Annex 02: Situational analysis

Health Status and Services in DRS and Pastoral Areas

There is limited information available on the health status of pastoral populations in DRS. Quantitative data come from the GOE Health Sector Development Programme IV (HSDP) Annual Performance Report, Health Management Information Systems (HMIS) or the Demographic and Health Survey (DHS). Although HSDP Annual Performance Report and DHS include information at the regional level, they are not designed to capture information on pastoral groups specifically or smaller geographic areas of interest, such as the pastoral areas of Gambella, Oromia, and SNNPR. Additionally, the representativeness of the DHS for pastoral populations, especially in Somali region, is questionable; for example, in the 2011 DHS, not all the enumerated, listed households were interviewed in the Somali region because of security concerns or drought. The Federal Ministry of Health (FMOH) recognizes the challenges of delivering health services in pastoral areas and the difficulty of creating an appropriate health delivery package.

1. Under-Five Mortality, Immunizations, and Child Nutrition

Although under five mortality rates are higher in Afar, Somali, and Gambella than nationally, the neonatal mortality rate is actually slightly lower in Afar (33 deaths per 1,000 live births) and Somali (34 deaths per 1,000 live births) than the Ethiopian average 37 deaths per 1,000 live births. It is not until a child reaches one year of age that larger differences in child mortality are evident between the pastoral areas and the Ethiopian average. According to the FMOH, the Afar region has the highest prevalence of stunting and underweight for children under five years of age. Likewise, some of the pastoral regions also suffer from low levels of vaccination. In Afar, 47.3 percent of children 12-23 months had received no vaccination. The corresponding percent in Somali region was 35.4 percent and 7.7 percent in Gambella region, compared to 14.5 percent nationally.

2. Maternal Mortality

Afar and Somali regions had the lowest percentage of deliveries attended by skilled providers, at 6.6 percent and 9.1 percent respectively. As would be expected, Afar and Somali also lag behind other regions in percent of births delivered in a health facility. The main reasons cited for not delivering in a health facility were that it was not necessary (Afar 37.0, Gambella 28.0, Somali 24.2, and national 44.9 percent), not customary (Afar 41.6, Somali 48.3, Gambella 10.4, and national 33.1 percent), or the health facility was too far or there was no transportation (Afar 35.2, Somali 45.9, Gambella 54.2 and national 21.7 percent).[1] Distance seems to be more of a problem in the pastoral areas than nationally and customs also are more of a problem in Afar and Somali than nationally. However, the proportion of the sampled population in all three pastoral areas that recognized that delivery is necessary in a health facility was higher than nationally.

3. Fistula

According to the 2005 EDHS, the prevalence of obstetric fistula is low in the pastoral regions. Yet, this data is based on self-reported prevalence and place of residence. Some established reports conclude that obstetric fistula is more common in rural areas where there is a lack of

[1] CSA 2014

obstetric services. In addition, obstetric fistula is a stigmatizing disease in Ethiopia and patients tend to migrate to urban areas for fear of stigma and discrimination in their rural communities.[2]

4. Family Planning/Reproductive Health (FP/RH)

In the pastoral regions, the low levels of adequate care during delivery combine with a high number of children born per woman. While the national TFR was 4.1 in 2014, it was 5.7 in Afar and 7.3 in Somali. Gambella is also well above the national average. Additionally, while national CPR was 40 percent in 2014, the rate is far lower in Afar (8.4 percent) and Somali (1.0 percent).[4] Anecdotal evidence suggests that traditionally a man's departure with the livestock served as a natural form of birth control in pastoral society, but as pastoralists become more settled, they are losing this period of separation. The periods of time that men spend migrating with livestock may also influence women's uptake of FP services if she requires her husband's permission to seek health services.

5. Gender

Many pastoral groups in Ethiopia are both patriarchal and patrilineal, in which men are the respected household heads. Pastoral girls in the Horn of Africa learn early on to accept their identity as helpers to their mothers, who are subordinate to their husbands. This might partly be a result of the transient role of women in a clan or household: at marriage they pass between clans and/or households.[3] The lower position of women is evidenced in the Afar ethnic group, where the blood price of a woman is half that of a man.[4] The importance of bride price and dowry at marriage in many pastoral societies only serves to further undermine the position of women. It contributes to the perception of women as commodities and makes it difficult for a woman to get a divorce if desired (Kipuri and Ridgewell 2008). Furthermore, it contributes to power inequalities in household gender relations by promoting age discrepancy in marriage, since usually only older men can afford the bride price (PFE 2008).

