Knowledge as a Vehicle for Change in Reproductive Health and HIV/AIDS Prevention

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A Case Study Focused on Women in Bahir Dar Special Zone, Amhara Regional State, Ethiopia

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Executive Summary

The purpose of this study is to ascertain out the role of access to information and consequently of the generated knowledge in reproductive health utilization, HIV awareness and in participation in own health in Bahir Dar Special Zone, Amhara regional state, Ethiopia. These processes are discussed within the structure of health service planning, management and provision with special focus on awareness raising strategies and behavioural communication change. The study applied the case study approach while utilizing both qualitative and quantitative research methods to triangulate the data. Field research period took place between February and June 2011. The introductory part of the data collection was held in Addis Ababa and briefly in Bahir Dar where qualitative data was collected through key-informant interviews in order to grasp the health service planning & provision structure while focusing on reproductive health and HIV/AIDS. Awareness raising strategies and behaviour communication channels were investigated in their relation to potential demand creation. In Bahir Dar Special Zone, two urban and two rural areas were sampled to execute the household survey, to carry out focus group discussions and selected services quality assessments. Semi-structured interviews were held with heads of the facilities. The household survey investigation focused on health care seeking behaviour of women in reproductive age, facility-based research collected data on health service provision and quality while identifying major challenges. Focus group discussions held mostly with female participants of reproductive age served as vital complement of each thesis objective.

Both clinical and community-based reproductive health & HIV prevention services were found to be highly cluster-cumulated despite the decentralized framework. This counts for service availability, medical supply and health workforce which to a large extent favour urban areas. Aspects of policy analysis & evaluation were applied to the Health Extension Programme which represents promising government effort in bringing services closer to the poor. However, the factual capacities of Health Extension Workers turned out to be questionable, partially as an outcome of ineffective training mechanisms and deployment. Awareness raising strategies with aim to positively influence individual & community health care seeking behaviour were present in numerous traditional and innovative forms creating a complex structure. Mostly NGO-led strategies were highly taking advantage of existing network of Health Extension Workers and assisting volunteers. The crucial role of knowledge was indicated in HIV prevention and although achieving higher levels than in the recent national statistics, comprehensive HIV knowledge was found to be rather unsatisfactory which triggers the discussion on quality of provider → user communication in voluntary counselling and testing (VCT). The functioning prevention of mother to child transmission (PMTCT) modality of service which reaches mothers through their ante-natal care (ANC) investigation whereas mediating the issue of HIV prevention and treatment is considered as a positive empirical finding. The functionality of this service was reflected by its positive association to comprehensive HIV knowledge. However, some gaps such as internalization of the knowledge in terms of active HIV prevention especially reflected by extremely low condom utilization still lag behind. Concerning relatively low skilled birth attendance the study reflects the low level of child birth preparedness and planning especially in rural areas which combines many issues from spatial inaccessibility to cultural determinants. Examining the level of citizen's participation in own health, few forms of community participation and accountability mechanisms were found albeit largely NGOs-driven. Even though the level of accountability remains administrative and upwards, women are obviously gaining knowledge of basic mechanisms such as complaint procedure rather slowly while facing many structural difficulties. This thesis concludes that knowledge is crucial in all aspects of reproductive health service provision, HIV prevention and health participation. Making information on reproductive health and HIV prevention & treatment services as well as on accountability procedures available should not be perceived as a luxury or a threat but rather as a win-win situation towards more equitable and responsive health system.

List of Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ANRS	Amhara National Regional State
ART	Anti-Retroviral Therapy
BCC	Behaviour Communication Change
BoFED	Bureau of Finance & Economic Development
BUCEN	United States Census Bureau
CBHWs	Community-Based Health Workers
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CNHDE	Centre for National Health Development in Ethiopia
CORHA	Consortium of Reproductive Health Associations
CPR	Contraceptive Prevalence Rate
CRC	Convention on the Rights of the Child
CRDA	Christian Relief & Development Association
CSA	Central Statistical Agency
CSWs	Commercial Sex Workers
DAH	Development Assistance for Health
DOTS	Directly Observed Treatment Short Course
EDHS	Ethiopian Demographic & Health Survey
EPI	Expanded Programme of Immunization
FGM/C	Female Genital Mutilation/Cutting
FHI	Family Health International
FP	Family Planning
GBV	Gender-Based Violence
GTP	Growth and Transformation Plan 2010/11-2014/15
HAPCO	HIV/AIDS Prevention & Control Office
HCT	HIV Counselling and Testing
HDI	Human Development Index
HIV	Human Immunodeficiency Virus
HRW	Human Rights Watch
HWs	Health Workers
ICG	International Crisis Group
ICPD	International Conference on Population & Development
IDPs	Internally Displaced Persons
IEC	Information, Education and Communication
IMCI	Integrated Management of Childhood Illnesses
IMF	International Monetary Fund
IPCC	Intergovernmental Panel on Climate Change
IUDs	Intra-Uterine Devices
MARPs	Most-at-Risk-Populations (to HIV)
MDGs	Millennium Development Goals
MNCH	Maternal, New-Born & Child Health
MoFED	Federal Ministry of Finance and Economic Development

MOWA	Federal Ministry of Women's Affairs
NFFS	National Family & Fertility Survey
NGO	Non-Governmental Organization
NPP	National Population Policy
NSRHS	National Sexual and Reproductive Health Strategy
OECD	Organization for Economic Cooperation and Development
OPD	Outpatient Department
PASDEP	Plan for Accelerated & Sustained Development to End Poverty
PPP	Parity Purchasing Power
PRB	Population Reference Bureau
RBA	Rights-Based Approach
SAPs	Structural Adjustments Programmes
SNNPR	Southern Nations, Nationalities & Peoples Region
SWAPs	Sector-wide Approaches
TFR	Total Fertility Rate
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Development Fund for Women
WB	World Bank
WHO	World Health Organization

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Introduction

Spider webs joined together can catch a lion.

Amharic proverb.

On October 31 2011, the Earth was officially inhabited by seven billion people. In many low- and middle-income countries population growth is threatening sustainable development and the need for reproductive health services is great. Governments that seriously fight poverty should also be serious about providing the services, supplies and information that women need to exercise their rights. One of the *raison d' être* of this thesis is that people with more information and knowledge about the existing system and about their rights are better able to represent their own interest and obtain the health services which they are entitled to (vide Deininger & Mpuga, 2005). Gender inequality is one of the social determinants of both poor reproductive health and high HIV/AIDS exposure of women. Cultural norms often do not accept publicizing of sexual issues which often hampers women's access to information about prevention.

Women often receive inadequate care and treatment while carrying the burden of caring for their dependents. It is a desirable trend that HIV policies have been increasingly integrated into other development efforts - into reproductive health in particular. Approaching those two, previously strictly separated, poles in programming, financing, advocacy, research and health service provision represents a promising way forward. Including HIV prevention and treatment into reproductive, maternal and child services means multiplying of health service entry points while boosting potentialities for prevention. Another challenge of the 21st century reproductive health service provision is how to effectively involve people to participate on decisions that affect their own health. Genuine participation and access to information are cornerstones of empowerment (Langford, 2008). Participation has many instrumental gains resulting in using local knowledge, exposing local preferences, raising resource allocation efficiency while maximizing ownership and sustainability of development efforts. However, to what extent people really influence decisions made about their own health? It should not end up just with utilization of that particular service although it is an important starting point. Health care utilization traditionally depends on the services available and the structure of the service provision. More recently, other elements such as social support networks, family systems, economic conditions, cultural traditions, physical and environmental conditions or political systems are recognized as other social important social determinants of health (also Shaikh et al., 2008).

Ethiopia is a low-income country with 39 percent of its 84.7 million people living below the international poverty line of $ 1.25 a day (UNFPA, 2011), HIV prevalence remains high and utilization rates for majority of reproductive and maternal health services remain low even compared to the whole Sub-Saharan region. However, the findings of this study indicate several signs of improvement compared to the 2005 and 2011 EDHS suggesting that major achievements were accomplished thanks to harmonized efforts. Various stakeholders realized the importance of bridging the distance between reproductive health services and HIV prevention and joined their resources in order to accomplish MDGs 4 to 6. Albeit the country is on the promising track in several aspects, higher utilization rates in the national and regional statistics do not necessarily ensure higher responsiveness and accountability of the whole system. These goals have

much longer expiry date than MDGs and they should not be taken as a threat to current health structures but rather as a road to a win-win situation for both citizens and the government.

This thesis attempts to combine several aspects of the current debate while investigating *how access to information influences HIV/AIDS awareness, reproductive health service utilization and demand articulation in Bahir Dar Special Zone (BDSZ), Amhara region*. The thesis is structured as follows: in the first chapter the theoretical aspects of health systems, health promotion, behaviour communication change, participation and accountability for health are discussed. Second chapter focuses on maternal and reproductive health introducing its historical trajectories and the trends of meeting agendas of HIV prevention and reproductive health. The third chapter describes the national, regional and local context of the study area while discussing relevant health policies, infrastructure and service utilization patterns. Chapter four presents the methodology including all research methods and techniques applied. The fifth chapter introduces the study population embedded in the sampled research areas. Chapter six maps the health system structure with focus on reproductive health provision and communication channels applied. The seventh chapter presents the dynamics between individual and community HIV awareness. Chapter eight focuses on practice in selected reproductive health services and its main drivers. Chapter nine presents the levels of participation and accountability found in reproductive health services in BDSZ; it is followed by the discussion when confronting the results with academic literature on similar topics. The study is closed by conclusion and policy recommendations while suggesting further research opportunities.

The thesis operates under the case study approach while utilizing mixed methods research so the conclusions certainly cannot be generalized for such a diverse country as Ethiopia. Bahir Dar Special Zone is, in comparison with the rest of the country, a relatively urbanized area which is highly reflected by the health provision infrastructure and therefore certain bias needs to be reflected. Nonetheless, the physical extension is the first step towards the improved health status of the population taken in BDSZ but as this study suggests, other aspects have to be taken into account when planning, financing and providing reproductive health and HIV prevention services. Communication channels towards raised awareness and behaviour communication change play a vital role in demand creation for the services which should not be underestimated. The main aim of this thesis is neither criticizing nor pointing a finger; it is rather an effort to provide a deep insight into certain geographically defined area while investigating in depth concrete aspects of supply and demand side of health service delivery. Hopefully this study could serve as a reference for health professionals at various levels of health structure not only in Bahir Dar Special Zone and Amhara, but eventually also at the national level to revise, design and evaluate health policies in the locally tailored manner.

1. Health in Development. Development in Health

The first chapter of the thesis attempts to deal with more universal concepts of health which are necessary for the comprehensive understanding of health service provision and demand in general: starting from broad relationship of health and development while emphasizing existing inequalities and their consequences. The concept of health systems and their strengthening with closer descriptions of three selected "building blocks" are provided then. The doctrine of the primary health care is not forgotten in this chapter since it represents the main roadmap in health care provision in low- and middle-income countries in order to achieve MDGs. The topic of access to health care is examined later on, with brief descriptions of three main academic approaches. From the supply side of service delivery the attention turns towards the 'demand side'; focusing on rights-based approach to health and its practical implications such as increased citizens' participation and accountability for health. The closing part of the first chapter focuses on awareness raising strategies and health promotion whilst introducing some practical tools.

1.1. Unequal Health & Development

The year 2000 symbolized a crucial milestone for framing two health and poverty campaigns: for the first campaign "Health for All by the Year 2000"[1] it meant the termination period whereas for the other one – "Millennium Development Goals"[2], the world's quantified targets for reducing extreme poverty in its various dimensions by 2015 promoting gender equality, education, health and sustainability - it symbolized a promising take-off period for global health. There are four years left for the termination point of MDGs campaign at the moment of writing of this thesis, but there are still many communities[3] around the world suffering from poor health status. There are multiple reasons which are contextually diverse (Connor, 2008).In order to gain the essential understanding of issues such as health inequalities, health systems[4], maternal, reproductive and sexual health, which this thesis attempts to deal with; we need to search for a definition of *health* in general - beyond the medical model, which sees health as the absence of a disease. Defining health in broader social construction was reflected in WHO's definition of health (1992) as a "state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, 1992). Sen (1999) understands health as an integral component of development (Sen, 1999). There are even broader definitions derived from the cultural traditions and local conditions (Connor, 2008) which confirm health as an integral part of development, which demonstrates the significant positive correlation of development and public health[5] (Flessa, 2007).Health problems are not

[1]Launched by WHO in 1981, aiming the removal of the obstacles to health, accessible through primary health care defined by *Alma-Ata Declaration*

[2]More detailed elaboration on Millennium Development Goals campaign and its relation to sexual & reproductive health in particular is provided in Chapter II.

[3] Community is defined by WHO (1998) as a specific group of people, often living in a defined geographical area, who share a common future, values and norms, and are arranged in a social structure according to relationships which the group has developed over a period of time (WHO, 1998).

[4] There is a specific section in this chapter dedicated to the functioning of health system with focus on low- and middle-income countries.

[5] Public health is defined by WHO (1998) as a social and political concept aimed at the improving health, prolonging life and improving the quality of life among whole populations through health promotion, disease prevention and other forms of health intervention (WHO, 1998).

homogenous in any country, at any time regardless of its stage of development. Disparities exist between social classes, gender and region, with the poorest at highest risk (Connor, 2008). It has been more than 20 years since the role of good health in development has been acknowledged for the first time (Barret, 2008). This process of "acknowledging" is to large extent connected with the *human development paradigm*. This ground shift in development thinking escalated in the publication of the first Human Development report in 1990. Ten years later, the UN Millennium Development Conference in 2000 launched the global Millennium Development Goals (MDGs), the campaign in which 189 states committed themselves to poverty eradication by 2015. Three out of eight goals directly address health issues: (1) reducing child mortality – MDG4, (2) improving maternal health – MDG5; and (3) combating HIV/AIDS, malaria and other diseases - MDG6 (ibid). The other five MDGs have indirect impact on populations' health status.

Box 1.A

Health Inequalities or Health Inequities?

Many scholars argue that any inequality in health is unfair or unjust if it is economically or socially determined (Barret, 2008). Here is the merit of debate moving from inequality to inequity. Fotso (2006) and Gatrell (2002) explain the difference between the two terms: a) *health inequalities* are differences and disparities in health of individuals or groups whereas b) *health inequities* refer to inequalities in opportunities which are avoidable and should be narrowed. They are unjust or unfair and therefore unethical.

There is clear evidence that the global burden of disease and illness is primarily situated in low- and middle-income countries (McMichael et al., 2005) where policymakers and academics situate their analyses how to achieve MDGs (Barret, 2008). It is possible to compare different countries according to their MDGs performance which can provide us with a general overview about different countries' ranking. Nevertheless, those achievements stated in MDGs are not sufficient indicators of a country's performance in health in relation to distribution of health and health inequalities (Gakidou et al., 2000). The answers to the question 'how to define and measure health inequalities?' are not the same. There are several definitions of health *inequalities* even though the term is often confusing and used for health *inequities* as Box 1.A clarifies. All the definitions of health inequalities (Gakidou et al., 2000; Shaw et al., 2002; Gwatkin, 2000) admit that health varies from country to country and among different groups of people within countries (Barret, 2008). Current standard (although not ideal) measurements of health inequalities or health status are infant, under-five and maternal mortality, often derived from demographic and health surveys (ibid). *Health Inequality Index,* which was introduced by WHO in the *World Health Report* in 2000 reflected this approach (WHO, 2000).That index is based on the child mortality data of 191 states and measures performance of different national health systems, taking into account their fairness and achievements. The health Inequality index also showed up that 35 out of 50 health systems with the worst performance was found in Sub-Saharan Africa[6] (WHO, 2000).

[6] The Index calculated and compared the data from the year 1997 which may not reflect today's (2011) reality. Nevertheless, it has been the last publication of that index so far.

1.1.1. Financing[7] Global Health

Health inequalities require an economic solution (Stillwagon, 1998). There is a need for the government financing of health (WB, 2004) even though the final fashion of perfect public-private mix is always context-specific subject to discussion. The government spending on health from domestic sources is an important indicator of a government's commitment to the health status of its population (Chunling et al., 2010). The challenge for governments in low- and middle-income countries lies in reducing the burden of out of the pocket payment for health, and reducing the spectre of catastrophic health care expenditures (WB, 2000). The important factor influencing the level of health systems in low- and middle-income countries is also the development assistance for health (DAH).

Over the past 20 years, DAH has generally increased albeit for some diseases such as HIV/AIDS more than for the others and in some countries more than in the others (Sridhar, 2010). Chunling et al. (2010) states that DAH has been rising steadily from 1995 to 2006.[8] Although global health aid accounts for only 0.3% of total expenditures on health globally, it is 6.5% in Sub-Saharan Africa and WHO estimates that 23 countries have over 30% of their health expenditures funded by donors (Sridhar, 2010). This also counts for Ethiopia. In countries where DAH has been sustaining a significant part of health systems' resources they have been adopting a different approach towards the health priority setting and financial management of health investment since the early 1990s (WHO, 2000; Abdella, 2008). This set of approaches called *sector-wide approaches* (SWAPs) according to the World Bank (2004) enhances the development impact not only in health care but in other sectors as well, to build stronger partnerships and to improve the management of all related sectors (WB, 2004).

SWAPs in relation to health sector[9] utilize *budget support*[10] and aim to strengthen health systems as a whole with emphasis on delivering improved services at the primary level with increased community participation (Harpham & Few, 2002). The merit of SWAPs lies in the government leadership, a partnership of donors within an agreement to work together in support of clear set of policy directions, often sharing implementation procedures, such as supervision, monitoring, reporting or accounting (WHO, 2000). On the other hand SWAPs can weaken the relation between policymakers and providers by taking the health sector out of domestic decision-making process. This system may favour donors in the budgetary process with financial management in particular, as the World Bank states (WB, 2004). SWAPs did not mean project-based funding of health in low-income countries as

Box 1.B

Health Financing: More than Generation of Funds

Health financing refers to the mobilization, accumulation and allocation of money to cover the health needs of the people in the health system, both individually and collectively. Health financing should ensure to make funding available with setting the right financial incentives to providers. The purpose is to ensure that all individuals have access to effective public health and personal health care (WHO, 2010: 72).

[7] Read the WHO definition of health financing in Box 1.B
[8] See the world comparison of DAH between 1995 and 2006 by global burden of disease for different regions in Appendix A1.
[9] The terms health sector and health systems are used in various literature interchangeably even though they have slightly different meanings. However, switching those terms is common even in academic sources.
[10] Providing funds to the general budget which should enable a better framework for inter-sectoral allocation as well as it reduces transaction costs of separate project units (WB, 2004).

Standing (2002) points out: much parallel funding occurred in countries with running SWAPs which implies the question to what extent were SWAPs were functioning aid policies and to what extent they were a fashionable rhetoric (ibid).There is a large and complicated structure of actors who are engaged in financing and supporting health in low- and middle-income countries at the moment of writing of this study. The Appendix B1 groups the major global donors into five clusters and presents some of their characteristics with the focus on their roles and challenges they have been facing. Current criticism focusing on existing DAH donor structure and its practices (Sridhar & Batniji 2008; Sridhar 2010) concerns several aspects such as:

(1) The ůack of coordination within the complicated donor structure despite latest agreements on aid effectiveness[11].

(2) Establishing new initiatives and bodies rather than strengthening the established ones (e.g. WHO or WB).

(3) Countries' priority setting driven by donors and lacking alignment with the national approach in terms of implementation, which could possibly harm national health strategies and systems.

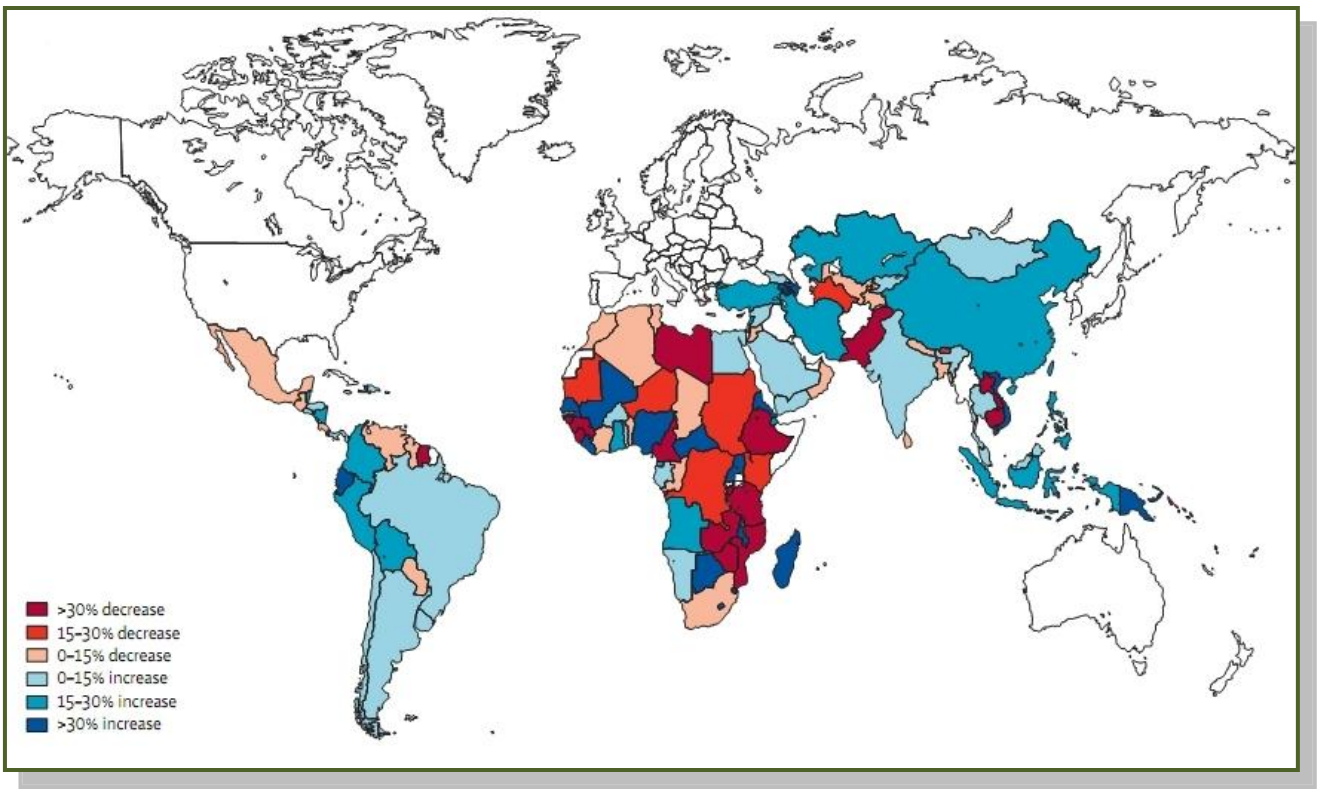
(4) Bypassing the national governments' in funding non-state actors, which on one hand increases their importance, on the other hand it threatens the health programmes' sustainability.

In addition to direct DAH, *debt relief* to low-income and middle-income countries allows the recipient government to redirect funds from debt servicing to health spending (IMF, 2009a). There were several initiatives such as HIPC – the Heavily Indebted Poor Countries and MDRI – Multilateral Debt Relief Initiatives that conditioned debt relief on spending intended on public services such as health and education (IMF, 2009b). On the contrary, Chunling et al. (2010) suggest that debt relief has not had that significant impact on government domestic health expenditures in low- and middle-income countries. As mentioned above, government spending on health from domestic sources indicates government's commitment to the population (Chunling et al., 2010). Government spending is essential for sustaining various health programmes within the countries. The recipient governments should treat DAH rather as a complement than substitution to their own spending in order not to weaken their health systems (Chunling et al., 2010). As a consequence, households might be driven to pay more out of their own pockets (WB, 2004) and be pushed below the poverty line by enormous health payments (Xu et al., 2003). According to Chunling et al. (2010) all low- and middle-income countries increased their public health expenditures from domestic sources by nearly 100%[12] between 1995 and 2006. Public financing of health has been a sensitive topic worldwide since the public sector is almost always targeted in the front line for budget cuts. Moreover, in the low- and middle-income settings where national ministries of health are often committed to increase the size of health budgets, ministries of finance have at times reduced financing of health of substantial DAH to government (Musgrove et al., 2002). Figure I.A displays the ratio of the fraction of general government expenditures spent on health between the years 1999 and 2002 compared to the period between 2003 and 2006.

[11] The Paris Declaration on Aid Effectiveness from 2005 and Accra Agenda of Action from 2008 aim to reform the management of aid in order to improve its effectiveness. There are five essential principles of delivering more effective assistance: ownership, alignment, harmonization, management for results and mutual accountability. The Paris declaration was designed by OECD and signed by 35 donor countries and agencies, 26 multilateral agencies and by 56 recipient countries (Better Aid, 2008). Accra Agenda for Action – the UN high level forum - deepened the Paris principles. Added value of Accra Agenda lies mostly in recognizing other stakeholders' such as NGOs' and civil society's importance in both global South and global North countries for delivering better aid consistent with principles of ownership.

[12] The authors of the study operated with both WHO and IMF data. According to WHO, the public health expenditures of low and middle-income countries increased by 88 % between 1995 and 2006 whereas IMF reported 120 % increase (Chunling et al., 2010)

Figure I.A: Government health expenditures as a share of general gov. expenditure 1999-2002 to 2003-2006



Source: Chunling et al. 2010 (derived from the IMF data

Figure I.A illustrates many countries in Sub-Saharan Africa exhibited decreasing government commitment to health. It is alarming since the largest reductions in the ratio general government expenditures/government health expenditures were found in countries with the highest HIV/AIDS prevalence, and also with the largest contributions of DAH to government (Chunling et al., 2010). In contrast, large parts of Latin America, the Middle East, and Asia showed the opposite trend. In most low-income countries the resources are not available for basic set of interventions despite the increase of DAH as mentioned above. The WHO Commission on Macroeconomics and Health estimated the cost of a *basic package*[13] to current prices with a need for approximately US $ 40 per capita per year with large proportion of underestimation (WHO, 2010). Unfortunately, for almost one third of all WHO member countries that level of funding was not available in 2005 while 33 countries spent less than US $ per capita per year (ibid). Fund raising and the system of their pooling is one of the crucial determinants of risk protection for different population groups. Direct user fees which were over advocated in the end of 1980s and in the first half of the 1990s by various agencies as a mean to overcome financial constraints showed to have negative effects upon access to health care, especially for the poor and marginalized groups (Travis et al., 2004). WHO (2010) states that direct user fees are aggressive when the rich pay the same fees as the poor which hampers health-care seeking behaviour of numerous population groups. Equitable fund raising from the same sources requires a certain degree of progressivity which practically means higher contributions by the rich (WB, 2010).

[13] In order to improve the quality of services, governments developed guaranteed packages of low-cost, selective services within primary health care (WB, 1993; Standing, 2002).

1.2. Health Systems

"Health systems are part of the social fabric of every country. There are not only producers of health or health care but they are also the purveyors of a wider set of societal values and norms" (Gilson, 2003:1461). As this author states, health systems are complex socio-political institutions and not only delivery points of bio-medical interventions (Gilson, 2003). Despite all external funding arrangements and the multifaceted nature of health systems, the central role in health systems functioning is played by the state (WHO, 2010; Gilson, 2003). "A health system consists of all the organizations, institutions, resources and people whose primary purpose is to improve health" (WHO, 2010:vi). To read the complete WHO definition of health systems, see the Box 1.C. There is mounting evidence that health systems can deliver services equitably and efficiently which makes them critical for improved health status of the populations Health systems-strengthening hence becomes a fashionable word in current global health agenda setting since there is a growing consensus that a primary bottleneck to achieving the MDGs in low-income countries are health systems, often too fragile and fragmented to deliver the volume and quality of services to the most vulnerable ones (Travis et al., 2004). The existence of various multiple and analytical and strategic frameworks towards health systems invokes confusion and does not prevent duplication[14]. However, this thesis operates with the WHO concept of *six building blocks of health* systems, which represent six core components of called building blocks of health systems (WHO, 2010). Those include: a) health service delivery, b) health workforce, c) health information systems, d) access to essential medicines, d) health financing, e) health governance

Box 1.C

Health Systems According to WHO

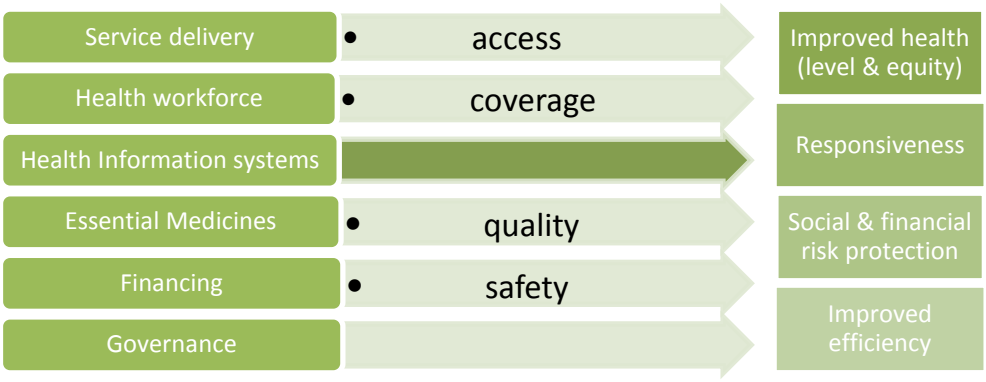
Health systems include efforts to influence determinants of health as well as more direct health-improvement activities. The health system delivers preventive, promotive, curative and rehabilitave interventions through a combination of public health actions and the pyramid of health care facilities that deliver a personal health care provided by both state and non-state actors.

The actions of health systems should be responsive and financially fair, while treating people respectably. A health system needs staff, funds, information, supplies, transport, communications and overall guidance and direction to function. Strengthening health systems thus means addressing key constraints in each of these areas. (WHO, 2010: vi).

Figure I.B pictures the aims and desirable attributes of *building blocks health systems framework*

[14] Existing frameworks have been developed by both the World Bank and the World Health Organizations although using different approaches and emphasizing different outcomes: 1) the WB's control knobs framework and, 2) the WHO building blocks framework.

Figure I.B: The WHO Framework of Health Systems – "6 Building Blocks"



Source: WHO, 2010

The six building blocks contribute to the strengthening of health systems in various ways. Some cross-cutting components such as governance and health information systems provide the ground for the overall policy and regulation of all the other health system components. Key input components to health systems include health financing and health workforce, in particular. The immediate outputs of health systems such as availability and accessibility of health care are reflected by essential medicines and service delivery (WB, 2010). However, the agreement on how health systems should be strengthened is lacking (Travis et al., 2004). As mentioned, stronger health systems are a probable prerequisite to health MDGs achievement but there is still little focus on ground system strengthening since the vast majority of global health initiatives with rich funds have been disease-specific and vertically oriented and this trend has been reversing very slowly (ibid).

Health systems in low resource settings are contextually unique whilst sharing many common features (Tanner, 2005) Standing (2002) emphasizes rather appropriate balance between health systems strengthening agenda, service delivery and vertical health programmes in order to create alliances towards progressive health sector reforms (Standing, 2002).During the last 30 years there have been significant shifts in international development strategies an in conceptualizing the most appropriated mix of horizontal and vertical approaches in health care. The Alma-Ata declaration advocated a *comprehensive* bottom-up approach to health improvements through primary health care (WHO, 1978). Read more on primary health care in box 1.D. This position has been challenged by those who have believe more in measurable achievements effect through limited number of cost-effective interventions within *selective* primary health care (Rifkin & Walt, 1986). Selective primary health care suggested a disease-control oriented approach with the main focus on a few diseases with the highest prevalence in the country, with the highest morbidity or mortality (ibid). Nowadays, we can still recognize the heritage of this approach in the names of different global health initiatives albeit many of those health initiatives admit the constraints far beyond their own focal disease. The two largest of those global health initiatives[15] have started advocating the broader health-system context analysis including increasing shares of their contributions to be used in health systems strengthening (Tanner, 2005; Travis et al., 2004).

[15] Global Fund to Fight AIDS, Tuberculosis and Malaria and the Global Alliance for Vaccines and Immunization

Weak responsiveness of health systems towards its users, particularly in low-income countries is one of the major concerns related to health systems constraints besides the "classical" ones such as human resources capacity, financing, drugs and supply system, and the last but not least: the production and utilization of health information, which is certainly crucial for health policy planning (Gilson, 2003; Travis, 2004). One of the cross-cutting issues concerning weak responsiveness of health systems are failed relations of *accountability* (WB, 2004). This challenge is closely connected with so-called 'environmental constraints'[16], which include factors such as the overall policy environment, political stability and the quality of governance (Travis et al., 2004). Apart from those known barriers towards more functioning health systems, Gilson (2003) brings into arena the issue of inter-personal trust within health systems. According to this author, dis-trust in health system - in service delivery and funding in particular - influences trust in individual providers as well as personal health practices[17]. The stated lack of trust leads providers to adopt harsh attitudes towards specific patient groups, which undermines the quality of patient interactions with the health system (ibid). And the quality of such an interaction and cooperation matters since it is a basic requirement for health production. There is a vast volume of literature (authored by WHO) which is focused on more detailed description of each building block of the WHO health systems framework, including their interconnectedness. Since the topic of health systems is not of a primary concern of this study, it does not provide a deeper insight into the aspects of health systems performance related to each component. On the other hand, the author acknowledges the importance of health systems approach related to her research focus – that is why there are only three out of six "building blocks" presented more closely. Those are:

a) Health financing – which was already brought into attention above,
b) Health service delivery – which is one of the main concerns of this study, and lastly
c) Health workforce - which appeared to be crucial in addressing the research objectives of this study and will be presented later on.

Box 1.D

Primary Health Care and the Alma-Ata Declaration

The year 1978, when the Alma-Ata International Conference on Primary Health Care took place, meant a significant milestone in rethinking health inequities. Those were for the first time termed as *politically, socially and economically unacceptable* (WHO, 1978) while setting an ambitious goal of' Health for all by 2000'. Although this goal has not been achieved, the doctrine of the '*highest attainable standard of health for everyone*' still remains vital. WHO defines primary health care as care which "addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly" (WHO,1978:2). As major duty bearer towards attaining primary health care of the world populations are denominated national governments whilst health systems are required to put people at the centre of health care in the spirit of primary health care values (WHO, 2008). The concept of primary health care has been widely acknowledged (Shrestha,2010).

