to share their experiences—both positive and negative—within the community, thereby impacting other women’s decisions. This answers the HAPN Gender Assessment recommendation to: “Consult with and inform women using maternal health services so as to improve their experiences of those services.”²⁴

Take advantage of the UHEP linkage between the facility and the community

Due to the UHEPs’ unique position as members of the facility staff who go out into the community to follow pregnant women, they hear everything regarding the communities’ perceptions of the services. This helps to explain their more measured views of the services found on page 11. Given the very difficult work that UHEPs have in getting often reluctant women to come for services, they are particularly invested in seeing to it that women are treated properly. If more UHEPs could do as the one in the quote below does, then providers would be more apt to deliver respectful care. UHEPs are in a good position to act as client advocates for pregnant women with the facility as the one below did.

“If there is mistreatment of a woman I talk to the health center, I am responsible. I convinced her to come here. So I come with her to complain about the mistreatment. The complaints have minimized.” – UHEP

The program needs to explore ways to take advantage of the information that UHEPs possess in terms of the quality of services, whether through existing tools or new mechanisms. Perhaps UHEPs, MSGMs, and Religious Fathers could all use the same updated forms to report on disrespect and abuse quality issues. The UHEPs and MSGMs have bi-directional opportunities: they can not only report in to the facility on what the community thinks regarding the quality of the services, but they can also take messages out into the community about the kinds of respectful, non-abusive care that pregnant women can and should expect from the HC.

Strengthen the client satisfaction element of the existing quality of care assessment tool

The Year 3 Implementation Plan reports that a quality of care assessment tool was developed and piloted in Year 2, with findings shared in Year 3 and that service delivery officers will apply a segment of the quality of care to their HC supportive supervision on a quarterly basis and “conduct another QOC [quality of care] assessment in the coming year.” This quality of care tool includes a client satisfaction aspect, although the team did not review it as part of the assessment nor did it come up in conversations. If this tool is being used to capture client satisfaction, it needs to be reviewed and updated in light of the assessment findings.

Empower MSG members to seek respectful care


The pregnant women who make up the MSG members provide a ready-made group for education and empowerment in regard to expectations for respectful, non-abusive maternity care. They have an added incentive to birth in the HC because they want to have healthy babies free from HIV. They regularly attend small group education activities. While UHEPs can do outreach on respectful care into the

²⁴ HAPN Gender Assessment, Page 2.

community one pregnant woman at a time, MSGs offer groups of pregnant women most likely to birth in the HC. While training and upgrading the quality improvement process and tools may empower the providers to deliver respectful maternity care, educated MSG members can provide a check on that service by being in a position, backed up by UHEP and MSGMs as client advocates, to demand respectful care. Training materials can draw on some of the existing materials listed in the Bowser study as well as the work done by the White Ribbon Alliance and USAID’s Health Policy Project on Respectful Maternity Care and the Rights of the Childbearing Women as reflected in the following quote and slide:

The concept of “safe motherhood” is usually restricted to physical safety, but childbearing is also an important rite of passage, with deep personal and cultural significance for a woman and her family. Because motherhood is specific to women, issues of gender equity and gender violence are also at the core of maternity care. Thus, the notion of safe motherhood must be expanded beyond the prevention of morbidity or mortality to encompass respect for women’s basic human rights, including respect for women’s autonomy, dignity, feelings, choices, and preferences, including choice of companionship wherever possible.²⁵

RESPECTFUL MATERNITY CARE: THE UNIVERSAL RIGHTS OF CHILDBEARING WOMEN



Category of Disrespect and Abuse ⁱ		Corresponding Right
1.	Physical abuse	Freedom from harm and ill treatment
2.	Non-consented care	Right to information, informed consent and refusal, and respect for choices and preferences, including companionship during maternity care
3.	Non-confidential care	Confidentiality, privacy
4.	Non-dignified care (including verbal abuse)	Dignity, respect
5.	Discrimination based on specific attributes	Equality, freedom from discrimination, equitable care
6.	Abandonment or denial of care	Right to timely healthcare and to the highest attainable level of health
7.	Detention in facilities	Liberty, autonomy, self-determination, and freedom from coercion

²⁵ Respectful Maternity Care: The Universal Rights of Childbearing Women, White Ribbon Alliance, 2011.

Expand existing volunteer community health workers' oversight responsibilities to include respectful maternity care

A community that is engaged and watchful can play an important role in ensuring that services meet the needs and rights of pregnant women. In reporting on the lack of such community involvement as a contributor to disrespect and abuse, Bowser et al., said:

Community and civil society oversight and participation in management of facility health services have been demonstrated in some studies to improve demand for quality of care and to increase accountability of facility providers and managers. For example, in a humanization of childbirth study in Ecuador, community health members worked closely with facility providers, sometimes as part of quality improvement teams, to improve responsiveness of childbirth services to client needs and preferences with some success (Ministerio de Salud Publica del Ecuador, 2007; USAID Health Care Improvement Project, 2008).²⁶

Under its IR 3.3 to “[e]nhance community management in oversight of services linkages,” the Ethiopia CPMTCT Project is already working with volunteer community health workers carrying out monthly review meetings. These monthly meetings with volunteer community health workers present an excellent opportunity to address the normalization of disrespect and abuse by strengthening the volunteer community health workers’ capacity for oversight in regard to this barrier to MNCH/PMTCT service use.

Work with primary health care unit to address disrespect and abuse

The Primary Health Care Unit or PCHU is comprises an HC and five satellite health posts. The project currently supports monthly PHCU meetings to review data, the quality of services, and referrals. This would be a natural venue to introduce the issue of disrespect and abuse as a quality of care issue and to build the capacity of the PCHU to address the issue.

Recommendation 2: Address the need for waiting room before/after delivery

Lack of available space for laboring mothers is hampering the HC’s ability to carry out safe delivery services and affecting women’s satisfaction and use of the those services. At a minimum, each HC needs to have a plan for dealing with an overflow of patients other than discharging them prior to the six hours recommended and for ensuring that mothers and their babies can be kept together after birth to encourage breastfeeding and bonding. But beyond that, each health facility needs to address client rights to privacy through such measures as providing a divider between clients when there is more than one laboring in the same room; allowing the laboring mother to birth in any position she chooses; and allowing her to have with her any companion of her choosing. When building new or renovating/allocating space in old HCs, priority should be given to providing adequate space to laboring mothers. What constitutes “adequate” was not determined by the assessment team. No

²⁶ Bowser, et al., Page 16.

standards for space needs/requirements for labor and delivery were examined. This responds to the findings of this assessment as well as that of the HAPN Gender Assessment:

On the basis of observation at health facilities and interviews with staff and beneficiaries, the gender assessment team recommends increasing the gender sensitivity of facility design with special attention to privacy and the ability to accommodate other family members.²⁷

Recommendation 3: Investigate why women are being sent home

Given the frequency that the issue of a women being sent home “and giving birth on the road” was raised and the real fear that women expressed of this happening, it seems that the first step is to determine how often this happens and why it happens. The project could carry out operations research examining the records for women who went to the HC in labor and were sent home, and then interviewing the provider, woman, and her family to identify why the woman was sent home and to determine what each understood about the reason. Identifying the reason will point the way to the solution. Under the current CPMTCT Supportive Supervision Checklist, under the Labor and Delivery Unit, Service Delivery section, there is a review of records. Perhaps a couple of questions could be added there regarding women who were sent home. The team did not review any records, so it is not clear if this type of information is captured.

Providers need to work with each woman to judge whether she is in a position to come back if she is sent home. This includes weighing not only medical reasons but also whether she has transportation/money to come again. It also calls for providers to enhance their communication skills so that a woman understands where in the process she is and what her options are so that together she and the provider can make the best decision for her and her baby. Some women expressed dissatisfaction with services because they were not told what was happening to them or their babies. Sending a woman home may be a good decision for a woman, but in the absence of an explanation, let alone being engaged in making that decision, a pregnant woman and her family may feel that she was mistreated. Much of this dialogue could take place during ANC education where a woman can learn how to determine if she is in labor, what might happen if she comes too early, that “delivery due dates” are best estimates—all to be figured into her birthing plan. If, however, the provider misjudged the stage of labor the woman was in, that calls for provider education. Each facility needs to have a plan in place so that no woman is turned away because of human resources issues or bed space.