Annex 03: Quality improvement activities

Transform Activities

Transform: Health in Developing Regions should have strong linkages with USAID's Health AIDS Population and Nutrition Office's Ending Preventable Child and Maternal Deaths (EPCMD) investments, namely the Transform awards, and other USAID/Ethiopia activities. The **Transform** awards' overall goal is to support the GOE's attainment of its HSTP, namely the reduction of Maternal Mortality Ratio (MMR), Total Fertility Rate (TFR), Infant Mortality Rate (IMR), Neonatal Mortality Rate (NMW) and Under Five Mortality (U5M). To reach these goals and impact, USAID, through its Transform approach, intends for its investments to achieve these key results over the next 5 years:

1. Expanded access to and uptake of family planning.
2. Increased numbers of healthy mothers and successful birth outcomes.
3. Increased survival of healthy newborns (birth to 28 days); and
4. Sustained gains in and improved child health

[2] Biadgilign et al 2013
[3] DHS, CSA, and ICF 2012
[4] Kipuri and Ridgewell 2008

1. *Transform: Primary Health Care*

Due to Ethiopia's largely rural population and the need for high-quality PHCUs (that will eventually be able to absorb the ever-increasing MNCH service demand, a long-term goal for the MOH), the largest component of the EPCMD portfolio is Transform PHCU. This component will focus on the four agrarian regions (Tigray, Amhara, Oromiya, and SNNPR) that have the greatest population density and the greatest needs for EPCMD-related services and improvements, while simultaneously having had the greatest improvements in some aspects of health care. Working through the PHCU structure, USAID/ Ethiopia will partner with an organization or consortium to build its capacity to support the improved health outcomes in lower performing Woredas and PHCUs and sustain achievements in strong Woredas.

2. *Transform: URBAN*

The urban aspect of the Transform portfolio, Strengthening Ethiopia's Urban Health Extension Program (SEUHEP), is currently being implemented by JSI. This component will continue to expand upon, and focus, USAID's support to the GOE's Urban Health Extension Program to better target EPCMD-related services, including urban WASH, in urban areas with particularly low MCH/FP outcomes.

3. *Transform: Water, Sanitation and Hygiene (WASH)*

The overall activity goal is to reduce mortality in children under 5 years old by increasing correct and consistent adoption of improved WASH behaviors by increasing: 1) WASH governance and management capacity at the subnational level; 2) demand for low-cost quality WASH products and services, with a focus on sanitation; 3) supply for low-cost quality WASH products and services, with a focus on sanitation; and 4) knowledge base to bring WASH innovations to scale. All activities will aim to achieve sustained (product-facilitated) behavior change by combining hygiene promotion, small-scale private sector hardware interventions, and enabling environment activities that reduce barriers to attaining scale (e.g., promote cost recovery; inform and promote policy change).

4. *Transform: Monitoring, Evaluation, Learning, and Evaluation Activity (MELA)*

This will be a five-year award that will provide technical assistance to monitor performance and measure the impact of the Transform interventions. Transform MELA will be responsible for collecting, analyzing, communicating high-quality monitoring and evaluation data for USAID/Ethiopia, with the purpose of guiding the USG and GOE in adaptive learning and management of its EPCMD portfolio. This contract will be implemented in parallel with the other Transform awards, and is responsible for completing detailed baseline, mid-line, and end- line evaluations. Additional MELA activities will include but are not limited to external performance evaluation of select mechanisms, high-level monitoring of broader EPCMD result areas, geospatial analyses, and learning forums. Utilizing and strengthening M&E capacity of local Ethiopian systems will also be a major component of Transform MELA. It is anticipated that learning generated from this contract will provide strategic information for programmatic decision-making throughout the life of Transform and help determine necessary realignments of resources for the greatest public health impact.