[16] Those external to the health system

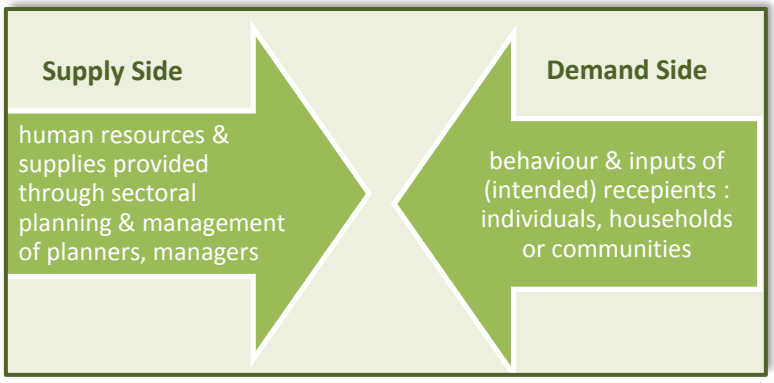
[17] Gilson presents an example of 2 types of dis-trust in South Africa settings: 1) provider-patient dis-trust, and 2) patient – provider dis-trust. The first type is illustrated by patients bringing their own needles for blood tests in public health facilities. The second type is represented by staff doubting about patients' capabilities to use methods/service correctly and appropriately (Gilson, 2003:1460).

1.2.1. Health Service Delivery

1.2.1.1. Health Service Delivery from the 'Supply Side' Point of view[18]

Health service delivery is crucial to the achievement of health-related MDGs, which include the delivery of interventions to reduce child and maternal mortality and the burden of HIV/AIDS, tuberculosis and malaria. Generally said, health service delivery is most tied to health outcomes[19] (WHO, 2000). Improved service delivery is only possible if forerun by the necessary combination of inputs: sufficient financing, capable workforce and effective procurement of medicine and supplies. The ensuring availability of health services that meet minimum quality standards and a securing spatial and social access to them are the key functions (WHO, 2010). Health services can be delivered either at home, or in the community, or at the workplace or in health facilities (clinical care). Improving access[20], increasing coverage, utilization and quality of health services also depend on the ways services are organized and managed, and on the incentives influencing providers and users (WHO, 2011), supply and demand sides respectively.

Figure I.C: Demand & Supply Side of Health Service Delivery



Source: Adopted from Standing (2004) and WB (2004)

1.2.1.2. Health Service Delivery from the 'Demand Side' Point of View

The supply side of health service delivery and its structure and organization are not the only determinants of health care utilization. There has been an increasing interest in understanding the demand side of health service delivery to the poor (WB, 2004; Standing, 2004) since the health outcomes are produced by households – with health service contribution (WB, 2004). However, the main reason of the highlighted interest in the demand side of service delivery has been a failure of many low-income governments to provide adequate and basic standard public health services through not really successful health sector reforms (Standing, 2004). Demand side barriers are as important as supply factors in deterring individuals, households and communities from obtaining treatment (Ensor & Cooper, 2004). Recently there have been several policy approaches to target 'demand side' of health service delivery in order to increase utilization rates of health services with the direct positive impact on health outcomes. Standing (2004) summarizes six major directions of possible 'demand side' approach including: 1)behaviour communication change (BCC), 2) rights-based approaches, 3) improving accountability through demand side, 4) participatory approaches, 5) multiple stakeholder approaches, and 6) demand side financing.

Three out of six concepts and their relationships are going to be presented in separate sections of the theoretical part of this thesis later on, even though not within the identical division. In order to terminate the section on health systems, short overview of health workforce is included with main aim to highlight the key role of the

[18] See the Figure I.C which distinguishes between the concepts of 'Supply side' and 'Demand side' within health service delivery.
[19] Most typically to decreased mortality and morbidity.
[20] The three dimensions of access to health care will be presented later on in a separate sub-chapter

health workforce in health service provision with a particular focus on the human resource crisis in health service delivery, which has negative impacts on health systems functioning.

1.2.2. Health Workforce

The extent of quality of health services provided depends largely on the knowledge, skills, motivation and deployment of the people responsible for the organization and delivery of health services (WHO, 2011). See the Box 1.E which defines the boundaries of the health workforce. Several studies (e.g. Anand & Bärnighausen, 2007) have confirmed a direct positive link between the numbers of health workers and population health outcomes. However, many countries lack the human resources needed to deliver essential health interventions (ibid). Health systems worldwide face the global shortage of health workers, which hinders numerous life-saving interventions (Global Health Council, 2007), it is widely spoken about *human resource capacity crisis* in health. Maldistribution of health workers occurs between countries and within countries themselves. For instance, about half of the global population lives in rural areas, yet more than 75% of doctors and 60% of nurses are founded in rural areas (Friedman, 2004, Global Health Council, 2007). Sub-Saharan Africa has 24 &% of the global disease burden, but only 3% of the world's health workers and 1% of global health financial resources (ibid). The lack of health workforce in rural areas is one of the crucial barriers to access to maternal and child health services (Global Health Council, 2007).

There are several causes of human resource capacity crisis some of which could be categorized as more or less country-specific. However, two of them could be generalized to the majority of low- and middle-income countries, and they in particular need to be paid a special attention: a) training inadequacies and, b) migration and brain drain. Training inadequacies are related to two main pitfalls: little good training and, in the contrary: training overload. The other major reason of the health workforce crisis has been migration and brain drain as its consequences. The international migration is one of the forms of this issue although not discussed in this thesis. The internal migration and its variations are more of this study's interest. Concerning the public sector health workers, it is not surprising that many of them worldwide leave for a non-governmental organization or another private sector body in order to increase their wages considerably. Additionally to inadequate wages, the public sector often lacks further educational opportunities and suffers from poor supervision and management (Global Health Council, 2007). Once health workers stay in the public sector, their deployment is another challenge since the majority of them seek urban opportunities in terms of higher service availability. That is why numerous large rural areas remain underserved or the turnover of health workers is significantly higher comparing to their urban counterparts.

Box 1.E

Who is a health worker?

Health worker is according to WHO anyone whose main activities focus on enhancing health including doctors, nurses, pharmacists, lab technicians, health management and planning officers, hospital cooks, and facility cleaning staff or community health workers (WHO, 2006). Health workers in private sector, workers who are unpaid (volunteers) but performing health-care tasks, or trained health service providers who are not currently working at health facilities or other service delivery points also belong in the category (WHO, 2011).

1.2.2.1. Community-Based Health Work

Community-based health workers (CBHWs), sometimes called grass-roots health workers, have been envisioned as the key personnel in the delivery of primary health care. CBHWs could be generally described as local inhabitants given a limited amount of training[21] to provide specific basic health and nutrition services to the community members in the area (Berman et al., 1987). Originally they were expected to perform the job in the area of origin, but not necessarily. They may be volunteers as well as civil servants deployed by the government (Prata et al., 2011). It is interesting to point out that many of the very first community-based health programmes were initiated on voluntary basis by local health workers frustrated by inadequacies of clinical services (Berman et al., 1987). It has been more than twenty-five years since various low- and middle-income countries started to launch community-based health programmes in order to increase coverage and equity of basic health services (Berman et al., 1987). The establishing of community-based health services has also been an attempt to address the critical manpower crisis in health sectors of low-and middle-income countries with shifting preventive, promotive and basic curative tasks to providers with limited training (WHO, 2006; Prata et al., 2011). The principal role of CBHWs within primary health care is to bring the services to the doorstep of the communities and households at a low cost in a community responsive fashion (Whaley & Hasim, 1995). This mode of health service delivery aims to increase the access, particularly of the poor, to high impact basic health services (ibid). Nevertheless, despite the optimistic prediction and hopes put into community-based health programmes worldwide, some of the main challenges have been already recognized (e.g. Nair et al., 2001). Overall, there is a high evidence (Nair et al., 2001, Prata et al., 2011, Haaij & Gerthnerova, 2011), that CBHWs reach people that are very unlikely to access clinical health care which increases the utilization rates of community health services and also partially

1.3. Access to Health Care

Access to health care is vital to good and equitable health (CSDH, 2010). Dimensions of access to health services differ with geographical, socio-economic, and cultural settings which causes inequalities. This issue is one of the major concerns in health and development debates (Shrestha, 2010). The access to health care can be investigated by a wide range of disciplines taking various factors and dimensions into account. There are basically three approaches which conceptualize the access to health care and its *barriers* or *determinants* (Obrist et al., 2007):

1) health-seeking behaviours concepts,
2) health services – "5 As" approach and,
3) livelihood framework.

Each of those approaches will be briefly examined with its main characteristics and contributions to health equity debates.

[21] The duration varies from weeks to years as well as the depth and skills gained throughout the training.

1.3.1. Health-seeking behaviours

The decision whether and when to seek health care starts much before in a facility and requires several choices to be made (Ensor & Cooper, 2004). Academics have always been interested in what influences people to behave differently in relation to their health (MacKian, 2003). Health seeking behaviours concepts are the oldest from the trinity of academic approaches investigating access to health care mentioned with its original roots in the 1960s (Suchman, 1965; Andersen, 1995; Christakis et al., 1994). There has been a wide range of studies addressing various aspects of health-seeking behaviours. MacKian (2003) together with Tipping and Segall (1995) distinguishes between studies on *health care seeking behaviour* and studies on *health seeking behaviour*. The first cluster of studies emphasizes the 'terminal point' – utilization of the formal health services[22] whereas the other cluster investigates more the 'process' of illness response and its pathways (MacKian, 2003). There are many variations within this approach as MacKian (2003) summarizes in Table a1.

Table a1: Division of Health Care-seeking Behaviour Determinants

Category	Determinant	Details
Cultural	Women's status	✓ Elements of patriarchy
Social	Age and gender	
Socioeconomic	Household resources	✓ Educational level ✓ Maternal occupation ✓ Economic status
Economic	Costs of care	✓ Treatment, ✓ Travel, ✓ Time
	Type & severity of illness	
Geographical	Distance & physical access	
Organizational	Perceived quality	✓ Standard of drugs & equipment ✓ staff competence & attitudes

Source: Adopted from MacKian, 2003

Together with Obrist et al. (2007) we can conclude that health seeking behaviours studies (of both types) focus on people, providing a deeper insight of why, when and how individuals (and communities later on) seek health care services until they feel capable of living with their conditions (ibid). They define numerous constraints on individual, social, spatial, socio-economic, cultural and economic levels. This type of approach attempts to correct health seeking behaviours through behaviour communication change campaigns (BCC). A closer insight on the BCC methods and techniques will be provided below.

[22] Studies on health care seeking behaviour and its determinants usually count on informal services utilization (such as traditional healers' or traditional birth attendants' visits) only as with complementary information. Even though the data is often available, majority of studies understand those informal services as a prevention target (MacKian, 2003).

1.3.2. Health Services – "5 As" Approach

This type of 'access' approach examines in depth different aspects of health service delivery which all contribute to the level of utilization of health services. Aspects like availability of health personnel, direct user fees, opportunity costs such as transportation costs or informal costs, physical distance to health service, health personnel's treatment or community acceptance of the service in terms of tradition - they all play a crucial role in the final health service utilization level. Many authors have studied those aspects differently (e.g. Millman, 1993, Bagheri et al., 2005); the major contribution to the 'access debate' was made by Penchansky and Thomas (1981), who grouped those aspects, called *barriers*, into *five dimensions of access*: 1) *availability*, 2) *accessibility*, 3) *affordability*, 4) *accommodation*, and 5) *acceptability*. Obrist et al. (2007) upgraded this division when they replaced the term accommodation by the term *adequacy*[23].Let us examine each of the aspects separately, mentioning their typical characteristics.

Availability – describes the extent to which existing health services meet client's needs in terms of sufficient drug and equipment supply, sufficient number of skilled personnel, emergency service together with adequate referral channels, the length of waiting time at site, language barriers, etc. (Obrist et al., 2007; Shrestha, 2010, Campbell et al., 2000).

Accessibility – refers to an appropriate geographic location of facilities in relation to (potential) users as well as to travel time and mode of transportation used to reach the health service (Obrist et al., 2007; Shrestha, 2010). Moseley (1979) stated that accessibility is influenced by socioeconomic position of (potential) users and spatial dimensions (Moseley, 1979).

Affordability – self-explanatory term used for financial dimension of access. It examines the (potential) users' ability to pay, including direct and indirect costs – namely user fees, transportation, bribes, time and income lost and also health insurance coverage (Obrist et al., 2007; Shrestha, 2010).

Adequacy – refers to users' expectations of the service and their meeting, sometimes called perceived quality of services considering staff attitude and treatment during the entire stay of a user in a health facility, maintenance, hygiene and general environment of a facility, additionally appropriate opening hours (Obrist et al., 2007; Shrestha, 2010).

Acceptability – deals with the ability of health services to provide treatment and counselling in socially and locally acceptable manner in order to respect users' dignity and its aspects such as gender, age, religion, cultural habits, etc. (Obrist et al., 2007; Shrestha, 2010). The issue of trust (Gilson, 2003) between users and providers plays a special role.

'5 As' approach attempts to address health service delivery constraints in a more 'user-friendly' (demand side) manner, but still more or less within the supply side itself. Even though, the demographic aspects of (potential) health service user population are taken into consideration as well as the level of their illness awareness[24], they only search for policy implications reducing supply side barriers (Obrist et al., 2007). This type of approach tries to intervene at demand side through information, education and communication (IEC) campaigns in order to raise awareness about health services.

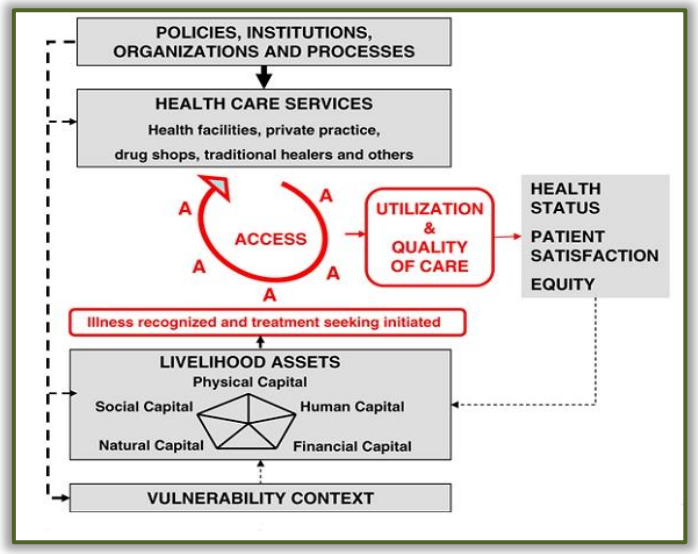
[23] Obrist et al. (2007) by adding the term *adequacy* mainly refer to the level of meeting user's expectations

[24] Awareness concept which this thesis utilizes will be presented in Chapter 4.

1.3.3. Livelihood Framework

The livelihood framework created by Obrist et al. (2007) within "health access studies" enriches the on-going debate on health service utilization determinants with a revolutionary aspect of *livelihood assets*. At this point the attention turns much more towards the 'demand side' even though the authors of this framework respect and use some of the previous concepts such as '5 As' concept. As Shrestha (2010) points out, this framework combines effectively the macro level (existing policies, institutions, organizations and processes) together with the micro level pictured by livelihood assets, both material and social (Obrist et al., 2007; Bakeera et al., 2009). Livelihood assets are grasped as five levels of *capital* (Obrist et al., 2007): 1) human capital, 2) social capital, 3) natural capital, 4) financial capital, and 5) physical capital. The authors add that the availability of livelihood assets is deeply embedded in so-called *vulnerability context* which is represented by climate change, natural disasters, economy turbulences or technology innovations less likely influenced by people (Obrist et al., 2010; Bakeera et al., 2009). To fully visualize this framework, see the Figure I.D. The livelihood approach contributed to the 'access debate' by an important acknowledgement that *social resources* (*capital*) need to be taken into account while studying health service utilization. As Bakeera et al. (2009) highlight, there are indications that the availability of social resources may compensate lacking material resources in relation to health care utilization, for the least poor in particular (Bakeera et al., 2009)

Figure I.D: Health Access Livelihood Framework



Source: Obrist et al., 2007:e308

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1.4. Three Ways to Approach the 'Demand Side'

There are several ways to approach the 'demand side' which are currently being utilized by both research and development practitioners in global health. Standing (2004) recognizes six main approaches of work on the demand side in order to tackle health inequalities. To preserve a balance between the objectives of this study and the relevance of the six approaches contributing to the current debate, three 'demand side' approaches are presented on health service delivery[25]:

1) Rights-based approach to health
2) Citizens' participation and accountability improving

[25] The division made by Standing is used only as guidelines in this thesis; especially the category on citizens' participation and accountability corresponds with her classification only partially. Standing also does not use the term *awareness raising strategies* unlike the author of the thesis. *Awareness raising* is used in this study as an umbrella term for both BCC and IEC since different literature operates with those terms interchangeably and their meanings overlap to a significant extent.

3) Awareness raising strategies – behaviour change communication (BCC) and information, education and communication (IEC) approaches

Point three is going to be discussed more deeply in a separate section as it has the most direct influence on the empirical part of this study.

1.4.1. Rights-Based Approach to Health

Recent efforts to apply human rights to the development include also health-related aspects of the development. Human rights and health are grounded in *fundamental rights* that a person inheres by birth as a human being and citizen, such as freedom from torture, slavery, gender discrimination, etc. These rights are prerequisite to a healthy life and they cannot be lifted by governments legitimately (Standing, 2004). A legal and moral imperative exists to respect, protect, and fulfil human rights in relation to health service delivery and for health in general (Gruskin & Daniels, 2008). WHO (2011) defines 'the right to health' as the right to the highest attainable standard of health which was first reflected in the WHO's Constitution (WHO, 2011). The right to health has been incorporated into several international human rights instruments[26], Kinney (2001) has identified 110 national constituencies that make reference to a right to health care (Kinney in Chopra & Ford, 2005) The right to health practically entails claims towards specific forms of treatment (Standing, 2004). The most authoritative interpretation of the right to health is specified in Article 12 of the *International Covenant on Economic, Social and Cultural Rights*, which has been ratified by 150 countries.

Gruskin & Daniels (2008) emphasize that a human rights approach to health means a broad range of rights, including the rights to education, information, basic liberties and political participation (Gruskin & Daniels, 2008). These authors also define a human rights approach framework of setting priorities in health considering distributive justice perspectives. Their framework overlaps to a high extent with an *equity approach* which also counts with human rights but its ground is constituted by *distributive justice* and social justice in general. As Standing (2004) points out: the rights-based approach to health claims citizens' *equal* consideration and treatment on the basis of need whereas the equity approach requires *unequal* consideration and treatment on the basis of need.

It is important to acknowledge that the rights-based approach to health is to a large extent associated with bottom-up processes and empowerment. Standing (2004) provides an example of *women's health movement* globally engaged especially in reproductive and sexual rights. As WHO (2011) concludes, the rights-based approach in relation to health means integrating human rights norms and principles in the design, implementation, monitoring and evaluation of health-related policies and programmes which includes:

- ✓ Attention to the needs & rights of vulnerable and marginalized groups; those are also actively involved in participation.
- ✓ Assurance that health systems are made accessible to all reflecting the principles of equality, freedom and non-discrimination.

[26] In May 2000 the UN committee on Economic, Social and Cultural Rights which monitors the Covenant, adopted the General Comment on the right to health that specifies the content of the right to health (WHO, 2011). Other central human rights treaties which reflect the right to health are: the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and the Convention on the Rights of the Child (CRC).

- ✓ Incorporating the accountability mechanisms which are available to all, with special attention to vulnerable and marginalized groups.

1.4.2. Accountability Improvement & Citizens' Participation for Better Health

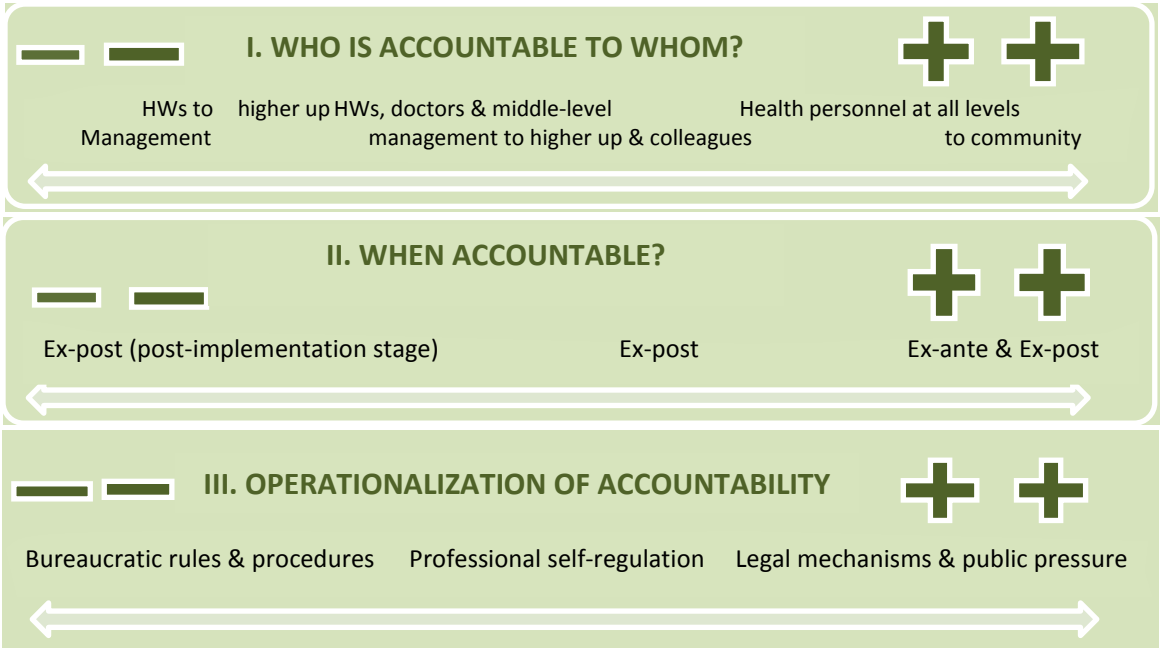
The human rights framework applied to health has added a principal value in the precise identification of individuals as *rights holders* and states, together with other actors, such as *duty bearer*s (Yamin, 2008) establishing the reciprocal relationship of *accountability* and *participation*. Participation and accountability are two main principles which enable the citizens all around the globe to be more actively involved in decision-making which affects directly their lives (Cornwall & Gaventa, 2001). Those principals apply to decisions made about populations', communities', families and individuals' health as well. In general, duty bearers are accountable towards rights holders in terms of fulfilling the responsibility towards them, whereas rights holders claim rights while *ideally* participating on duty bearers' decisions, policies, programmes or interventions. Greater participation is linked to accountability improvement (Standing, 2004; Cornwall & Gaventa, 2001). Murthy & Klugman (2004), who write about health sector reforms in Asia, state that there have been three main steps towards greater participation and accountability within health sector reforms: 1) establishing new community health structures; 2) decentralization, and 3) community financing although admitting that the point 3) has not led towards greater service accountability in Asia (Murthy & Klugman, 2004). According to those scholars, communities had only a few opportunities to determine their health needs and health services within the policy context given (ibid).

1.4.2.1. Accountability in Health & Ways to Improve It

Considering accountability in health decision-making processes, we should critically *ask how* to define accountability[27] in health points, particularly in relation to health systems where the state bears the primary responsibility but there are other *collective* actors whose interventions are at stake such as NGOs
. Such question has been posed by several authors (e.g. Yamin 2009; Yamin 2008; Cornwall et al., 2006; Murthy & Klugman, 2004; Cornwall & Gaventa, 2001). George (2003) suggests that the accountability in health points is "best understood as two way relationship between health providers and service users, different levels of health service delivery, health and finance ministries, elected representatives and health officers, and elected representatives and voters." (George, 2003:161). Murthy & Klugman (2004) base their work on other numerous other authors and conclude there are several *degrees of accountability* in health points which can take the form of lower and higher degrees depending on three main aspects: 1) *who* is accountable to *whom* ? 2) *when*?, and 3) *how?* Which means how accountability is operationalized – throughout which mechanisms? These aspects of accountability cast up by Murthy & Klugman (2004) are summarized in Figure I.E which the author of this thesis calls *spectrum of accountability* varying from lower to higher degrees answering three questions posed above.

[27] There are several types of accountability defined by various authors, there are only three examples mentioned for sake of the relevance such as: a) political, fiscal, legal, constitutional (George, 2003); b) political, administrative and public (Standing, 2004); c) administrative, professional, financial, social, political and legal (Yamin, 2008).

Figure I.E: Spectrum of Accountability in Health Points



Source: Adopted from Murthy & Klugman (2004)

Obviously, authors of this classification took into account downward and upward directions of accountability counting especially with *communities.* It is important to distinguish between various definitions of communities varying from a too narrow view of service users (consumerist view) to an inclusive definition of communities represented by marginalized members who have a voice (Murthy & Klugman, 2004; Yamin, 2008).

Most of the authors agree that accountability mechanisms should not miss two important features: 1) *answerability* and 2) *enforceability* (Gore, 2003). Answerability refers to the obligation to inform and explain the decisions and actions (Standing, 2004). It can involve media, monitoring committees, ombudsmen or advocacy groups and others (George, 2003). Enforceability practically means the systems of sanctions and rewards for bad or good performance (WB, 2004). One of the interesting points of Yamin (2008), who examines the false understanding of accountability is a position of front-line health workers. Especially front-line health workers in maternal health services in resource-poor settings are often made the only accountable for maternal deaths whereas the systematic decisions are made upwards in the hierarchy (such as medicine supply or distributions of specialists). A maternal death is then often a reason to dismissal or transfer without any investigation whether the provider was really responsible. This phenomenon only creates more fear towards the utilization of emergency obstetric care and complete misunderstanding of accountability relations (ibid). According to Yamin (2008), accountability demands *transparency* and access to information which is not enough per se. Gruskin & Daniels (2008) come up with the concept of "*accountability for reasonableness"* in health policy-making processes which combines transparency, access to information and fair deliberation (Gruskin & Daniels, 2008). As authors of this concept point out, under this *accountability for reasonableness* model, the governments cannot hide their unwillingness to improve health behind the cloak of resource limitations (ibid). This model could easily show whether the improvements in health service delivery are slow because of government financial incapacity or unwillingness.

As Yamin (2008) adverts, mapping accountability has no point where there are no consequences for failures to meet commitments. There have already been some mechanisms how to hold the state and the other actors in health service

planning and provision accountable put in practice. Although these tools might be more context-specific, they can provide some inspiration for further initiatives. Let us mention a few of them from macro to micro level: a) *international mechanisms* (see Yamin 2008; Yamin 2009); b) *national human rights institutions* (Yamin, 2008); c) *courts* (ibid); d) *maternal death audits* (see Murthy & Klugman, 2004; George 2003); e) *women's health groups* (vide Mahmud, 2002; George 2003); f) *patients' charters* (George, 2003) or g) *publication of health centre records* (ibid).It is important to keep in mind that accountability mechanisms always relate to challenging current power structures between unequal partners in favour of the *powerless* (Cornwall, 2008; George 2003; Yamin 2009) which makes it highly political issue.

1.4.2.2. Community Participation in Health and Its Dimensions

The Alma-Ata declaration constituted community participation as a *key aspect* of primary health care, stating that full participation of communities at every stage of planning, organization, operation and control of primary health care contributes to all stages of their development (WHO, 1978). However, participation is often viewed as a question of good project design rather than as an empowering tool, and a question of rights and dignity. As Khan (2008) argues, when participation is seen primarily as an implementation tool of development projects and as a means rather than as an end point, we cannot talk about participation (Khan, 2009). According to Wallerstein (2006) the most effective empowerment strategies are those that build on and reinforce authentic participation ensuring autonomy in decision-making, sense of community and local bonding.

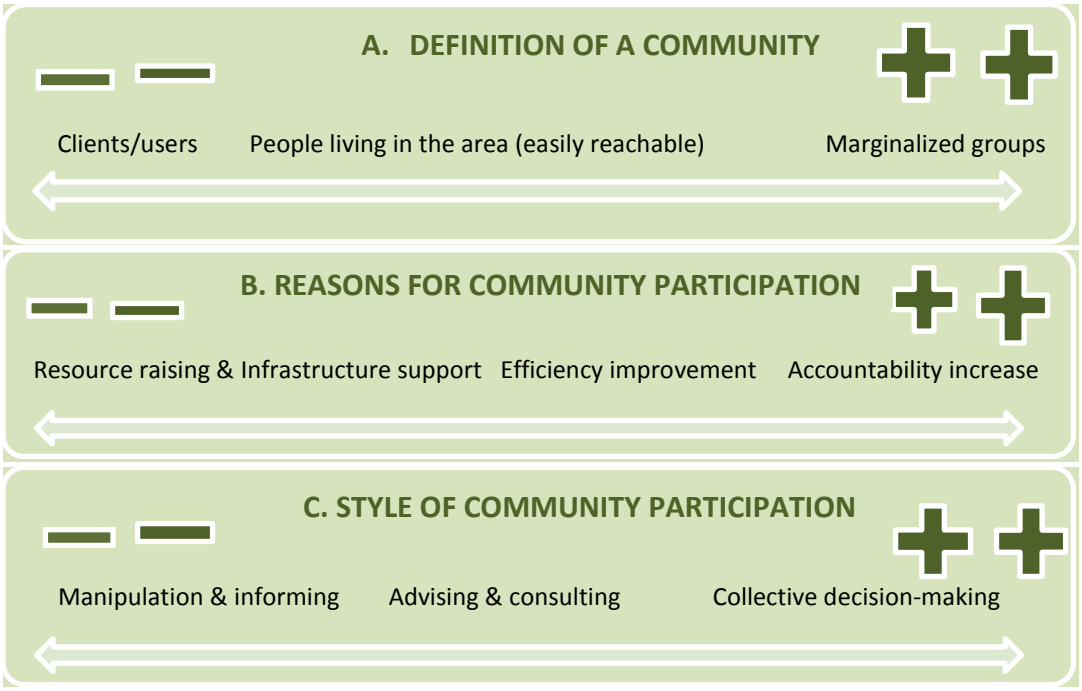
His view on health improvement through community participation and empowerment[28] expresses many of current participation trends in health and development interventions since the 1980s. However, there is less attention paid to *operationalization* of two terms widely used by different actors varied from the WB to radical NGOs from low-income countries. The first term is *community* and the other one is implicitly *participation*. (Cornwall, 2008; Murthy & Klugman, 2004). There are several typologies of participation created by different authors[29] (Arnstein, 1969; Pretty 1995; White 1996), all of them more or less normative examining the mean, depth, intention and initiation of participation (Cornwall, 2008).

A simplified overview of community participation approaches in health which the author of this study calls *spectrum of community participation* is summarized in Figure I.F. This figure also includes the operationalization of the term *community* varying from lower to higher degrees (in a normative manner) to achieve greater participation. Higher degrees of participation entail the definition of the term community to include representatives of marginalized groups who have a voice. Higher degrees in spectrum of participation require all community representatives to have decision-making power in service delivery, programme management and health policies design. This degree of participation ensures institutionalized mechanisms for community representatives in decision making about health policies and services (Murthy & Klugman, 2004).

[28] Published by WHO Europe

[29] See the famous concept of Arnstein (1969) in Appendix C1

Figure I.F: Spectrum of Community Participation in Health Points



Source: Adopted from Murthy &Klugman, 2004

Cornwall's concept (Cornwall 2008; Murthy & Klugman, 2004) of so-called *invited a*nd *demanded spaces* or *invited* and a*utonomous participation* respectively makes critical comparison of participation as a mean and participation as an end. Another important point made by Cornwall (2008) is the categorization used by external actors (e.g. state or international agencies) to distinguish between different segments of "the community". Labels such as *the poor*, *women*, *marginalized* might be viewed by the groups themselves completely differently, and they would not identify themselves with those labels at all. Treating them as isolated social groups may undercut the evolved social networks between the poor and their better-offs. Social networks have a certain role in the resource mobilization (Bakeera et al., 2009) therefore their role should not be underestimated in health points. A special category is the active *choice not to participate* (regardless obstacles mentioned); particularly in cases where the *real* decisions have already been made elsewhere and people are asked only for marginal choices. Most typically it has been experienced with the WB's Poverty Reduction Strategy Papers (PRSPs)[30] (ibid). Khan (2009) appeals for so-called '*voice-enabling environment*' where respect for basic rights is assured and diverse groups are encouraged to organize and make their views known, including the health rights. Standing (2004) adds that the participation of "non-official stakeholders" in SWAPs has not also been successful in relation to the poor; she even uses the word *disappointing* (Standing, 2004).

One of the valuable classifications of community-based participation in health programmes was created by Rifkin (1990). She argues that a health programme whose aim is community participation has to specify *which level* of participation it wants to achieve. Rifkin (1990) indicates five levels of community participation in health points:

I. Participation with *health benefits* where communities are only utilizing health services or education.
II. Participation in *program activities* where there is local contribution of labour, land or money.
III. Participation in *implementation* which focuses on communities' managerial responsibilities and decides about carrying on the activities.

[30] PRSP process requires governments that aim to receive the WB's funding to prepare papers outlining their poverty reduction strategies. Governments are expected to draft these strategies within inclusive participation of civil society.

IV. Participation in *monitoring* and e*valuation* of programme activities

V. Participation in *decision-making* what programme activities should be carried out with the outside support in terms of resources and knowledge.

There are several examples around the world of citizens' participation in health care which more or less reflect Rifkin's (1990) classification; the extent of the autonomous participation recognized by Cornwall (2008) and its institutionalization varies from lower to higher levels, indeed. Let us again mention a few of them: a) *village health committees* (see Population Council, 2004), b) *providers-users alliances* (see Gorge, 2003), c) *community-based health information systems* (ibid); d) *resources mobilization* (see Standing, 2004; Rifkin, 1990), e) *community-based home care initiatives*, f) *user groups* (see Barnes & Shardlow, 1997).

We should bear in mind that active citizen's participation fostering greater accountability has one crucial precondition which is *access to information*. Access to information is often mediated by *awareness raising strategies*, frequently organized by non-state actors since the governments often fail to provide accurate and up-to date health information, which might be in limited cases even purposive. Access to information itself does not safeguard greater access to health care but it is essential when people are to take part in the decisions that affect their lives (Khan, 2009). Here is the room for health promotion as a mediator of information, education and communication and a behaviour communication change.