Recommendation 4: Clarify and communicate free service policy

Although the government policy is that delivery services are free it is unclear to many—community members and providers alike—what that means as illustrated in this quote from a UHEP:

“We tell them it (delivery) is free. A woman was asked for a pregnancy test. She searched for money for the test, but she couldn’t find so she didn’t come to the facility. Sometimes it isn’t clear what is free and what is not.”

²⁷ HAPN Gender Assessment, Page 5.

In each HC, staff should all know what services, supplies/drugs are free and which are not. There should be posted on the wall a copy of the government policy, listing each service or supply and whether it is free and, if not, then what it costs. UHEPs, MSGs, Religious Fathers and WACs or other oversight groups could help disseminate this information so that pregnant women and their families know what to expect and can plan as well as to help hold facilities accountable to the policy.

Recommendation 5: Ensure that necessary supplies are there: gloves, sheets, drugs, cards

Related to the issue of free services is the issue of necessary supplies being on hand. Some places reported that women were asked to buy supplies that should have been free. It was not clear if this was because the HC was violating the policy for free services or the items were stocked out. If it is a stock out problem, then this should be captured through supportive supervision checklists, as each of the supplies or drugs mentioned is on the checklist. This mundane issue—supplies—has an impact on women’s respectful maternity care. Communicating this back to “USAID partners and others involved in supply chain” could help illustrate one tangible gender dimension of commodities procurement and delivery per the HAPN Gender Assessment recommendation.²⁸

Recommendations 6: Women in labor should get services with or without a card

There were a few stories of a woman in labor making it to the HC only to be turned away because she did not have her card with her. This should not happen. Any issue regarding a card can be resolved after the baby has been safely delivered.

Recommendation 7: Develop gender standards for respectful maternity care in Ethiopia

If the project moves forward with implementing all of the above recommendations, they will have taken major strides toward ensuring that HCs within their geographic focus areas are offering respectful maternity care. If approached as a whole, these recommendations offer nearly all of the elements for ensuring quality from a gender perspective. This work could be compiled into standards for respectful maternity care and be offered to meet the HAPN recommendation “. . . to develop gender quality ‘credentials’ for health facilities. HEWs are offered certificates for the training they receive in gender; the same sort of recognition could be offered to facilities that meet certain ‘gender equitable standards.’ This kind of thing has been done successfully in other settings, as in Pakistan’s Greenstar facilities, and includes criteria that touch on outreach, counseling protocols, facility setup, and so on.”²⁹ Taking a whole-facility approach would also mean looking at all of the staff and addressing issues with unfriendly and unwelcoming HC guards and cashiers who were singled out in a few FGDs for their behavior.

²⁸ USAID/Ethiopia HAPN Gender Assessment, Page 5.

²⁹ *Ibid.*, Pages 40-41.

FINDINGS: MALE PARTNER TESTING

For the purposes of this gender assessment, male service users were those who had undergone male partner testing as part of PMTCT.

What Is Working

Religious fathers are influential in encouraging partner testing and disclosure

In one of the sites where there was an FGD of male service non-users and one of female service non-users that was held at a local parish, both groups had come thinking that they would be tested. This was extraordinary, as none has tested before, and several expressed the belief that they were protected by God and, therefore, did not need to test if they were Christian. But as a direct result of intervention by their Religious Father they were convinced of the need to test and came to the FGD expecting to test that day. As the last quote demonstrates, Religious Fathers also play a strong role in helping women to safely disclose and encourage their partners to test. Religious Fathers utilized a variety of approaches to influence religious daughters to birth in a HC and religious sons and daughters to test. They counteract religious daughters' and their families' reluctance to be "exposed" to strangers as a barrier to institutional delivery; Religious Fathers provide community education through door-to-door visits and Sunday gatherings. They escort couples planning to marry to HIV testing and counsel newlyweds to test when they go to bless their house. The openness of the priests to discuss the issue was refreshing and somewhat shocking, or as one put it:

"We are young priests, and we discuss these things. The elderly priests do not discuss. When we younger priests bring the issue to the community, they are confused because these types of things were not discussed. We do not fear talking to married people because we are married."

Religious Fathers also are playing an important role in their communities as role models for the desired behaviors:

"We can bring couples together so we should. . . . In our community most are Muslim. I went with my wife, and when I tested many also came. Once I have the card that revealed I am tested, I showed others. This is our religious duty to the community."

"The Religious Father advises us on testing. He says that it is thanks to God that health providers can save lives."

"We always confess ourselves to priests, so we are open to our Religious Fathers even if we commit adultery. So when we do that to get forgiveness, we shouldn't commit two sins at one time. When we confess and ask forgiveness, we should also test." – Male service non-user

"The priest asked us if we had done HIV testing and I said, 'Why do you tell about HIV when you should talk about the Bible?' He said it is a matter of life." – Female service non-user

"My friend's husband is a driver. He gets sick often. She asked him to test, and he said, 'Don't you trust me?' He beat her, and

they quarreled. We called the priest to mediate. The woman said, 'I want him to test.' She said, 'He cannot live with me until he tests.' The priest takes them to the center and both are found to be negative." – Female service non-user

"At first they said, 'Why are the clergy talking about this?' But now they thank us." – Religious Father

"We refer to the Bible and say, 'You should accept her request (to test).'" – Religious Father

"From the religious point of view, God values everyone's life. This (HIV) will affect not just the country but the church. You should know your status. You will be counseled." – Religious Father

"At the mass media level, we don't encourage some things (condoms), but at the household level they tell us everything, and we counsel them." – Religious Father

"The disclosure should be done by the priest and the wife. The man distrusts her and blames for bringing the virus. This needs close follow-up and spiritual counseling." – Religious Father

"Nowadays priests advise to test and if positive to live positively. God doesn't allow punishment or divorce due to test results. Priests have a positive influence on all of us. God will forgive us for our sins. I will get tested if I know God will forgive me and I can live positively. I will be tested." – Male service non-user who came to FGD thinking he would be tested.

People are aware of the benefits of PMTCT and partner testing

Across the board, in all of the FGDs, both women and men could express the benefits of HIV testing: in general, individually, as a couple, as part of marriage preparation, and for the purposes of PMTCT.

"Partner testing means men accompany their wives for HIV testing to get an HIV-free baby. To sit as a couple to protect themselves and to know one's status." – Male service non-user

"For the sake of my baby, I should know my status. My baby should not share my problem. He should not be affected." – Male service user

"I know from the media that men and women should test." – Male service non-user

"If one is infected, if they test together then they can decide together on treatment, can protect one another." – Male service non-user

"For me, PMTCT is about protecting the next generation." – Male service non-user

"Getting tested as a couple gives you a chance to protect the child from HIV." – Male service non-user

"If my wife is tested alone and I am not, it affects the family and community." – Male service user

"If a couple is tested together and both are positive, they can live together positively." – Male service user

"Men need to get tested because they travel for work and the risk factor is high. He has the responsibility to protect his family and children." – Male service user

"A man has a responsibility to protect his family and wife." – Male service user

"I know that you can prevent mother-to-child transmission." – Male service non-user

"(If my wife asked me to test) I'll say ok because now we have knowledge and understanding. You can only say 'OK.' What separates man from animals is rational thinking. There is a virus. We know we have seen those who live long with HIV. There is treatment. So there is nothing to be afraid of. It is good to be tested and know your status. There is treatment." – Male service non-user

"Now you can live positively if you are HIV-positive. You can work. There is nothing to be afraid of." – Male service non-user

"A pregnant woman going to the health center gets tested with her husband—if they test together it creates an emotional attachment. But if they test alone, it will create problems." – Male service non-user

"If both are free, they can continue. If both are positive, they can protect their family and be treated." – Male service non-user

"Of course there are benefits to testing together. You can decide your future life—live positively and protect others." – Male service non-user

"If we test together, we know our health status as a family. We can support one another if our results are different. If I have the virus and she doesn't, I'll protect her and not infect her." – Male service non-user

Men are testing—just not as partners

One surprising aspect of the male service non-user FGDs was that many of the men who participated had actually been tested, some more than once, but on their own. It was not clear if they had disclosed their status to their partners. There seems to be a variety of reasons, some problematic (he has risky behavior and wants to conceal it from his wife) and some less so (tested before marriage and have no risky behavior). There is also a tracking problem because men who test in a voluntary counseling and testing room may not get recorded in the ANC register. Men are testing just not in ANC. These findings echo that found by Larsson et al. which found that men had a variety of reasons for not wanting to test with their wives, including the desire to hide a positive result, distrustful relationships, as well as more benign reasons such as lack of understanding of why testing was important and perceived rude attitudes among health workers.³⁰ Some of these reasons are discussed in more detail under barriers beginning on page 44.