General activity guidance

The following operational guidance is provided that will be critical for the successful and sustainable implementation of this Activity. These principles relate to a. Collaborating, Learning and Adapting; b. Technical Approach; c. Geographic Focus; d. Guiding Principles; e. Coordination and Sustainability Plan; f. Gender; and g. Management Approach.

a. Collaborating, Learning and Adapting

USAID's Bureau for Program Planning and Learning (USAID/PPL) has developed an approach to learning called Collaborating, Learning and Adapting. This approach facilitates a process for strategic collaboration among partners, systematically generates and captures learning, facilitates the exchange of knowledge, and promotes a learning culture. CLA posits that development efforts yield positive changes more quickly if they are collaborative, test new approaches in a continuous search for improvement, and adapt based on what works and what does not. CLA will be important, where investments at different levels of the health sector and the enabling environment are implemented by different implementing partners. Effective strategies for collaborating and collective learning will be essential.

b. Technical Approach

The poor outcomes in DRS result from: **(i)** *Weaknesses in the health care system*: limited coverage of essential MNCH/FP services; non-functional referral systems and weak Primary Health Care Unit (PHCU) structures; health workforce challenges including few qualified women health workers; barriers to implementing the Health Extension Program (HEP); weak supply chain management systems; limited communication and transport infrastructure; financial constraints and unavailability of data for decision making. **(ii)** *Poor utilization of health services*: limited access to health facilities for the highly mobile pastoralist population, low commitment, and unwelcoming attitude of health providers. **(iii)** *Socio-cultural and behavioral barriers*: lack of women's decision-making power, harmful traditional practices, limited awareness of MNCH/FP services; low satisfaction and confidence in the health services and low community engagement in health and social wellbeing. The Government of Ethiopia's (GoE) HSTP has targeted these barriers as a priority through its transformative agenda focusing on equity and equality; woreda transformation; a caring, respectful, and compassionate health workforce; and effective use of information, all critical elements that are lacking in the DRS.

To reach EPCMD goals, our strategic pillars will include: (i) provision of comprehensive and integrated clinical interventions in MNCH/FP; (ii) implementation of context and culturally appropriate communication strategies for MNCH/FP service uptake; (iii) capacity development in the management and use of data for decision making and action; (iv) partnerships for health systems strengthening; and (v) gender equity programming. Through these interventions, Amref Health Africa and its partners will support the ambitious HSTP targets for MNCH/FP and aim to contribute at least 50% of the HSTP MNCH impact and outcome indicators by the end of the Activity. These contributions will be clearly defined and translated into targets once baseline assessments and prioritization of needs are completed, and detailed M&E operations plans drawn up in consultation with the respective RHBs and USAID/Ethiopia.

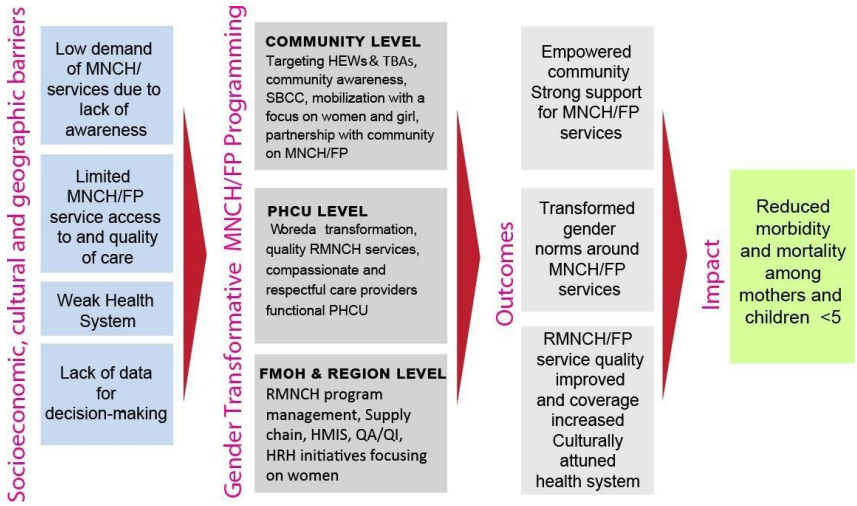
c. Geographic Focus

This Activity will focus on the Developing Regional States in Ethiopia, specifically Afar, Beninshangul-Gumuz, Gambella and Somali regional states. Transform: HDR will use a mix of factors that are pertinent to achieve scale and value for money in the selection of intervention woredas. The Activity will use weighted criteria to prioritize woredas and health facilities for the interventions. For example, one criterion is the presence of other RMNCH projects/partners in the DRS. To understand the overall coverage of activities by other partners, the Recipient will conduct a resource mapping exercise. The Recipient is committed to ensure optimum site coverage to improve the health outcome of children and women and adolescents in the DRS. For planning purposes, the Activity intends to support approximately 58 woredas. Below is a proposed criterion that could be used in prioritizing target woredas. The criteria, weight given to each of the factors and final woreda selection will be discussed and agreed with USAID/Ethiopia, FMOH and respective Regional Health Bureaus. The final number of implementations woredas and locations will be determined through a consultative process (through the annual implementation plan process) with USAID/Ethiopia and FMOH to maximize geographic coverage while maintaining optimum quality and intensity of services.

d. Guiding Principles

The *socio-economic, cultural,* and *environmental* context in the DRS will be considered in designing interventions that are relevant, ensure *quality* health services, leverage existing resources and local knowledge, and deliver a transformative gender equitable health agenda to EPCMD (see Figure 1).