Box 1.F

Health Promotion: Ottawa Charter & Jakarta Declaration

Ottawa Charter for Health Promotion defined health promotion as "the process of enabling people to increase control over determinants of health and thereby improve their health" (WHO, 1986:1). Main focuses of health promotion are: equity in health and supportive environment which includes access to information, life skills and opportunities for making healthy choices. According to WHO (1986) health promotion should be mediated through governments, health and other sectors, local authorities, industry and *media* since health promotion is not a concern only of health sector. *Health promotion strategies* require adaptation towards local needs as well as towards different social and cultural settings. Health promotion includes *changing patterns* of life which have a significant impact on health. *Jakarta Declaration* from 1997 deepened the principles from Ottawa while appealing for tackle with *health determinants* and creating greater gains for health through human rights, communities' participation and social capital construction (WHO, 1997).

1.4.3. Health Promotion towards Greater Awareness: Traditional & New Ways

The highest quality, the most available health care services are pointless if people do not know about them or do not want them. (Salem et al., 2008). The promotion of health has been attempted traditionally via *health education* and public awareness campaigns (Roe et al., 2001) since the WHO's "Health for All in the Year 2000" initiative (WHO, 1984). Naidoo (1986) on the other hand declares that educational initiatives based upon open access information on local health services and policies with group work may prove more effective in raising public awareness rather than large national campaigns (Naidoo, 1986). Those authors also provide a definition of health education which is of a rather didactic nature. Health education according to Tones & Tillford (1993) involves any intentional activity designed to achieve health or illness related learning. Policy developments and initiatives on health promotion culminated in the

Ottawa Charter in 1986 (WHO, 1986) which was later revisited in the *Jakarta Declaration* in 1997 (Gilles, 1997). Read more on health promotion defined by Ottawa Charter & Jakarta Declaration in Box 1.F.

Lamont (1993) points out that providing information has been cited as a major factor for improving users' satisfaction with health services (ibid). Additionally, Carlisle (2000) comes up with two types of health promotion: (1) *medical health promotion*, and (2) *social health promotion*. Medical health promotion according to her seeks to prevent or ameliorate diseases or injuries drawing on objective evidence to prevent clinically defined conditions (e.g. the benefits of using condom during sexual intercourse). In the contrary, social health promotion seeks to change current power structures and challenge the injustices improving the lives of the least well-off members of society (Carlisle, 2000). This attitude is supported by Lomas (1998), who argues that public health as a discipline has been occupied by the individualist ethics of economics and medicine. He believes that the emphasis on screening, immunization and lifestyle change deteriorates more radical change in health (social) system. This implies that *medical health promotion* has been a dominant model with consequences how health inequalities are tackled (Lomas, 1998).

1.4.3.1. Behaviour Communication Change & Information, Education & Communication

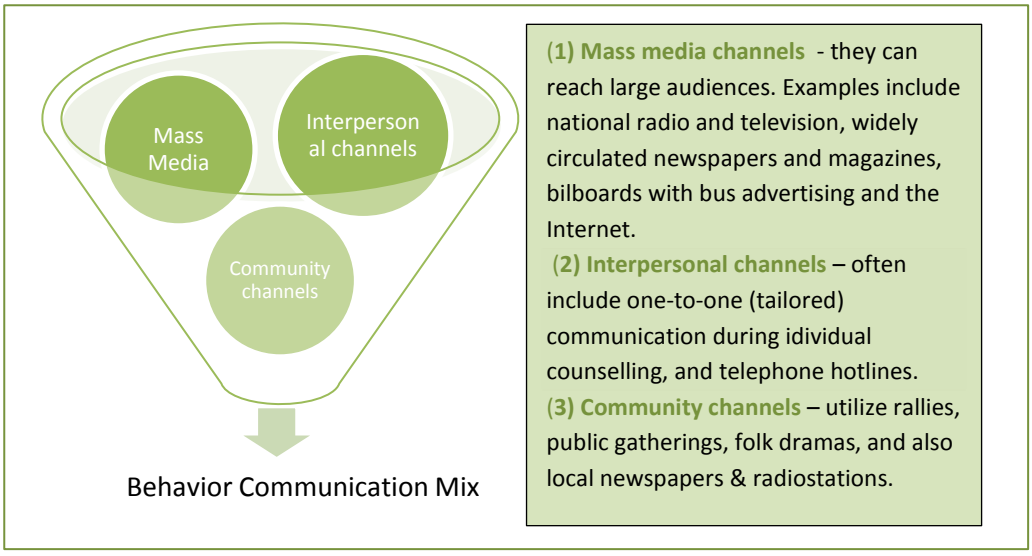
The behaviour communication change (BCC) aims to motivate people to either change their unhealthy behaviour or to continue with healthy behaviour. They influence attitudes and social norms[31] and attempt to address myths and misconceptions (Salem et al., 2008). BCC is built on two major types of behavioural theories from psychology: a) *theories of behavioural prediction,* and b) *theories of behavioural change*. The first type of theories addresses the question *why* people change their behaviour. They identify internal and external factors that prompt people to perform (or not to perform) a health-related behaviour. The initial research is needed to explore *target audience*[32] (ICN, 2008), communicators identify both factors that stand in the way of desired behaviour and factors that provide crucial support for the desired behaviour (Salem et al., 2008). The *communication messages* designed are based on ways to eliminate the key negative factors and/or reinforce the key positive factors (Fishbein et al., 2001). *Theories of the behaviour change* explain *how* people change their behaviour. They describe stages that individuals may go through as they change their behaviour. Identifying the target audiences' current stage of the behaviour change assists to tailor approaches and messages and move them to the next stage (Salem et al., 2008). There is a slight confusion in the literature and in NGOs' BCC programmes in terminology. Some authors (Salem et al., 2008) state that the terms evolved in a way that *information, education and communication (IEC)* is a former terminology and more up-to date is BCC, however some authors use the terms interchangeably. Furthermore, larger BCC programmes utilize a mix of three major communication channels[33]. See Figure I.G. for more information on Behaviour Communication Mix.

[31] Social norms are understood as perceived standards of behaviour or attitude accepted as usual practice by groups of people (ICN, 2008).

[32] Target audience is a group(s) of individuals to whom the message is intended to be conveyed. ICN (2008) distinguishes also *secondary target audience* which can assist in reaching or influencing the intended audience segment, but is not considered as a part of the problem.

[33] *Communication channel* is a way in which individuals receive information.

Figure I.G: Three Major Channels of Behaviour Communication Mix



Source: Adopted from Salem et al. (2008)

Each type of channel has its own strengths[34], although in most BCC programmes one type of channel has the leading role (O'Sullivan et al., 2003). Together the three reinforce each other to achieve changes in behaviour and maximize the BCC effect. Some authors (e.g. Figueroa et al., 2002) argue that BCC programmes must be integrated with overall health programme to fully address most heath issues. Such an intervention should besides BCC programme also require a supportive political and policy environment with aims to improve functioning of service delivery system (Figueroa et al., 2002). For instance BCC programmes can motivate people to space births, which requires preparedness and responsiveness of FP services. This requires convenient opening hours and locations, a variety of contraceptive choices in sufficient supply, competent and helpful providers. This example shows that BCC in health promotion should not be understood as an end point but rather as a *complement* which together with other policy tools can increase demand for particular health services. Table b1 summarizes main opportunities and limitations of BCC programmes.

There has been a strong move towards community participation in BCC programmes design and implementation recently. As described the extent of participation can range from mean to end point. As Salem et al. (2008) points out when community members assist with design and guide BCC programmes and messages, those programmes are more capable of addressing communities' concerns and needs.

It also has a great potential to strengthen communities' capacities to identify and address health and social issues (ibid). Recent communication strategies focus more on creating social change in communities in order to achieve greater social cohesion and community empowerment. It is important to distinguish them from traditional BCC approaches which have tended to focus on individuals' awareness – combination of knowledge, attitude and practices – and consequently their change (Figueroa et al., 2002). The credibility of BCC messages in general can be better achieved w while involving wide range of stakeholders such as the Ministry of Health, NGOs, health care professionals' associations, re

search organizations, faith-based groups and the media throughout the programme process (Cabañero-Verzosa, 2003)

[34] I.e. mass media entertainment and reality programming can depict healthy behaviour for large audiences. Interpersonal communication with health provider or a peer helps users to learn the skills, and to practice new behaviour. Community-based approaches spread new ideas through social networks, and, over time encourage wider support of them throughout the community

Social norms contribute to sustain individuals' healthy behaviour and might increase the need for intensive BCC programmes. However, sustaining healthy behaviour requires a *continuing investment* in BCC as part of an overall

Table b1: Opportunities & Limitations of BCC Programmes

Opportunities	Limitations
✓ **Increasing awareness of a health issue and possible solution**	× Cannot substitute for health care services when those are limited/poor quality
✓ **Demonstrating or depicting healthy behaviour & changing risk perceptions**	× Cannot produce sustained changes in complex health behaviours when the changes require the support of a larger health programme incl. appropriate policy & services
✓ **Improving skills and sense of self-efficacy (→ feeling capable of performing certain behaviour)**	
✓ **Showing the benefits of adopting healthy behaviour**	
✓ **Help shift social norms to encourage healthier behaviour**	
✓ **Advocating a position on health policy**	
✓ **Increasing demand for health services**	
✓ **Refuting myths and correct misunderstandings**	
✓ **Prompting behaviour change**	

Source: Adopted from FHI, 2002

health programme. People need to hear messages repeatedly and to discuss them with others before they take an action (Salem et al., 2008). Furthermore, as people go through the process of changing their behaviour, they need to hear different messages. Additionally, every year young people reach adulthood and take on the responsibility for their own health, thus, there are new audiences to reach and even those who adopted healthy behaviour may need an occasional reminder (ibid). However, as Rifkin (1990) argues knowledge will not automatically create desired changes in behaviour. Communities do not change their types of behaviour because new practices are communicated by community development workers (Rifkin, 1990). Behavioural change either for better or for worse takes a long time (ibid) therefore it is more than worthy to multiply the efforts in addressing health inequalities using more progressive concepts such as health advocacy.

1.4.3.2. Health Advocacy

Health advocacy is often understood as a key strategy for achieving *health promotion* aims, but multiple and contradictory definitions exist (Carlisle, 2000). Traditionally the potential of advocacy lies in addressing health inequalities, even though the concept is not universally accepted (ibid). However, the concept of advocacy operates within an assumption that people have rights which are enforceable (such as the right to adequate health care) and consequently it focuses on ensuring that these right are exercised, respected and addressed (ICN, 2008). Advocacy has been recognized by WHO (1986) as one of major strategies for achieving health promotion. WHO (1997) then describes advocacy for health as a "combination of individual and social actions designed to gain political commitment, policy

support, social acceptance and system support for particular health goal or programme" (WHO, 1997). Those actions may be taken by or on behalf of individuals and groups to create living conditions conducive to health and the achievement of healthy lifestyles (Nutbeam, 1998).

1.4.3.3. Social Marketing, Media & Technology for Health

Social marketing has been used to address a range of health and social issues from fighting racism to empowerment campaigning (Hastings, 2007), applying marketing strategies to the analysis, planning, implementation and evaluation of programmes designed to influence the voluntary behaviour of target audiences in order to improve their personal welfare, including health (ICN, 2008). It should not be understood as a blueprint approach towards behavioural changes, it just brings different idea s from marketing, which strongly focuses on consumers'/users' needs (ICN, 2008). Consumer orientation means higher level of identifying and responding to the needs of the target audience. Generally, social marketing provides a framework to combine marketing principles with socio-psychological theories to develop programmes which are better capable to accomplish behavioural change aims (ibid).

The main philosophy is to reduce psychological, social, economic and practical distance between the consumer/user and the healthy behaviour. Appropriate social marketing also concerns the analysis of social consequences of marketing policies, decisions and activities (Hastings, 2007). Practically, social-marketing driven programmes which incorporate more than communication messages include components commonly referred to as "4 Ps" - planning variables from marketing, the well-known concept of *marketing mix*" – read Box 1.G. Health-related social marketing assumes that power over individual health behaviours, even though some social marketers do include policy-level interventions by focusing their advocacy efforts on changing the behaviours of policy makers (ICN, 2008). Health-related social marketing provides people with accurate information so they can better participate in improving their own health (ibid). Social marketers generally believe that they address the *key shortcomings* 'traditional' public health communication campaigns in which target audiences have little input into message development.

Social marketing and/or BCC programmes often use different types of appeals in their messages such as informing, entertaining, persuading, educating or empowering. For instance Salem et al. (2008) mention *entertainment-education* approaches that can content is an entertainment format such as dramas on radio or television, popular music or street theatre (ibid). This type of approach can contribute to social change and influence people peoples' awareness – knowledge, attitude and practice by showing desirable behaviour rather

Box 1.G

Marketing Mix – "4 Ps" in Health Promotion

Marketing mix operates with four main variables while planning an intervention: **product**, **price**, **promotion** & **place**. Product refers to something the consumer/user must accept (an item, a behaviour or an idea). The product could be i.e. a condom. Price refers to psychological, social, and economic or convenience costs associated with message compliance. For example, the act of not having sex at high school can have psychological costs of anxiety & social costs of the loss of status. Promotion pertains to how the behaviour is packaged to compensate for costs: what are the benefits of adopting this behaviour & what is the best way to communicate the message promoting it. This could include better health, higher self-esteem or freedom from inconvenience. Lastly, place refers to availability of the product. If the intervention is promoting condom use, it is essential that condoms are widely available. Equally important to physical availability is social availability. E.g. condoms are more likely to be used when such use is supported and reinforced by peer groups and the community at large (Wallack et al, 1993: 22).

than describing them by addressing norms and beliefs that may be too controversial to confront directly. It is important to acknowledge that with the boom of cellular technology and Internet, the so-called *target audiences* are becoming the creators of public space and to a certain extent also the authors of social marketing interventions. Social marketers who use mobile phones in health campaigns design do not view them as another communication channel. As Lefebvre (2009) suggests mobile phones are unique amongst other mass communication channels thank to their immediate response capability. For instance, the local health provider can send a voice message to a user to complete a survey from their mobile phone and provide them with important insight utilizable for health service planning (Lefebvre, 2009).There is also a significant opportunity for mobile phone usage in sexual and reproductive health in particular, where confidentiality and stigma can keep many people away from information and health service facilities. There are several examples in academic literature (Levine et al., 2008, Ramey 2007 or Boland, 2006) of functioning projects successfully utilizing cell phones in sexual and reproductive health in different countries; two of them are summarized in Appendix D1. It is obvious that mobile phones cannot replace the *traditional* communication channels between provider and (potential) user but they should be a valuable component while planning and implementing communication strategies with different segments of populations globally.

1.5. Conclusion

The first chapter showed that the struggle for better health in low- and middle-income countries goes far beyond the fences of health centres or clinics. Investigating health inequalities and their determinants requires a comprehensive approach which understands the macro level of health systems and their components at one side as well as *target audiences* with the micro level of their health seeking behaviours on the other side. Understanding the 'demand side' of the service delivery has become more urgent than ever (Standing, 2004) since tailoring the health service interventions for different populations' segments aims to ensure higher access to health services with a major focus on primary health care. One fundamental aspect of the 'health for all' agenda is firstly the (further) existence of opportunities which would let citizens to participate on decisions that affect their own health; secondly, a genuine political commitment to this agenda. The mechanisms of *autonomous citizens' participation* and institutional accountability deserve more attention in formulating and implementation national health policies; as well as in health systems strengthening strategies at local, national and global levels. As soon as universal access to health care is a universal *right*, it is also important to bear in mind that the access to information (through different channels) and a sufficient level of awareness are important prerequisites for claiming this right.

2. Women's Health: From Fertility Control to Sexual & Reproductive Rights

This chapter provides the evolution of thinking on reproductive health from its first attention in development debates in the 1950s up to current challenges dealing with different levels of service integration bridging the sexual and reproductive health with HIV/AIDS agenda. The chapter is opened with the historical trajectories and the paradigm change crowned with the International Conference on Population and Development in 1994 and 4th World Women Conference in Beijing in 1995, which constituted the fundamental shift towards universal sexual and reproductive rights.

The fumbling for concept, definition and position of reproductive health is presented later on including the crucial relationship to MDGs and human rights. Since the empirical part of this thesis focuses on a few selected SRH services, those are introduced together with their global trends later on. The chapter also aims to present some of the highly topical issues of the currentSRH debate such as synergy of SRH and HIV/AIDS issues with some practical aspects and challenges. The topic of promotion, advocacy and education for sexual and reproductive health closes the whole chapter as well as the whole theoretical framework of this study.

2.1. Historical Trajectories

Gender and sexuality have been central to all human cultures. Across history, societies have regulated procreation and exercised various forms of fertility regulation. Since the late 18th century, the statistical measurement of population became a regular state procedure. Additionally, women's status and sex became increasingly politicised (Corrêa, 2008). It is important to point out, that the greatest boom concerning maternal health improvement efforts, acknowledgement and conceptualizing of reproductive and sexual rights has occurred in the twentieth century and is embedded in the whole concept of modernity and development. That is why the main historical trajectories outlined in this thesis concern only 20th and 21st century, they also do not account for indigenous birth control trends, including traditional family planning.

By the 1950s during the greatest resonations of the *modernization theory* the population control was promoted by various economic & demographic scholars and bodies as one of the strategies towards development. The UN and multilateral and bilateral donors argued that rapid demographic growth hinders development in poor countries. At the same time, rapid population growth in those countries became to be viewed as a geopolitical issue and security threat (Bernstein, 2005). *The UN World Population Conference in Bucharest* in 1974 pressed the issue of family planning programme implementation in low- and middle-income countries facing opposition just by those countries. In the contrary, a couple of years later, China and India came up and implemented strict population control policies[35] (Corrêa, 2008). As a reaction, in the late 1970s, a significant critique of fertility control initiated by women's movements, both in poor and rich countries occurred. Those movements claimed gender equality and citizenship rights in relation to reproductive and sexual self-determination. *Feminists* stated that none of the proclaimed population control programmes would address real women's needs and self-determination. In 1984, in Amsterdam, there was the first *International Reproductive Rights Conference* which acknowledged *reproductive rights* as a global feminist concept (ibid).

[35] "Development is the best contraceptive" (Bernstein, 2005:128).

Simultaneously, WHO introduced the terms *reproductive* and *sexual health*, including HIV/AIDS which gained the first major attention worldwide. In the 1990s, embedded in the *human development paradigm*, the UN launched many conferences that continuously legitimated *human rights*, in particular then: gender equality and reproductive and sexual autonomy.

Box 2.A

Gender-Based Violence

Gender-based violence (GBV), previously also called as *violence against women* is recognized as a global public health & human rights problem. It affects women's health, including their sexual & reproductive rights (Garcia-Moreno & Stöckl, 2009). WHO (2002) defines violence as: "the intentional use of physical force of power, threatened or actual…that results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation." (Krug et al., 2002). Intimate male partners are often the main perpetrators of a GBV known as *intimate partner violence* (or *domestic violence*). Violence is associated with a wide range of negative health outcomes for women. It contributes to women's increased risk of unwanted pregnancies, which may lead to unsafe abortion and gynaecological problems (Rodrigues et al., 2008), which has been documented in many countries (Kaye et al., 2006).. In conflicts and/or war situations, as we have witnessed in civil wars in some African countries and elsewhere, GBV has increasingly become a part of war tactics and has taken sickening forms (Watts & Zimmerman, 2002). In terms of service provision, as regards health care, providers should as minimum be informed and aware of the possibility of violence as an underlying factor in women's health (Garicia-Moreno & Stöckl, 2009). This is especially important for obstetric and gynaecologic care – as it is one of the common points of contact with the health service for women. Awareness raising among the general public & actions targeted at specific groups should be the first step.

The most fundamental conferences concerning those issues were:

1) *The International Conference on Human Rights in Vienna* in 1993,
2) *The International Conference on Population and Development in Cairo* (ICPD) in 1995, and
3) *The IV. World Women Conference in Beijing* in 1995

There are numerous human rights definitions concerning sexual and reproductive health, the most relevant are summarized in Appendix A2.Overall, the reproductive health paradigm emphasizes the importance of seeking to understand women's individual experience and constraints; and the social factors that influence sexual and reproductive health across the lifecycle. It is an integral part of the social determinants of health agenda (CSDH, 2008; Kerber et al., 2007).

2.1.1. SRH's Conceptual Achievements & Struggles

Corrêa (2008) admits that reproductive and sexual rights are followed by conceptual controversy. There are several critiques which argue that the language of sexual and reproductive rights (together with the rights-based approach) is framed around cultural relativism. Therefore sexual and reproductive health it must be embodied within a larger framework which combines adequate nutrition, access to health care, education, housing, jobs and social security. The sexual and reproductive rights framework includes both positive and negative rights. Positive rights mean for instance right to reproductive health care whereas negative rights represented by i.e. protection against discrimination or gender-based violence (see box 2.A on gender-based violence).

Saiz (2004) suggests, the human rights approach to reproductive health has the potential to sustain claims for sexual and reproductive rights based on agency and accountability. The central achievement of ICPD, however, stays the recognition and demand for *universal access to reproductive health care* within functioning primary health

care system (See the ICPD quantifiable targets in Appendix B2). This goal appeared to be even more difficult than expected since the implementation and realization of these rights took place during the most *neo-liberal environment* ever when SAPs of the WB dictated drastic budget cuts on public health care, reproductive health including (Standing 2002; Bernstein, 2005). Following ICPD, the women's movements directed their attention to further extension of the rights-based approach to *gender equality* in Beijing in 1995. However, in the area of sexual and reproductive health the difficult negotiations concerning abortion at ICPD chastened movement activists (Bernstein, 2005). Other issues that had emerged in Cairo such as harmful traditional practices (HTPs), gender-based violence (GBV) and women's access to education were developed further. As Bernstein (2005) highlights Beijing agenda rather attempted to reinforce than to extend the definition of sexual and reproductive rights. Unfortunately, a strong opposition[36] towards Cairo and Beijing achievements of gender equality, reproductive autonomy and sexual plurality mobilized in a way which had regressive consequences on revisited programmes of Cairo & Beijing: Cairo +5 and Beijing +5 with the aim to undermine previous agreements on gender-sensitive policies, abortion and sexual and reproductive health rights in 1999 (Corrêa, 2008). As the same author admits, the legitimizing of reproductive and sexual rights in international documents in the 1990s did not mean the end of moral controversies about gender, abortion and sexuality in societal contexts (ibid).

2.1.1.1. Is there a definition?

There is no universally accepted and unified *definition of reproductive health*. However, there is a consensus on principles how to approach the reproductive health definition grounded in ICPD. If we ground our search for the definition of reproductive health on WHO's definition of health presented in the first chapter, we will find out that within this definition, reproductive health "addresses the reproductive processes, functions and systems at all stages of life. Reproductive health, therefore, implies that people are able to have a responsible, satisfying and safe sexual life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so." (UNFPA, 1995). The *Programme of Action* of the ICPD also defines the range of sexual and reproductive health (SRH) services, although there is no unified international agreement on reproductive health services, either. Combining the definition of UNFPA (1999) and WHO (2010) we can conclude that *sexual and reproductive health services* have eight main aspects:
(1) Family planning counselling, information, education and communication (IEC);
(2) Maternal health – namely IEC and services for prenatal care, safe delivery and post-natal care, especially breast-feeding and infant and women's health care
(3) Prevention and appropriate treatment of infertility,
(4) Abortion[37] - including prevention of abortion and the management of complications arising from abortion,
(5) Treatment of reproductive tract infections (RTIs)/sexually transmitted infections (STIs) including HIV/AIDS,
(6) Other reproductive morbidities – cancers,
(7) Referrals for further diagnosis and treatment as required for family planning services,

[36] This opposition was formed mostly by US-religious right groups supported by former presidential administration, Vatican, Islamic nations and few other countries (Corrêa, 2008:386)
[37] The document clearly states that abortion should not be promoted as a FP method: "In no case should abortion be promoted as a method of family planning! In circumstances where abortion is not against law, such abortion should be safe" (8.25 of the Programme of Action ICPD – UNFPA, 1995)

(8) Active discouragement of harmful practices – e.g. female genital mutilation (FGM) (Say, L.: WHO – Department of Reproductive Health & Research, 2010; UNFPA – Office for Oversight & Evaluation, 1999).

According to UNFPA (2011) *reproductive health services* and information allow:

- ✓ All individuals to make informed choices about sexuality and reproduction, and to have a safe and satisfying sexuality and reproduction, and to have a safe and satisfying life, free of violence and coercion.
- ✓ Women to go safely through pregnancy and childbirth.
- ✓ Couples to have the best chance of having a healthy infant.
- ✓ Women to avoid unwanted pregnancy and to address the consequences of unsafe abortion.
- ✓ Access to prevention, treatment and care for RTIs/STIs including HIV/AIDS.

Generally reproductive health care is a set of methods, techniques and services contributing to reproductive health and well-being through prevention and solving reproductive health problems mentioned above with other related activities, ideally within an inter-sectoral ground linked to an education and/or environment. It is important to point out that several confusions might occur due to large extent of terminology overlapping between *maternal health* and *reproductive health*. Maternal health according to WHO (2011) refers to the health of women during pregnancy, childbirth and the postpartum period whereas reproductive health is a broader term including maternal health. Some authors (e.g. Kerber at el., 2007) extend the area of reproductive health towards children health, writing about so-called *continuum of maternal, new-born & child health* (MNCH) while appealing for more integrated concept of continuality of individual care. This approach does not require only a deeper level of integration[38] at service delivery level in order to avoid dichotomies between either mothers and children or places of service delivery and single health issues, but also a certain paradigm shift (Kerber et al., 2007).

2.2. Positioning Sexual & Reproductive Health

2.2.1. MDGs Framework and Reproductive Health

The Millennium Development Declaration & the Millennium Development Goals – the UN Millennium campaign aiming the eradication of extreme poverty while achieving universal primary education, promoting gender equality and empowering women, reducing child mortality, improving maternal health, combating HIV/AIDS, malaria and other diseases, ensuring environmental sustainability and establishing the global partnership for development. These goals overlap to a large extent with the comprehensive framework introduced by ICPD in Cairo (Germain & Dixon-Mueller, 2005; Bernstein & Juul-Hansen – UN Millennium Project, 2006). Although reproductive health is not named as a concrete goal, there is a wide consensus supporting the fact that universal access to reproductive health services, including family planning is a prerequisite for meeting MDGs (Bernstein & Juul-Hansen – UN Millennium Project, 2006; WHO, 2004; Germain & Dixon-Mueller, 2005). The multidimensionality of the concept of reproductive health could also be easily applied to each MDG examining each component of reproductive health, as Bernstein & Juul-Hansen suggest in the UN Millennium Project (2006):

[38] The topic of integration in reproductive health service delivery will be presented in Sub-chapter 2.3

(1) Addressing demographically driven poverty traps under the MDG 1.
(2) Promotion of gender equality and empowerment of women under the MDG 2 and MDG 3.
(3) Safe motherhood; child survival & universal access to SRH under the MDG 4 and MDG 5.
(4) Prevention as part of a continuum of services of HIV/AIDS under the MDG 6.
(5) Population and environmental linkages under the MDG 7.
(6) International cooperation for equitable access to basic medical interventions under the MDG 8.

Being specific, most maternal and new-born deaths could be prevented by improved access to well-integrated reproductive health services, including ANC, skilled attendance during childbirth and immediately after birth, and emergency & obstetric care for complications. Family planning with modern contraception offer a choice and opportunity for women to make informed decisions and have more control over their lives. Enabling young women to avoid pregnancy too early in life, when they are at much greater risk of complications, reduces maternal and child deaths. Better spacing of births reduces child mortality and improves maternal health. Sexual and reproductive health information and services are essential to efforts to prevent HIV/AIDS. Two key components of sexual and reproductive health are explicitly included in MDGs – *improving maternal health* and *combating HIV/AIDS*. These goals together with their targets and indicators are crucial but it is important to bear in mind that there is a wide range of issues directly or indirectly linked to those goals which are not yet addressed, such as gender-based violence or discrimination. As some authors (Germain & Dixon-Mueller, 2005) argue that if the MDGs mentioned are to be reached, these burning issues must be fully addressed. Reproductive health targets & indicators within the current MDG framework include: a) the proportions of births attended by skilled attendants - under the MDG 4 and, b) HIV/AIDS prevalence among 15-24-year-old-pregnant women under the MDG 6, and newly added target as of 2008 c) *universal access to reproductive health by 2015* under the MDG5[39] (WHO, 2010).However, as Bernstein & Juul-Hansen - UN Millennium Project (2006) argue, the importance of sexual and reproductive health to the attainment of development goals has not been adequately translated into action frameworks and monitoring mechanisms at international, regional and national levels on time. The complexity of the concept has not contributed towards coordination at different levels, including decentralized units or sectoral ministries which would represent a significant challenge in monitoring. On the other hand, it would be fair to admit that sexual and reproductive health and rights agenda has been re-affirmed in other different forums[40]. International political support[41] is the first step in addressing the issue, however, complicated resolutions and political mobilization are often needed at the national and district level where different understandings of sexual and reproductive health, and associated service delivery shape the depth of interventions and the amount of resources allocated. As Bernstein & Juul-Hansen - UN Millennium Project (2006) point out, the topic of sexual and reproductive health and its relation to development are relatively new, discussed at international forums only within last 15-20 years (ibid).Achieving the target of universal access to sexual and reproductive health services would require two types of health systems strengthening (Germain & Dixon-Mueller, 2005):

I. The provision of appropriate information & services within all health facilities obtained from trained personnel with the access to proper equipment and supplies (with primary health care focus).
II. A sufficient number and equitable geographic distribution of such facilities. Scaling up the capacities of health systems while integrating them is therefore critical to reproductive health agenda, nevertheless how explicitly the issue resonates in the MDGs agenda.

[39] With targets: a) contraceptive prevalence, b) ANC coverage, c) unmet need for FP and, d) adolescent birth rate.
[40] See the Appendix D2 summarizing recent initiatives of international institutions and their engagement in SRH.
[41] Opposition is also prevalent in donor community as mentioned above.

2.2.2. Bridging Public Health & Human Rights through Reproductive Health

Human rights, or *rights-based approach* have increasingly form the terminology and approach of numerous international agencies, governments, NGOs and/or CSOs involved in sexual and reproductive health , this application is now widely accepted that human rights have been named as central to achieving MDGs (Cottingham et al., 2010). Human rights are also a core guiding principle for WHO – especially for its 2004 *Reproductive Health Strategy* (WHO, 2004). Since 1994, human rights have been incorporated in diverse approaches addressing sexual and reproductive health, HIV/AIDS, child health or the provision of essential supplies and medicines. Rights-based approach to reproductive health, used by various agencies, NGOs or UN bodies which usually develop "a common understanding of rights-based approach to programming" is sometimes criticised for limited scientific relevance and/or unclear role in health policy debate (Abdella, 2008). Those organizations utilizing the rights-based approach to RH generally focus on three aspects while intervening in the area of sexual and reproductive health:

1) Participation of affected communities – the level of *autonomous* participation varies
2) Avoiding discrimination during intervention design or implementation – mechanisms also vary
3) Existence of different accountability mechanisms

However, as Cottingham et al. (2010) emphasize, a major achievement of the ICPD conference was recognition of *the responsibility of governments* to translate international health commitments into national laws and policies that promote sexual and reproductive health. Supporting the argument concerned with an unclear role of the rights-based approach, it should be said that some organizations simply invoked RBA principles whereas others have been using human rights as a conceptual framework for their actions. This diversity has been resulting in several interpretations of the meaning of linkages between public health and human rights in practice. As the same source underlines, linking human rights and public health is a new phenomenon and there are few experts who can work simultaneously within those broad disciplines.

As Gruskin et al. (2008) suggest human rights analysis has a potential to create a country's mapping tool of its legal and regulatory environment in relation to SRH. Some governments in low- and middle-income countries have already been seeking assistance to improve the legal and regulatory frameworks[42] to be more supportive to sexual and reproductive health of their populations (Gruskin et al., 2008). Implementation of RBA in sexual and reproductive health does not only concern *policies*, but also *laws* and *regulations* which ensure greater *accountability* through the system of sanctions and rewards as mentioned above.

2.2.3. Introducing Selected SRH Services: Trends & Challenges

Poor people, especially women and young people, face huge social, economic and systematic barriers to sexual and reproductive health services[43] in low- and middle-income countries in particular. Every year, 529.000 women die from

[42] For instance a state ratifies the Convention on Elimination of All Forms of Discrimination against Women (CEDAW) which founded its political commitment to eliminate violence against women in its territory but there is no appropriate legal and policy implementation framework which would bring an adequate response.

[43] See the overview of barriers to reproductive health with underlying causes & operational strategies defined by Kerber et al. (2007) for each service delivery level in Table a2.

complications of pregnancy and childbirth and 3 million children die in their first week of life. 33.3 million people are currently living with HIV[44] (UNAIDS, 2010) and 340 million people contract STIs each year. 120 million couples do not have access to the family planning services and contraception they need (DFID, 2004). The failure of accountability of health duty bearers adds the barriers that poor people have to face in accessing SRH services and information with adopting healthy behaviours. The gap might be narrowed as a better application of human rights and participation, inclusion, non-discrimination, accountability (within and beyond the health sector) is implemented. That can make a real difference in people's health and lives. The empirical part of the thesis concerning service delivery of sexual and reproductive health services has shortlisted the following SRH services: 1) family planning (FP); 2) ante-natal care (ANC); child delivery (CD) at a health facility, and 4) HIV voluntary counselling & testing (VCT). Since those services were selected as of major focus SRH services, they will be briefly presented together with their global trends. Other services such as safe abortion which were not shortlisted but they are directly connected with women's reproductive and sexual wellbeing will be mentioned complementary throughout the text of the study.

2.2.3.1. Family Planning

Contraception and family planning (FP) in general make up a cost-effective and life-saving intervention that can improve both child and maternal health (Kerber et al., 2007). Use of effective contraception by women[45] who want to delay or stop child-bearing can prevent 32% of maternal deaths (WHO, 2010). However, more than 80 million women faced an unwanted or unplanned pregnancy in the year 2008 (Singh et al., 2010). Larger than desired family size often makes it harder for households to escape poverty and hinder the nutrition, health and education of children (DFID, 2004).