"We have three children, and I went with my wife all three times to the health center. But I had my own appointment. My wife was not happy." – Male service non-user

"People prefer to go alone." – Male service non-user

"I tested alone using the mobile VCT [voluntary counseling and testing]." – Male service non-user

"One religious daughter trusts her husband, but he is distrustful. She asked him to test and he refused. He finally said why he refused. He had tested separately and is negative." – Religious father

"Men say, 'We've tested. Once is good enough. We believe in each other, so once in life is good enough.'" – UHEP

³⁰ Larsson EC et al. Mistrust in marriage-Reasons why men do not accept couple HIV testing during antenatal care- a qualitative study in eastern Uganda. *BMC Public Health*, 2010, 10:769.

"The first time I tested alone." – Male service user

"I usually test at church events." – Male service non-user

"I tested ten years ago." – Male service user

"We test to know our status, for future planning, if we plan to get married. Or to correct past mistakes, risky behavior. A man tests to know his status, then his wife tests and children." – Male service user

"I travel for work, so I went on my own to test." – Male service user

"We counsel the woman to come with her partner. But he comes by himself using her card. When he comes alone, we advise him to support his wife." – Facility-based provider

"Men test. I know they do. But they take it somewhere else and don't share with their partner." – Female service user

Perceptions of Services

When looking at the perceptions of services, it is only the male service users, obviously, who could comment on the actual male partner testing services. For the most part their comments regarding those services were positive. They also shared perceptions of facility-based delivery services as reported in that section of this assessment above. Male service users were asked what could be done to improve services. Male service non-users talked about the facilities overall and were much less positive. Just as in the section on facility-based delivery, occasionally individuals in both groups were referring to a public hospital or a private clinic.

Positive male service users' perceptions

"I was treated well and was comfortable with the provider."

"I didn't want the counseling. Just wanted to draw the blood and go. After 30 minutes, I got my results, and I was happy."

"It was a nice place—quiet and confidentiality could be kept."

"The service is satisfactory, but it could be improved."

"It was nice. It should continue this way. He advised us to come together to have a virus-free child."

"The test is so nice. They gave us education."

"It was nice . . . We were advised to have the test. My wife was pregnant with our second child, and we went to the facility, and it was a nice situation."

"I tested at the health center. It was nice. A doctor tested. There was counseling."

"I was tested at the health center. The place was nice."

"The health centers in Addis are tired of serving. They discourage people to come, but here the service is good. People get served quickly."

“The health center works 24 hours. . . . We get service and can go back home.”

Negative male perceptions

When men were asked their impressions of the HC overall, they were much less positive. While the comments refer to all kinds of HC services, it stands to reason that if a man has a poor opinion of the providers or any service, he is unlikely to seek care there.

“Services are linked to money. If you have money, you can get the service you want at a private clinic. But public facilities providers aren’t motivated.” – Male service non-user

“There are some things to be improved particularly when they care and look after HIV-positive patients. You expect a positive and welcoming environment, but they are not on time. It’s not like they say in the media. Caring for the needy isn’t enough. They have to have a passion for their profession. We say we need to lower stigma and discrimination, but sometimes it is the providers who discriminate. They are paid for their work, but there is also a spiritual component.” – Male service non-user

“Most of the problems are at the health center when we take the sick—it is not a welcoming environment. Some use holy water because they prefer to beg God rather than to beg the providers. Their support is minimal.” – Male service non-user

“Sometimes when they vaccinate, they leave the needle in the child’s arm while they chat.” – Male service non-user

“Previously they provided services that satisfied us, but now it is collapsing. Maybe because the drugs are working. Like when a new hotel opens, it provides a welcoming environment, but once there are clients the service goes down.” – Male service non-user

“The government should pay attention because these people are causing problems.”

“There are students coming from university—new to the health center—but they are given direct responsibility to the students who have no experience.” – Male service non-user

“The health facility should give us proper services. There are no trained providers in this town.” – Religious father

“A provider gave me an injection in the wrong place.” – Male service non-user

“By the time providers get to public sector they are already fed up and tired.” – Male service non-user

“Public providers sometimes encourage clients to come to private facilities where they work part-time. Sometimes drugs are prescribed wrongly.” – Male service non-user

“It is important to have a good waiting room for clients. There is a lack of cleanliness. The room is not clean.” – Male service user

“The health center doesn’t provide testing because there is no electricity and no room for counseling and testing.” – Male service user

“Providers need words to ease people just like other diseases.” – Male service user

“My understanding is that it (testing in hospital and health center) is the same, but the skill of the provider can be different. The lower in his class goes to the health center to work.” – Male service non-user

Barriers

Despite the high levels of FGD participants who could and did name the benefits to testing overall and partner testing in regard to PMTCT and the numbers of men who reported that they had tested, it did not seem to translate into actual male partner testing. This discrepancy has been noticed and remarked on in other studies by Falnes³¹ and Theuring,³² with the latter concluding that it highlights “the importance of scrutinizing generally expressed supportive attitudes to the degree of their veracity not only in theory, but in daily life practice.”³³

Men find ANC sites and times inconvenient

The first and quite frequent reason given, by both men and women, for men not attending male partner testing is that the testing site and time are not convenient. This may very well be true, but it may also be the easiest and most acceptable excuse. “He is working and cannot come” may be the real reason a women’s partner cannot attend, but it may also be an excuse to protect her from sharing with her partner that she has tested without his approval—a potential sign of distrust and threat to the relationship.

“If he’s a civil servant, he has to go to the office, and so he doesn’t have time.” – Male service non-user

“Most of our friends have tested, but I didn’t because I was busy. My wife went to test. I said ‘ok’ to her request but I didn’t go.” – Male service non-user

“My husband when I asked him to test together, he said, ‘You go. I don’t want to leave the farm. I’m busy.’ Most men say this. They have the awareness but are busy.” – Female service non-user

“My husband works somewhere else, therefore I tested alone. The provider asked me to bring my husband, and I explained he was not here.” – Female service non-user

“Most men are not available to come here: they move about.” – Female service user

“In my case it was not convenient for him. They do not work on weekends or national holidays.” – Female service non-user, whose husband was sent an invitation letter, on why he didn’t go

“We need public facilities near to work.” – Male service non-user

“We start with visiting women and then try to get men, but most are in the fields. It takes more time and appointments to get men.” – UHEP

However, the project is doing quite a bit, particularly the UHEPs, to respond to the barriers that the men and their partner identify. They go directly to the man’s house, at a set appointment time and test there. They work on nights and weekends. It is important to try and overcome these barriers and the project

³¹ Falnes EF et al. “It is her responsibility”: partner involvement in prevention of mother to child transmission of HIV programs, northern Tanzania. *Journal of the International AIDS Society*, 2011, 14:21.

³² Theuring S et al. Male involvement in PMTCT services in Mbeya region, Tanzania. *AIDS and Behavior*, 2009, 13:S92–S102.

³³ *Ibid.*, Page 98.

should continue the outreach effort. But as suggested in the last three quotes, there may be more at play than just simple inconvenience.