Figure 1. Conceptual Framework for EPCMD in the DRS



e. Coordination and Sustainability Plan

Aligning with existing systems and programs, our sustainability strategy is anchored on: (i) building on the government's political will and investment in MNCH/FP services in DRS; (ii) ensuring a fully consultative and coordinated approach of key MNCH/FP stakeholders including FMOH, RHB and local non-governmental organization (NGO) to implement MNCH/FP policies and programs, and allocate budgets; (iii) leveraging the predominantly cultural and religious

leadership structures in the target regions including Amref Health Africa's existing non-US government (USG) projects to create synergy, leverage resources and maximize impact; (iv) harnessing resources from the private sector and other local and international resources; (v) coordinating with and building the capacity of local organizations.

f. Gender

Gender inequality is a key challenge in attaining EPCMD in the DRS. This is because the s*ocio-cultural environment in the DRS* perpetuates the disenfranchisement of women from decision making power; harmful traditional practices (FGM and early marriage) are pervasive; women are generally not involved in making decisions affecting their health, and health worker attitudes towards women seeking health services are poor. The consortium will take a *gender-transformative approach* to improve women's access to key MNCH/FP services and create communities' understanding of the challenges and social norms that perpetuate inequalities between men and women.

Gender will be integrated across the program cycle, from assessment at the baseline through implementation and M&E to learn about effect on behaviors, using gender equality indicators from Measure Evaluation[12] and gender outcomes related to violence, decision making for equitable health and well-being, health service access and gender equitable social structures. The Activity will use gender disaggregated data promoting gender affirmative action in community groups and health worker recruitment. The Recipient will guide its gender interventions by engaging men and women through community structures in a synchronized way, adapting the Steppingstones gender relations methodology[13] and using RHB and FMOH guidance to address gender inequities. The Activity will target socio-cultural norms that drive these forms of violence using assessments, services and SBCC (*See details under IR 3*). This methodology will be linked into the planning and implementation of the systems for Alternative Rites of Passage, Maternity Waiting Homes, Mother support groups and TBA re-positioning approaches, to reinforce positive gender norms and behaviors.

The Recipient and its partners recognize the different gender power relationships and dynamics based on the context, social norms, and values of each region. For example, in Afar, type IV FGM, the most harmful form of FGM causing major complications at delivery, and early marriage are the most prevalent forms of violence against women that need to be prioritized. Understanding the economic factors that play a critical role in the lives of Afari women is very important; for example, where children are seen as resources, FP methods are typically refused, unless they are introduced as methods for birth spacing instead of preventing pregnancy[14]. The labor-intensive lifestyle of Afari women, engaged in animal herding, from early hours to night, limits their ability to participate fully in demand creation interventions, such as group discussions on MNCH/FP, and therefore their schedules need to be considered when identifying appropriate times to get women involved. In Somali region, Somali women are more engaged in economic activities through small businesses such as selling camel milk, vegetables, or chat, and although they have cultural assertiveness, they are still subordinate to their husbands. Understanding trends of Somali pastoralist women transitioning to agrarian lifestyles, called the "pastoralist drop-outs", have different needs than women who remain pastoralists. These women, whose husbands remain pastoralists, tend to have a higher demand for FP services, requiring customized FP needs using a culturally sensitive approach.

[12] http://www.cpc.unc.edu/measure/resources/publications/ms-13-82

[13] http://steppingstonesfeedback.org/index.php/page/Resources/en?resourceid=8

[14] Reproductive Maternal and Neonatal Health Fund (RIF) Pastoralist Forum – Key Findings and Progress, Jijiga, June 2016 - Unpublished

In Gambella, which has a more agrarian population and widely dispersed communities, the UNICEF study reflects that this region has the highest figures for early marriage in the country[15]. Prioritizing these "hot spot woredas" with intensive targeted interventions focusing on awareness creation on the effects of early marriage could be a major opportunity. In a society that perceives married women as "sold", critical interventions to change these perceptions among both men and women are critical. Most importantly, addressing the economic dimensions, since Gambella women work in the fields for over 12 hours a day, calls for multi-sectorial engagement for improved MNCH outcomes.