There is a global unmet need[46] for contraception represented by more than 120 million couples. Although globally more than 60% of women who are married or living in a union use contraceptives (WB, 2011), significant differences are reported across regions. Women in Sub-Saharan Africa have the lowest level of contraceptive use – 21% in 2009 (WB, 2011). Unmet need for family planning changed little in Sub-Saharan Africa: every fourth women who is married or living in a union has an unmet need for family planning. This indicator has shown to be higher for poorer women than for their richer counterparts (WHO, 2010). Use of contraception promotes birth spacing and it is estimated that it prevents 10% of infant deaths (ibid); it also contributes to women's empowerment and gender equality by enhancing opportunities for participation in societal activities which affect their lives. Despite the huge focus on family planning programmes since 2000 the use of contraceptives has even slowed (Van Lancker, 2010). There is a global effort to turn towards long-term family planning methods which has attempted to promote those methods especially among married women. However, the use of *intrauterine devices (IUDs)* remains to be limitedly reported (WHO, 2010). According to the same source, just over a half of the WHO member countries have introduced specific regulations/policies on long-term FP methods since the mid-1990s, following the ICPD.

There has been an increasing need to tailor family planning for various population segments such as youth, whose reproductive preferences have been constantly underserved – the unmet need for contraception of adolescents is over

[44] UNAIDS' latest annual epidemic update sates that there were between 31.4 to 35.3 million people living with HIV at the end of 2009 (UNAIDS, 2010:23).

[45] Most of the statistics done by various agencies utilize the reproductive age group of women: 15-49 years.

[46] Unmet need is usually defined as situation when not using any contraception despite the expressed desire to avoid or to space future pregnancies. The unmet need for family planning thus comprises women at risk pregnancy who do not desire another birth – *limiting desires* or those who wish to space their birth giving at least two years – *spacing desires*.

two times higher than of the general population (Bernstein & Juul-Hansen - UN Millennium Project, 2006). Another underestimated population segment is represented by HIV positive women: preventing their unintended pregnancies will not only improve maternal and child health but also prevent new HIV infections in infants (Wilcher & Cates, 2009).

2.2.3.2. Antenatal Care

Although there has been progress in the last decade, only about 70 % of births in low- and middle-income countries have been preceded by even a single ANC visit (WHO, 2010). It is important to remind that effective antenatal care optimum counts for at least four visits appropriately timed and spaced. Disparities in utilization of ANC are striking between the wealthiest and the poorest women and between urban and rural areas. There is some evidence (WHO, 2007) that lack of or insufficient antenatal care is related to missed opportunities to identify obstetrical risks. Obstetrical and neonatal outcomes can be improved with comprehensive antenatal care, which emphasizes the specific medical, nutritional, and social needs of pregnant women and prospective mothers (ibid). Special attention should be paid again to adolescent pregnancies and their ANCs respectively. Pregnant adolescents are more likely to be threatened by malnourishment and anaemia than their older counterparts. This could be improved effectively during ANC, if accessible (in all aspects discussed above). However, as pregnant adolescents often receive inadequate ANC, anaemia during their pregnancy, labour and postpartum represents a serious risk to their health. Indeed, this health risk also applies to large extent to mature women since anaemia always increases risk of maternal mortality and morbidity and also adversely affects infant health by increasing odds for prematurity and low birth weight (Bernstein & Juul-Hansen - UN Millennium Project, 2006).

2.2.3.3. Skilled Birth Attendance

There is evidence showing that attendance at child delivery by skilled health personnel reduces maternal mortality (Ekirapa-Kiracho et al., 2011). According to the WB (2011) 65.3% of all deliveries worldwide were assisted by a skilled health attendant in 2009. The proportion of births assisted by a skilled birth attendant has risen dramatically in several world regions[47]; however, Sub-Saharan Africa lags behind other world regions with only between 41% and 44% of births assisted by a skilled attendant (Bernstein & Juul-Hansen – UN Millennium Project, 2006; WB, 2011). It is important to add that the rates are even lower in rural areas and among the poorest groups of the population. That low service utilization level contributes to a large extent to the high maternal mortality of the subcontinent. The category of '*skilled birth attendance*'[48] usually includes both deliveries at health facilities and deliveries at home while assisted by a skilled birth attendant (e.g. a nurse, a general practitioner, a midwife, a specialist, a community health worker – if trained in less complicated child deliveries, the same applies for traditional birth attendants if officially trained and recognized by a national health system which is always country-specific). Access to the basic and emergency obstetric care with functioning referral systems is also a crucial factor of health status of pregnant and/or child bearing women.

[47] Southern Asia, Eastern Asia and the Pacific, and from higher initial numbers in Latin America and the Caribbean (Bernstein & Juul-Hansen – UN Millennium Project, 2006)

[48] WHO (1992) definition of a traditional birth attendant (TBA) refers to: "a person who assists a mother during childbirth, and who initially acquired skills by delivering babies herself or through apprenticeship to other TBAs" (WHO, 1992).

Table a2: Barriers to Essential SRH Services According to Service Delivery Level

	Underlying causes	Operational strategies
Clinical care		
Lack of trained staff	✓ Inadequate human resources policies ✓ High turnover, low pay, disincentives to work in rural areas	✓ Introduce national human resources plans including training, deployment, skill mix ✓ Appropriate regulation, consider performance-based payment and/or hardship allowances for rural postings
Poor quality of care in public sector	✓ Inadequate standards of care, including emergencies ✓ Non-skills based training ✓ Lack of accountability and/or motivation Insufficient basic supplies and drugs	✓ Adapt and implement clinical guidelines ✓ Do clinical and mortality audits of maternal, perinatal, and child birth ✓ Improve supply and management of drugs and essential laboratory services
Delayed use of services and/or poor compliance with treatment	✓ Delays in recognition of illness, slow decision-making and inadequate transportation	✓ Use a mix of strategies including birth and emergency preparedness, transport & finance strategies, maternity homes, and telecommunication for timely responses
Affordability barriers	✓ Low income and resources ✓ Insufficient social security system ✓ Corruptive practices by providers ✓ High user fees	✓ Adopt an approach mix including: user fee protection, community funds, health insurance, subsidized care, conditional cash transfers & voucher-based reimbursements for providers
Outpatient/outreach		
Low quality of care	✓ Lacking standards for care ✓ Failure to disseminate or adopt global guidelines ✓ Poor supervision and accountability	✓ Promote usage of evidence-based guidelines and standards ✓ Strengthen pre-service and in-service training ✓ Provide supervision ✓ Include perspectives of women and vulnerable groups when improving health
Low demand for care, late use	✓ Insufficient information ✓ Negative experience with health system ✓ Physical inaccessibility of facilities ✓ Opportunity costs	✓ Promotion & campaigning for health ✓ Improve links with communities through dialogue and mobilisation ✓ Monitoring of follow-up dropouts, especially for PMTCT and immunisation
Family/community		
Inadequate information on healthy behaviours & care-seeking	✓ Lacking mechanisms for community participation ✓ Irrelevant or inappropriate messages ✓ Poor dissemination strategies ✓ Lack of law enforcement for gender equality & women's status	✓ Review policies related to family & community support for maternal, new-born and child health (MNCH) ✓ Strengthen existing community groups for community mobilisation ✓ Develop specific messages and use multiple communication channels ✓ Address cultural practices
Low supply of affordable commodities for health	✓ Insufficient access and transport to communities ✓ Cost of commodities ✓ Deficient markets	✓ Strengthen logistics, including community-based distribution ✓ Use social marketing ✓ Subsidize commodities, if appropriate
Scarcity of community workers and/or ineffective linkages to the health system	✓ Inconsistent policies for primary health care ✓ Poorly defined roles and training ✓ Reliance on volunteerism and/or lack of supervision ✓ Insufficient remuneration or other rewards	✓ Revitalize existing community health workers' roles and include remuneration or other rewards ✓ Design effective training packages with continuous supervision & refresher training ✓ Create effective links to the health systems

Source: Kerber et al., 2007

Box 2.B

Obstetric Fistula

It is most likely developed during prolonged, obstructed labour in settings where women have no access to emergency obstetric care, particularly *caesarean section*. Obstructed labour that is unrelieved by medical intervention can last even for days, often resulting in a still birth and in fistula. A hole that forms due to the prolonged pressure of the baby's head on the woman's vagina and bladder and/or rectum is called *fistula*. The fistula leaves the affected woman chronically incontinent with no control over her urine and/or bowel movement. Aside from psychological effects of fistula, it also often leads to social exclusion of the woman by her husband, family and community. The risk of fistula is often associated with early marriage and consequent pregnancy whilst the body is not sufficiently developed to go through pregnancy. Fistula is said to be a tracking indicator for inadequate health services for poor pregnant women in low- and middle-income countries. Fistula can be repaired even if the woman has lives with the condition for several years.. Many women do not even have the access to information that their condition can be treated. (Wall et al., 2005; Bernstein & Juul-Hansen – UN Millennium Project, 2006).

Skilled Birth Attendance (Continued)

If this type of care lacks, it has potential life threatening effects, and may lead to serious complications[49] which require specialized treatment which is normally costly (Ekirapa-Kiracho et al., 2011). Pre-term labour and delivery is another high risk situation both for the mother and the infant requiring the assistance of a skilled birth attendant.

2.2.3.4. HIV Voluntary Counselling and Testing

HIV voluntary counselling and testing (VCT) is a service initiated by a (prospective) user who usually seeks the service in order to find out his/her HIV status. VCT services have grown rapidly in countries heavily affected by HIV/AIDS epidemic. The function of this service is both HIV prevention (supports user in 'staying negative') and the gateway to HIV care & treatment (helps users to 'live positive'). Bradley et al. (2008) distinguish between *situational reasons* when a user comes for pre-martial testing, travel/visa requirements or PMTCT; and *self-initiated reasons* when a user is only eager to 'know her/his health status' (Bradley et al., 2008). Ideally a typical single visit includes pre-test counselling, HIV testing itself, HIV prevention counselling, delivery of test results and post-test counselling. In both pre-test and HIV prevention counselling, the clients are offered condoms during post-test counselling and receive information how to negotiate condom use. The demonstration of correct use should also take a part; otherwise the user should be at least informed about the location and services of the nearest family planning facility where can he/she can obtain information on correct condom use (FHI, 2007). There is a similar service of HIV testing and counselling which is different from VCT in the initiation of the testing and which is *provider-initiated*, fully called **provider-initiated counselling and testing (PICT)**. This service is requested by a health service provider as a part of the diagnostic clinical management for patients who came with other concern than HIV testing. Most of the time PICT service is focused on patients who exhibit symptoms that may be attributed to HIV or suffer from illness associated with it. When these symptoms are present, PICT should be offered as standard care (ibid).

[49] Read the Box 2.B on Fistula

2.3. Synergy of Reproductive Health & HIV/AIDS Agenda

HIV/AIDS has a myriad of effects on individuals' lives[50], including their reproductive health and rights. Simultaneously, SRH services are critical for women and men living with HIV/AIDS (Berer, 2004). Considering the feminization of the epidemic, the disease has a tremendous impact on the lives of women living with HIV/AIDS - on their roles as mothers, economic providers and caregivers (Myer et al., 2005). HIV positive women therefore require a special attention in SRH services; similarly, advanced HIV/AIDS is associated with substantial increase in several reproductive tract conditions and a range of STIs (Moodley et al., 2002). The links between sexual and reproductive health and HIV/AIDS treatment & prevention might be obvious, nonetheless in the recent past, little considerations of the connections between those two phenomena occurred (Myer et al., 2005). As Berer (2004) emphasizes, SRH services can contribute to HIV/AIDS prevention & treatment to great extent, given their current and potential outreach to wide sections of the population through primary health care and *sexual education*[51]. Even though it might not be possible to integrate all SRH services into a single delivery HIV/AIDS care & treatment in resource-poor settings; there is a clear need to include basic SRH services, such as family planning and counselling with management of unwanted pregnancies (Myer at al., 2005).

As Wilcher & Cates (2009) summarize, calling for stronger linkages between SRH and HIV/AIDS policies, programmes and services which would facilitate access to RH services for women living with HIV while protecting their reproductive rights has been issued by several international organizations. Regardless their HIV status, increasing access to SRH services would not only offer them more control over their reproductive lives and help them achieve their desired fertility, but also would produce significant public health benefits on maternal & infant mortality and morbidity (ibid).

The most typical example of HIV/AIDS and SRH services synergy is the prevention of mother-to-child-transmission (PMTCT) service. Wilcher & Cates (2009) together with Berer (2003) summarize main shortcomings and obstacles in effective implementation of PMTCT & other programmes on treating HIV positive women:

I. Too narrow focus of current PMTCT programmes on treating HIV positive women who are already pregnant.
II. Separate and parallel funding & budgeting mechanisms for SRH and HIV/AIDS programmes in most national health systems.
III. Vertical programme structures often maintained in spite of the support for the need of integrated approaches.
IV. Traditional training of health workers to implement vertical programmes.
V. Lack of political will from major HIV/AIDS donors & policy-makers to include SRH as an important HIV/AIDS component.
VI. Evidence gaps in effective approaches for integrating SRH and HIV/AIDS services.

The entry point for most PMTCT programmes is ANC. The emphasis is on identifying HIV-infected pregnant women and increasing their access to ART. However, according to UNICEF/UNAIDS/UNFPA/WHO (2008), only 33% of HIV positive pregnant women in low- and middle-income countries have access to ART to prevent transmission. Additionally, as Berer (2004) highlights, there is still one million HIV positive women delivering at home annually and who are excluded from all maternal services; altogether out of a total 60 million women globally still delivering at home each year. That is why there is a strong call for more effective PMTCT programmes which would reach women and their

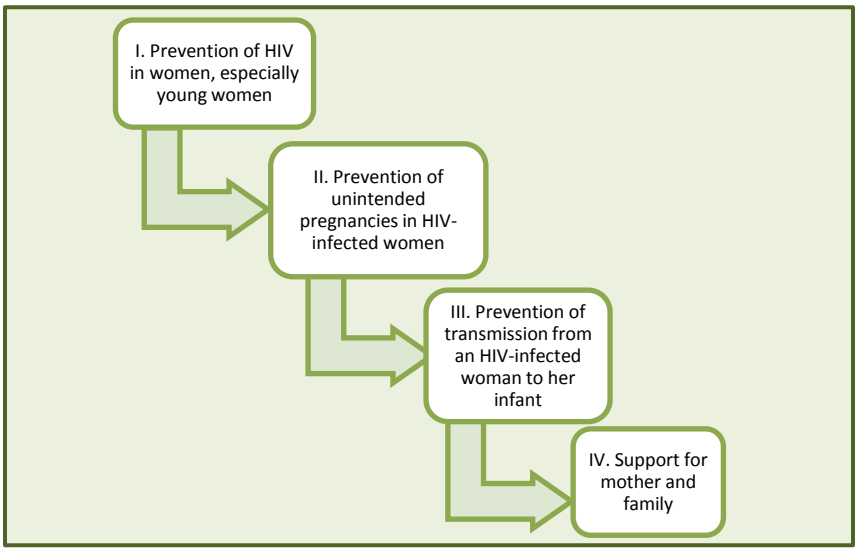
[50] See the Appendix C2.
[51] WHO (2008) operates with the term *sexual and reproductive health (SRH) education*, the concept will be presented in Sub-chapter 2.3.3.1

partners outwards of ANC settings even before they become infected, and if infected, before they become pregnant (Wilcher & Cates, 2009). See four elements of perinatal HIV prevention in figure II.A.

.

The authors of the strategy for perinatal HIV prevention refer to Element III. in Figure II.A as to the most directed point in PMTCT in terms of resources and attention. The current provision of ART to HIV infected pregnant women is a significant public health achievement, however, the current impact of PMTCT programmes is limited by their failure to address effectively the unmet need for contraceptives of women with HIV (Wilcher & Cates, 2009).

Figure II.A: 4 Elements Strategy for Perinatal HIV prevention



Source: Adopted from Wilcher & Cates, 2009

Bradley et al. (2008) conclude that reaching more women and their partners through integrated HIV/AIDS and SRH services is a logical programmatic response which will extend the coverage and care which otherwise would not be accessible or obtained. Despite the overall theoretical support for the service integration, the institutional problems towards it arise when national health ministries have to determine who has the responsibility for each of the services, and under which budget lines to place them (Berer, 2004). These problems are further complicated in the context of health sector reforms which have led to decentralization and devolution of responsibilities (Abdella, 2008) for the management, budgeting and financial control, as well as decisions regarding clinical care in most countries. Where those lines have not been clearly drawn yet, or the responsibilities fully transferred, the assumption of responsibility for integration at local, as well as national and level may be even more uncertain.

2.3.1. Integration in Theory and Practice: A Case of VCT & FP

Integrating VCT and FP (with other SRH services) is seen as an effective strategy for expanding VCT service delivery in resource-poor settings (Bradley et al., 2008). There are several reasons supporting this approach:

a) HIV and FP interventions have similar target audiences. According to UNAIDS (2010), slightly more than a half of HIV infected persons worldwide are women in reproductive age (15-49 years).
b) Offering these services jointly would maximize the use of scarce resources, improve users' access, increase uptake for both service types and embrace the opportunity by reaching (potential) users not typically targeted with either FP or HIV prevention & treatment information (Berer 2003; Reynolds et al., 2006).

c) Users' types are differently attracted to the facilities depending on *service integration modality*[52] and other facility-level characteristics.

VCT is usually the primary entry point of HIV/AIDS prevention & treatment services and may also prevent transmission of the virus by reducing risk behaviour (Mola et al., 2006). Some studies (Hoke & Reuben, 2006; Reynolds et al., 2006) have shown that health providers are overall supportive towards the service integration and challenges such as health providers' time constraints, inadequate space or shortages of equipment may be overcome by adequate training and structural improvements. Bradley et al. (2008), who carried on the research in Ethiopian private VCT facilities[53] , came up with the result which stated that 42% of facilities had VCT and FP co-located within the same compound, 16.6% of integrated services were offered in the same rooms and another 42% provided the highest level of integration where counsellors provided both VCT and FP services simultaneously (Bradley et al., 2008). They concluded that although the counsellor level of integration might increase users' waiting ties, especially married women might be more likely to accept this cost for "one-stop shopping".

Another opportunity might be greater anonymity for VCT found by young and single people at RH facilities focusing more on maternal and child health and family planning, respectively (ibid). There is also a strong appeal on FP services to raise awareness on STIs/HIV risk among married women, and at the same time expand their outreach to vulnerable groups of women whom they have marginalized: young single women, migrant & refugee women and commercial sex workers (CSWs) (Berer, 2004). Where resources lack and there are major constraints in provision of needed sexual and reproductive health services, structural integration is seen as a way to increase health service provision efficiencies (Berer 2003; Bradley, 2008). On the other hand, there are already some lessons learned from recent integration efforts which need a special attention for further implementation. Bernstein & Juul-Hansen - UN Millennium Project (2006) underline some of the recent experience:

1) Integrated services require more complex management with specific roles and responsibilities at each level of service delivery.
2) It is more difficult to hold health managers accountable in integrated environment.
3) Monitoring and evaluation of integrated services is complex, including input, process and impact indicators.
4) Integration may lead to a loss of focus within SRH.

As long as people are central to efforts to provide better-integrated services, any efforts to integrate services must be centered on a '*continuum of care*' over a person's life cycle (Bernstein & Juul-Hansen - UN Millennium Project, 2006).

[52] There are basically three ***levels of service provision integration:*** 1) facility level – which means co-locating HIV & FP services within the same service delivery compound; 2) room level – those offering services in common rooms that are regularly (often weekly) rotated for confidentiality, and 3) counsellor level – facilities where counsellors simultaneously offer HIV and FP services. All these three categories are mutually exclusive.

[53] Facilities run by the local NGO Family Guidance Association of Ethiopia (FGAE), representing approx. 5 % of all VCT facilities in the country.

2.3.2. Continuum of Care: Integration of SRH Services throughout Lifecycle

The attention to the concept of person-centred continuum of care over her/his lifecycle and to reproductive health programmes has increased over the last decade (Bernstein & Juul-Hansen - UN Millennium Project, 2006). Those tendencies are directly linked to horizontal integration efforts. Some authors such as Kerber et al. (2007) refer to so-called '*maternal, new-born, and child health (MNCH) continuum*' of care which means continuality of individual care throughout adolescence, pregnancy, child birth, the post-natal period and childhood. A continuum of care consists of two key elements: i) service provision continuum , and ii) continuum over time. That practically means that the continuum of care is necessary throughout the lifecycle and also between places of health service provision – including households, communities, outpatient & outreach services and clinical-care settings (Kerber et al., 2007).

There are several definitions of MNCH continuum of care created by different international organizations and/or researchers. Selected definitions are compared in Appendix E2. The concept of continuum of care arose from the dissatisfaction with the practice when (potential) users were often targeted simultaneously by cross-cutting programmes – such as nutrition programmes for infants and programmes with separate funding and management streams (HIV/AIDS, malaria or TB). The lack of integration between such programmes often results in fragmented service delivery that negatively affects quality and continuity of care, and cause discontent between both health service providers and users (PMNCH, 2006).

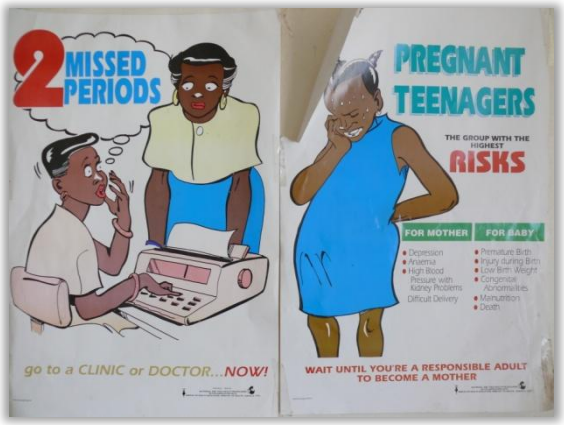
A continuum of care aims to provide services meeting the user's needs in a convenient and affordable way. For instance, if a pregnant woman comes for her ANC check-up, it means counselling on pregnancy-related issues but also checking if there are other relevant issues, such as intimate partner violence, nutritional problems or the need for condoms to prevent HIV infection during pregnancy (Makokha et al., 2002; Bernstein & Juul-Hansen – UN Millennium Project, 2006).

2.3.3. Promoting Sexual & Reproductive Health

2.3.3.1. Sexual & Reproductive Health Education

As mentioned a few times, adolescents (youth) are one of the most vulnerable groups often suffering from poor reproductive health while lacking access to services and information. School-based sexual and reproductive health (SRH) education is one of the most important and widespread ways of assisting adolescents to recognize and advert risks and to improve their reproductive health (Wellings et al., 2006; WHO, 2008). Read the WHO's definition of SRH education in Box 2.C Adolescents' reproductive health status is one of fundamental public health concerns since it was estimated that there were 1.8 billion adolescents in 2008 with 85% represented by adolescents from low- and middle-income countries (Tegegn et al., 2008 ;WHO, 2008). Promotion

Figure II.B: BCC Material for SRH Education



Source: author, internship in Jamaica 2007

of *youth-friendly SRH services*[54] should be one of the major interests of national health systems. Education itself can be a powerful vehicle for improving the health of adolescents. Schools are the primary institutions able to reach the majority of adolescents while also having an impact at the community level. Four out of every five of the world's children were enrolled to secondary education in 2005, which is now considered as compulsory education in most countries (UNESCO, 2008).

In many countries around the world teachers possess a key role in the community while often serving as role models to many adolescents. WHO estimates that school health education of *some form* (not specified) is taking place in over 50% countries worldwide, varying in regard to their objectives, structure, length, content, implementation strategy and other characteristics. In low- and middle-income countries most of them are funded by international donors to improve both learning and health through schools (ibid). The most well-known SRH education initiatives are summarized in Appendix F2. The implementation of SRH education into stable national school curricula remains a challenge since public education in low and middle-income countries face similar shortcomings as health sector such as funding constraints, human resources crisis, etc. (WB, 2004). As Rosen and Conly (1998) highlight the emergence of HIV gave many governments the input to strengthen and expand SRH education efforts and, currently, it is estimated (WHO, 2008) that in 2008 there were approximately 100 countries with some SRH education programmes, including the majority of Sub-Saharan countries (WHO, 1998; Rosen & Conly, 1998).

Box 2.C

Sexual & Reproductive Health (SRH) Education

WHO (2008) defines SRH education as :"educational experiences that develop the capacity of adolescents to understand their sexuality in the context of biological, psychological, sociocultural and reproductive dimensions and to acquire skills in managing responsible decisions & actions with regard to SRH behaviour. SRH education aims to achieve a range of behavioural & health outcomes, including reduced sexual activity (such as postponing age at first intercourse & promoting abstinence); reduced number of sexual partners; increased contraceptive use (use of condoms among adolescents who are sexually active, dual protection); lower rates of early marriage, lower rates of early unwanted pregnancies & resulting abortions; lower rates of HIV infections & other STIs and improved nutritional status." (WHO, 2008:1).

2.4. Conclusion

As this chapter has summarized, the multidimensionality of the concept of sexual and reproductive health provides a lot of opportunities for protecting and promoting women's health as well as a lot of challenges with practical implementation into policies, laws and regulations. Nonetheless, lots of promises remain missed once browsing the statistics on maternal mortality and morbidity, unintended pregnancies or skilled birth attendance with special attention to Sub-Saharan Africa, which still lags behind the progress of other low- and middle-income regions. As obvious, more than 15 years after the constitutions of Cairo and Beijing, the global fight for better health of girls and women has not finished. This fight does not include only resource mobilization or more effective management. There is a great need to pay more attention to excluded and vulnerable groups which lack access to both information and

[54] Those RH services which are developed and provided in a way, that recognizes that the challenges, difficulties and obstacles are very different to those confronted by adults (Tegegn et al., 2008; Webb (ed.), 1998).

services. Those groups are constituted especially by the youth and HIV positive women. The disparities between rural and urban areas, between the rich and the poor play a fundamental role as well. Developing more functional awareness raising strategies tailored to various populations' segments and improvement of the current ones while using more progressive methods would not only ensure a greater awareness level but also greater access to basic SRH, services which consequently safeguards the universal right to sexual and reproductive health.

3. The National, Regional & Local Context of the Study

This chapter is going to provide the contextual and geographical framework of the study area where the empirical part of the research was carried out. First, a general overview is presented with a focus on geography, environment, administration and governance of Ethiopia; followed by a socioeconomic outline. The description of the socioeconomic situation of the country includes the examination of poverty and development patterns and demographic trends. The third sub-chapter is dedicated to the central research focus – sexual, reproductive and maternal health while contextualizing it in a relation to gender and HIV/AIDS epidemic. Further, the health sector is presented highlighting health and other relevant policies, service delivery system and financing health care with emphasis on reproductive health and HIV/AIDS. Finally, the regional context of Amhara regional state is provided with closer focus on its geography, administration and demographic patterns. The last section of this chapter presents some relevant characteristics of the study area – Bahir Dar Special Zone.

Figure III.A: Ethiopia & Eritrea

Source: CIA, 2010

3.1. General Overview

Ethiopia: a country with more than 3.000 years of history with a unique position at crossroads between the Middle East and Africa. Having preserved independence even during the worst colonial periods, Ethiopia is culturally and environmentally unique within the whole continent. For almost four decades of political unrest the nation has been facing challenges of large threats to sustaining food security for its almost 80 million inhabitants together with other resources scarcity. Nevertheless, Ethiopia attempts to march forward working hard for a position of the most stable country in the region.

3.1.1. Geography & Environment

Ethiopia is situated in the heart of the Horn of Africa on the Northern-Eastern side of the African continent covering the surface area of 1.104.300 sq. km between latitudes 3°30'N and 18°N and longitudes 33°E and 48° (FAO, 2011). Being an inland country, the national borders are shared with Eritrea in the North-East, with Djibouti in the East, with Somalia in the East, and South-East, with Kenya in the South. The border line in the West is shared with South Sudan while the North-Western border line demarcates the country from the Sudan. The issues of nation self-determination and borders demarcation have been still very delicate in the region. (Read on the geo-political instability in the Horn of Africa in the Box 3.A). The terrain of high plateau with the central mountain range divided by the Great Rift Valley constitute the elevation extremes of Ethiopia: the highest point of the country is the highest peak of the Simien Mountains - Ras Dejen (4.533 m above sea level) whereas the lowest point lies in Danakil Depression (125 m below sea level) (CIA, 2010) which simultaneously constitutes the lowest point in the world. The massif is divided into two plateaus: the Central Ethiopian and Galla-Somali plateaus. Many of the rivers have cut deep valleys; some of them are up to 600 m below the level of the plateau. The tropical monsoon climate is subjected to wide topographic variations from arid to humid, which is reflected by diverse vegetation formations. These range from the dry to very dry bush lands in the arid and semi-arid areas of the North-East, East and South to the tropical rain forests in the Southwest and the cloud forests on the eastern brows and mountains (Lakew, 2010), there is less than 3% of the country surface currently forested (Bekele & Hailemariam, 2010). Great Rift Valley is still geologically active, which increases the likelihood of earthquakes and volcanic eruptions. Other natural hazards which are threatening the country apart from volcanism

Box 3.A

Political instability in the Horn of Africa

Ethiopia inhabits a difficult neighbourhood (WB, 2008). The newly established Republic of South Sudan proclaimed independence after referendum in July 2011, joining the United Nations and the African Union in the same month. Being a post-conflict country with constant tensions with its northern neighbour Sudan may result in numerous humanitarian and political issues, possibly involving the neighbours such as Ethiopia. Almost 50% of Ethiopian borderline with Somalia is shared with an unrecognized self-declared sovereign state called *the Republic of Somaliland*, which is internationally recognized as an autonomous region of Somalia even though it seeks self-determination. The independence from the rest of Somalia was declared in 1989 after the collapse of the central government. The government of Somaliland has informal ties with some foreign governments; however, its self-proclaimed independence stays internationally unrecognized. Since the political situation in both neighbouring countries Somalia and South Sudan does not provide an easy judgement and the conditions are even life-threatening due to famine and/or political unrest Ethiopia faces inflows of refugees particularly close to boarders with those countries. Refugee camps are maintained with huge assistance of international organizations. The on-going long-term dispute on borders with Eritrea in the presence of troops at both sides of the border also does not contribute to stability in the region.

are especially frequent droughts followed more often by floods with erratic tract. These climate change impacts have already brought many challenges because of country's low adaptive capacity and heavy livelihood dependence on climate (Edwards, 2010).

The population pressure contributes significantly to environmental degradation, namely to deforestation, overgrazing, soil erosion, desertification and water shortages caused by water-intensive farming and poor management (ibid). The Intergovernmental Panel on Climate Change (IPCC) defined three most vulnerable sectors in Ethiopia as: (1) food security, (2) water resources, and (3) health (Amsalu & Gebremichael, 2010). Considering the access to water resources, since the whole coastline along the Red Sea was lost for Ethiopia due to Eritrea independence in 1993, the key water source is the Blue Nile (Abay river) rising in Lake Tana in North-West of Ethiopia. The Government of Ethiopia has launched the construction of the Grand Renaissance Dam across the Blue Nile River in the North-West. Designed to be the largest hydroelectric power plant in Africa, the dam is supposed to supply more than 5.000 megawatts of power and to cost over $ 4.7[55] billion aiming to supply neighbouring countries (Aljazeera, 2011). However a very limited assessment of environmental and human costs was realized (PAESTA, 2011). There have systematic attempts occurred to negotiate with upstream countries, especially with Egypt to revise colonial treaties which entitle Egypt to almost two thirds of the Nile's water flow (Aljazeera, 2011).

3.1.1.1. Land & Agriculture

Directly related to water access, there is an issue of land cultivation and agricultural production which is heavily dependant on precipitation complemented by irrigation (Amsalu & Gebremichael, 2010). Since rain fed agriculture and pastoralism sustain livelihood for the vast majority of Ethiopian population, the issue of access to land has remained sensitive. There is only 10% of the Ethiopian surface covered by arable land (CIA, 2010) while Bekele & Hailemariam (2010) state that over 50% of Ethiopian arable land has been seriously degraded by erosion, which enormously decreased the soil fertility and consequently the final agricultural production. They indicate continuous removal of nutrients without any replacement in combination with steep terrain, large areas of slopes coupled with the high intensity of rainfall during the rainy season leading to accelerated soil erosion (Bekele & Hailemariam, 2010).

Due to increasing human and livestock population pressure on arable land and forest resources large areas of the country, especially in the northern and central highlands, have highly degraded land where the soil has lost its fertility and there is an overall ecological imbalance (ibid). It is important to point out that land is a non-tradable commodity in Ethiopia: it is state-owned and allocated to peasants by local councils and they cannot buy it or sell it[56] (Dercon, 2006). There are three agricultural systems for food production defined in Ethiopia: (1) the smallholder farming system, (2) the pastoral nomadic system, and (3) the commercial farming system (CSD, 2002). Even though agriculture is a major domain of rural areas of Ethiopia, as Edwards (2010) mentions urban agriculture is gaining popularity and support from local authorities, however, there is a great shortage and degradation of urban green areas (Edwards, 2010). Summarizing the environmental assets of Ethiopia, it could be said that despite its natural endowment, Ethiopia is trapped in a vicious downward cycle of land resources degradation and poverty. The population growth and lack of appropriate farming methods for smallholder farmers are the major driving forces compelling farmers to cultivate land unsuitable for annual crop cultivation in rural areas.

3.1.1. Administration & Governance

On 24th August 1995 Ethiopia adopted a new constitution that established the *Federal Democratic Republic of Ethiopia*. The republic is structured along the lines of bicameral parliament with the *Council of Peoples' Representatives* being the highest authority of the federal government while the *federal council* represents the common interests of the nations, nationalities and peoples of the states. Members of both councils are elected by universal suffrage for a five-year term (MoFA, 2010). Federal Democratic Republic of Ethiopia is constituted by nine ethnically-based regional states[57] and two self-governing city administrations: Tigray, Amhara, Afar, Gambella, Benishangul-Gumuz, Somalia, Southern Nations, Nationalities & People (SNNPR), Harari, Dire Dawa (city administration) & Addis Ababa (city administration), which is simultaneously the capital. Lower administration units called *woredas* (urban administrations) form each regional state. There are almost 700 *woredas* in Ethiopia (WB, 2008a) albeit their number has been changing constantly. The lowest administrative unit in Ethiopia is *kebele* (village), which usually constitutes approximately 5.000 inhabitants. The number of kebeles also fluctuates due to merging or new divisions. Apart from the federal government & the parliament, each region has its *regional council*. Council members representing each woreda are directly elected. Those councils have legislative & executive authority, *regional bureaus* hold administrative functions. In each regional state a *cabinet* with a *regional president* hold an executive function. This trilateral system is performed at woreda level as well. There is a *woreda council* consisting of directly elected representatives from each *kebele*, holding an executive function and preparing the *annual woreda development plan & budget*. There are *woreda sectoral bureaus* and lastly, there is a *woreda cabinet* derived from elected representatives & heads of sectoral offices. Urban administrations have in principal the same status as *woredas* although their daughter cells – *municipalities/towns* do not have the *woreda status* and they belong under their jurisdiction[58] (WB, 2008a). *Kebele* administration constitutes more simple structure with an elected *kebele council*, an *executive committee* and a *social court.* Kebele council together with the executive committee prepares *an annual development plan* (ibid). Since this thesis data collection period was executed primarily at *kebele* level, read more detailed information on structure of a kebele in the Box 3.B.Considering the modern history of Ethiopia, the 20th century was represented by modernization, the fall of monarchy, sudden political turbulences, constant civil unrest and violence, military dictatorship, severe living conditions including hunger and restrictions of civil rights and constitution of a federation with multiparty political system with development as the leading agenda. For general overview of Ethiopia's governance between 2000 and 2006 according to the WB, see the Appendix C3.