"We want to have group discussions, but men don't come, only women." – UHEP

"So we advise them to use other facilities, if they are more convenient, because he is busy." – Facility-based provider

"It's not convenient for him to come. He is busy. He has no time. So we link the woman to a HEW to arrange a convenient time for him to test." – Facility-based provider

"The man decides. He is the decision maker, so how can we involve?" – UHEP

"As a UHEP, we feel responsible. We don't get men, so we go house to house [to] visit. Little opportunity for traders who move about to get services." – UHEP

(The men say)"We have done it. We are tested.' The men leave the house when they see the UHEP arrive." – UHEP

"We use the weekends, but still men don't come. We ask women when their partners are available and then go then. They don't tell the men there is an appointment." – UHAP

"We go in the front (of the house) and the man goes out the back." – UHEP

Men fear positive result/stigma

Although much work has been done, as reflected in some of the quotes about living positively, unfortunately stigma and discrimination remain very real and persistent barriers to male partner testing, among other desirable behaviors. In none of the FGDs did any participant say anything discriminatory about people living with HIV, but in nearly every FGD there was discussion about needing to hide testing or ways that neighbors can find out if someone is HIV-positive (they get home-based care). There were those in FGDs who were open about being HIV-positive and were supported by their family and neighbors, but it was clear that no one wanted to be in their shoes.

"If they go together and are found to be positive, they will quarrel and people will hear." – Male service non-user

"My husband refuses to test, and I told the provider. They said to bring him in when he is sick. I tell him everyday what I learned at the facility. I tested positive two years ago. We are close and use condoms. Still he hasn't tested." – Female service user

"They don't come directly. . . . If distant, then the partner comes. If nearby, they don't come with a partner." – Facility-based provider

"There is stigma and discrimination if you are positive." – Female service user in answer to why a man might not test

[They don't test] "Because they are afraid they will be stigmatized." – Male service user

(He will say no if I ask him to test) "Because the neighbors will know, and there is stigma and discrimination." – Female service non-user

There is a lack or perceived lack of confidentiality, so men prefer outside and/or more removed places

Related to the previous two barriers is the issue of confidentiality. Sometimes when FGD members talked about a lack of confidentiality, it was a perception that one had. But other times there appeared to be more than just a perception of lack of confidentiality. Even if there is just a perception of lack of confidentiality, it becomes a very real barrier to men who are afraid that neighbors will be able to guess that they are testing or their results just because a UHEP comes to their house, or they accompany their spouse to the HC, or they argue with their wife after going to the HC.

"People don't want to go to the health center because they don't trust it will be confidential. I prefer mobile testing or in a tent. At the local health center, there is an issue of confidentiality. Some of the providers know us and they talk to each other. This is a worry." – Female service non-user

"We go to a facility where confidentiality can be kept. A priest and a doctor should keep information confidential." – Male service non-user

"We bring couples to the facility, but there isn't confidentiality. The religious fathers are responsible, but the providers should also be responsible." – Religious Father

"There needs to be more effort to keep confidentiality. Providers need to be disciplined in confidentiality." – Male service user

"Sometimes there is a problem. I was provided the result of another person. So there are cases where people are told the wrong results." – MSG member

"A friend of the service provider comes to the center and enters the room and sees the results. It affects privacy having another person in the room." – Male service user

Men think that her result equals his result "proxy testing"

An oft-repeated reason for men not to test is that the female partner had tested, and it was assumed that her result would be the same as his, so there would be no need for him to spend the time to test as well. This came up quite a bit in the conversations with the religious fathers who intervene on behalf of pregnant religious daughters who have tested and request their help getting their partners to test but who also do education with religious sons regarding the need to test. This is not an unusual finding. The recent World Health Organization (WHO) literature review on male involvement cited just this barrier:

One potential epidemiological reason for a lack of focus on couples is a misapprehension on the part of professionals concerning the extent of HIV serodiscordancy, and denial on the part of the public that it is possible. In the literature review conducted for this paper, it was noted on at least a few occasions that men did not seek testing and counselling because the serostatus of their partners was known to them and they assumed that their HIV status would be the same as their partners' (e.g. Brou et al. 2007).³⁴ The other two reasons the study by Brou found that male partners of pregnant women did not seek testing was the fear of discovering his HIV-positive status (and); the need to personally and actively request HIV testing

³⁴ Ramirez-Ferrero, E., *Male involvement in the prevention of mother-to-child transmission of HIV*. World Health Organization, 2012. Page 22.

(unlike pregnant women, who were offered HIV counselling and testing during antenatal care). . .³⁵

"He pushed me to test and said, 'Your results are my results.'" – Female service non-user

"They say, 'If she is tested, I am tested.'" – Religious Father

"We say his result could be different from the wife's result." – UHEP

"Most men do not want to go. They assume that whatever the woman's status is their status, too." – Female service user

"Men say, 'If you know your status, I know mine.' But we insist that they bring their partners to appointments because you could have different results." – Facility-based provider

"But men are not going with their wives. The men say, 'If she is tested, I am tested.'" – Religious Father

"Women have many opportunities to test, but the men don't. The men say, 'If you test, it is good enough for me.'" – Religious Father

Men test alone when they feel sick or have reason to "suspect themselves" while others refuse to test as a sign of trust

The whole issue of partner testing either alone or together was fraught with issues of mistrust and assumptions of risky behavior. For some men, being sick was an impetus to test, especially if he had reason to "suspect himself," and FGD participants also felt that men who worried they had done something risky also preferred to test alone. On the flip side, men who felt that they had not engaged in any risky behavior and were faithful felt no need to test.

"My relative got tested, and the man didn't. He was sick, so he went by himself. He was asked to test. He was negative." – Female service user

"I went to the clinic when I was sick." – Male service user

"I started to get sick. I learned about HIV. I went to be tested." – Male service user

"I went alone because I was the only one who was sick." – Male service user

"You don't have to be sick to be tested. Still men don't come." – Female service user

"If testing alone, there is something they are worried about. That says that one has some risky behavior. So testing alone creates fear." – Male service non-user

"Men test if they have something to suspect or risky behavior. They prefer to go alone if they have risky behavior." – Male service non-user

"There are people who think that HIV is only transmitted through sex. Most men are engaged in work far away from their wives, so they have something to be worried about. It discourages men." – Male service non-user

³⁵Brou H et al. When do HIV-infected women disclose their HIV status to their male partner and why? A study in a PMTCT programme, Abidjan. *PLoS Medicine*, 2007, 4:e342.

"I don't have risky behavior." – Male service non-user

"If I am married, and I don't have risky behaviors. I don't understand the need to be tested." – Male service non-user

"I am faithful to my wife. I have never gone to another woman, so I didn't want to test. I understand that both partners should test, but I didn't." – Male service non-user

For some women, religious women and older women in particular, not testing was seen as an act of trust. These sentiments were most often expressed by older women participating in the female service non-user group organized at the local parish.

"We are Christians, and we trust God. We have the knowledge. I know how HIV is transmitted, but we trust God. We are faithful. So, we don't test." – Female service non-user

"Both my husband and I haven't tested. Once when I was sick, (he) took me to the health center, and they wanted blood, and he said, 'If they need to treat you, they don't get blood.'" – Female service non-user in parish FGD

"We are attached to the church in every way. We are faithful and trust God. I trust my husband. He was asked to give blood at the health center, and I said, 'No, trust God.'" – Female service non-user

Gender roles emphasize ANC/PMTCT as female

Some of the strongest and most persistent barriers to male partner testing and indeed to positive male participation in reproductive health or child health are the socially constructed gender roles that are assigned to men and women which dictate appropriate behaviors and spheres for men and women, wives, husbands, mothers, and fathers. Many of the FGD participants—both male and female—expressed that they were doing what was expected of them. For women that meant taking care of reproductive issues and children; for men, that meant providing for the family. This is similar to the Falnes et al. study which found that "[f]athers generally seemed to have a favorable view of HIV testing, and the majority knew that they were requested to undergo testing at the antenatal clinic during their spouses' pregnancies. Nevertheless, most admitted that they had not been tested there. Common explanations were a lack of time, not seeing the benefits of testing, and a perception that they would have the same result as their wife. However, in the course of the discussion, deep-seated ideas about gender roles emerged as a bigger challenge to partner testing."³⁶

"I am married, but I have a hard time understanding a man's role in PMTCT. Sometimes when we go with our wives to the health center, friends and family will say, 'This isn't your role.'" – Male service non-user

"Even if a woman wants family planning, the man may say, 'This is up to you. Why bring it to me?'" – Male service non-user

"They tried to mobilize men, but they said, 'This is not my problem. Living and economics is my problem.'" – Male service non-user

³⁶ Falnes (2011),page 6.