In Benishangul Gumuz, one of the critical traditional harmful practices of giving birth in the forest has a tremendous effect in MNCH outcomes. Such problems have proven solutions by supporting initiatives and building on the efforts of organizations such as *Mujejeguwa Loka* Women Development Association (MLWDA) that have a successful model that could bring major impact ~~and is scalable. Supporting s~~such effective interventions that are proven to be effective represent excellent opportunities for the project to be engaged in to support life changing interventions for women in Benishangul Gumuz. These examples reflect a snapshot of the range of discriminatory and harmful traditional practices and their variation from one region to another, and potential opportunities to address them. TRANSFORM HDR's gender interventions across the program will ensure that:

- Gender is integrated in all interventions - health systems strengthening, clinical activities and community level activities.
- The project's gender strategy aligns with existing regional structures and strengthens the government structure from the region to the woreda level. A multi-sectorial approach will be taken engaging women's affairs and economic development sectors at each level.
- Mainstreaming gender at health facility level – working with health providers in each region addressing compassionate respectful maternity care and improving the health sector response to sexual violence against women, for example working with RHB on standard approaches for PEP and emergency pills' provision at the MNCH unit at health facilities.
- Implementing interventions that directly address violence against women, with a segmented approach targeting adolescence and youth separately, and women of childbearing age, and most importantly considering regional variations and priorities as reflected above.

While the Recipient will work closely with implementers working on gender issues such the DfID funded RMNH Innovative Fund, the Recipient will conduct a gender analysis as part of our baseline and to validate current data on gender and barriers to MNCH services. This approach will enable us to better guide activity design that will appropriately respond to the needs of the specific regions taking these contextual and cultural variations into play and engaging a multi- sector approach. Outcomes of these interventions across all regions will be critical with specific gender-related indicators such as proportions of women with increased health seeking behavior towards MNCH services and proportions of women who reported making decisions on their own health care or jointly together with their partner.

[15] National survey Study on FGM/CM UNICEF, 2015, Ethiopia - Unpublished

A Gender Advisor at the national level will conduct a gender gap analysis, develop interventions based on the above tools and will be supported by all program and technical staff in implementation. The project will also work closely with the FMOH Gender Directorate and the Ministry of Women, Children, and Youth Affairs to ensure alignment with GoE mainstreaming efforts.

Activities required.

The Recipient will conduct activities designed to achieve the objectives set forth above. The activities conducted under this Activity will be consistent with the results framework below.