Box 3.B

The Structure of *Kebele*

The kebele council represents the neighbourhood consisting exclusively of political parties members. The administration is subjected to seven or eight members of kebele executive committee, elected by the kebele council. There are other kebele officials who are supervised by a kebele manager. Kebele officials make referrals for secondary health care, determine the eligibility for food assistance, and provide recommendations for jobs & educational opportunities. They are also in charge of distribution control of state subsidies such as credit, seeds, fertilizers and other agricultural inputs. Community social courts which are under the kebele administration supervision deal with minor claims & disputes. Somewhere there has been local security ran to maintain order. Citizens must seek the kebele officials for various administrative functions, including any kind of government documentation. If the kebele authorities do not consider a citizen favourably, daily life can be more than difficult (HRW, 2010; fieldwork, 2011).

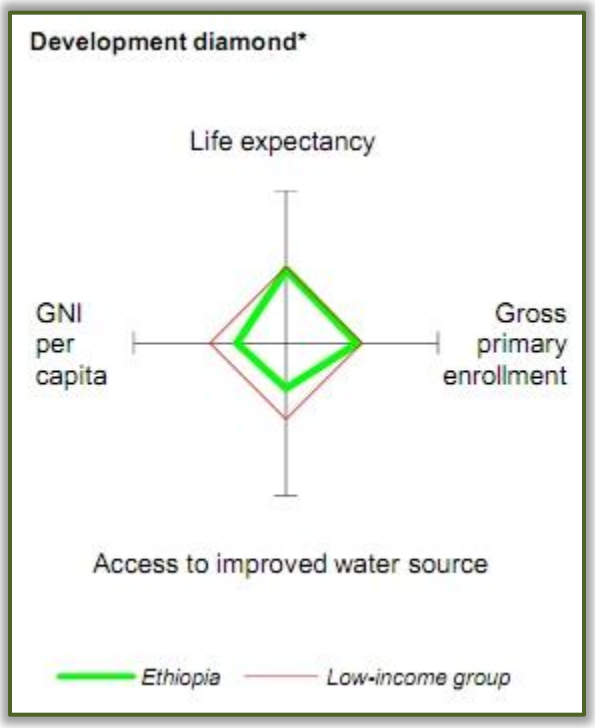
[57] *Killoch*, in singular *kilil*

[58] WB (2008) estimates that increasing number of municipalities might seek to become urban administrations with *woreda status* in the future.

3.2. Socioeconomic Situation

3.2.1. Poverty and Development

Figure III.B: The WB's 'Development Diamond' for Ethiopia



Source: WB, 2011a

All standard measures of poverty identify Ethiopia as one of the poorest countries in the world. The country has one of the lowest per capita GNI - $ US 330 in 2009 (WB, 2011a); and a large proportion of the population - 39% - lives below the international poverty line of PPP $ US 1.25 a day[59]; additionally, there was 72.3% living in severe poverty (UNDP, 2011). The severity of poverty in the country is clearly reflected in terms of short life expectancy at birth, high levels of maternal and early childhood mortality rates, poor basic health service coverage and extremely low access to safe drinking water and sanitation facilities (Alemu et al., 2011). Only a little bit more than half of the Ethiopian population (53.8%) has access to safe drinking water (UNDP, 2011). Mean of the schooling years was 1.5 years[60] in 2010 (ibid). Overall Ethiopia ranks 174th place in the *human development index* (HDI) ranking out of 187 countries included in *Human Development Report* calculations which attributes it the low level of human development. Figure III.B summarizes Ethiopia's development outputs in so-called 'development diamond' defined by the WB. The diamond shows four key indicators in the country compared with its income group average (which is low-income group to Ethiopia). Summarized by Abdella (2008) Ethiopia's poverty situation could be described as self-reinforcing mechanism of numerous poverty dimensions with various implications on development. It ranges from macroeconomic policies, socio-political history, environmental threats or traditional cultural patterns disempowering women. Let us explore two of the most relevant dimensions even though it is often difficult to make a clear distinction between various non-income poverty dimensions since especially the health and gender dimension of poverty are closely interrelated. Since the reproductive health dimension of poverty is a cross-cutting issue of the whole thesis, it is not presented in this poverty & development overview but separately in the following sub-chapter.

3.2.1.1. Macro & Micro Economic Dimension

The economic dimension of poverty refers to material deprivation, lack of access to goods and services, measured in terms of income and consumption as indicators (Alemu et al., 2011). Considering the macroeconomic perspective, it has to be mentioned that Ethiopia has been experiencing 'an unprecedented spell of economic growth' (WB, 2008) even though accompanied by growing economic imbalances. For more than four years (period 2004-2007) the average growth of GDP fluctuated around 10%, it is estimated that between 2009 and 2013 the growth is about to declare 6.5% (WB, 2011a). Yet given the extremely low GNI per capita, the country remains one of the poorest in the world, underscoring the urgency of accelerated growth and development on sustained basis (WB, 2008). Almost 10% of the country's GDP ($ US 837 million) has been constituted by 2010 remittances generated by the 1% diaspora population

[59] According to the nationally defined poverty line there were 38.9% of Ethiopians living between 2000 and 2009.
[60] This indicator applies to average number of years of education received by people ages 25 and older converted from education attainment levels using official durations of each level (UNDP, 2011:130).

(Nazret.com, 2011). The economy faces several risks such as inflation, which causes a significant increase in food prices and in the cost of living consequently (The Reporter, 2011a). The government experiments from time to time with food trading anti-competitive practices which mostly brings the bloom of black market and shortages of basic food items in secondary urban areas in particular[61]. Pro-poor spending has been indicated by the WB (2008) as high and increasing, constituting the highest efforts amongst low-income countries while spending 14.6% of GDP on poverty reduction in various sectors (WB, 2008).

Household's final consumption expenditure represented 87.7% of GDP in 2009 (WB, 2011). Agriculture accounts for 50.7% of GDP (WB, 2011a) and nearly for 85% of the population's employment (WB, 2008). In the microeconomic context, smallholder agriculture & pastoralism provide livelihood to the entire rural population. Chronic poverty especially in rural areas was found to be significantly correlated to 'household and community assets', such as the ownership of land, a certain level of education, the distance to towns with physical infrastructure access and the access to credit (Alemu et al., 2011).

The fundamental livelihood assets to the rural households are land and stock, which together with labour availability, land and livestock ownership basically determine food security and poverty status of a household (ibid). Estimated annual income for rural households from crop production, livestock breeding and non-farming activities was averaged to 6.805 Birr[62] (approx. $ US 709) in 2008 (Alemu et al., 2011), which does not reflect Ethiopia's vulnerability to income and asset shocks. Both urban and rural households' incomes fluctuate strongly and since there is very limited scope for insurance, household consumption and poverty vary considerably over time (Bigsten & Shimeles, 2008). Given the reliance of the majority of the population on agriculture, Ethiopia needs to raise productivity of agriculture to broaden the base of growth; however, the productivity in this sector has not grown significantly, leaving the large number of households chronically dependent on food assistance. According to the WB's estimate (2008) there was 8.3 million of Ethiopians yearlong dependant on food security programmes in 2008.

Lost economic opportunities remain in Ethiopian youth and women. A rapidly growing number of young Ethiopians with secondary school education face long-term unemployment. Women still remain in a disadvantaged economic position despite significant progresses at the policy, laws and regulation level (AMREF, 2010). If the country is not able to engage these two population segments in more productive economic activities, the waste of resources, loss of growth and possible social tensions might be the result (WB, 2008).

3.2.1.2. Gender Dimension

As mentioned, women's participation in the Ethiopian economic sphere is narrow and largely constricted to (unpaid) domestic work and low-paid manual jobs in informal sector which makes them dependant on men for economic support of themselves & their households (MOWA et al., 2010). Women's burden of domestic duties and caring for the vulnerable members of the family (the young, sick and elderly) competes with their capabilities to invest in themselves and to undertake a paid job (ibid). As mentioned above, Ethiopian economy is agriculture-based, nonetheless, the majority of agricultural holders are men, which counts for great diversity in agricultural holdings. Only 19% of women own land (ibid) which constitutes one of the crucial livelihood assets as mentioned above. Moreover, many of these women land-owners are forced to rent their property to men since there are still some traditional restrictions still in

[61] The researchers have witnessed the application of *price caps impositions* on sugar, oil and bananas which had devastating implications on both households and retailers whilst enormous extreme rice in prices.
[62] 1 Birr equals approximately 0.01 Euro

place[63]. As obvious, women and girls are at a distinct disadvantage in relation to a range of indicators including health, education, livelihoods, participation in civic affairs, and leadership compared to men and boys in Ethiopia. *Gender development index* (GDI) measuring the women's empowerment in the country[64] had the ranking of 142nd place out of 156 countries (MOWA et al., 2010). A significant portion of Ethiopian households are headed by women, precisely 27% in the whole Ethiopia and 39% in urban areas (MOWA et al., 2010), which adds burden to the women who head these households and presumably mainly contribute to economic sustenance of the household.

Women's educational attainment level lags behind men's educational attainment level to an enormous extent. According to 2011 EDHS (ICF Macro & CSA, 2011), 50.8% of Ethiopian women in reproductive age (15 - 49 years) have no education[65] compared to 29.5% of men of the same age group. Significant disparities also remain also in higher educational levels (i.e. 7.3% of men have more than secondary education compared to 4.4% of women with the same educational background). Considering the percentage of the population who can read & write (full literacy), in all Ethiopian regions there were only 35.5% of fully literate women between 15 and 29 compared to 59.9% of fully literate men of the same age (MOWA et al., 2010). Women also represent the majority of internal migrants, migrating especially for family reasons such as marriage or accompanying other family members whereas men migrate mostly for work and/or schooling. Although not yet supported statistically, many young women migrate to the Middle East searching domestic working jobs which may even worsen their situation (MOWA et al., 2010).

The 2005 EDHS[66] (ORC Macro & CSA, 2006) detected high levels of acceptance of gender-based violence – i.e. 80% of Ethiopian women and 50% of Ethiopian men believed that there are circumstances in which wife beating is justified (MOWA et al., 2010). However, few micro studies in Ethiopia have measured actual levels of gender-based violence (Population Council & UNFPA, 2010) even though the 2005 EDHS states that domestic violence is "a common phenomenon in Ethiopia" (ORC Macro & CSA, 2006:244). Excluding the enormous burden of sexual and reproductive health mortality and morbidity[67] and feminization of HIV/AIDS epidemic, the health and nutrition status is also considered as gender-imbalanced in Ethiopia. According to 2011 EDHS (ICF Macro & CSA, 2011) 17% of Ethiopian women suffer from any type of anaemia[68] compared to 11% of men. There are again huge regional disparities: there were fewer than 10% of anaemic women in Addis Ababa whilst the prevalence level of anaemia for Somali women was 44% (ibid). Ethiopian women are also the most undernourished segments of the population, one of every four women of reproductive age (26%) suffers from under nutrition, twice the Sub-Saharan average of 13.3% (Bitew & Telake, 2010).

Examining the women's participation and leadership, Ethiopian women have traditionally limited power and decision-making. The absence of women from political life and leadership undermines their ability to influence matters that affect their lives, health and well-being. Very little is known about the decision-making power of Ethiopian women[69], however, the 2005 EDHS (ORC Macro & CSA, 2006) revealed that only 45% of rural Ethiopian women are able to decide on health care of their children when those are seriously ill. Ethiopian women are underrepresented in positions of leadership and decision-making in both public and private sectors (MOWA et al., 2010): out of 526 seats in the Ethiopian Parliament, only 116 are held by women; in the 2005 parliamentary elections there were only 14.7% women out of all candidates registered; in the case of regional elections women constituted 22% of all candidates in 2005 (ibid).

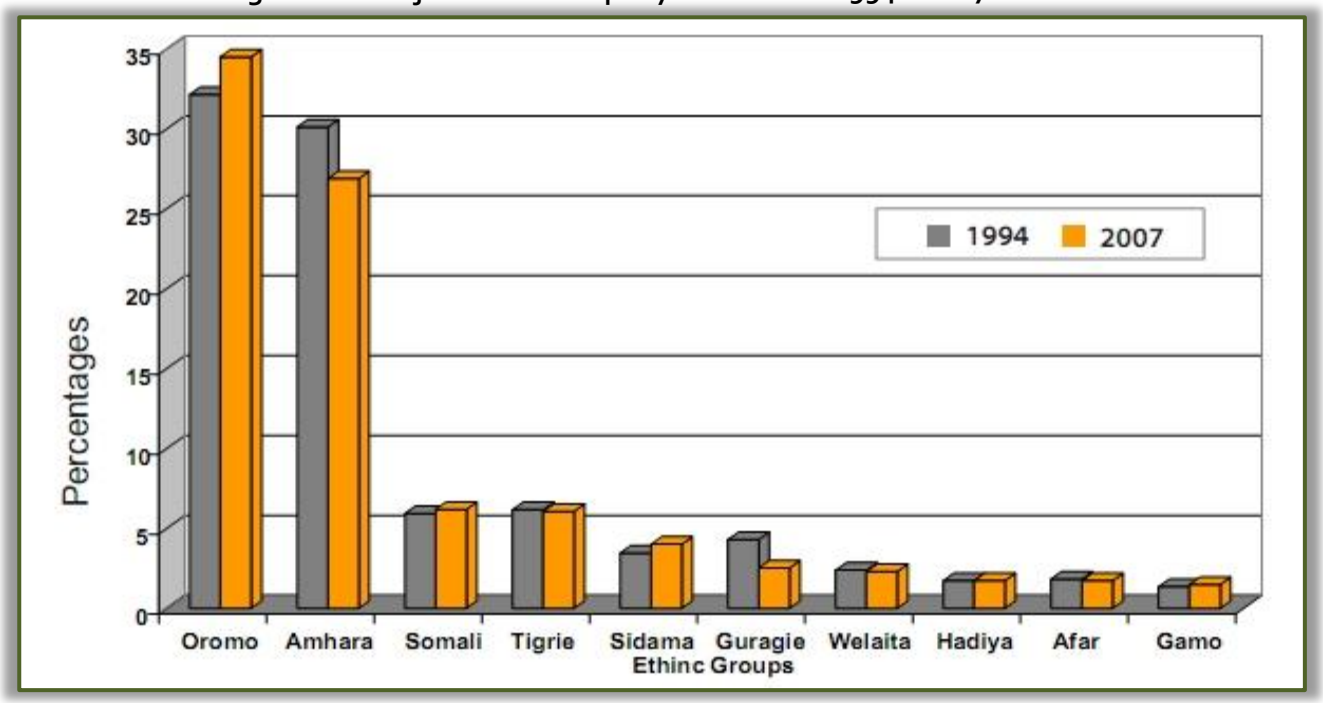
[63] For instance, traditionally women are not supposed to plough, they can only work with hoe (MOWA et al., 2010).
[64] Combining measures of life expectancy and education
[65] Education level stated in EDHS carried on in Ethiopia mostly refers to the highest level of education attended not to the highest level of education completed. This might be a source of the data bias.
[66] The 2011 EDHS was published at the beginning of October 2011 in a form of *preliminary report* therefore some indicators were not yet available at the momentum of writing this thesis.
[67] This issue will be specified in a separate sub-chapter focused on RH in Ethiopia
[68] EDHS distinguishes between mild, moderate and sever type of anaemia
[69] See the study of Haaij (2011) on decision making & women's autonomy in reproductive health seeking behaviour in Bahir Dar Special Zone, Amhara

A 2006-2007 the Federal civil service reported that among 28 ministries only 2 were women-held and among 39 state ministries only 6 were women. In the judiciary system over the country the number of women judges in federal and regional courts was limited to 16.9% in 2004 (AMREF, 2010).

3.2.2. Demography

Ethiopian population has been steadily increasing since the turn of the 20th century. It took 60 years to double from 11.8 million in 1900 to 23.6 million in 1960 but only 27 years to double again and reach 47.2 million in 1987 (Bekele & Hailemariam, 2010). The rate of population growth increased from about 2.2% annually in 1960s to a peak of 3% in the late 1980s and mid-1990s. Implicitly the population increased by more than three times in 1960 reaching 73.8 million in 2007 (ibid). See the trends of growing population size in Ethiopia in the Appendix B3. Considering the fact that the last census took place in Ethiopia four years ago (2007), there should be estimations for the total current population size mentioned. Several well-respected institutions have published the following figures: a) WB (2011): 82.8 million in 2009 with annual population growth 2.6%; b) UNFPA (2011) 84.7 million in 2011 with five years growth of 2.1%; c) PRB (2011): 87.1 million in 2011 with the annual population growth of 2.7%. Even though the population growth of Ethiopia has been stagnating or slightly decreasing, it is projected by BUCEN (2009) that the population will have exceeded 160 million by 2030. The vast majority of Ethiopian population live in rural areas (84%) since the country has one of the lowest urbanization rates (16%) in Sub-Saharan Africa, though the percentage of urban population has slightly increased since the previous census in 1994 (CSA, 2008). This trend is supposed to continue. Considering the ethnic structure of Ethiopia, albeit there were more than eighty ethnic groups listed in the 2007 census (CSA, 2008), only 10 ethnics out of these have exceeded the million population figure. The most populous ethnic groups are: (1) Oromo – 34.5% of the total population, (2) Amhara – 26.9% and, (3) Somali – 6.2% (CSA, 2008). Figure III.C summarizes ten most populous Ethiopian ethnic groups and their percentage distribution out of the total population while comparing the figures with census from 1994[70].

Figure III.C: Major Ethnic Groups by Distribution 1994 & 2007



Source: CSA, 2008

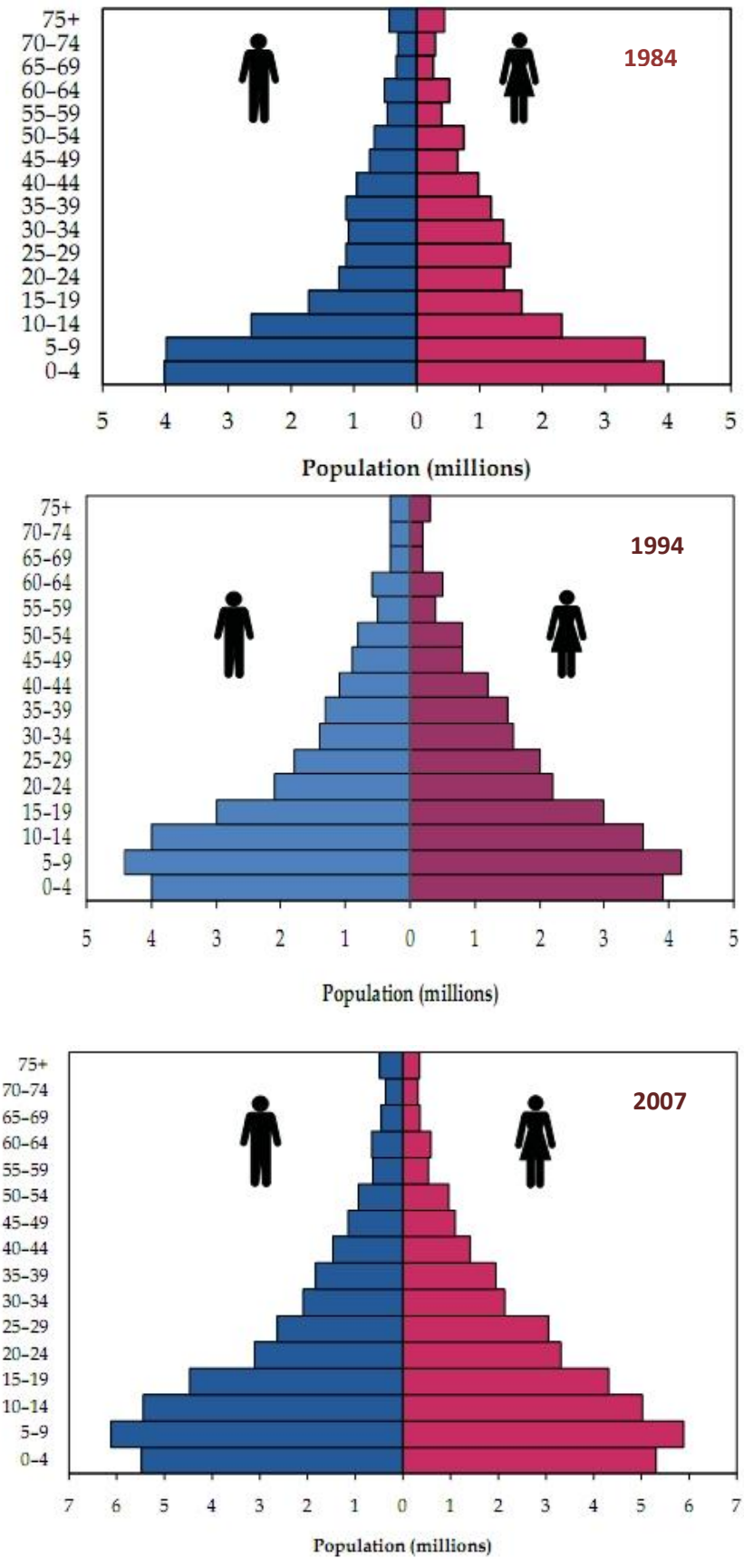
[70] Other ethnic groups which did not exceed the threshold of 1 million were excluded from the total figures by CSA

Religious structure of Ethiopia is diverse though with two major beliefs (CSA, 2007): the most numerous religion is Orthodox Christianity with 43.5%, followed by Islam with 33.9%. Another populous religion is Protestant Christianity represented by 18.6%. Traditional beliefs have 2.6% adherents; Catholic Christianity is a minor belief with 0.7% of the total population.

Ethiopian population is young. Bekele & Hailemariam (2010) clarify that a population is considered young if a the median age lies under 20 years, the proportion of children under 15 years is more than 40% and the proportion of elderly (65 years and above) is less than 5%. All those characteristics apply to Ethiopia, if we take into account the last population & housing census in 2007 (CSA, 2008), when median age was 17.1 years, population under 15 years represented 45% of the total population[71] and only 3.2% lived longer than 65 years (ibid). To compare the population age & sex structure more in depth, please see Figure III.D presenting the population pyramids of Ethiopia for the years 1984, 1994 and 2007. CSA (2008) reflects the difficulties to obtain some reliable data on age in Ethiopia and other low-income countries, taking into account the illiteracy, which limits the individual's awareness and capacity to record one's children's age and/or one's own age. The civil registration system for vital events (births & deaths) is not yet in place which also plays a significant role in obtaining population data on age (Bekele & Hailemariam, 2010).

As obvious, the pyramids are wide at the bottom and narrow rapidly with increasing age. That indicates high birth and death rates with low life expectancy. Life expectancy calculated for Ethiopia by UNDP (2011) in the latest *Human Development Report 2011* states 59.3 years for both sexes, if we highlight the disaggregated data calculated by UNFPA (2011) life expectancy for men is 58 years whereas a girl born this year would live for 62 years, which is a bit more optimistic comparing to WHO's (2011) statistics for 2009: 54 years both sexes, 53 years for males and 56 years for females. The type

Figure III.D: Population pyramids of Ethiopia: 1984, 1994 & 2007



Source: Bekele & Hailemariam, 2010

[71] UNFPA (2011) states for the year 2011 that median age in Ethiopia is 18.7 years while representing 50% of the total population

of all three population pyramids presented in Figure III.D is characterised as *expansive* and it is related to the *demographic transition model* (Korenjak-Černe et al., 2008). As Bekele & Hailemariam (2010) remind, the pyramids are typical for low-income countries' populations where further and rapid population growth is to be expected. The rapid population growth, attributed mainly to the high fertility rate in the country is one of the major issues for sustainable development in Ethiopia (CSD, 2002). Even though there has been a considerable decline in the total fertility rate (TFR) in the last two decades, the overall population growth is still predicted to be rapid for many decades even after birth rates have declined. This counts for the last decade as Table a3 illustrates. It compares TFR throughout the years considering the residence, wealth and education.

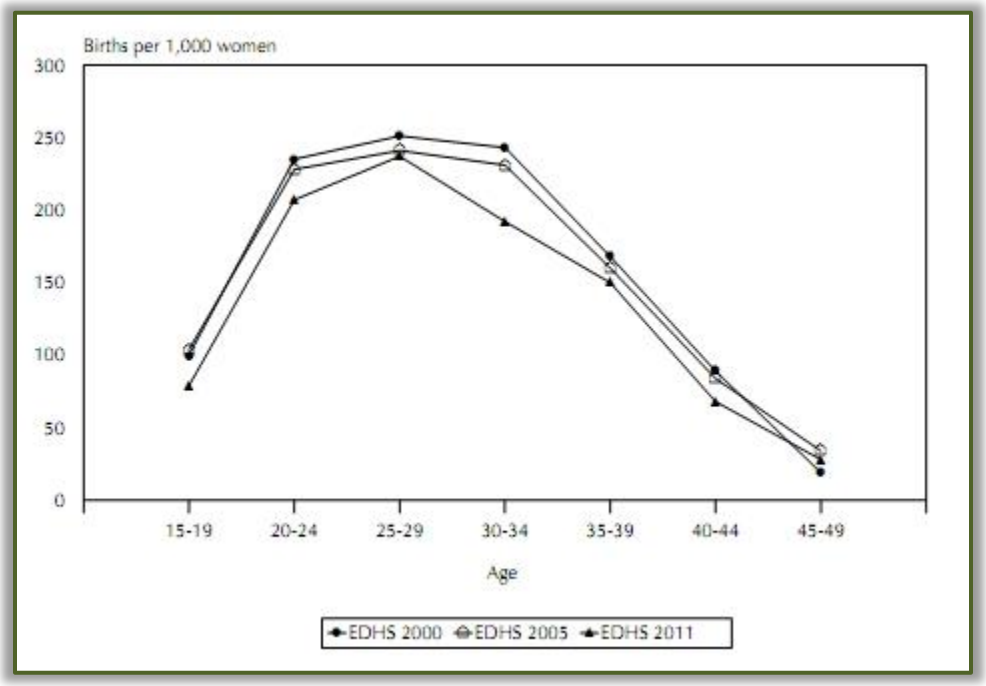
Table a3: Total fertility of Ethiopia according to selected characteristics in selected years

Year	Residence		Total	Wealth*		Education		Source
	Rural	Urban		Rich	Poor	None	Secondary ≤	
2011	5.5	2.6	**4.8**	N/A	N/A	N/A	N/A	EDHS
2005	6.0	2.4	**5.4**	3.2	6.6	6.1	2.0	EDHS
2000	6.4	3.3	**5.9**	--------	--------	6.1	3.1	EDHS
1990	6.9	3.5	**6.4**	--------	---------	------	----------	NFFS

Sources: CSA & ICF Macro 2011;CSA & ORC Macro 2006; CSA & ORC Macro 2001 & CSA 1993;
* defined as the highest/lowest wealth quintile; ----- was not measured

The table gives a clear indication that determinants such as type of residence, income category or education level highly influence the access to family planning services and the total fertility rate consequently. The major gaps are enormous especially concerning the level of education and income. EDHSs carried out in Ethiopia often distinguish between age-specific fertility among women in reproductive age (15-49). EDHS 2011 (CSA & ICF Macro) specified that the highest birth rates are among women between 25 and 29 years (158 births per 1.000 women) whereas the age group with the lowest fertility rate is between 40 and 44 years (ibid). See the trends in the age-specific fertility rates throughout the last decade in Figure III.E.

Figure III.E: Age-specific fertility trends 2000, 2005 & 2011



Source: CSA & ICF Macro, 2011

Fertility preference is closely related to the number of living children. 55% with no living children want a child soon, compared with 7% of women with six or more children (EDHS, 2011). Although fertility trends and its determinants almost belong to reproductive health indicators, it attributes an important demographic exponent; therefore it is presented in this demographic subchapter. Other relevant indicators related to population trends will be presented in a separate subchapter describing maternal

and reproductive health in Ethiopia. The last demographic indicator presented in this sub-chapter is under-5 mortality[72]. The overall under-5 mortality rate for the period 2006-2010 has been 88 deaths per 1.000 live births. Majority of all under/5 children deaths (67%) occur before the child's first birthday (CSA & ICF Macro, 2011). See the table b3 for general overview of decrease in early childhood mortality in Ethiopia between 1996 and 2011.

Table b3: Trends in Early Childhood Mortality between 1996 and 2010

Period	Neo-natal mortality*	Infant mortality*	Child mortality**	Under-5 mortality*
2006-2010	37	22	31	88
2001-2005	48	40	49	133
2000-1996	54	47	72	166

Source: Adopted from CSA & ICF Macro, 2011; **calculated for 1.000 children surviving 12 months of age,* expressed for 1.000 live births

The country has accelerated its updating of policies that affect the demographic transition, including the *1993 National Population Policy* (NPP), which turned to be quite revolutionary at that time. NPP was one of the first population policies in Africa (Bekle & Hailemariam, 2010). The major goal of this policy was to recognize the rate of population growth and the capacity of the country for further development while reasonable utilization of its natural resources. In order to achieve this goal, five main policy objectives were set (ibid):

I. Closing the gap between the high population growth and the low economic productivity through planned population growth reduction and increasing economic revenues;
II. reduction of rural-urban migration;
III. improving the capacity of the environment by taking appropriate protection and conservation measures
IV. raising the economic and social status of women by freeing them from the restrictions of traditional life while enabling them to participate productively in the larger community;
V. significant improvement the social and economic status of vulnerable groups like women, youth, children and the elderly.

NPP has given a special priority attention to reproductive health service delivery (quality and scope), population research (data collection & dissemination) and the expansion of IEC activities and social mobilization (Bekele & Hailemariam, 2010). NPP defined in 1993 has been more than visionary and many of its policy objectives and priorities serve as a 'road map' even more than 18 years after its launch addressing issues such as population pressure on the environment as mentioned at the beginning of this chapter. Since the population activities are multi-sectoral, they attempt to be complementary with sector policies such as *the National Health Policy (NHP)* and the *National Policy on Women*, both launched in 1993, too. More recently, the *2006 National Reproductive Health Strategy* and the *2006 Poverty Reduction Strategy (PASDEP)*[73]have been implemented. The main demographic policy issues are related to acceleration of fertility transition in rural areas and shortening the time lag so that the population growth rates decrease, which would overcome one of the major obstacles towards poverty alleviation (Teller et al., 2008).

[72] There are several sub-categories in the category so-called '***early childhood mortality***': 1) *neo-natal mortality* – the probability of dying within the first month of life; 2) *infant mortality* – the probability of dying before the first birthday, 3) *child mortality* – the probability of dying between the first and fifth birthdays and, 4) *under-5 mortality* – the probability of dying between the birth and the fifth birthday.

[73] The National Health Policy (NHP) and the Reproductive Health Strategy (NSRHS) together with the Plan for Accelerated & Sustained Development to End Poverty (PASDEP) and its successor Growth & Transformation Plan (GTP) will be presented below

3.3. Reproductive & Maternal Health

3.3.1 Women's Burden

Women in Ethiopia face extreme challenges to their health and well-being. Health challenges include unintended pregnancies or unwanted pregnancies, unsafe abortion, maternal complications and death, sexually transmitted diseases (STIs) including HIV/AIDS and gender-based violence. Women bear the burden of sexual and reproductive health morbidities and mortality partially because of their child-bearing roles and mainly because of limited access to quality health services. The total fertility rate still indicates high number of children Ethiopian women have during their lifetime (assuming they complete their reproductive years).

Childbearing is often a life threatening experience to majority of Ethiopian women putting at risk their lives during the process of having a child (MOWA et al., 2010). High maternal mortality ratio (MMR) of 673 deaths per 100.000 live births considered as one of the highest in the world (Tesfaye, 2010) represents a serious risk that Ethiopian women challenge any time they give birth. Childbearing-related complications such as untreated obstetric fistula plaguy endanger life and health of estimated 100.000 women with other 9.000 who develop fistula each year (ibid). Obstetric fistula is frequently related to early marriage[74] which in women's case highly overlaps with sexual initiation and frequent unprotected sexual activity (MOWA et al., 2010) soon leading to early pregnancies with high risk of maternal morbidities. According to the same source, about 1 in 5 Ethiopian women are married by their 15th birthday with much higher prevalence in rural areas – more than 20% married before reaching the age of 15 with significant regional disparities (ibid). Concerning other HTPs in Ethiopia, it is estimated that there were 74% of Ethiopian women have undergone a form of FGM/C in 2005 (Population Council & UNFPA, 2010), indeed characterised by regional differences – e.g. in Somali 84% of women experienced FGM/C in 2005, mainly infibulation (ibid). AMREF (2010) indicates that overall support for the FGM/C practice has declined from 60% in 2000 to 31.4% in 2005. 52% of Ethiopian mothers with at least one daughter had a daughter circumcised compared to 38% of mothers in 2005 (AMREF, 2010).

Women's economic dependence and/or limited self-autonomy often results in their inability to access health care without the financial and/or moral support of their partner (ibid). However, many barriers are recognized to be supply-side-related. According to ORC Macro & CSA (2006) the most common obstacles in accessing health care identified by women in reproductive age in 2005 EDHS have been: a) a concern there may not be a health provider (80.5%); b) getting money for the treatment (75.6%); c) concern there might not be a female health provider (72.5%); d) the necessity to take a means of transport (72.6%); e) concern there may be no one to complete household chores (69.3%) and getting permission to go for a treatment (34.5%). There is also growing evidence that the access towards SR and maternal health services in Ethiopia is highly influenced by multidimensional poverty (UNDP, 2011) which was also confirmed in the 2005 EDHS highlighting the gap between the service utilization between the wealthiest and the poorest quintile of the population (ORC Macro & CSA, 2011). The access to media & information and the level of education[75] are also thought to be positively correlated with SRH utilization level (Salem et al., 2006; MOWA et al., 2010). According to the 2005 EDHS (ORC Macro & CSA, 2006) 58% of urban women had access to at least one type of media[76]compared to 12% of rural Ethiopian women.