"There are a lot of activities at the health center like family planning that is in the hands of the woman." – Male service non-user

"Very few men in the community support their wives (by testing)." – Male service non-user

"In rural areas when partners are asked to support their wife, they say, 'This isn't our culture.' But men can change if they get the knowledge." – Male service non-user

"It's not common. Most men, even if you ask me, will say that vaccinations and investigations are for her. Only one man goes (for male partner testing); the rest don't." – Male service non-user

"A woman goes alone for testing. If she asks her husband to go, only if she is very sick will he go. If she can walk, he will tell her to go alone and get treatment. Only if she is very ill will he go with her. After the services and drugs, she tells her husband—otherwise, there is no culture of going together." – Male service non-user

"The men are raised not to go to the health center. But the women test. The men say, 'I am not going.'" – Religious Father

Women and men fear the impact of testing and disclosure on their relationships

Ethiopia is a conservative and religious society centered on the family unit. It follows that anything that could potentially threaten that family unit would be feared. For women in particular, navigating the process of testing and disclosure—both of having tested and the results—was especially perilous with interpersonal violence (IPV) a feared outcome, but the dissolution of the marriage an even more dreaded one. This is in line with the WHO paper which found that fear of a partner's reaction was a significant barrier and that "the strongest predictor of willingness to accept an HIV test was the woman's perception that her husband would approve of her testing for HIV."³⁷ While some studies have suggested that women's fear may be overestimated, particularly in the abstract, there were several women in the FGDs who had been abandoned by their spouses. Just as disrespect and abuse of pregnant women has been normalized, so too has IPV. A 2005 WHO multi-country study on gender-based violence (GBV)³⁸ showed that 71% of Ethiopian women had ever experienced physical or sexual violence or both. The 2011 Demographic and Health Survey (DHS) found that, "Domestic violence is common in Ethiopia, in both urban and rural families. When a society tolerates and accepts violence against women, its eradication is more difficult."³⁹ The DHS further found that the more likely a woman was to agree with any justification for wife beating, the less likely she was to participate in household decisions, including decisions regarding her own health.⁴⁰

Women

³⁷ Ramirez-Ferrero, WHO, page 4.

³⁸ *WHO multi-country study on women's health and domestic violence against women: summary report of initial results on prevalence, health outcomes and women's responses*. Geneva, World Health Organization, 2005.

³⁹ Central Statistical Agency [Ethiopia] and ICF International. 2012. *Ethiopia Demographic and Health Survey 2011*. Addis Ababa, Ethiopia and Calverton, Maryland, USA: Central Statistical Agency and ICF International. Page 256.

⁴⁰ *Ibid.*, Page 259

"We lived together for long. I tested and found I was positive. I called to tell my husband since he worked away. Before I finished he hung up. That is the last I spoke to him. It hurts more than the virus." – Female service user

"The woman was HIV-positive, and when I told her to bring her partner, she said, 'No, he will kill me.'" – UHEP

"My friend's husband is a driver. He gets sick often. She asked him to test, and he said, 'Don't you trust me?' He beat her, and they quarreled." – Female service non-user

"A woman disclosed her status to her husband, and he kicked her out. She came to deliver alone. He got married to another wife. Both women are positive. He knew and didn't disclose. Men assume that women bring the disease." – Health facility provider

"My husband died. I married another. He said no (to testing): he didn't want to see others in the health center. I convinced him to be tested. He is negative, but our life isn't good. He doesn't live with me." – HIV-positive female service user

"I went for vaccination, and I tested, but I was afraid to tell him. We lived in separate areas. I asked him to test, and he said, 'Why?' I said we live separate. He said, 'I am faithful. If you suspect yourself, you test.'" – Female service non-user

"I lived with my husband for seven years. He was HIV-positive. When I became pregnant, he left." – MSG member

"I wanted to go abroad. He was going for the military, so we tested, and we were both positive, but he left me, and I have had no contact with him. You cannot believe people, only God. Men dominate the family." – Female service user

"Women are low economically. An HIV-positive woman may be kicked out of home. We should share that there are cases when this happens, and she is difficult to disclose because she is dependent on the man. 'Where can I live without my husband?' When we counsel the women, they tell us this way. Sometimes we counsel the men, and they take them back." – Facility-based provider

"If I ask my husband, I anticipate him asking me, 'Why are you asking? Do you suspect me?' It will affect our relationship. I am confident he will say that. Even if he asks me, I will say the same. 'I am always home. Do you suspect me?' We create fear in our minds." – Female service non-user

"They say, 'My marriage will be disrupted. He will kick me out and say, "You should have consulted me before being tested."'" – Facility-based provider

"They are afraid that their marriage will be dissolved. Even educated women don't want to tell their husbands." – Facility-based provider

"Some men run away if there is discordance." – Male service non-user

"When you test together, you can discuss how to live positively together and plan for your children. But if one has low understanding of HIV and is positive, then he escapes." – Male service non-user

There were men, too, who expressed fear for the relationship as an outcome of partner testing and disclosure.

Men

"Testing together has a negative impact, unless they have a deep knowledge of health and HIV." – Male service non-user

"People perceive that if they test, they will lose their marriage." – Male service non-user

"In our community, after a woman went to the health center, they separated, so people suspect that one is HIV-positive." – Male service non-user

"Yes (my partner refused to test.) Partners fear different results. I tested negative, and he said, 'What if I am positive?' They fear discordance." – Female service non-user

While the potential harm to women from perceived violation of relationship trust by testing or by disclosure was openly discussed in every FGD, it is important to note that an atmosphere where women cannot safely disclose puts men at risk, as the following two stories illustrate:

Women's Fear Puts Men at Risk: Two Stories

"I knew a pregnant woman. She knows her status, but he doesn't. When asked to bring her partner to test, she said he was away. She gave birth, and he came. Then he went away for work. He was sick. The health worker asked him to bring his partner. They said, 'We know this woman. She takes ARVs [antiretrovirals]. Why didn't you tell?' And she said, 'Because if he was HIV-negative, he would divorce me.'" – MSG member

"My neighbor refused to be tested during ANC. She tested after I encouraged her. She was positive, and she said she wouldn't disclose the results. I asked him to test and he refused. She gave birth at home. I assisted her at home. She gave birth at night. We gave medicine/vaccinations. She insisted not to tell her husband. 'I'm not going to disclose because I am already positive if he kicks me out of the home.' They asked me to deliver another baby." – Facility-based provider

There were women, particularly among the mother support group members, who stand as strong counterpoints to the image of the abandoned HIV-positive mother as helpless victims:

"She must be strong. If she is not strong enough, whatever type of man she marries, she will have no confidence. I live on my own and support my children. If I have a partner, I will not be afraid of him or under his control. When my husband left, he took everything. I made my own house. Women should not be afraid." – Female service user

Opportunity: Men Want to Be Involved but Don't Know How

As the quote above demonstrates, there are women who are willing and able to move beyond expected norms for them. Significantly—and in contrast to the traditional gender norms detailed on the previous pages that equate reproductive health in general, and PMTCT in particular, as female spheres, thereby putting women, men, and their babies at risk—there were many *men* who expressed either frustration at being excluded or a desire to be included in reproductive health and PMTCT efforts.

"For me, PMTCT is about protecting the next generation. Why focus on pregnant women only?" – Male service non-user

"Health education for men provided by the HEW through house to house shouldn't just focus on women but include men." – Male service non-user

"In most cases, a woman gets tested when she is pregnant, and she goes to the health center. But there hasn't been an

intervention to get men. Men have to be convinced that pregnancy is their issue.” – Male service user

“Women only decide on minor things, so we must include men in the teaching.” – Male service non-user

“UHEPs can go out to educate groups and counsel men at home, so the idea of testing is not a new idea when they come to the health center. She (the pregnant woman) is counseled over time, but we only meet the father once, so it is difficult to convince him. We don’t have any follow-up for the partners.” – Facility-based provider

“Some women who test, when she is told to bring her partner, he is not coming. The man is dominant. There is no role for him. Some of us accept this, and some don’t.” – Male service user

“Health care providers should get trained in male involvement.” – Facility-based provider

“We need to focus on the men.” – Male service user

“When they provide FP services, they should provide counseling to both the wife and husband. But they only talk to the wife, and it causes problems at home.” – Male service non-user

“As for us, I support my wife. If I get the knowledge and counseling, I can go for testing if I get the knowledge.” – Male service non-user

“If I tell my wife to go to the health center—the service provider should ask if she has a partner. They should encourage her to bring her partner. If this happens, we will go. But most men think, ‘If she is ok, I am ok.’” – Male service non-user

“It has to be the two—the husband and wife—who discuss the issue. It is a shared life. Each of us has our role. If it is up to me. My wife is my responsibility and duty. To teach others, I must get responsibility from the government. But my health is my responsibility.” – Male service non-user

While all of these quotes reflect a desire on men’s part to get involved in reproductive health, a good thing, it presents a challenge. The oft-repeated challenge of male involvement programming is how to engage men in reproductive health services in ways that, at a minimum, do not exploit power imbalances that exist in relationships, such as reflected in the quote about women only deciding on minor things, but offer very real opportunities to transform gender roles in ways that meet the needs and aspirations of women *and* men.