Figure 2: Results Framework

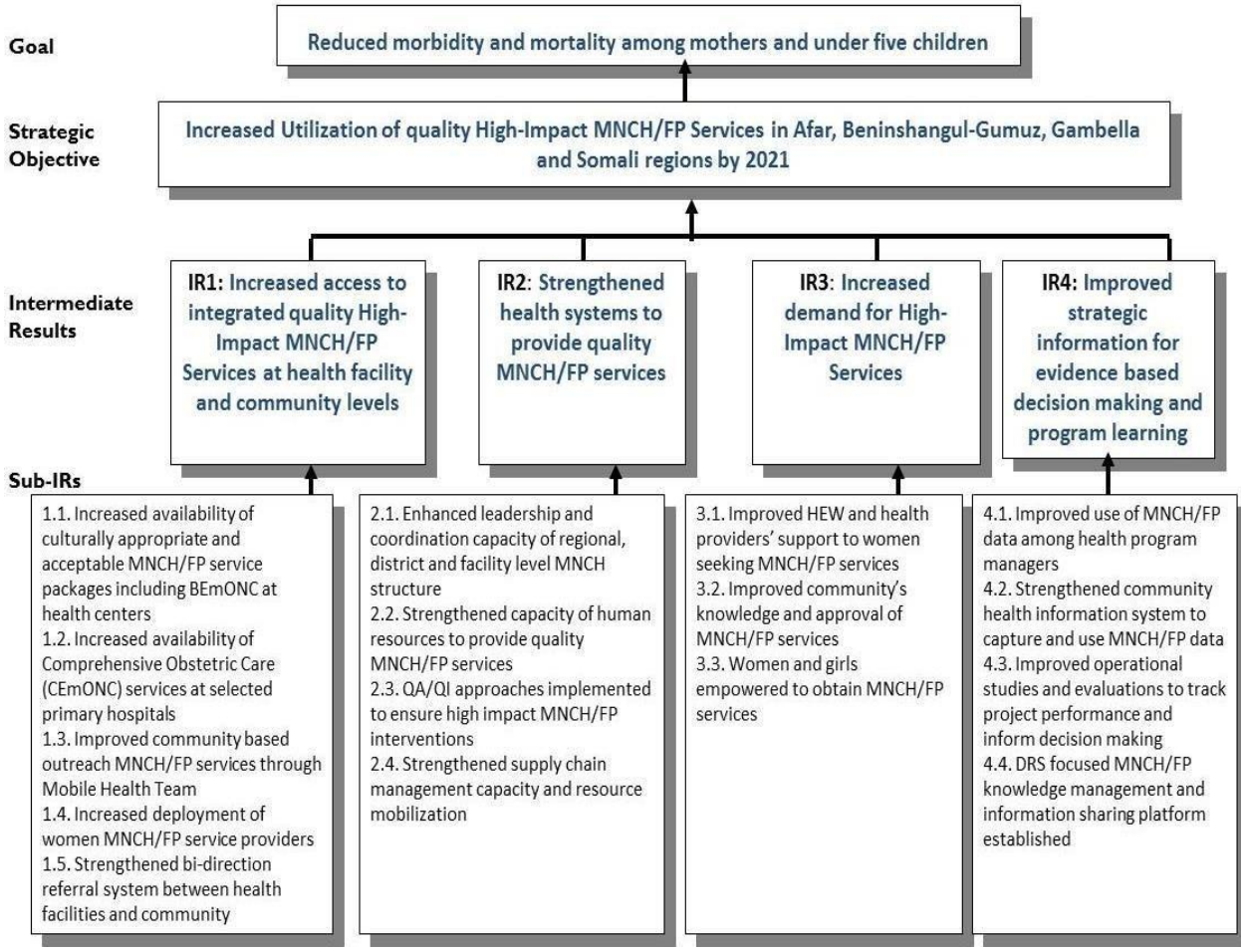


Table II. Summary of Core Package of High Impact RMNCH Interventions

Care level & Level of Effort (LOE)	Key intervention	Core Package of High Impact RMNCH Interventions proposed in the project
Pre-pregnancy LOE = 30%	Family Planning (CPR)* Tetanus Toxoid immunization (PAB)	LARC scaling up, YFS, FP service. strengthening
Pregnancy LOE = 20%	Focused ANC (4/more visits)* Iron Folate Supplementation* PMTCT and ART for HIV+ pregnant women* Tetanus Toxoid immunization (PAB) ITNs for pregnant women (Malaria endemic areas)* Antenatal Corticosteroids for preterm labor* Mg So4 during pregnancy & at Birth* PAC	ANC, PAC, Nutrition in pregnancy, Mg So4, and Antenatal Corticosteroids, maternity waiting rooms, essential lab testing
Birth and postnatal LOE = 25%	Skilled attendance at birth* Neonatal resuscitation Chlorhexidine for cord care Thermal regulation KMC Antibiotics for Premature Rupture of Membranes (PROM)*	BEmONC, CEmONC, KMC, Essential Newborn Care (WHO, HBB, Chlorohexidine for cord care, Newborn corner, essential lab support, e.g. Hb
Infancy LOE = 17.5%	Postnatal visit for mothers and newborns within 48 hours* Antibiotics for neonatal sepsis Early initiation of breastfeeding (within 1 hour of birth) Exclusive breastfeeding (up to 6 months) Complementary feeding (age 6-9 months) and continued breast feeding Penta 3 (DPT-HepB-Hib) vaccination Pneumococcal vaccine Rota Virus vaccine Measles immunization Vitamin A supplementation every 6 month*	PNC IMNCI, and referral IMNCI, ICCM, CBNC Strengthening both static and outreach immunization service
Childhood LOE = 7.5%	Antibiotics for pneumonia Oral Rehydration Therapy (ORS) and Zinc Malaria ACT treatment Antibiotics for dysentery Children sleeping under insecticide- treated nets (ITNs)* Management of children with SAM* Improved drinking water (household)* Improved sanitation facilities (household)* Deworming	Support IMNCI, ICCM Essential lab testing e.g. malaria confirmation before treatment Community mobilization for ITN utilization in collaboration with other projects Link with other project intervention Community mobilization for environmental sanitation Deworming integrated with outreach and MHT activities