[74] De facto child marriage, it is defined as a marriage to a person below the age of 18 defined by Ethiopian Family Law
[75] In relation to health it is sometimes called as *health literacy*
[76] Newspaper, television or radio

3.3.1.1. Family Planning

There is a considerably high level of unmet need for family planning in Ethiopia reaching 25% of currently married women in reproductive age (ICF Macro & CSA, 2011) – 16% for spacing and 9% for limiting. However, this RH indicator has scored a significant decline within the past five years – the level of unmet need constituted almost 34% for the same population group in 2005 (ORC Macro & CSA, 2006). Though there is no doubt about this significant progress, the current figure demonstrates that there has been still an important proportion of Ethiopian women who do not have control over their fertility albeit they would like to (MOWA et al., 2010). Investigating the various age groups within the reproductive age, the highest unmet need is among adolescent groups (15-19 years) reaching 33% whilst the lowest unmet need as among women in their late 40s – 15% of them would like to either space or limit their pregnancies (ICF Macro & CSA, 2011). At the regional level women residing in Oromiya regional state indicate the highest unmet need (30%) whereas female inhabitants of Addis Ababa have the lowest unmet need for contraceptives (11%).

The contraceptive prevalence rate (CPR) of currently married Ethiopian women assessed in the 2011 EDHS is 29% (ICF Marco & CSA, 2011). Out of 29% CPR only 1% of currently married women utilize traditional FP method[77]. Again, Ethiopia almost doubled the percentage of women who currently use modern FP method compared to 15% CPR in 2005 (ORC Macro & CSA, 2011). As the 2011 EDHS states while CPR among urban women increased only slightly (from 47% to 53%) in case of currently married women the increase has been substantial: from 11% to 23% between 2005 and 2011 (ibid). As it applies for the majority of population indicators in Ethiopia, there are considerable regional disparities highlighting the disproportion between the capital (63%) and regions like Afar and Somali where CPR remains below 10%. Amongst the most popular modern FP methods belong injectables (used by 21% of currently married women); implants (used by 3% of women) and IUD, which was reported by 2% of currently married women. As MOWA et al. (2010) emphasize, the family planning methods available limit women's choice. The preference for injectables may reflect their availability over other methods rather than the genuine informed choice.

3.3.1.2. Ante-natal Care

There has been a slight increase in universal ante-natal care (ANC) coverage in Ethiopia between 2005 and 2011.The proportion of women who had received at least one ANC consultation[78] was 28% in 2005 (ORC Macro & CSA, 2006) in contrast to 34% in 2011 (ICF Macro & CSA, 2011). However, the effectiveness of ANC applies for at least four visits properly timed and spaced. In 2005 there were only 12% of women who received comprehensive ANC (four or more visits) and out of this proportion only 6% visited the health provider before the 4th month of the pregnancy, the median duration of the pregnancy for the first visit was 5.6 months – at that time a woman already exceeds the half of the pregnancy period. The data about number and timing of ANC visits for 2011 were not available at the momentum of writing the thesis. As AMREF (2010) points out the further analyses on ANC coverage have to pay more attention to timing and spacing of ANC visits, not just highlighting the level of universal coverage. According to the 2005 EDHS urban area of residence, wealthier population quintile and higher level of education play a considerable role in higher levels of ANC utilization. Compared to the 2005 EDHS there is one category which is new in 2011: the percentage of women who received ANC from a health extension worker (HEW)[79]: there were 10% of women who received this care from this type of semi-trained health professional (ICF Macro & CSA, 2011). Regional disparities are also highly present in universal ANC coverage in 2011: 94% of women residing in Addis Ababa received at least one ANC consultation compared to 10% of Somali women.

[77] Rhythm, withdrawal and folk methods such as drinking herbs or others
[78] During their most recent birth 5 years prior to the survey
[79] Their role in health service provision will be described in following subchapter focused on Ethiopian health sector

3.3.1.3. Skilled Birth Attendance

Ethiopia still remains a country with vast majority of women outside health facilities at the crucial time of child delivery (Koblinsky et al., 2010). During the period of 2000-2005 only 6% of all birth giving women were assisted by a health professional[80], 28% utilized the service of a traditional birth attendant (TBA) and the vast majority – 61% delivered at home with relatives and 5% delivered alone (ORC Macro & CSA, 2011). Having a look at the EDHS 2011 data, we can observe only a slight increase: overall 10% out of all delivering women delivered with a health professional during 2006-2011, adding 0.9% of women who were assisted by a HEW. Urban-rural disparities are extreme: there were 50% of urban women's deliveries assisted by a health professional compared to 4% of all rural deliveries between 2006 and 2011. The highest rate is traditionally found in Addis Ababa where 83.9% of deliveries were attended by a health professional contrasting with SNNPR where only 6.1% delivering women were assisted by skilled health personnel (ibid). The results from the 2011 EDHS also showed that the level of education is positively correlated with the level of utilization of skilled delivery assistance. Comparing the national figures with the rest of Sub-Saharan Africa is worrisome since the indicator for births attended by skilled health personnel reached 42% already in 2004 (El-Saharty et al., 2009). Koblinsky et al. (2010), who refer to numerous small-scale researches compared to the 2000/2005 EDHS, argue that there had been no substantial improvement of this RH indicator for more than 10 years; confirming that supply-side barriers such as facility infrastructure and human resources constitute major gaps.

3.3.2. HIV/AIDS Epidemic

Ethiopia is one of the countries most severely affected by HIV/AIDS pandemic (Mesfin et al., 2010), together with Nigeria, South Africa, and Zimbabwe she belongs to the category of the largest epidemics in Sub-Saharan Africa, however, there is growing evidence that it has stabilized with signs of decrease (UNAIDS, 2010; HAPCO, 2010). According to HAPCO (2010) adult HIV prevalence estimations fluctuated between 1.4% and 2.8% in 2009; 1.8 % HIV prevalence accounted for males whereas 2.8% HIV prevalence accounted for females (HAPCO, 2010). There were about 1.2 million people living with HIV/AIDS (PLWHA), traditionally in more urbanized areas whilst only circa 33% eligible for ART. Ethiopia's epidemic pattern remains to be heterogeneous with significant regional variations. However, 1.5 times as many Ethiopian women are HIV positive compared to HIV positive men. In urban areas, over three times as many women are infected - 7.7% - compared to men - 2.4% (MOWA et al., 2010). Adult women in their late 30s and early 40s have the highest rates of HIV in the country: 4.4% of women age group 35 -39 and 3.1% of women age group 40 – 44 were HIV infected (ibid). Considering the marital status, divorced women are the most affected by HIV/AIDS: 21% of divorced urban females are HIV positive compared to never-married rural women (0.1%) (MOWA et al.,2010). HAPCO (2010) identified young females as particular at risk population due to reduced ability to control and negotiate safe sex circumstances of the sexual intercourse, including intra-marital sex (MOWA et al., 2010). As Population Council & UNFPA (2010) conclude, the younger the age group, the greater the gender imbalance in rates of HIV infection, with far greater rates among young women compared to young men - e.g. there is 3.5% HIV prevalence among 15-24 age group (HAPCO, 2010).

Regional HIV prevalence disparities are enormous: according to HAPCO & MoH estimation (2007) 9.2% of Addis Ababa residents were HIV infected in 2010, followed by Dire Dawa 4.9% prevalence and Harari 3.8% prevalence. Those areas are highly urbanized; nonetheless HAPCO (2010) identified peri-urban and small market towns residents as the recent most at risk and/or affected population segments. The increasing prevalence in smaller towns is considered as worrisome since they can serve as bridging channels of HIV spread from urban to rural areas. While gender-based

[80] Including doctors (GPs or specialists), nurses or midwives

violence and drug addictions (alcohol, chat) were considered as factors that deteriorate the spread of HIV among certain groups, widow inheritance, polygamy, high divorce and traditional skin tattooing have intensified the magnitude in some areas of the country (HAPCO, 2010). As other highly at risk groups were identified: commercial sex-workers (CSWs), long distance truck drivers, high-school & university students; further were identified migrant labourers, refugees and internally displaced persons (IDPs). Due to the combined effect of poverty and AIDS more than 5.4 million children under the age of 18 years were orphaned, 16% out of those lost at least one parent due to HIV/AIDS (ibid).

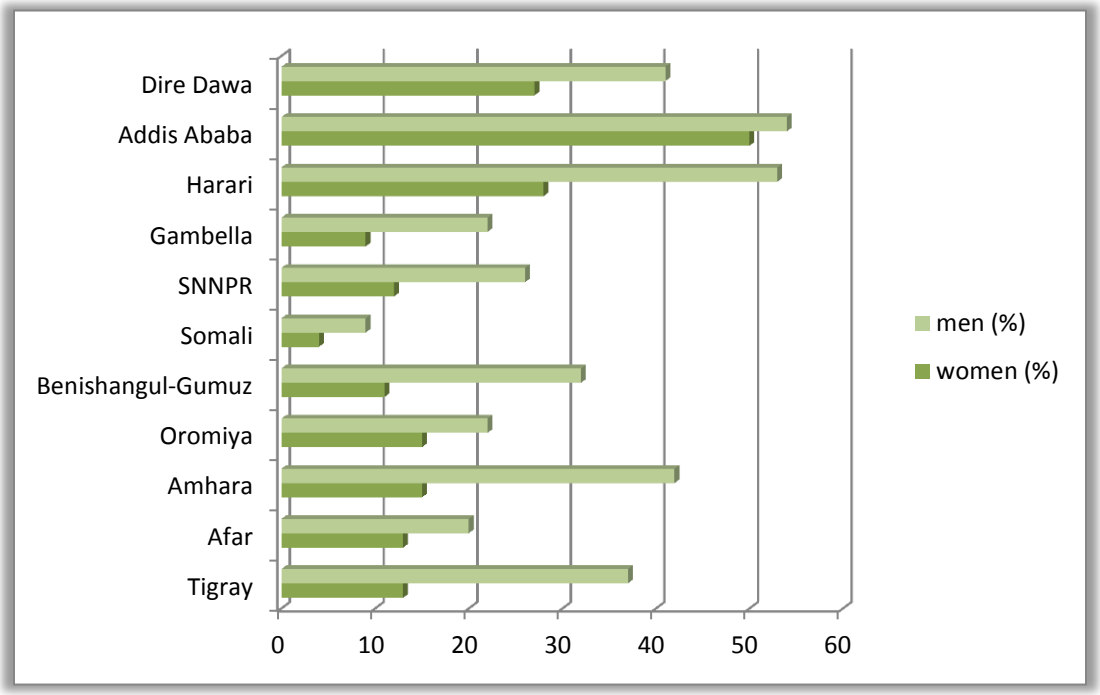
3.3.2.1. HIV/AIDS Awareness: Knowledge, Attitude and Practice

The levels of *knowledge of HIV transmission* vary both between and within at-risk groups and general population (HAPCO, 2010), MOWA et al. (2010) also report considerable gender disparities: 64% of Ethiopian men know that using a condom can help prevent HIV infection compared to only 40% of women. The same source indicates that differences in knowledge levels may be related to levels of education and access to media. As the most known method of HIV prevention reported in 2005 EDH was sexual abstinence (80% of men knowledgeable of this method compared to 62% of women), secondly limitation of sexual intercourse to one uninfected partner was mentioned - 79% of men compared to 63% of women (ORC Macro & CSA, 2006). If we take into account the *comprehensive HIV prevention knowledge* [81] (further only as 'HIV comprehensive knowledge') of the general Ethiopian population, this knowledge remains shallow (HAPCO, 2010). There were only 30% of male who had the complete comprehensive knowledge compared to only 16% of Ethiopian women according to the 2005 EDHS results (ORC Macro & CSA, 2006). The 2005 EDHS also assessed the prevalence of misconceptions about HIV transmission and AIDS. Many Ethiopians still lack accurate knowledge about the ways in which the HIV virus can and cannot be transmitted. Only 51% of women and 69% of men know that a healthy-looking person can have and transmit the virus which causes AIDS (ibid). Many women and men also enormously believe that AIDS could be spread by mosquitoes: only 47% of women and 57% of men in the 2005 EDHS rejected this misconception.

As for the results for at-risk groups 33.3% of young males (15-24 years) have the comprehensive HIV knowledge in contrast to only 20.5% of females of the same age group (HAPCO, 2010). The level of comprehensive HIV knowledge of female CSWs has proved a bit higher represented by 35.7%. The 2005 EDHS also documented a considerable variety in HIV comprehensive knowledge across regions and age groups. See the regional & gender disparities in comprehensive HIV knowledge in figure III.F. Generally concluded, the highest levels were found in Addis Ababa whereas the lowest levels of HIV comprehensive knowledge were reported in Somali. Education and wealth were also found to be directly linked to HIV comprehensive knowledge (e.g. 7% of women with no education proved to be 'HIV comprehensive knowledgeable' in contrast with 54% of those with secondary or higher education).

[81] Respondents answered correctly 5 questions examining their knowledge on virus transmission and major misconceptions

Figure III.F: Comprehensive HIV Knowledge by Region and Gender in 2005



Source: Adopted from ORC Macro & CSA, 2006

Measuring the *attitude towards HIV infected people* (further only as 'HIV attitude') is usually implemented by using standard sets of questions[82] indicating one's positive or negative attitude. Higher education, wealth, and urban residence are related to more accepting attitudes towards those who are HIV positive (ORC Macro & CSA, 2006). For instance among men, the percentage expressing positive attitude towards PLWHA in all measures exceeds 40% among urban residents with secondary and higher education of Addis Ababa, Dire Dawa or Harari. Respondents also tend to be more tolerant (with higher HIV positive attitude) towards their own relatives than towards strangers such as shopkeepers and/or teachers. Women's attitudes turned to be less tolerant – as the least tolerant group in the 2005 EDHS showed to be women from the lowest wealth quintile – only 2.5% expressed positive attitude in all 4 measures (ORC Macro & CSA, 2006).

Measuring *practice* is also categorized as *sexual behaviour* within HIV/AIDS awareness (knowledge-attitude-practice framework) and it usually refers to the assessment of sexual behaviour prior to the data collection[83]. It aims to assess the prevalence of multiple partners and high risk sexual activities in order to plan BCC programmes effectively in order to decrease HIV prevalence. This type of assessment often suffers from major shortcoming, which is often related to 'low self-report' of certain risky behaviour (i.e. having multiple partners, experiencing homosexual intercourse, etc.). This is generally more attributed to women. In the case of Ethiopian DHS 2005 the results for risky sexual behaviour were considerably low: aiming those who had sex in 12 months preceding the survey less than 1% of women in reproductive age and only 4% of men of the same age group reported two or more sexual partners during that period (ORC Marco & CSA, 2006). A little bit larger proportion of the population had a sexual intercourse with someone else than their spouse or cohabiting partner – 3% of women and 9% of men during the same period (ibid). Marital status also plays a significant role in reporting the sexual behaviour - 33% of divorced/separated/widowed men reported their

[82] 4 questions examining their willingness to buy goods from an infected person, to let an infected person continue with teaching profession, to share the HIV status of family members and to care of an infected relative
[83] In the case of the 2005 EDHS 12 months period prior to the data collection was investigated

engagement high-risk sexual encounters. Examining age-specific groups, the proportion of young women (15-24 years) reporting experiencing sexual intercourse by the age of 15 turned to be 16% (HAPCO, 2010).

3.3.2.2. HIV Voluntary Counselling & Testing (VCT)

The mapping of VCT utilization levels in Ethiopia is not easy since the 2005 EDHS only reports on general HIV testing & counselling (HCT) while not distinguishing client- and provider-initiated [84] which does not assure that the decision to get tested is entirely the choice of that individual (whether it was 'voluntarily'). The only national figures on VCT utilization the researcher had at her disposal were absolute figures of persons who utilized the VCT service collected by MoH in each regional state in 2008 (MoH, 2008). After simple percentage calculations[85] the *approximate* VCT region disaggregated utilization rates for each region in the year 2008 were acquired. Those could be found in Table c3 showing generally higher level of VCT utilization in urban areas and Tigray region.

Table c3: Approximate VCT utilization rates in 2008 by Region

Regional State	Total population in 2007 (CSA)	Estimated total population in 2008 - 2.1% annual population growth considered	VCT clients tested in 2008 (MoH)	% of VCT clients out of the total population
Tigray	4 314 456	4 405 060	562 004	1.76
Afar	1 411 092	1 440 725	91 626	6.36
Amhara	17 214 056	17 575 551	1 401 241	7.97
Oromiya	27 158 471	27 728 799	1 274 640	4.60
Somali	4 439 147	4 532 369	77 266	1.70
Benishangul Gumuz	670 847	684 935	31 474	4.60
SNNPR	15 042 531	15 358 424	757 103	4.93
Gambella	306 916	313 361	7 977	2.55
Harari	183 344	187 194	24 110	12.88
Addis Ababa	2 738 248	2 795 751	260 834	9.33
Dire Dawa	342 837	349 694	44 331	12.68
Special Enumeration	96 570	98 598	27 448	27.84

Source: Calculated from CSA (2008) and MoH (2008) data by author

Bradley et al. (2008), who carried out a research in Ethiopian private not-for-profit health facilities providing VCT, distinguish between *situational reasons* when a user comes for pre-martial testing, travel/visa requirements or PMTCT; and *self-initiated reasons* when a user is only eager to 'know her/his health status'. Ideally a typical single visit includes pre-test counselling, HIV testing itself, HIV prevention counselling, delivery of test results and post-test counselling. In both pre-test and HIV prevention counselling, the client is offered condoms during post-test counselling and receives

[84] The main difference will be explained in the chapter describing health service provision in Bahir Dar Special Zone

[85] The 2007 census population figures for each regional state calculated with the 2008 MoH figures, considering the annual population growth of 2.1%.

information how to negotiate condom use. The demonstration of correct use should also take place; otherwise the user should be at least informed about the location and services of the nearest family planning facility where can she/he can obtain information on correct condom use (FHI, 2007). According to MoH (2008) there were 1.336 health facilities providing HCT services compared to 719 providing PMTCT services and only 353 facilities offering ART services in 2008.

3.4. Health Sector

General environment of Ethiopian health system is influenced by 'primary strategy' – *decentralization* in the form of devolution of authority to the regional level in 1996 and to the *woreda* level in 2002. There have been other corollary strategies related to decentralization at the regional level: i) health service delivery and quality of care; ii) health facility rehabilitation and expansion, iii) human resources development, iv) pharmaceutical supply and management, v) information, education and communication (IEC); vi) health sector management & health management information systems, and vii) health care financing (El-Saharty et al., 2009). This decentralization process has targeted the process of service delivery to local governments and attempts to create a platform for citizen participation while improving access and equity in service delivery (Abdella, 2008). However, as El-Saharty et al. (2009) argue decentralization was sometimes influenced by centre-region 'clientelistic' power relationships while challenging an issue of the lacking community voice putting "available resources at risk of political capture by the local elite" (El-Saharty et al., 2009). The same source admits that sequencing of the whole process made the decentralization more manageable even though it was slightly premature (ibid). Nonetheless, the improvements in more comprehensive policy development and concrete strategies are visible.

3.4.1. Health Policy Development

Health sector reform in the country is still an undergoing process that started with *Civil Service Reform* covering the entire public sector of the country (MoH, 2010a) and emphasizing stronger and more efficient human resource management[86]. There are several health policies/programmes which are crucial for the whole Ethiopian health system structure. Those are:

- ✓ *The 1993 National Health Policy (NHP)*
- ✓ *The 1997 – 2016 Health Sector Development Programme I-IV (HSDP I-IV)* – in balance with PASDEP and recently with GTP
- ✓ *Health Extension Programme*

In 1993 the government launched the country's first health policy in 50 years setting the vision for the health care sector development. The policy has attempted to reorganize the health service delivery system with the objective of

[86] The reform in the health sector has been applied to a new concept known as *Business Process Reengineering (BPR)* used as a tool for comprehensive analysis and redesign of the health sector in Ethiopia focused on critical contemporary measures of performance such as cost, quality, service and speed (MoH, 2010a:21)

contributing positively to the overall socio-economic development effort of the country, strongly emphasizing the needs of the rural population. Major aspects of this policy focus on fiscal and political decentralization, expanding the primary health care system and encouraging partnerships and the participation of non-governmental actors (Wamai, 2009). In order to implement the national health policy Health Sector Development Programme (HSDP I) was introduced in 1997/1998. HSDP I covered five years between 1997/98-2001/02 and prioritized disease prevention and decentralizing health service delivery. However, the targets set in HSDP I were not reached and a new programme – HSDP II - was developed for the period between 2002/03 and 2004/05 while aiming to include NGOs in the implementation of the basic health service package (MoH, 2002). In pursuance of the overall goal to improve the overall health status of the population, another strategy framework – HSDP III was launched for the period 2005/06 – 2009/10 with theaim to provide adequate and quality promotive, preventive and basic curative and rehabilitative health services to all segments of the population (MoH, 2006a). The most up-to date health strategy policy implementation framework is HSDP IV for the period 2010/11-2014/15, which is going to be described more in depth below.

3.4.1.1. Health Sector Development Programme IV

HSDP IV serves as a guideline towards the development of subnational health plans and sets the rules of engagement in the health sector for the indicated period while echoing the international commitments (MoH, 2010a). The Millennium Declaration towards the MDGs attainments the African Health strategy 2007-2015, the Paris Declaration on Aid Effectiveness (2005) enriched by the Accra Agenda for Action (2008) and the Abuja Declaration (2001) on financing health care in Africa. HSDP IV is, compared to its forerunners (HSDP I-III), highly specific about federal, regional and local governments' mandates in terms of budgeting, duties & responsibilities, health service administration and control. See the major competencies of different government levels summarized in Table d3.

Table d3: Major Roles & Competencies at Government Levels Defined by HSDP IV

Body	Competencies
Federal Ministry of Health (MoH)	✓ Policies, laws and research initiation, budget preparation, ✓ causing the expansion of health services, ✓ establishment and administration of referral hospitals and research centres, ✓ quality standards determination, ✓ supervision of foreign-established health services, ✓ determining the qualifications of professionals requiring engagement in public health services & certificates provision
Regional Health Bureaus (RHBs)	✓ Regional health care plan & programme preparation and implementation, ✓ organization & administrations of hospitals, health centres & health posts incl. research institutes & training institutions established by the regional government, ✓ issuing of licenses to health facilities established by NGOs incl. their supervision ✓ ensuring drug, medical and equipment supply in the region
Woreda Health Offices (WHOs)	✓ Management & coordination of the primary health care services at woreda level incl. planning, financing, monitoring & evaluation of all health service delivery programmes in the woreda.
Regional, Zonal & Woreda Councils	✓ Addressing communities' demands for health care, political leadership for health; ✓ planning, resource mobilization & allocation, monitoring & evaluation of health service delivery

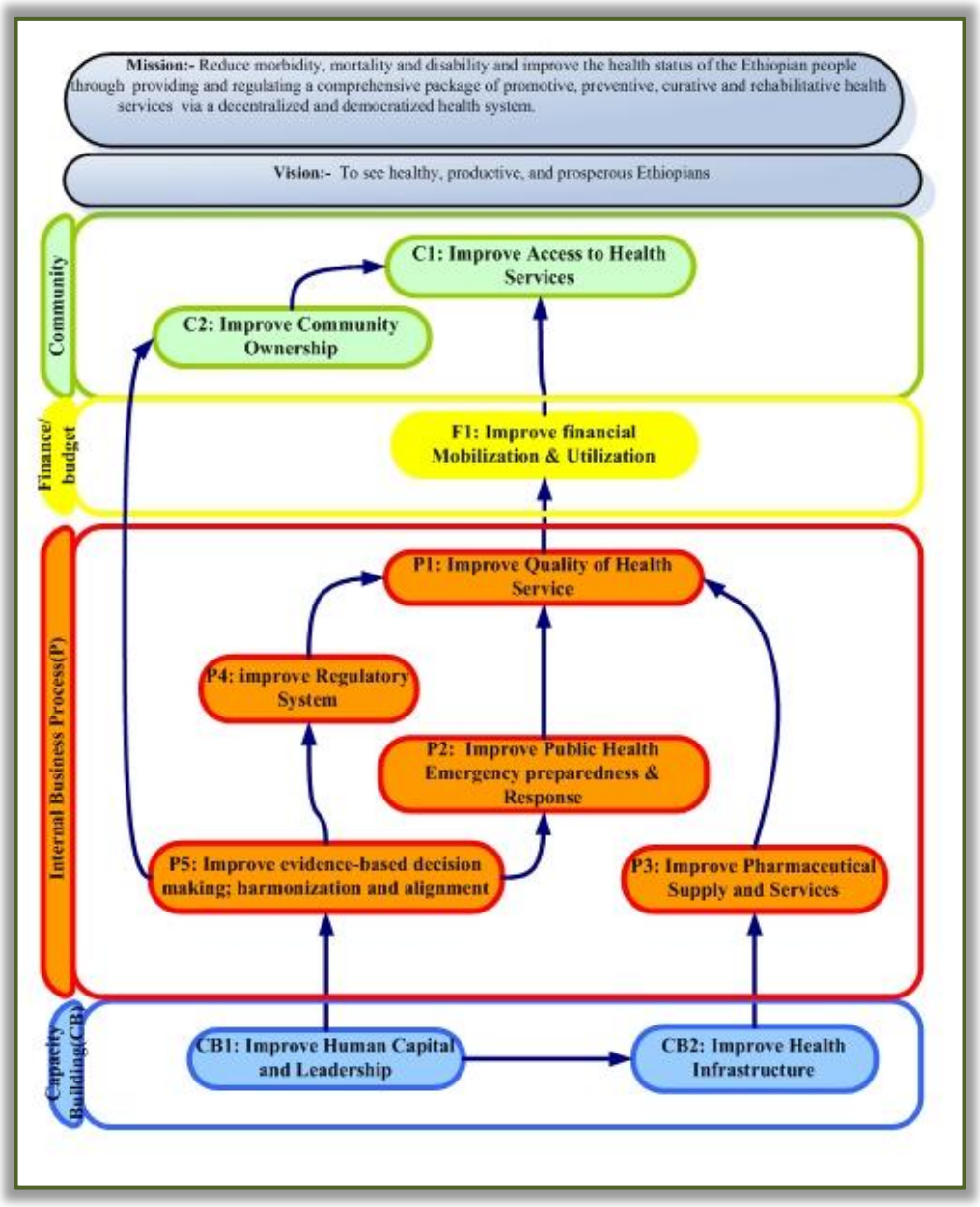
Source: Adopted from MoH, 2010a

It is important to mention that in this decentralized context, RHBs and Woreda Heath Offices, while both being parts of the health system, are not directly accountable to the MoH. RHBs are accountable to their regional government, Woreda Health Offices to the local government. Nevertheless, the lower-level health entities are technically accountable to their higher counterparts being supposed to submit regular reports (MoH, 2010). HSDP IV also defines 10 *strategic objectives* lying at four different levels: a) community level, b) financial level, c) internal business processes and d) capacity building. The most relevant objectives for this study are set as:

- ✓ improved access to health services
- ✓ improved health services quality
- ✓ improved community ownership
- ✓ improved pharmaceutical supply & services

The complex scheme of objectives within various levels of health system under HSDP IV called 'Health Sector Strategic Map' is presented in Figure III.G.

Figure III.G: HSDP IV Health Sector 'Strategic Map'



Source: MoH, 2010a: 47

It is obvious that HSDP IV with its objectives and strategic levels reflects the necessity of health system strengthening as a whole and complex process addressing the issue of human resource management; observing mutual causalities and aiming at the central objective of better *access to health services*. This type of strategy also reflects the awareness of multidimensionality of the concept of access to health care. Two out of six *priority areas* defined by HSDP IV are also very much in context of this study – maternal & new-born health and HIV/AIDS (MoH, 2010). It should be mentioned that HSDP IV also targets specific population segments such as: mothers & neonates, children, adolescents & youth. HIV prevalence decrease amongst all population segments together with lowering incidence of other communicable and non-communicable diseases is more than urged. As an

interesting emphasized outcome stressed in HSDP IV was found to be the issue of citizen's *trust* towards their national health system therefore expected higher health-care seeking behaviour proactively searching for prevention (MoH, 2010). In order to achieve these desired results, HSDP IV relies heavily on the *Health Extension Programme* This health programme will be explained within the following sub-chapter on health service provision in Ethiopia.

3.4.1.2. Reproductive Health and HIV/AIDS Policy Response

Making Pregnancy Safer (MPS) 2000

The very first strategic initiative launched by the government was planned as the health sector strategy to reduce maternal and new-born mortality. Central to the MPS approach has been the critical role of skilled birth attendance and the importance of ensuring a functional continuum of care from the community to the referral level for effective reduction of maternal and new-born deaths (AMREF, 2010). According to MoH (2010a) this initiative has been intensively evaluated.

National Reproductive Health Strategy (NRHS) 2006 - 2015

The first genuine national strategy on reproductive health serves as a road map to enhance the reproductive health status of women, men and young people in order to meet sexual and reproductive health needs of a culturally diverse population (MoH, 2006b). There are six areas of concern prioritized in NRHS:

1) Social & cultural determinants of women's reproductive health
2) Fertility & family planning
3) Maternal & new-born health
4) HIV/AIDS
5) Reproductive health of young people
6) Reproductive organs cancers

To a large extent it builds on momentum occasioned by the MDGs 4, 5 & 6 and sets its own pretty ambitious targets which some of them turned not to have been achieved (such as increase CPR to 60% by 2010). According to Tesfaye (2010) a mid-term review of HSDP III related to national sexual and reproductive health showed that there has been a very limited progress in implementing of NRHS in terms of IEC/BCC and mobilization efforts at the community level regarding early marriages, danger signs during pregnancy & childbirth and the establishment of community referral mechanisms (Tesfaye, 2010). It is important to mention that NSRH openly endorses the protection of sexual and reproductive rights of women in particular while committing to their promotion (MoH, 2006b).

National Adolescent & Youth Reproductive Health Strategy (NAYRH) 2007 - 2015

This policy document dedicated to youth & adolescents' RH builds on other key policies including the *2004 Youth Policy* and the *1998 HIV/AIDS Policy.* The strategy introduces youth policy guiding principles, such as tailoring programmes according to the age and life stages, encouraging youth involvement and reaching marginalized populations (USAID, 2007). It also addresses a range of key elements of adolescents & youth RH policy including pregnancy, harmful traditional practices, such as early marriages and FGM/C. It also examines the relationship between poverty and youth reproductive health, prevention of HIV/AIDS and other STIs is also included. NAYRH also defines standards of *youth-friendly RH services in Ethiopia* (AMREF, 2010): a) Information & counselling on SRH issues & sexuality; b) Promotion of healthy sexual behaviour of various methods including peer education; c) FP information, counselling and methods including emergency contraceptive methods; d) Condom promotion & provision; e) HCT and pregnancy testing; f) management of STIs; g) ANC, delivery services, postnatal care & PMTCT; h) Comprehensive abortion services and i) appropriate referral linkages between facilities at different levels. The issue of adolescent's & youth's reproductive health is directly linked to the access to information on sexuality and reproductive health.

Sexual & Reproductive Health Education

The topic of reproductive health and sexuality education is in Ethiopia incorporated into The *Population and Family Life Education (POP/FLE)* embodied in three subjects: a) population education; b) family life education and, c) sex education (AMREF, 2010). POP/FLE was introduced as a pilot project from 1989/90 to 1993. Initially it was incorporated in three subjects: biology, geography and home economics. During the institutionalization process the number of subjects increased. According to AMREF (2010) the main themes in POP/FLE include: economic development & population size; social development & population change; health, nutrition and population dynamics; demographic variables/processes; family size in relation to family welfare; sex, marriage, FP & responsible parenthood; values & benefits in population matters; family, law & civic responsibilities and youth, women & development. The recent assessment (2010) of family life & sexuality education in Ethiopia showed that although students at the primary level are introduced to family life topics such as personal hygiene, HTPs and environmental hygiene, there is limited awareness on RH topics related to psychological aspects, reproductive cycle and life skills among others (ibid). From grade 7 onwards POP/FLE is incorporated in natural and social sciences with RH issues mainly incorporated in biology while HIV/AIDS proclaimed to be integrated in all subjects. According to Population Council & UNFPA (2010), who carried out the research on young adults in seven Ethiopian regional states, the fact that young people receive information on reproductive health and sexuality is a myth (Population Council & UNFPA, 2010: 83). In their survey only one quarter of young people reported some exposure to family life education at school and relatively small proportion of young people had been aware of puberty before it happened to them (ibid). The same research also highlights special attention to communication with boys on RH and non-violence so that they are more involved in their future family life and do not feel pressure on their manhood.

The 1998 National HIV/AIDS Policy

The policy effort launched in 1998 by the government represents an overarching framework towards enabling environment to fight the epidemic (HAPCO, 2010) showing the government's commitment to fight the epidemic. The policy is currently (2010/2011) under revision. According to HAPCO (2010) the support in relation to HIV/AIDS has increased over the years and progress has been made towards a more specific HIV/AIDS related legislation. Revisions have been made in order to promote and protect human rights of PLWHA. Civil society involvement in the process of planning, monitoring and evaluation of HIV/AIDS responses have improved at various levels. A number of other supporting policies, strategies and guidelines have been developed to guide comprehensive HIV/AIDS prevention, treatment, care and services aiming affordable costs for all people in need. HCT and ART programmes are meant to be provided free of charge. The main national strategies developed and implemented at national level to mitigate and address the burden of pandemic were defined as:

a) Promote VCT and other BCC interventions
b) Promote the use of female and male condoms
c) Provide user-friendly reproductive health and STI services
d) Enhance bargaining and negotiation skills for safe sex where applicable
e) Provide safe and alternative income generating & employment opportunities where applicable
f) Strengthen and expand school anti AIDS and mini medias
g) Integrate HIV/AIDS in life skill education and basic curriculum
h) Develop youth centres and entertainment resorts
i) Organize the youth on voluntary basis and provide peer education

Ethiopia has ratified several laws and regulations that protect PLWHA against discrimination. Lion's share on their enforcement has civil society particularly Ethiopian Human Rights Commission, the Ethiopian Women Lawyers Association, the Women's Coalition, the Women's PLWHA network and others (HAPCO, 2010).