The conceptual framework used most often by USAID programming is the *Gender Integration Continuum*, developed by the USAID Interagency Gender Working Group (IGWG).⁴¹ It is useful both as an analysis tool but also as a guide for planning a gender approach. (See also the recent HAPN Gender Assessment, pages 9-10.) This framework has five categories for gender:

Gender Blind refers to little or no recognition of local gender differences, norms, and relations in program/policy design, implementation, and evaluation.

Gender Aware refers to explicit recognition of local gender differences, norms, and relations and their importance to health outcomes in program/policy design, implementation and

⁴¹ <http://www.igwg.org/about.aspx>

evaluation. This recognition derives from analysis or assessment of gender differences, norms, and relations in order to address gender equity in health outcomes.

Gender Exploitative refers to approaches to program/policy design, implementation, and evaluation that take advantage of existing gender inequalities, behaviors, and stereotypes in pursuit of health and demographic outcomes. The approach reinforces unequal power in the relations between women and men, and potentially deepens existing inequalities.

Gender Accommodating refers to approaches to project design, implementation, and evaluation that adjust to or compensate for gender differences, norms, and inequities. These approaches respond to the different roles and identities of women and men. They do not deliberately challenge unequal relations of power or address underlying structures that perpetuate gender inequalities.

Gender Transformative refers to approaches that explicitly engage women and men to examine, question, and change institutions and norms that reinforce gender inequalities, and as a result achieve both health and gender equality objectives.⁴²

With this gender analysis/assessment, the CPMTCT Project moves from gender blind to gender aware. Implementation of the various recommendations contained herein, for both institutional delivery and male partner testing, offers the possibility of moving along the continuum with some of the activities offering gender accommodation and yet others a more transformational approach.

Some men have already begun the process:

“As a partner, I have to encourage and support her, even before getting pregnant. I help her to challenge norms so she can deliver in a facility. Most women prefer to deliver at the home of the mother, but I encouraged her to go to the health center.”
– Male service non-user

“I support my wife by sharing household tasks. I take care of the children. Most don’t support their wives because they have no knowledge or understanding. In our culture men are dominant. But supporting his wife, he will support her health. Once a man understands that, he will do it.” – Male service non-user

Male Partner Testing Recommendations

The very recent WHO literature review *Male involvement in the prevention of mother-to-child transmission of HIV* offers insights for the suggested programming recommendations in this area. Two overall characteristics found for successful male involvement programs are:

⁴² This framework draws from a range of efforts that have used a continuum of approaches to understanding gender, especially as they relate to HIV/AIDS. See Geeta Rao Gupta, “Gender, Sexuality and HIV/AIDS: The What, The Why and The How” (Plenary Address at the XIII International AIDS Conference), Durban, South Africa: 2000; G.R. Gupta, D. Whelan, and K. Allendorf., “Integrating Gender into HIV/AIDS Programs: Review Paper for Expert Consultation, 3–5 June 2002,” Geneva: World Health Organization 2002; and WHO/ICRW, “Guidelines for Integrating Gender into HIV/AIDS Programmes, 2003.

1. "Programmes that combined different types of intervention, particularly with community outreach, mobilization and mass media campaigns, were most effective in producing behavioural or health outcomes..."⁴³
2. They included these critical elements:
 - "Critical reflections about what it means to be men
 - Reinforcing messages in well-designed community and mass media campaigns
 - Engaging girls, women, the community and service providers
 - Engaging community allies
 - Acknowledging men's needs as well as their need to support and accept women's rights."⁴⁴

Some of these, such as the need for different types of interventions, especially community mobilization, are already being done through the demand creation work as are certain of the critical elements. Others, such as the critical reflection on what it means to be a man or acknowledging men's needs as well as supporting and accepting women's rights, clearly are not. The WHO document recommendation section ends by posing the following question: "...do men participate in PMTCT programmes because of the good outreach efforts conducted by these programmes? Or is it men who already feel a sense of commitment and have good communication with their partners that participate? Studies seem to support the latter conclusion."⁴⁵

Recommendation 1: Expand and strengthen religious fathers' role in partner testing/disclosure and as role models for testing

While it may be tempting to integrate many of the recommendations from the WHO document, the reality is that the project is past the halfway mark. There are, however, things that are working that could be expanded or intensified.

It was clear that Religious Fathers were in unique positions to not only influence their religious sons and daughters to seek PMTCT services but also to navigate the sometimes treacherous relationship perils that participation seemed to highlight. Currently, the project supports Religious Fathers in 57 of 511 sites. Depending on available funding and partner capacity, the project should consider scaling up the number of sites (perhaps first to all of the 211 demand creation community mobilization priority sites) as well as strengthening the Religious Fathers' capacity to support:

- Couple's testing for PMTCT (acting as role models for testing, and directing couples to testing)
- Assisting with disclosure
- Promoting facility-based delivery.

⁴³ Ramirez-Ferrero, WHO, page 16.

⁴⁴ *Ibid.*

⁴⁵ *Ibid.*, page 22.

In order to accurately assess the effectiveness of this relationship, the project needs to ensure that Religious Fathers have and health facilities accept referral cards from them. There was a problem with a health facility not accepting referral cards reported in one site.

Given men's preference to test anywhere other than the health facility, offering testing both as individuals and couples, with an emphasis on couples, at church events offers a good way to reach men as family members and to give messages from someone that they respect and are willing to listen to. Religious Fathers could partner with UHEPs, with Religious Father providing religious counseling and referral and UHEPs providing at-home testing. Together UHEPs and Religious Fathers can work to help women test and disclose without being afraid of their partners.

"People perceive that if they test, they will lose their marriage. Nowadays priests advise to test and if positive to live positively. God doesn't allow punishment or divorce due to test results. Priests have a positive influence on all of us. If I know God will forgive me, and I can live positively, I will be tested." – Male service non-user who came to FGD because his priest had advised him to come and be tested

"Get the religious father involved. They have more acceptance than anyone in the community." – Male service user

"There is education by the religious fathers, but it has to be regular. I suggest that religious fathers integrate [it] into their routine spiritual teaching." – Male service user

"Religious fathers teach at church and mosque but are focused on primary prevention and not on testing and telling where it (testing) is available." – Male service user

Recommendation 2: Scale up outreach and testing to men through multiple channels

We need to take counseling and testing to where men are and use more men in outreach. The UHEPs are doing a tremendous job, but from the stories told, men either cannot or will not make themselves available. The WHO paper found men advocated for peer education and outreach, including "recruiting leaders from men's support groups to serve as peer discussion leaders to deliver educational sessions to other men in their communities about the importance of men's support and engagement . . . in PMTCT." Clearly the UHEPs cannot reach all men, and men would like to hear from other men. Religious Fathers can fill some of that void but not every man is religious. The HAPN assessment recommends "drawing on groups of men, including farmers' groups, from which to recruit outreach workers and promote discussions about HIV prevention, partner reduction, spousal communication, and so on." The project needs to explore what groups of men exist in the communities.

In a step toward that more transformational work, Religious Fathers and other male peers/outreach workers could be trained to offer either Population Council's Addis Birhan program for husbands or EngenderHealth's work. One ironic moment in the assessment came when the team interviewed the staff at EngenderHealth only to find that IntraHealth had partnered with EngenderHealth for a year around 2009 on work focusing on male involvement in PMTCT. They offered two-day trainings to Religious Fathers, peer groups, and influential community members in Oromia and Amhara. The team

did not review a copy of that training, but it would be worth reviewing those materials and the published evaluation to see if they could be used.

Participants in the FGDs suggested reaching out to men using kebele meetings; church events; workplaces; monthly/weekly gatherings of religious men; Idir; community conversation and coffee ceremony. This is in keeping with the WHO literature review, which found that men had a clear preference for community-based events and especially wanted ways that they could hear from and ask questions of men who had tested, HIV-positive men, and from health workers regarding services being offered.⁴⁶ The community events could serve to highlight the work of Religious Fathers, UHEPs and male peers. UHEPs and Religious Fathers working in tandem could do a great deal to mobilize men.

Given some men's professed reluctance to test with their partners, it is good to follow the WHO suggestion that the antenatal clinics offer the men options for both couple and individual counseling.⁴⁷

Recommendation 3: Strengthen the information, education, communication/behavior change communication regarding discordance

Many women and men in the FGDs expressed the belief that men did not need to test if their wives had tested because their status would be the same. This is clearly not true and dangerous for both women and men. As suggested by a provider: "We need to tell now continuously that results can be different." This message needs to be disseminated through all of the channels to all parties: through providers, UHEPs, MSGs, and Religious Fathers to men, women, and communities.

Recommendation 4: Strengthen confidentiality through information, education, communication for the community and increased training for the providers

The perceptions of community members and some Religious Fathers that HC staff members do not maintain confidentiality should be explored to see if it is just a perception or if there are really potential issues. If there are issues, then training for staff needs to emphasize confidentiality. Given men's reluctance to test and their fear of stigma and discrimination, no matter whether there really are confidentiality breaches, behavior change communication/information, education, and communication materials need to emphasize what confidentiality is, what a client can and should expect, and what can be done if there is a breach of confidentiality.

Recommendation 5: Explore the opportunity to address GBV within the facility

IPV is common and does not stop during pregnancy. Indeed, studies have found that GBV can escalate during pregnancy. Relationships which are already distrustful and abusive can become moreso with the added stressors of pregnancy, HIV testing, and disclosure. IPV and disrespect and abuse of pregnant women are both forms of GBV.

⁴⁶ *Ibid.*, Page 19.

⁴⁷ *Ibid.*, Page 17.

Women who are already under significant stress are put under even more by health providers who do not acknowledge their situation or even express concern for their safety. Imagine the poor woman who is afraid who faces a provider with this attitude: “(Even if she is afraid), she knows her status using ANC. She must insist that he come to be tested because the health worker says so.” – Facility-based provider

A study in South Africa found “a myriad of benefits to IPV screening. Not only were the questions well-received by female clients, but it also enabled women to access treatment and psychosocial sources of support. Women found that simply discussing experiences of violence was helpful. The authors report that women easily made the connection between their experiences of violence and gender inequality (Christofides and Jewkes 2010).”⁴⁸

Addressing disrespect and abuse within the HC sets the stage nicely for addressing IPV. Both can be addressed as issues of quality care. Although GBV services are not widely available, the project can still identify ways that the issue can be addressed. It also provides another way to implement potentially gender transformational programming. HC providers, Religious Fathers, UHEPs, and MSGMs could all be involved given their potential to identify women at risk and offer support.

Recommendation 6: Offer counseling and testing for male partners at labor and delivery when wife gets couch counseling

Male partners who have not tested and accompany their partners to delivery should be offered counseling and testing at that time. A study in Uganda offering individual and couples counseling demonstrated that intrapartum HIV counseling and testing could increase individual and couple participation in PMTCT interventions.⁴⁹

⁴⁸ *Ibid.*, Page 27.

⁴⁹ Homsy J et al. Routine intrapartum HIV counseling and testing for prevention of mother-to-child transmission of HIV in a rural Ugandan hospital. *Journal of Acquired Immune Deficiency Syndromes*, 2006, 42(2):149–154.

"On behalf of the community, we are telling our problems. We expect you to take them to the government. We tried to reflect on the problems: it is up to the government to find the solutions." – Female non-service user

ANNEX A: SCOPE OF WORK FOR GENDER ASSESSMENT

Scope of Work for Technical Assistance

Ethiopia Community PMTCT

Cooperative Agreement No. 663-A-00-09-00429-00

I. Identification of Task

Maryce Ramsey, IntraHealth Senior Gender Equality Advisor, over the course of the two week TDY will carry out a gender assessment with the CPMTCT project team to identify gender biases and barriers that are affecting uptake of male partner testing and institutional delivery/SBA services. The assessment will result in an action plan to strengthen the project's approach to addressing the key gender barriers and improving results.

II. Background

The Community Prevention of Mother to Child Transmission of HIV (CPMTCT) is a five year (10/09-09/14) PEPFAR/USAID funded project that aims to increase uptake of MNCH/PMTCT services and improve follow-up and referral of HIV-positive pregnant women/mothers and their infants. There have been dramatic improvements in the uptake of services, especially male partner testing and SBA, at CPMTCT sites, but overall coverage is still low. For example, comparing 100 sites with data for Oct-Dec 2010, and Oct-Dec 2011, there was a 101% increase in male partner testing and a 48% in SBA, however, this increase is an increase to only 30% of male partners of ANC clients tested, and in terms of SBA, 20% of ANC clients.

Poor PMTCT performance in general has led the GoE to launch the "*Accelerated Plan for Scaling-up PMTCT in Ethiopia.*" This Plan includes a demand creation directed toward HEW supervised Health Development Army and Women's Coalition efforts to promote at least one HC level ANC visit, couple counseling, male partner testing, institutional delivery.

III. Purpose of the Gender Assessment

The CPMTCT project has been implementing Demand Creation & Community Mobilization (DCCM) activities aimed at increasing utilization of MNCH/PMTCT services for the last 2 years, particularly ANC, including testing and counseling for the pregnant women and their partners, institutional delivery, especially for HIV-positive women, and post natal care/family planning.

As stated above, there has been significant improvement in ANC, PW tested for HIV, SBA and male partner testing at project supported HCs over the last two years. Nonetheless, the dramatic increase in male partner testing (100+%) still represents only 20% of ANC clients tested. Male partner testing also varies dramatically between HCs and regions. The same can be said for other indicators, including ANC and SBA.

A gender assessment/analysis “is a systematic analytical process used to identify, understand, and describe gender differences and the relevance of gender roles and power dynamics in a specific context. Such analysis typically involves examining the differential impact of development policies and programs on women and men, and may include the collection of sex-disaggregated or gender-sensitive data. Gender analysis examines the different roles, rights, and opportunities of men and women and relations between them. It also identifies disparities, examines why such disparities exist, determines whether they are a potential impediment to achieving results, and looks at how they can be addressed.”⁵⁰

In the context of the Community Prevention of Mother to Child Transmission of HIV (CPMTCT) project, a gender analysis will examine how gender barriers and enablers affect the uptake of male partner testing and institutional delivery/SBA services. We will specifically look at the effect of male involvement as an approach, in order to determine the impact on male behaviors (testing) as well as female behaviors – both service use and non-use.

In a review article on male participation and PMTCT in Africa, the authors noted that: “The concept “male participation” might be thought to be supportive attitudes and behavior toward a pregnant partner to prevent mother-to-child transmission. However, in previous articles included in this review male participation has been found to have an effect on pregnant women’s attitudes, decision-making and behavior and it has been both supportive and non-supportive. Accordingly, in this article male participation means not only supportive attitude and behavior but also all kinds of male effects on expressed aims.”⁵¹

In line with this definition, the gender assessment will look broadly at male involvement in PMTCT in order to increase positive male involvement and decrease negative involvement because we are in agreement with the same article’s conclusion that: “Advanced qualitative knowledge about male participation in a certain culture may help to develop PMTCT programs in a direction that increases the health of mother and babies.” We would add that also increases the health of husbands and fathers.

The assessment will include individual interviews with key staff and partners; group discussions with targeted health cadre, male and female clients and community members; a literature/document review; and a gender review of service use data.