Strategic Plan for Intensifying Multisectoral HIV/AIDS Response II (SPM II) 2009 – 2014

This second multisectoral HIV/AIDS policy framework has been adapted from SPM I to react to its achievements, challenges and gaps while harmonizing government efforts with multilple stakeholders. SPM II focuses on *enabling environment* such as capacity building, community mobilization and empowerment, leadership and governance, mainstreaming, coordination and partnership with networking. Strategic issues in the programmatic thematic areas combine: intensifying HIV prevention, increasing access and quality of chronic care treatment, strengthen care and support, and enhancement and use of strategic information (HAPCO, 2011). It also identifies selected strategies addressing gender inequality incl. gender-based violence. The SPM II also promotes the education of girls and gender norms to facilitate gender equality (GoE & GoUSA, 2010).

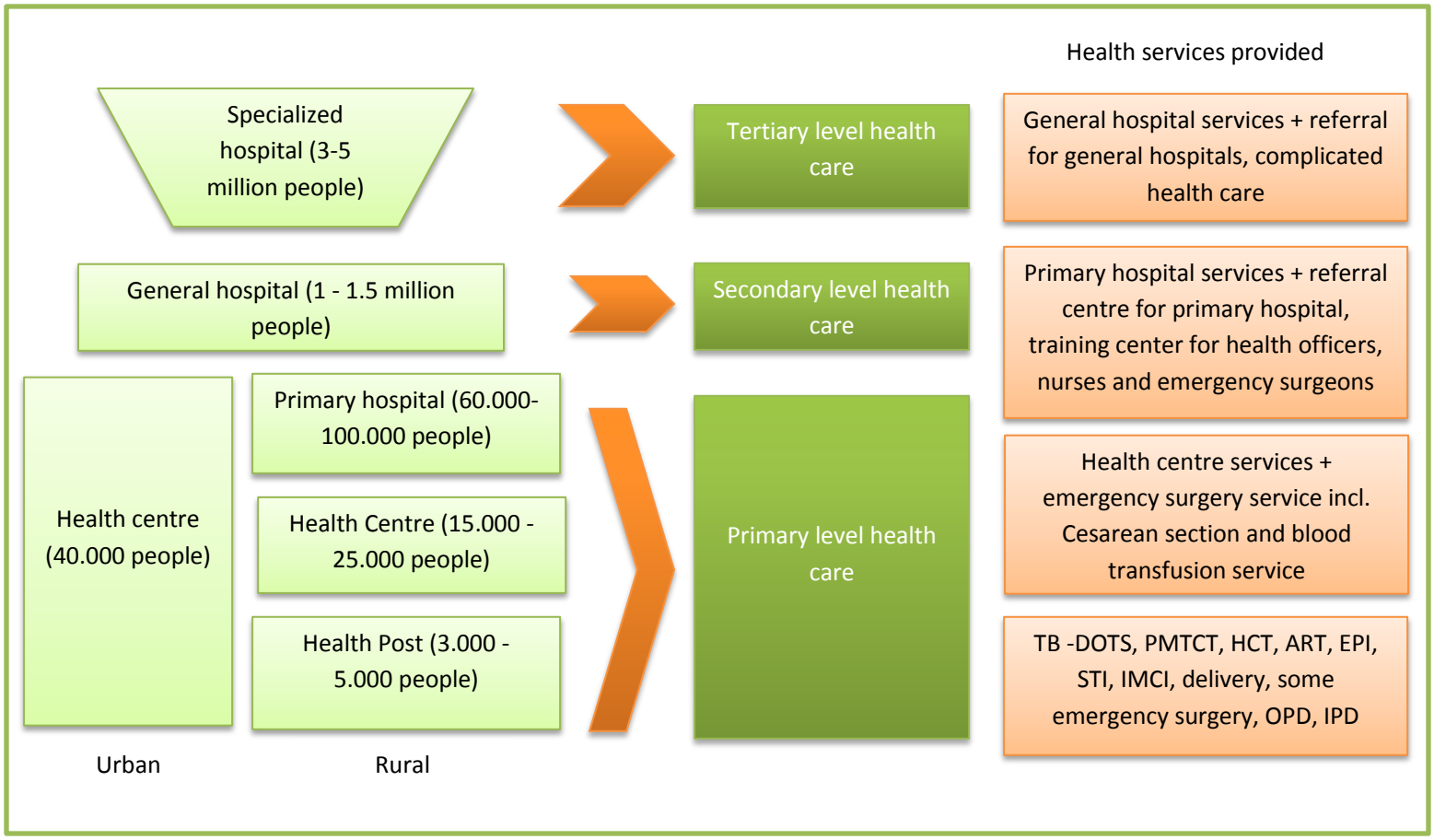
HAPCO together with MoH developed different guidelines framed by the National HIV/AIDS policy for various HIV-related services (PMTCT, ART, VCT, PICT, etc.), amongst other relevant national policy documents are counted *Multisectoral Plan of Action for Universal Access to HIV Prevention, Treatment, Care & Support 2007 – 2010* and *Road Map for Accelerated Access to HIV Prevention, Treatment & Care 2007* which induce the whole country HIV/AIDS policy response framework.

3.4.2. Health Service Delivery

The central effort of public service delivery in Ethiopia is the geographical expansion of health care services, primarily in rural areas in order to increase their availability. Due to those efforts the government has been currently reorganizing (2010 and further) the expiring four-tier service delivery health system into a *three-tier service delivery system* consisting of: 1) primary health care units (PHCUs), 2) general hospitals, and 3) specialized hospitals (MoH, 2010b). A different structure of PHCUs for rural and urban areas is being implemented: rural PHCUs are going to comprise health posts, health centres and a primary hospital. Urban PHCUs will be exclusively constituted by health centres.

A rural system of PHCUs is meant to serve a maximum of 100.000 people whereas urban health centres are planned to serve 40.000 people. General hospitals are expected to serve 1-1.5 million people, specialized hospitals from 3.5 to 5 million people (ibid). Figure III.H summarizes the new three-tier scheme of health service provision defined by PASDEP IV. Another challenge in health service delivery in Ethiopia is distribution of adequate pharmaceutical supplies since 87% of the pharmaceuticals are imported through commercial purchase and donations. To supply safe and affordable pharmaceuticals on a sustainable basis the Pharmaceutical Fund and Supply Agency (PFSA) was established in order to maintain timely procurement and distribution of pharmaceuticals to health facilities (MoH, 2011b). As a vehicle for prevention, health promotion, behavioural change communication and basic curative care is currently considered the Health Extension Programme, which aims to bring the services closer to the poor.

Figure III.H: The New Ethiopian Three-tier Health Service Delivery System



Source: MoH, 2010c, adopted from HSDP IV

3.4.2.1. Health Extension Programme (HEP)

This community-based service provision shift introduced in 2002/03 during the HSDP II period meant a significant resource allocation of both health workforce and services from urban to remote rural areas where the majority of Ethiopian population resides; bringing the primary health care services at the households' doorstep.

Health promotion and prevention are the key areas of HEP target particular segment of the population suffering most from negative health outcomes – predominantly mothers and children (MoH, 2010a). HEP promotes 4 health care areas:

1) Disease prevention and control
2) Family health
3) Hygiene and environmental sanitation and
4) Health education and communication

Those areas are further developed into 16 packages, later increased to 17 with the adoption of emergency services (MoH, 2011b). Disease prevention & control combines four packages: HIV/AIDS prevention & control, malaria prevention & control and first aid. Family health services area covers packages of: maternal and child health, family planning, immunization, adolescent reproductive health and nutrition (MoH, 2006a). Health education and communication area is considered as one package. For more information on health education & communication in HEP read Box 3.C. The most relevant areas for this study are points 1, 2 and 4 due to the focus of the research. The 4 HEP areas are further developed into 16 different health intervention packages delivered by Health Extension Workers

(HEWs) – semi-skilled female health personnel trained for one year by either implementing bodies or technical and vocational training institutions (MoH, 2010b). Presumably HEWs are well accepted by communities and possibly motivate for increasing demand for primary health care (ibid). During the period of HSDP III efforts were made to introduce the programme to urban areas in order to increase the universal health coverage. A 24-package urban HEP has been created and preparatory work in the urban settings has been completed (MoH, 2011b). By the end of HSDP III period more than 33.000 HEWs were trained and deployed which surpassed the planned bar (ibid). The approach of *model households* has been introduced also in the end of HSDP III period with the aim to train 16 million households as a sort of 'peer educators' - new BCC channel towards positive health-care seeking behaviour of the communities while increasing health literacy. The households have been expected to keep their family records (*family folder*) on births, deaths, immunizations, medications, etc. after the termination of the training. Another implementation strategy under the HEP complementing the progress towards universal PHC coverage has been the physical extension of health services – especially health post construction followed by the equipping. The construction itself seems to be encouraging – 89% of the planned health posts (target set by HSDP III) were constructed by the end of 2010 (MoH, 2010). However, further equipment lags behind with only 83.1% of newly constructed health posts being equipped (ibid).

Box 3.C

Health Education & Communication in HEP

Health education & communication in HEP is understood as an alternative to change positively knowledge, attitudes and practices towards increased health seeking behaviours of the whole communities (MoH, 2003). This package defines the role of a HEW as a health educator who plays a major role in disseminating the right health information, developing individuals' and communities' knowledge and mobilizing people to action. HEP also admits a failure of traditional health education through mass media in Ethiopia building a strong education & communication base in ***peer education*** which primarily utilizes two-way interpersonal communication. MoH (2003) also aims health education & communication to support individuals and communities to solve their health issues through their own initiative and think more about prevention. The package further contains the explanation of the health education & communication concept, message communication methods with general *clarity* as a main criterion. Communication skills of HEWs and ethical considerations during their job performance are other areas of concern (CNHDE, 2009).

3.4.2.2. Health Workforce

Ethiopia is one of 57 countries recognized by the WHO as having a health workforce crisis, marked by chronic under-production of trained personnel, especially at high and mid-levels, and poorly motivated underpaid staff with low retention. Additionally, there are major urban - rural disproportions with health worker density ranging from 0.24 to 2.7 per 1.000 inhabitants, respectively (GoE & GoUSA, 2010). There were 2.151 physicians in the country, a ratio of 1 to 36.158 people in 2009 (MoH, 2010a) which is far below the WHO standards (1:10.000). Regional variations in health personnel deployment are also typical – i.e. nurse/population ratio in Somali was 1:14.882 compared to Addis Ababa

where the same indicator was 1:845 in 2009 (MoH). See the complete table e3 of health personnel deployment (physicians, heath officers, nurses, midwives and HEWs) in all regional states in 2009.

HSDP IV defined health workforce and human resources management in health care as one of the major priorities while setting human capital targets counting with strategies towards decrease of the health personnel/population ratios (MoH, 2010a). Kitaw & Hailemariam (2009) argue that health workforce in Ethiopia has grown substantially in the last ten years but not according to the WHO categories and benchmarks. The authors target particularly the increase of 'new' categories such as health officers and HEWs, whose role of health promoters and primary health care frontline workers in rural areas is recently understood as cardinal. The WHO benchmarks reflect neither voluntary community-based workers (often assisting to HEWs) nor traditional practitioners who still possess a significant proportion of overall health care utilization in Ethiopia (Kitaw & Hailemariam, 2009).

Table e3: Health Workforce Deployment & Population Ratios by Region in 2009

Region	Physician (GP & specialist)	Physician : Population Ratio	Health Officer	HO : Population Ratio	All Nurses	Nurse : Population Ratio	Midwives	Midwife: Population Ratio	HEWs	HEW : Population Ratio
Tigray	101	1:44,880	188	1:24,111	2,332	1:1,944	185	1:24,502	1,433	1:3,163
Afar	15	1:98,258	29	1:50,823	185	1:7,967	–	–	572	1:2,577
Amhara	304	1:58,567	434	1:41,024	3,790	1:4,698	212	1:83,983	7,471	1:2,383
Oromia	378	1:76,075	448	1:64,189	5,040	1:5,706	287	1:100,197	13856	1:2,075
Somalia	71	1:65,817	12	1:389,415	314	1:14,882	45	1:103,844	1,427	1:3,275
Ben-Gumuz	12	1:59,309	42	1:16,945	452	1:1,575	37	1:19,235	499	1:1,426
SNNPR	242	1:65,817	220	1:72,398	3,980	1:4,002	316	1:50,404	7,915	1:2,012
Gambella	13	1:25,585	13	1:25,585	91	1:3,655	4	1:83,150	457	1:728
Harari	29	1:6,655	31	1:6,226	276	1:699	29	1:6,655	47	1:4,106
Addis Ababa	934	1:3,056	170	1:16,791	3,377	1:845	244	1:11,699	NA	-
Dire Dawa	53	1:6,796	19	1:18,957	272	1:1,324	20	1:18,009	142	1:2,537
National	2,152	1:36,158	1,606	1:48,451	20,109	1:3,870	1,379	1:56,427	33,819	1:2,301

Source: MoH, 2010a

3.4.2.3. The role of NGOs in the Health Sector

In 2005 there were more than 400 NGOs managing health projects or projects potentially contributing to the alleviation of major public health problems in the country (CRDA, 2005). Most NGOs operated in Oromiya, Amhara, SNNPR and Addis Ababa. NGOs have been involved in health service delivery, health service rehabilitation and expansion, human resource development, pharmaceutical services, strengthening health management and information system, operation research, BCC/IEC and health care financing (ibid). NGOs apply diverse programme

strategies to improve access to health services in Ethiopia in their operation areas. CRDA (2005) summarized them into five main approaches (See the Table f3).

Table f3: NGOs' Major Strategies towards Improved Access to Health Care

I.	**Direct management approach**	NGO builds or renovates & then manages a health facility. Missionary groups, faith-based organizations or churches adopt this system. Managers & senior staff have long-term commitment & retain direct control over funds & staff, maintaining 'high standard' curative services.
II.	**'Clinic adoption' approach**	NGO 'adopts' one or more government facilities and provides material & support by refurbishing the clinic & supplying equipment and drugs. It is usual for an expatriate health professional to work in the clinic, giving the staff in-service training in curative, rehabilitative and maternal & child health work
III.	**'Impact area' approach**	NGO concentrates its effort in a small-defined geographic area involving facility expansion, support & health workers' trainings combined with intersectoral activities; sometimes termed as *community-based integral rural development*.
IV.	**Air-drop of resources' approach**	A visit by a consultant is followed by channeling of resources directly into public health system which is responsible for implementation.
V.	**'Health system strengthening' approach**	The use of NGOs' technical & material support to help analyze and then develop & implement systems & processes of district/woreda health management & care. The focus is on the general health management system for decentralized process of implementation, highlighting district-based training & supervision

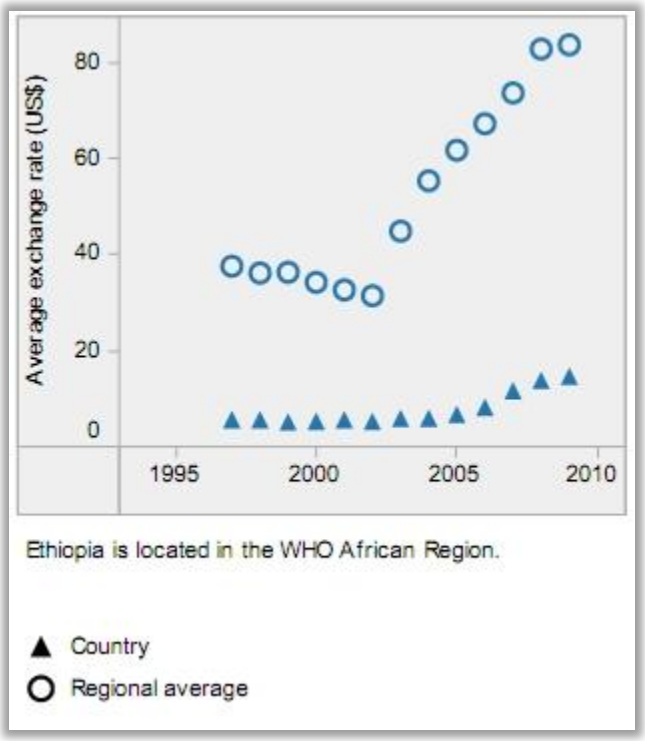
Source: Adopted from CRDA, 2005

The participation of NGOs in health policy and national programme formulation is limited, though there is a positive trend of improvement through creating platforms and alliances which define common goals and constitute an equivalent partner for negotiations with the government. Such a platform is for instance the *Consortium of Reproductive Health Associations (CORHA)* having more than 100 member local, national and international organizations involved in reproductive health in Ethiopia (CORHA, 2010). This platform represents their members, mobilize resources and build capacities as well as advocate for policy and law changes towards more inclusive and equitable access to reproductive health. According to CRDA (2005) NGOs have several comparative advantages in their participation in the health sector when compared to public and private for-profit sector, i.e. they are key stakeholders to ensure community mobilization, community-based care, and in institutionalizing early warning systems for early detection of public health problems. The major Achilles' heel for NGOs-managed health projects is linked with financial sustainability and community 'dependency'. CRDA (2005) also admits that there is lacking comprehensive data on NGOs operating in Ethiopian health sector and deeper NGO integration at woreda/region level is needed.

3.4.3. Health Care Financing

Ethiopia's health sector has multiple financial resources for health including federal, regional and woreda levels of government treasury, bilateral and multilateral donors, household – out-of -pocket expenditures, international and local NGOs, private and semi-state employers and insurance enterprises (MoH, 2010b). Health care in Ethiopia is heavily under-financed, documented by per capita total health spending[87] of $ US 16.1[88] per capita in 2007/08 (MoH, 2010b) makes it one of the countries that invest the last in health care in the Sub-Saharan region (Figure III.I). According to the WB (2011b) the total health expenditure constituted 4.3% of Ethiopian GDP whereof 47.6% constituted public spending[89] in 2009 which recorded a slight decrease compared to 2006 when public health spending constituted 55.3% of total health expenditure. Out-of pocket health expenditures constituted slightly more than 80% of private expenditure on health between 2007 and 2009 (MoH, 2010b; WB, 2011b). Wamai (2009) points out an enormous regional disparity in terms of health financing illustrating the variations from $ US 0.4 spending per capita in Dire Dawa to $ US 6.3 in Harari. The disparity in spending is to a large extent due to the fact that fiscal decentralization grants regional governments the right to allocate (federally provided) government funds. About 80% of health expenditures at regional levels are grants allocated to each region on account of weighted variables such as population size, level of development and level of revenue generation (Wamai, 2009).

Figure III.I: Total Health Expenditure per Capita



Source: WHO, 2011

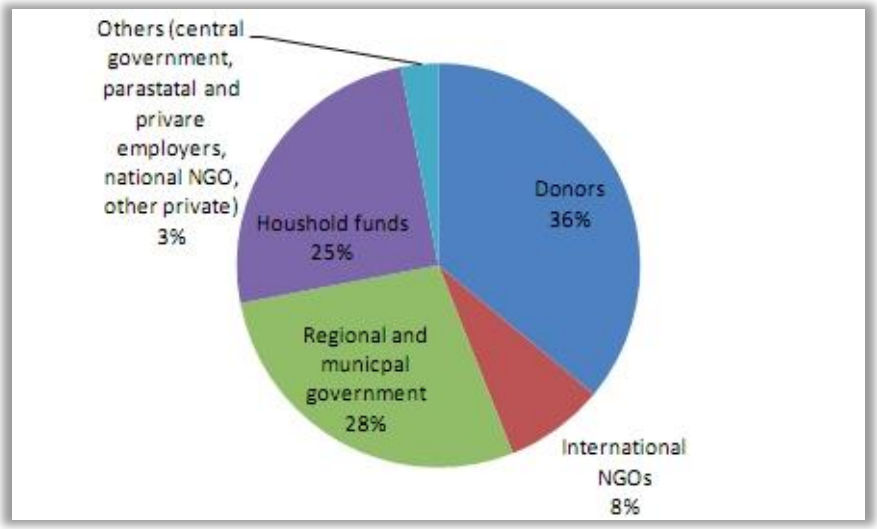
There have been several reforms and financing strategies considered and/or implemented, such as revision of user fees charged at public health facilities and retaining the collected fees at the facility and using that revenue to improve quality; systematizing rules for fee waivers, increasing managerial autonomy and accountability of the hospitals, opening private wings at public hospitals and outsourcing non-clinical health services (ibid). According to the same source two types of health insurance schemes –comprehensive *social health insurance* for the formal sector and *community-based insurance* for the informal sector[90]will be implemented (MoH, 2010c; MoH, 2010b).

[87] The WB (2011) clarifies that total health expenditures do not include provision of water and sanitation
[88] WHO's recommendation is $ US 34 per capita
[89] Defined by the WB (2011b) as recurrent and capital spending from government central and local budgets, external borrowings and grants – including donations from international agencies and NGOs, enriched by social and/or compulsory health insurance funds
[90] The pilot implementation has been taken in 12 woredas of 4 regions of the country – Amhara, Oromia, Tigray and SNNPR

3.4.3.1. Sexual & Reproductive Health and HIV/AIDS Financing

Total reproductive health expenditure was $ US 150.9 million, which represented 13% of total spending on health in Ethiopia in fiscal year 2007/08 (MoH, 2010b). This amount constitutes per capita spending per women of reproductive age approximately $ US 8. Almost half of the total RH expenditure (44%) was internationally financed, even though the share of federal and regional government sources substantially increased – contributing with 29% of the total RH spending. Households (out-of-pocket-expenditures) carry a substantial cost burden covering their RH expenses – 25%, which is an alarming figure considering the fact that the government covers almost the same share. For more general overview of financing sources of RH in Ethiopia see Figure III.J. The major recipients of RH resources were public PHCUs receiving 36% of overall RH spending in 2007/08. Other public health providers received 24%, government hospitals 15% and private PHCUs[91] 12% out of total RH spending (ibid). Funds for RH were spent mostly on outpatient care being the most financially supported service, followed by FP and counselling programmes (17%) and maternal health programmes (8%).

Figure III.J: Sources of Reproductive Health Financing in 2007/08



Source: MoH, 2010b

Total HIV/AIDS expenditures represented more than 20% ($ US 248 million) of total spending in the Ethiopian health sector in 2007/08 (MoH, 2010b) constituting the largest amount spent on specific diseases or activities. The HIV/AIDS national health expenditure per capita was $ US 3.27 while the same indicator for PLWHA in the same year was $ US 180. HIV/AIDS activities in Ethiopia are highly donor financed, covering more than 84% of total HIV/AIDS expenditures from international resources. The government (federal, regional and woredas) contributed around 11% in the year 2007/08 (MoH, 2010b). PLWHA shouldered higher burden of financing for their health. This population segment contributed 3.5% of the total spending on HIV/AIDS, they spent on average (both groups ART-enrolled and ART non-enrolled) $ US 32 per capita in 2007/08. This amount was more than five times higher than the amount which is spent by general population on overall health per person ($ US 6). All the other private resources, including local NGOs and for-profit organizations, covered only 1% of total HIV/AIDS expenditures (ibid). As obvious from the title of the thesis, the empirical part of this study is set in Amhara regional state, namely *Bahir Dar Special Zone*.

[91] Both non-profit and for-profit

3.5. Amhara – The Regional Context

3.5.1. Geography & Administration

The Amhara Regional state extends from 9° to 13° 45′ N and 36° to 40° 30′ E. It boarders on: Tigray region in the North, Oromiya region in the South, Benishangul-Gumuz region and Sudan in the West, and Afar region in the East. It covers circa 161.828 sq km. Amhara has a very diverse topography ranging from 500 to 1.500 m above sea level. More than 50% of the region constitutes the mid highlands and fringe areas between 1.500 and 2.500 m above sea level. About 25% of the region is the North-western lowlands, the stretch of lower river valleys and deep gorges. 25% of the region's surface is constituted by the extensive high plateaus and mountains located in the northern, central and North-western parts of the region (ANRS BoFED, 2010). The largest lake in the country ,Lake Tana (3.087 sq km), is found in this region where the Blue Nile springs. The region climate varies corresponding according to its topography from semi-arid to tropical. The region is administratively divided into 11 zones (including Bahir Dar Special Zone), 128 woredas and 23 town administrations (see Appendix A3). There were about 3.461 kebeles in 2009; however, these administrative divisions fluctuate as already mentioned. The ten remaining administrative zones are: North Gonder, South Gonder, West Gojjam, East Gojjam, Awie, Wag Hemra, North Wollo, South Wollo, Oromia and North Shewa (ANRS HAPCO, 2010). See Figure III.M.

3.5.2. Demography

The population size of the Amhara region represents around 18.2 million inhabitants with annual growth 1.8% which accounts for roughly 22.8% of the total population of the country in 2009 (BoFED, 2010). The vast majority of its population resides in rural areas (87.4%) sustaining their livelihoods through agriculture. Again, population distribution is unbalanced considering the population density – i.e. Wag Hemra zone population density of 51.1 inhabitants per sq km contrasts with the regional capital Bahir Dar density of 673.0 inhabitants per sq km. The age structure of the region more or less reflects the national figures while having young population: 42.6% of the population is younger than 14 years whereas people living more than 65 years represent roughly 4% in Amhara. Life expectancy at birth is less than 54 years (ibid). About 90% of the population is Amhara by ethnicity and 80% of all its inhabitants belong to Orthodox Church (ANRS HAPCO, 2010). Subsistence farming constitutes livelihoods for more than 90% of the total population.

3.5.2.1. Maternal & Reproductive Health Indicators

According to BoFED (2010), the total fertility rate per woman in Amhara was 5.1 in 2009. The maternal mortality rate remained as high as 590 deaths per 100.000 live births (ORC & Macro, 2006) as well as infant mortality ratio (94 per 1.000 live births), which even exceeds the national average of 77/1.000 (BoFED, 2010). The contraceptive prevalence rate (CPR) among currently married women is moderate compared to other regions - 33% of women reported utilization of any modern family planning method (ICF Macro & CSA, 2011). The most popular modern FP method among Amhara married women in reproductive age were injectables (26.5%) outdistancing other methods (4.0% for implants and 1.5% for IUD). The unmet need for family planning in Amhara attributed to 22.1% in 2010 (ICF Macro & CSA, 2011), which is one of the highest levels amongst the Ethiopian regions. According to the latest EDHS carried out in 2011, there were 33.6% of women receiving at least one ANC consultation from a skilled health professional, 8.4%

receiving the same service from a HEW. Institutional child deliveries remain low mirroring the national trends – only every tenth woman delivered her child at a health facility (ibid).

3.5.2.2. HIV/AIDS Epidemic

Adult HIV prevalence at Amhara regional level between 2006 and 2010 was between 1.6% and 1.4% (HAPCO 2007; BoFED, 2010). However, the figures vary according to the source, even the same sources state a different prevalence in another section of the same report: the total HIV prevalence between 2006 and 2010 ranged between 2.7% and 2.9%. What is undisputable is the wide gender gap in HIV prevalence: there was 2.3% HIV prevalence among Amhara men whereas it was 3.5% of Amhara women who were infected in 2010 (HAPCO 2007; BoFED, 2010). Amhara region accounted for about 31% of the total PLWHA living in Ethiopia (estimate of 379.096 people in 2009), 31% of all the newly infected lived in this region and 37% of total AIDS orphans lived there in 2009 (BoFED, 2010).

Special studies (Amhara MARPs Survey) revealed how highly HIV vulnerable the population segments in Amhara are: commercial sex workers, daily construction labourers, students, mobile merchants and refugees (HAPCO, 2010). HIV prevalence among these groups ranged from 11.6% to 37%, which was considerably higher than the national urban adult population level (7.7%). Higher prevalence was linked to a high sexual partner change, concurrent sexual partnerships and low and inconsistent condom use (ibid). 4.0% of men in reproductive age living in Amhara and 1.8% women of the same age group got HIV tested[92] 12 months prior to the 2005 EDHS (ORC Macro & CSA, 2006).

The level of comprehensive HIV knowledge amongst women in reproductive age in Amhara has remained alarming while only 15.2% of this population group proved comprehensive HIV knowledge in 2005 (ORC Macro & CSA, 2006). Amhara women also showed not to be significantly tolerant towards PLWHA – only 8.6% were tolerant in all four aspects explained above (ibid). Comprehensive HIV knowledge among Amhara youth (15 – 24 years) appeared to be a bit higher; however, with a large gender gap: 19.9% young women residing in Amhara had a comprehensive HIV knowledge compared to 44.8% of young men in 2005 (ORC Macro & CSA, 2006).

3.5.2.3. Traditional Gender Inequalities

One of the significant gender inequalities predominantly present in Amhara region is an early marriage which is related to high levels of early sexual initiation with a considerably older husband (Natoli et al., 2008). According to MOWA et al. (2010) 37% of Amhara girls are married before their 15th birthday, which represents the highest figure in the country. According to Erulkar & Muthengi (2009), 80% of Amhara girls are married by the age of 18. Compared to other regions, marriage by abduction is less common in Amhara than in the past since only 2.4% of ever married women in reproductive age got married in this manner (MOWA et al., 2019). However, arranged marriages are still very common in Amhara, particularly among highland pastoralists and farmers who

Figure III.K: Abduction in Amhara

Source: author, fieldwork 2011, Bahir Dar Memorial Museum Museum, painted by an unknown artist

[92] It is not known whether it was client- or provider-initiated HIV testing.

often wed off a girl without her own consent. According to Erulkar & Muthengi (2009) 81% of married girls in their sample reported that their first sexual intercourse had occurred against their will. Early marriage often leads to early divorces, Amhara is considered to be the highest divorce rate region in Ethiopia (ibid).

The practice of FGM/C remains widespread in rural parts of Amhara, typically performed during the eighth day of life (Natoli et al., 2008). According to MOWA et al. (2010) 67% of Amhara women in reproductive age were circumcised in 2005. Law enforcement towards this harmful traditional practice still remains a challenge.

Women in Amhara make up more than 50% of the population, however, their access to various social and economic services is found to be low (BoFED, 2010). Since gender inequality & poverty are deeply rooted in the region – e.g. due to population's limited access to safe drinking water[93] women are expected to bear the burden of walking long distances to fetch water which further reduces their economic contribution or participation in the education process. According to MOWA et al. (2010), there were only 28.3% of Amhara women aged 15 to 29 who were able to read and write in 2004/05. According to BoFED (2010), there were 36.8% of women employed in regional public institutions in 2009. Women's participation in political, social and economic activities is then very limited in Amhara.

3.5.3. Bahir Dar Special Zone (BDSZ)

Bahir Dar is the capital of the Amhara regional state situated approximately 600 km Northwest from Addis Ababa. It is located on the Southern bank of Lake Tana. Bahir Dar is one of a few Ethiopian secondary cities and regional urban centres growing at an unprecedented rate, mainly due to in-migration (Amera, 2010). The total population of BDSZ was 220.344 in 2007 (CSA, 2007). BDSZ is an urbanized area with 180.094 inhabitants of all urban kebels (ibid); however, regional sources indicate (Health Zonal Office Bahir Dar, fieldwork 2011) that there were 252.786 inhabitants of all urban kebels in 2011, which may document the rapid population growth. CSA (2007) states that there were 40.250 inhabitants residing in rural kebeles of BDSZ in 2007. Regional sources (BoFED or other bodies) do not clarify figures on the total rural kebeles' population of BDSZ; unfortunately the researchers[94] were not successful to obtain those figures in the field. Overall, Bahir Dar Special Zone consists of 17 urban and rural kebels.

3.5.3.1. Urban Challenges

Being the main cereal producer in the country and a fast growing urbanized area, Bahir Dar has been starting to face challenges such as uncontrolled/unplanned growth, lacking infrastructure, congested traffic, housing shortages and environmental degradation (Amera, 2010). Urban poverty in Ethiopia is likely to be a strong persistent component often associated with long-term unemployment, exclusion or being trapped in insecure livelihoods (Kedir & McKay, 2005). Social problems related to urban poverty are on the increase in Bahir Dar: prostitution, begging, drug and alcohol abuse, kids (often orphans) living in the street[95] (BoFED, 2010). There has been a small scale study conducted on prostitution & street children in Amhara towns including Bahir Dar and the prevalence of both phenomena has been increasing (ibid). Social welfare programmes that would address these issues effectively are lacking. BoFED (2010) states that the social problems are expected to enlarge in the area.

[93] According to BoFED (2010) less than 64% of the total Amhara population has access to safe drinking water.
[94] As the researchers are meant two MSc candidates from the Utrecht University in the Netherlands – the author of this thesis and Ms Hannah Haaij, the empirical part was carried on in a team.
[95] The researchers regularly observed small homeless children making a living of begging, sleeping on Georgis main square of Bahir Dar, often sniffing glue

3.5.3.2. Public Health Infrastructure

Figure III.L: Felege Hiwot Referral Hospital Entrance

Source: author, fieldwork, 2011

BDSZ has a special position in public health service delivery in Amhara due to the presence of a large referral special hospital (Felege Hiwot Referral Hospital – Figure III.L) which serves to almost 7 million people, predominantly from the Amhara region but also to same areas of the neighbouring regions (medical staff interview, fieldwork 2011), having 273 beds available (BoFED & ARHB, 2010). Sources on other public health infrastructure in BDSZ differ: according to BoFED (2010) there were 9 health centres and 5 upgraded health centres together with 9 health posts with unspecified status[96] in 2010. Health Zonal Office in Bahir Dar (fieldwork, 2011) provided the figures of 11 existing health centres whereof 3 were waiting for equipping after the finished construction at the momentum of data collection. According to ARHB report 2005 – 2009, there were 3 new and fully equipped health centres at the end of the year 2009 (ANRS BoFED, 2010).

3.6. Conclusion

This chapter presented the national, the regional and the local context of the study while indicating crucial aspects of poverty related to health and gender; the reproductive health challenges together with HIV/AIDS epidemic and relevant policy responses. Institutional framework of the health system structure with several programmatic changes was also presented. The following chapter will provide an insight into the methodology adopted for the preparatory, the empirical and the analytical parts of the study.

[96] It was not clear whether those health posts are upgraded, under construction or waiting for equipping.