The objectives of the assessment are to:

⁵⁰ Tips for Conducting a Gender Analysis at the Activity or Project Level Additional Help for ADS Chapter 201, March 2011, USAID, Office of Women, Girls and Gender Equality. Available at: www.usaid.gov/policy/ads/200/201sae.pdf

⁵¹ Male participation and prevention of human immunodeficiency virus (HIV) mother-to-child transmission in Africa, Auvinen, J., Suominen, T. and Valimaki, M. Psychology, Health & Medicine Vol. 15, No. 3, May 2010, 288–313.

- Understand existing services and programming in PMTCT and men's and women's involvement;
- Identify barriers/enablers to male partner testing and SBA service use;
- Identify where improvements in strategy, access, quality, service delivery, messaging, policy and/or measurements/indicators are needed;
- Identify opportunities to collaborate with other partners as appropriate;
- Develop recommendations for improving service uptake
- Develop a work plan based on the recommendations.

IV. Period of TDY: April 21 - May 6.

V. TDYer: Maryce Ramsey, Senior Gender Equality Advisor, IntraHealth International

VI. Deliverables

- Staff orientation presentation.
- An action plan to improve male partner testing and SBA based on identified gender constraints and enablers affecting service uptake and corresponding strategies/best or promising practice models to address them.
- Trip report.

VII. Contacts

- Aynalem Yigsaw, IntraHealth,
- Patricia McLaughlin, Intrahealth, 0913-202875

VIII. Overview of Schedule

1. Day 1 - Gender orientation for project staff
2. Days 2-3 Meetings with project partners and other partners,
3. Days 4-9 Health facility and community site visits and discussions
4. Days 10-11 Analysis and action planning with CPMTCT staff
5. Day 12 Debrief with USAID

ANNEX B: INDIVIDUALS INTERVIEWED

Organizations and individuals contacted:

Organization	Individual	Title
EngenderHealth	Carla Rull Bousen	MARPS Project Director
Pathfinder International	Tilahun Giday	Country Representative
	Heran Abebe	Senior Gender Advisor
Population Council	Annabel S. Erulkar	Country Director
	Gebeyehu Mekonnen	Chief of Party
UNFPA	Ane Etxebarria Atxutegi	Junior Professional Officer – Gender & Advocacy
	Tsehay Gette	Program Officer – Gender Advocacy
	Berhanu Legesse	NPO – Gender and Advocacy
USAID	Alemnesh Haile-Mariam	Gender Advisor

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ANNEX D: FOCUS GROUP DISCUSSIONS AND SITES

Sites	Male service Users	Male non-users	Female users	Female non-users	Facility-based providers	MSGMs	Religious fathers	UHEPs	Total FGDs
Buanbuha (A)	X (8)	X (9)	X (5)		X (7)			X (11)	5
Segno gebeya (A)	X (8)	X (7)	X (9)	X (7)	X (6)				5
Kombolcha 05 (A)	X (0)	X (9)	(8)	X (10)	X (8)		X (5)		5
Legetafo (O)	X (7)		X (8)			X (7)*			3
Bulchana (O)		X (8)		X (8)				X (6)	3
Bokushenen (O)			X (7)	X (8)	X (6)		X (9)		4
Total FGDs	3 (23)	4 (33)	5 (37)	4 (33)	4 (27)	1 (7)	2 (14)	2 (17)	25FGDs (191 people)

*This group only had two MSGMs and five MSG members.

 = low partner testing

 = low delivery

 = high in both partner testing and facility-based delivery

 = medium for both male partner testing and facility-based delivery

A/O = Amhara or Oromia Region

(number) = number of people in the discussion

ANNEX E: FOCUS GROUP DISCUSSION GUIDES

Female Service Users

Begin with introductions and informed consent.

We would like to start by talking about birthing customs in your community.

1. How and where do women give birth in your community? Why?
2. What do people think about delivering in a health facility?
3. What might keep a woman from delivering in a health facility?
 - If we don't hear it, then probe for who makes the decision regarding facility-based delivery and any expenses associated with it.

For those of you that have delivered in a health facility we would like to ask you a few questions about that experience.

4. What encouraged you to deliver in a health facility?
 - If we don't hear it then probe for decision making regarding facility-based delivery and expenses associated with it.
5. Were you happy with the service?
 - If yes, why? What did you like?
 - If no, what did you not like about it?
6. What improvements would you like to see?

Now we would like to talk about partner testing.

7. Why might a man agree to test? Why might he not?
8. Can you ask your partner to test? Why or why not?
9. In general what can be done to encourage men to test?
10. Is there anything that you would like to ask us?

Thank you!

Female Service Non-Users

Begin with introductions and informed consent.

We would like to start by talking about birthing customs in your community.

1. How and where do women give birth in your community? Why?
2. What do people think about delivering in a health facility?
3. What might keep a woman from delivering in a health facility? Probe for:
 - Decision making
 - Expenses associated with it.

For those of you that delivered somewhere other than a health facility, we would like to ask a few questions about that experience now.

4. Why did you deliver at home (or where you did)? Probe for:
 - Decision making
 - Expenses associated with it.
5. Were there things you liked about delivering there? Things you didn't like?
6. What could be done to encourage women like yourselves to deliver in a health facility?

Now we would like to talk about partner testing.

7. Why might a man agree to test? Why might he not?
8. Can you ask your partner to test? Why or why not?
9. In general what can be done to encourage men to test?
10. Is there anything that you would like to ask us?

Thank you!

Male Service Users

Begin with introductions and informed consent.

We would like to start by talking about male partner testing in your community. Be prepared to define this.

1. Why might a man test? Why not?
2. How did you make the decision to test?
3. Did you test with your partner or alone? Why?
4. How were you treated by the person that did the testing?
5. Where were you tested? How did you feel about this place?
6. How could the services be improved?
7. What could be done to encourage more men to test?

Now we would like to talk about where women give birth in your community

8. Where did your wife give birth? Why?
9. What role did you play?
10. What could be done to encourage women like your wife to deliver in a health facility?
11. Is there anything that you would like to ask us?

Thank you!

Male Service Non-Users

Begin with introductions and informed consent.

We would like to start by talking about male partner testing in your community. Be prepared to define this.

1. Have you heard about partner testing?
2. If your partner asked you to test with her, would you? Why or why not?
3. Would you test alone? Why or why not?
4. Are there benefits to testing with your partner? Problems?
5. What are your overall impressions of the health facility?
6. If you were willing to test, where would you prefer to test?
7. What can be done to encourage men to test with their partners?

Now we would like to talk about where women give birth in your community

8. Where did your wife give birth? Why?
9. What role did you play?
10. What could be done to encourage women like your wife to deliver in a health facility?
11. Is there anything that you would like to ask us?

Thank you!

Facility Service Providers

Begin with introductions and informed consent.

We would like to start by talking about facility-based delivery.

1. How do you think the community perceives facility-based delivery services at your HC?
2. How would you describe the women who come to deliver at your facility?
3. Are you able to provide the kind of care you would like as a laboring woman or for your wife? If not, what do you need? Skills? Equipment?
4. Please describe what happens from the time a pregnant woman arrives until she leaves.
5. What kinds of things that happen during delivery might make a woman want to come back? Not want to come back?
6. Why do you think that the number of women delivering at this facility is High/Low?
7. What do you think would encourage more women to deliver in a health facility?
8. How would you describe the men that get tested in this facility?
9. Do more men test with their partners or alone?
10. Do you counsel men differently than women? If yes, how?
11. Why do women tell you they don't want to disclose to their partners?
12. How do you support women to disclose?
13. How can you improve the male partner testing services here?
14. What recommendations do you have for getting more men to test?

UHEP/Religious Fathers/MSGMs

Begin with introductions and informed consent.

We would like to start by talking about facility-based delivery.

1. How do you think the community perceives facility-based delivery services at the HC?
2. When you follow up with pregnant women, why do they tell you that they don't want to deliver in the facility?
3. What do you think would encourage more women to deliver in a health facility?
4. What could be done to improve facility-based delivery services?
5. When you encourage women to disclose to their partners, what do the women tell you?
6. What can you do to support the women to disclose?
7. How do you encourage men to test?
8. Do you encounter any problems doing this?
9. When you encourage men to test, what do they say?
10. What do you recommend to improve male partner testing?
11. Is there anything that you would like to ask us?

Thank you!