4. Methodology

This chapter is going to provide readers with the information on methodological approach of this study. Initially, the conceptual framework of this study will be described including the research questions and objectives, operationalization of the terms and the conceptual model. The second sub-chapter will draw the research design introducing the case study approach and concrete data collection methods & techniques. The following sub-chapter will discuss data analyses incorporating both content and statistical aspects. Finally, pressing issues such as dealing with ethical considerations and study limitations are going to close the chapter.

4.1. Research Questions & Conceptual Framework

4.1.1. Central Research Question, Research Objectives & Sub-questions

This study seeks to answer the following central research question:

"How does access to information influence HIV/AIDS awareness, reproductive health service utilization and demand articulation in Bahir Dar Special Zone (BDSZ), Amhara region?"

In order to structure the findings and follow the logical sequence of the findings from the 'supply side' towards the 'demand side', the central research question is split into four research objectives (1.-4.) with corresponding sub-questions. The sub-questions are aimed to answer the research objectives which, after an analytical examination, further compound the answers to the central research question. The organization of the objectives and the sub-questions is as follows:

1. To identify and understand various forms of selected RH services in BDSZ (ANC & child delivery, FP & VCT) provision as they are embedded in public service delivery system of Ethiopia.
    - ✓ What is the structure of RH services? Who are these actors (providers & other stakeholders) and how do they interrelate in delivering selected RH services? What are their roles and functions?
    - ✓ What kind of targeting strategies/communication channels do the actors use to target different population groups in order to increase their HIV/AIDS awareness and utilization of selected RH services?
2. To investigate the extent of HIV/AIDS awareness in BDSZ.
    - ✓ What is the individual level of HIV comprehensive knowledge and HIV/AIDS practice?
    - ✓ What is the community awareness towards HIV/AIDS?
3. To examine the level of utilization of selected RH services with their main drivers in BDSZ.
    - ✓ What is the FP knowledge and practice?
    - ✓ What is the ANC knowledge and practice?
    - ✓ What is the CD knowledge and practice?
    - ✓ What is the VCT knowledge, attitude and practice?
4. To explore existing strategies of demand articulation for reproductive rights/needs in BDSZ.
    - ✓ How do people articulate their RH rights/needs and to whom do they express them?
    - ✓ Are there any mechanisms which enable people to claim their RH rights/needs and participate in their health?

4.1.1.1. Organization of the Findings

In regard to the presentation of the findings, each research objective is going to be presented in a separate chapter; additionally the introductory findings chapter will be added in order to visualize the studied population including its socio-economic characteristics (Chapter 5). The structure of the reproductive health service provision in BDSZ with special attention to targeting strategies and communication channels (Research objective 1) will be presented in Chapter 6. Chapter 7 will present the extent of HIV/AIDS awareness in BDSZ (Research objective 2). The level of utilization of selected reproductive health services complemented by the level of their knowledge (Research objective 3) will be examined in Chapter 8. Finally, Chapter 9 will investigate the ways people in BDSZ articulate their rights/needs and whether there is any room for their participation (Research objective 4).

4.1.2. Terms Operationalization

Selected (RH) services – services selected for further investigation: family planning (FP), ante-natal care (ANC), skilled child delivery (CD) and HIV voluntary counselling and testing (VCT).

HIV/AIDS awareness – its level is examined at two stages: a) individual comprehensive HIV knowledge and, b) community HIV/AIDS awareness[97]. Those two levels constitute the overall HIV/AIDS awareness.

Comprehensive HIV knowledge (individual) – a respondent was considered to have a comprehensive HIV knowledge when positively answering all the six following questions on HIV transmission: a) not using condom correctly during sexual intercourse with an HIV infected person, b) having sexual intercourse with a person who acquired HIV without condom, c) getting blood transfusion with blood of a person with HIV/AIDS, d) from an HIV infected needle, e) by birth from a mother with HIV/AIDS and, f) by breast-milk from a mother with HIV/AIDS. Simultaneously that person had to avoid all the misconceptions while negatively answering five following questions on HIV transmission: 1) kissing a person with HIV/AIDS, 2) shaking hands with a person with HIV/AIDS, 3) eating something prepared by a person with HIV/AIDS, 4) touching a toilet seat or a door-knob after an HIV/AIDS positive person had touched it and, 5) transmitting the virus by mosquitoes. This individual comprehensive HIV knowledge was assessed through household survey.

HIV/AIDS practice (individual) – the way an individual protects against HIV transmission

HIV/AIDS awareness (community) – the level of community HIV/AIDS awareness was assessed through focus group discussions. Since the nature of FGDs is not designed for the arbitrary assessment and more appropriate for grasping different dimensions, the HIV/AIDS awareness of that particular community was analysed in more dynamic manner such as pointing out at issues identified.

Community – a specific group of people living in a defined geographical area (by kebele & settings: urban/rural) who share common characteristics (culture, values and norms – sex disaggregated) and who are arranged in a social structure according to relationships which the group has developed over a period of time.

Attitude – a predisposition towards an object (condom), a person (HIV infected) or group (VCT users or HIV/AIDS high risk populations) that influences to be either positive or negative about that, favourable or unfavourable.

[97] It has to be mentioned that even though some of the terms are similarly operationalized as in the EDHS, in this study awareness is operationalized differently. The EDHS approach utilizes awareness as a percentage of respondents who "have heard of AIDS". Since the researchers were instructed about the differences in Amharic language between the expressions 'have you heard of' and 'do you know about' they decided to operationalize that in the way which examines the phenomena more in depth.

Service Practice – a state of utilization or non-utilization of selected RH services.

Utilization – is defined for each service in a specific way due to different nature of their delivery.

- ✓ *FP utilization* - a respondent currently uses a modern contraceptive method
- ✓ *ANC utilization* – a respondent received ANC service at least once during her last pregnancy
- ✓ *CD utilization* – a respondent delivered her last child in a health facility,
- ✓ *Skilled birth attendance* – includes the previous characteristics adding the situation when she delivered with an assistance of skilled health personnel or even assisted by a HEW (researchers considered this still as a skilled birth attendance).
- ✓ *VCT utilization* – a respondent got at least once voluntarily tested for HIV

Knowledge – is similarly defined for each service separately.

FP knowledge **–** a respondent knows a method of delaying or avoiding pregnancy, the knowledge was assessed particularly for each method including both traditional and modern methods simultaneously that respondent knows where to obtain a modern method.

ANC knowledge – a respondent knows what ANC is and is able to identify correctly the number of visits for effective ANC (4 visits), simultaneously she knows where the service could be obtained.

CD knowledge – a respondent knows a health facility where can she deliver.

VCT knowledge – a respondent identifies a health facility for HIV voluntary counselling and testing.

VCT attitude – personal attitude towards people seeking VCT service; a respondent was to indicate through three Likert scale (1-5) questions the level of agreement with statements focusing on shame from seeking the service, negative labelling and payment for the service.

Targeting strategies – the ways information, attitudes or ideas on reproductive health and HIV/AIDS are disseminated and targeted on different population segments in order to influence health care seeking behaviour in a positive way. The information that is designed by different actors in RH service provision streams through different communication channels.

Communication channels - the way in which individuals and communities receive information on reproductive health or HIV/AIDS with the aim to influence their health care seeing behaviour positively. Types of channels include interpersonal communication, mass media, formal educational system and others.

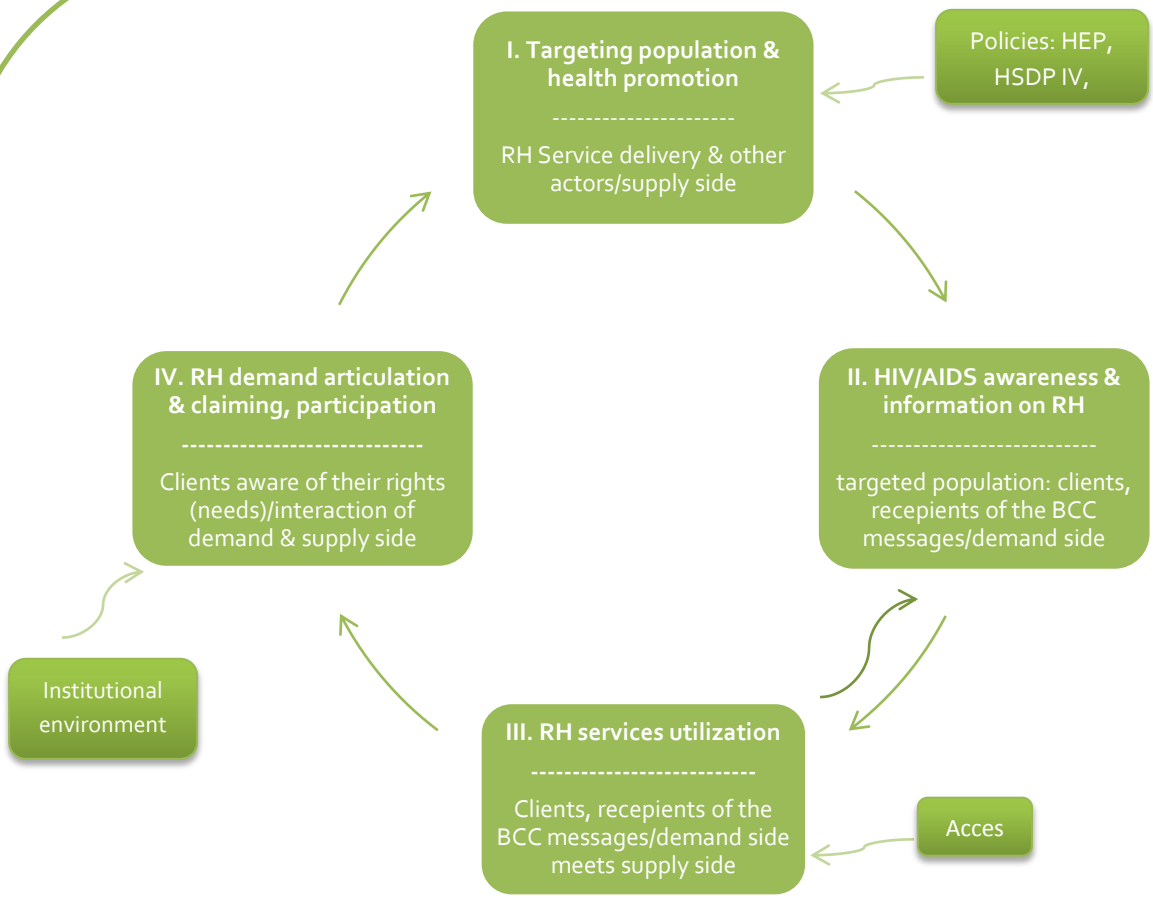
Reproductive health rights/needs articulation – in the Ethiopian context the health rights discussion has been recently operationalized as 'health needs' discussion[98] since the government is not in favour of rights-based approach to health (several in-depth interviews, fieldwork; 2011). The researchers have adopted this terminology in order not to bring controversies onto their host organization assessing any type of action taken in order to influence one´s own health and participate in it; as that type of action was considered complaining on quality of health service (or on other shortcomings), participation in health-related community meetings or demanding the information on health services available.

Other stakeholders – institutions apart from health service providers – mostly local and international NGOs & different levels of regional and local government responsible for health service provision and promotion.

Access - is understood in three main dimensions from the demand side perspective: *physical* (in terms of availability and accessibility), *financial* (in terms of affordability) ,and *social* (in terms of adequacy and acceptability).

[98] The issue of rights/needs claiming will be discussed in Chapter 9

4.1.3. Conceptual Model of the Study



The conceptual model reflects the major assumption of this study. It suggests that the right health information disseminated through different channels (**Sequence I**.) enables people to gain their knowledge and awareness (**Sequence II.**) which is assumed to influence their health care seeking behaviour positively (**Sequence III.**). Further on, as they experience the existing level of service provision, their knowledge and awareness empower them to articulate their demands, influence their own health and participate in the matter (**Sequence IV**.). It has to be acknowledged that this conceptual model should be viewed as an on-going process rather than as a 'status-quo' position since the target audience (demand side) is never static, including specific population segments with their unique needs. It has to be acknowledged that there are other factors which have an impact on almost every stage of the main cycle in the conceptual model. Sequence I. is highly influenced by the existing policy framework and the extent of which it values health promotion, education & behavioural change in policy implementation. Sequence III. is influenced by the level of access to health services. Lastly, the fact whether people would take actions and claim their health rights to satisfy their needs is embedded in overall institutional environment in health service delivery and how comfortable people feel within this framework.

4.2. Research Design

4.2.1. Case Study Approach

The guiding approach of this study has been the *case study approach* following its main features, such as studying the phenomena in their context, utilizing multiple data collection methods while supporting the multiplicity of perspectives in a specific context in order to gain detailed and in-depth understanding (Lewis, 2003). This study utilized Q-squared matrix – both quantitative and qualitative methods were used to triangulate the data. Since this approach allows to present profiles of different social groups within the study population it enables to focus on both disparities and similarities. Since the case study approach structures the sample design around 'the case' which could also be a certain geographical area (Vaus, de; 2001) Bahir Dar Special Zone serves as this study's case.

4.2.1.1. Bahir Dar Special Zone

Reproductive health within the administrative area of Bahir Dar Special Zone (BDSZ) appeared to be a wise decision both in terms of diversity and practicalities. BDSZ with its 11 kebeles combining both urban and rural areas conveyed a rich study base while enabling manageable data collection in terms of human resources allocation within time and financial limitations of the researchers. Out of 11 kebeles, 4 kebeles were sampled for a deeper investigation.

4.2.1.2. Site Selection

The entire section of the data collection areas (concrete kebeles) proceeded in close cooperation with the host organization Family Health International[99], which advised the researchers to scale down their original idea to consider as the whole *West Gojjam* as the case. Time and logistic advantages have already been mentioned. Hence purposive sampling was utilized. Despite the numerous and enduring efforts to gather information on population figures and maps of different kebeles of BDSZ were not able to assemble the data, even supported by the Zonal Health Office in Bahir Dar. Moreover, it seemed that these data have either never been produced or preserved in town. Consequently sampling became highly intuitive task. The final decision on **urban kebeles** was based upon the following requirements:

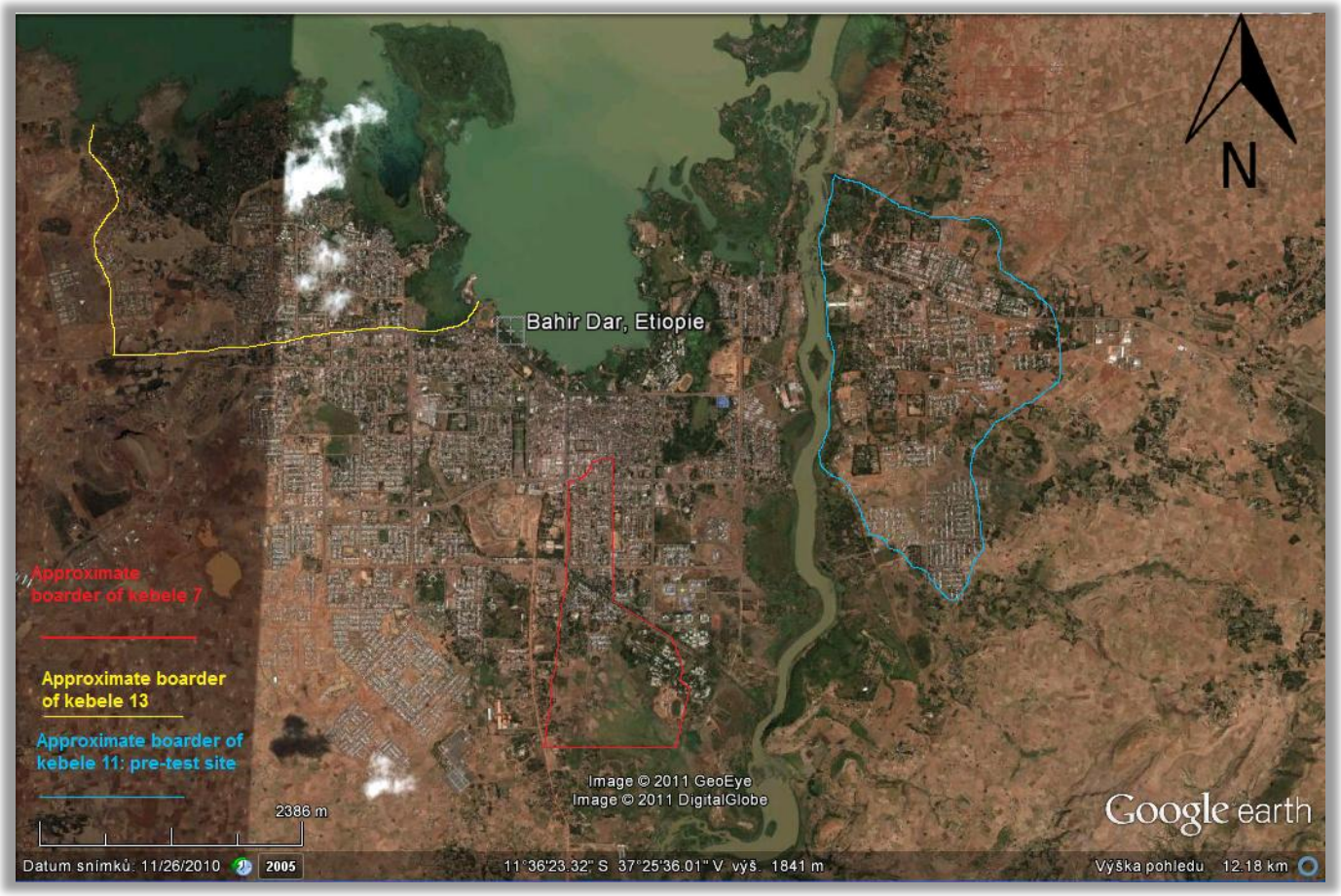
a) The selected kebeles had to have functioning health centres providing RH services for a certain period of time[100] in order to gain deeper understanding of health care seeking behaviour patterns of the sampled population.
b) The pre-tested kebele (kebele 11) was not able to be included further into the data collection.
c) The kebele where the special referral hospital is situated (kebele 13) had to be included in the sample.
d) The selected kebeles should be similar in terms of population size and geographical accessibility while not neighbouring with each other.

Taking all these points into an account, kebele 13 and kebele 17 were finally selected. By coincidence, during the data collection itself the researchers discovered that kebele 17 later merged with kebele 7 due to some administrative reasons. However, this urban data collection was still carried out only in kebele 17.

[99] Amahara Regional Office in based in Bahir Dar
[100] Some health centres have been newly constructed and hardly equipped neither with staff not materials. In addition, some kebeles had no health centre at all.

Concerning **rural kebeles,** the selection criteria have not been that strict in terms of population size or proximity. The main precondition was the functioning health centre which eased the final selection to so-called *satellite towns*. Those satellite towns are in the Ethiopian context labelled as 'satellite towns' by the local authorities. However after the initial mapping the researchers have decided to deem those kebeles as rural specifically just for the purposes of the study. As rural kebeles were finally chose Tis Abay and Meshenti on the outskirts of BDSZ. See the figure IV.A where the urban study area is imaged, for rural areas, see Appendices A4 and B4.

Figure IV.A: Selected Urban Areas of the Study in BDSZ



Source: Google Earth CZ; approximate boarders were derived from a hard copy map provided by the Zonal Health Office in Bahir Dar

4.2.2. Data Collection Methods and Research Informants & Participants

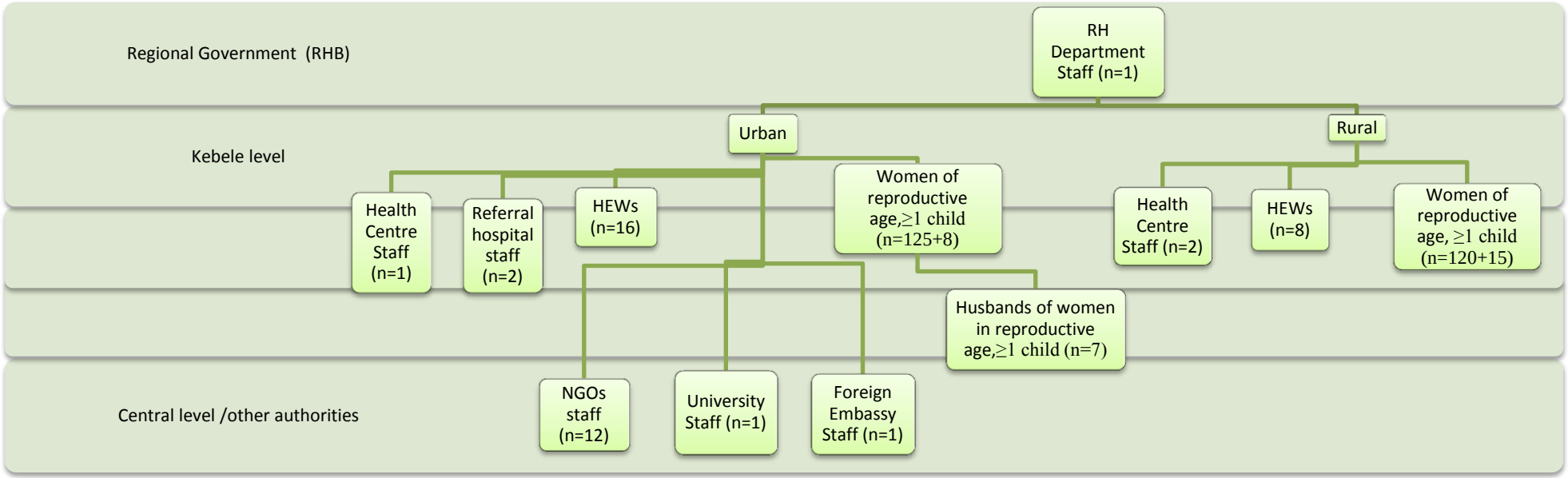
4.2.2.1. Synopsis of the Data Collection

The initial period of this study started with a literature review in regard to research topics including both academic articles and policy documents issued by various publishers. Additionally, an early design of a household survey had begun prior to arrival in Ethiopia. The introductory part of the data collection occured in Addis Ababa where data were collected through in-depth interviews from various agencies (mostly NGOs) operating primarily in the area of reproductive health and HIV/AIDS, additionally dealing with gender and poverty. The researchers were sometimes provided with contextual documents which were lately reviewed. After the relocation to Bahir Dar, in-depth interviews with key informants continued (including health service providers) while focusing more on study area specifications. Consultations with the host organization staff supported the site sampling procedure as well as recruitment of the research assistants' team. After the finalization of the household survey and research assistants training in qualitative data collection techniques, the survey was pre-tested. Several aspects were improved after the pre-test and genuine data collection had started. Simultaneously in-depth interviews were still in progress and preparations for FGDs initiated. Again, research assistants passed training on qualitative data collection techniques, such as FGDs and quality assessments. During the period of the first conducted FGDs quantitative data entry began and the period of in-depth interview closed in. Quality assessments have occurred in public facilities while the last FDGs were carried out. Finally, the preliminary data were analysed and disseminated to stakeholders involved (mostly to key informants). After the departure from the country, careful data analysis followed.

4.2.2.2. Informants & Participants Sampling Frame

The data was collected through various methods and techniques while involving numerous informants (qualitative part) and participants (quantitative part) at both supply and demand sides of reproductive health services. There were totally 319 people contributing to our study, see the Sampling frame in Figure IV.B.

Figure IV.B: Sampling Frame Scheme: Research Participants & Informants (n=319)



Source: fieldwork, 2011

4.2.2.3. Data Collection Methods & Techniques

In-depth interviews

In-depth interviews were conducted during the entire research period in order to gain better understanding of both functioning of reproductive health services in Ethiopia and targeting different population segments in order to raise their awareness and influence their health care seeking behaviour positively. In-depth interviews were the key method particularly during the introductory part of the data collection, starting in Addis Ababa and continuing in Bahir Dar. All key informants were professionally experienced with reproductive health agenda embedded in the Ethiopian whole health sector, often referring to financing and resource allocation. Informed consent including the consent to use recording devices was obtained from all key informants, no one refused to participate in the study, and only one key informant refused to be recorded. In-depth interviews usually took place during working hours in the offices/working places of the key informants. Additionally, apart from the official in-depth interviews, there were also numerous informal opportunistic discussions which helped the researchers to gain complete understanding of the research-related phenomena.

Household Survey

The survey used a structured questionnaire for targeting women in reproductive age (15-49) who have at least one child. The tool was designed by the researchers with initial assistance of their co-supervisor in the Netherlands and lately finalized with cooperation of the host organization after their critical feedback. Afterwards it was translated into Amharic by an affiliated research assistant. The household survey was executed to measure: a) household profile & economic status; b) knowledge & practice of FP, ANC and CD and knowledge, attitude and practice of VCT; d) experienced and perceived quality of FP, VCT, ANC and CD; e) male involvement in health seeking behaviour of women; f) communication channels for information on sexual and reproductive health and, c) rights/needs articulation for reproductive health services.

The tool was pre-tested in a similar population in keble 11 at the edge of Bahir Dar town to test clarity, validity, reliability and translation accuracy of the questions. After its revision, the questionnaire was finalized for use. Respondents were selected through random cluster sampling. The selected kebeles were considered as clusters. After field mapping by the researchers, each kebele streets were equally divided amongst conductors. Each conductor from the research team got the task to try every eighth house in urban kebeles (13 & 17), every third house in Meshenti and, every fourth house in Tis Abay[101]. If the household inhabitant did not meet the criteria or refused to participate, then the assistant tried the house right next door.

Focus Group Discussions (FGDs)

This technique was applied in order to explore the level of HIV/AIDS community awareness and factors influencing utilization of selected RH services. FGDs provided the researchers with valuable opportunity to observe interaction between participants to show and discuss the difference. Purposive sampling was used to select the participants meeting the criteria outlined in Table a4.

[101] Due to larger size of Tis Abay kebele compared to Meshenti kebele.

Table a4: Sampling Criteria for FGD Participants

Women aged 15-49	having minimum 1 child living in kebele 17
	having minimum 1 child & never using FP, living in kebele 17
	having minimum 1 child currently or ever using FP
Men aged 15-49	married and having minimum 1 child
HEWs	working in Tis Abay & affiliated rural kebeles
	working in kebeles 13 and 7-17 in Bahir Dar

Source: fieldwork, 2011

Informed consent including the approval to use recording device was obtained from all FGD participants. On average, each FGD consisted of around 9 participants (ranging from 7 to 16 persons). FGDs were conducted in public health centres on Sundays. A trained facilitator designated from the research team mediated the discussion with the support of a note-taker responsible for audio recording and structured notes. After each finalized FGD a debriefing session of those two took place in order to fill in the report for the researchers.

Quality Assessments & Non-Participant Observations

This technique was applied to support the findings gathered by the main tools, especially to investigate the supply side – service provision of the selected RH services. The researchers adopted the UNFPA standardized observation checklist (UNFPA, 1999 - 2002), which was also approved by the host organization. Each RH service – ANC, VCT and FP (new client) had its own format. Sampling was purposive in order to assess the quality of each public health facility[102] in selected areas. Since the researchers had to obtain an approval from the head of each facility and follow the (selected) service provision schedule, the final number of assessments was in favour of ANC service (see the Table b4).

Table b4: Quality Assessments by RH Services & Facilities

FP	1 new client session	Han Health Centre (kebele 17)
ANC	5 sessions	Meshenti Health Centre, Han Health Centre (kebele 17), Felege Hiwot Referral Hospital (kebele13), Shembet Health Centre (kebele 13), Tis Abay Health Centre
VCT	2 sessions	Han Health Centre (kebele 17), Felege Hiwot RH (kebele 13)

Source: fieldwork, 2011

A research assistant conducting the assessment had to obtain the permission both from that particular health provider and service user before assessing the interaction between them by non-participant observation. This observation also followed up the manner of communication and treatment. Research assistants were strongly advised to be as discreet as possible and not to interfere in any case; both the provider and the service user were assured of confidentiality, no names were recorded.

[102] Excluding health posts

Mapping & Field Observations

This tool was minor in the data collection, mostly limited to kebele observations. Those observations were primarily used to assign the research assistants to sites/streets for household data collection later. However, it turned out to be a very useful tool to compare the spatial settings of each kebele – walking around different neighbourhoods while acquiring a lot of photographic material provided researchers with valuable insight on a daily life of their studied areas. With regard to existing maps of the research sites, it turned out to be an incredible challenge to obtain any kind of maps at kebele level from the local authorities[103]: those materials either did not exist at the moment of data collection or were produced recently and not archived in Bahir Dar.

Figure IV.C: Kebele 17 Field Observation

Source: fieldwork, 2011

4.3. Data Analysis

4.3.1. Data Storage & Sharing

All data was entered into a password protected computer owned by the researchers. The hard copies of filled questionnaires were stored in the host organizations' office and destroyed four months after data entry. Quantitative data entry and cleaning was done using SPSS 16.0 for Windows. All the recorded interviews and FGDs were transcribed in the following manner: a) when an interview was held in English then it was transcribed by the researchers, b) when an FGD was conducted in Amharic, then it was transcribed by the head research assistant and afterwards translated into English by translators affiliated with the research. UNFPA checklists were scanned for a backup and both hard and soft copies preserved. All transcripts and SPSS data set together with contextual documents brought from Ethiopia were shared with the research co-supervisor[104]. The Interim Report was produced as a part of the information dissemination process when preliminary findings were presented to research stakeholders – primarily to the host organization and mostly to the same key informants. Representatives from the regional government were also invited.

4.3.2. Content Analysis

The content analysis for each transcription occurred: the issues relating to the study were identified, the themes were developed and classified. Those were:

[103] Zonal Health Office and BoFED based in Bahir Dar

[104] PhD candidate Dinasas (Dinu) Abdella, Department of International Development Studies, Utrecht University in the Netherlands

a)	Health Service Delivery & Obstacles	l)	Family Planning
b)	HEP & HEWs	m)	ANC
c)	National RH Strategy & MDGs	n)	Child delivery
d)	Donors' Perspective	o)	VCT
e)	Other Actors	p)	Abortions
f)	Targeting strategies	q)	FGM/C
g)	Communication channels	r)	HIV/AIDS Community Awareness
h)	Service Integration	s)	Male involvement
i)	Access to RH services	t)	Rights/needs articulation & Participation
j)	Quality of Services	u)	Population Groups in Need of Special Attention
k)	Utilization Barriers	v)	Sexual & Reproductive Health Education

The triangulation of data sources and methods was employed while comparing information from sources (various clusters of informants and participants) and methods, which increases the internal validity of the results (Ritchie & Lewis, 2003). The attention was also paid to the context in which the themes were presented noticing their frequency (Spencer et al., 2003). The content analysis of this study also applied many aspects of *policy analysis & evaluation* in relation to the Health Extension Programme attempting to provide 'answers' about the context of this health programme referring to the effectiveness of its delivery and impact (ibid).

4.3.3. Statistical Analysis

Even though the 2005 EDHS served as a ground for the questionnaire design, the researchers took a critical stand to that being inspired by numerous academic articles, taking into account the co-supervisor's feedback and their own invention in order to investigate the desired phenomena.

The intro part of the questionnaire was designed to take socio-economic variables such as age, years of education, marital status and type of marriage, number of living children, religion, ethnicity, literacy, occupation, income, health expenditures and household assets.

Income – monthly household income was assessed followed by the calculations of per capita monthly income. This was calculated as division of the total household income by the number of household members.

Health expenditures – were assessed for the whole household for six months prior to the survey as total amount. Later on monthly spending was calculated.

Household assets – even though there have been many variables measuring household socioeconomic status present in the questionnaire, for this study have been relevant two categories of assets: a) means of transportation ownership and, b) media channels ownership.

Individual Comprehensive HIV knowledge – the measurement was explained in the operationalization section.

Individual HIV/AIDS practice – a respondent indicated one (main) protection method she practiced against HIV transmission from the selection of: a) correct and consistent condom use, b) taking medicines/drugs, c) abstaining from sex, d) having one faithful sexual partner. Option 'other' which was offered in the questionnaire was not finally used. Option 'taking drugs/medicines' was after the discussion between the researchers remained as legitimate. Since it

could have shown the option chosen by a PLWHA who 'protects' herself against aggravation of her HIV positive situation.

VCT attitude - a respondent should have indicated through three Likert scale (1-5) questions the level of agreement with the following statements: a) people seeking VCT should be ashamed b) people seeking VCT are only prostitutes or sex workers, c) people seeking VCT should pay for the service.

Selected RH services knowledge – the measurement was explained in the operationalization section

Barriers to utilization – given a broad selection of reasons (categories opposition to use, lack of knowledge and service related reasons), a respondent identified the main reason not to utilize selected RH services.

Rights/needs articulation – a respondent indicated whether she had attended any community meeting on health organized by the local authorities with specifying the frequency of reproductive health issues being discussed. Follow up question investigated whether the respondent had participated in a group initiative concerning health.

4.4. Relevant Issues

4.4.1. Ethical Considerations

The research received formal approval/clearance issued by the Ethical Committee of the Amhara Regional Health Bureau, which means it met all the requirements set by the regional authorities. All participants and informants contributed to the study voluntarily, providing free and informed consent while being assured of anonymity and confidentiality. Further assurance of confidentiality during the household survey occurred (especially in the sections on HIV/AIDS or VCT). The only incentives provided were the refreshments during the FGDs, each participant received a small present at the end of each FGD[105]; no monetary or other incentives were provided. There was no one else apart from the researchers who had access to the data during the data collection period. No names of participants were recorded, considering the key informants; their names appeared only in the Interim Report produced for the host organization and academic supervisors. This Interim Report was a part of the information dissemination process when preliminary findings were presented to research stakeholders – primarily to the host organization and mostly to the same key informants. Representatives from the regional government were also invited.

4.4.2. Study Limitations

The author of the study has identified three levels of limitation: there are limitations in design, process & outcomes and, in the nature. Let us explain each of them. Initially, the design limitation considers the attitude level towards the selected RH services which apart from VCT service was not measured. Ideally, awareness studies (knowledge-attitude-practice) measure all the three aspects. As the study combines interests of two researchers and the service utilization was primarily set as a key issue, the quantum of categories/variables had to be scaled down in order to combine a wide range of topics (from women's self-autonomy to HIV comprehensive knowledge). VCT was finally the only service measured in terms of attitude, partially also due to potential stigma associated with the service. Due to similar reasons

[105] A cake soap for ladies and a package of tea for men.

the individual HIV/AIDS practice – risky sexual behaviour – was not assessed in-depth[106], partway because of the resource limitations and small-scale nature of the research, partially due to the researchers' limited experience[107]. On account of this design limitation it cannot be concluded to what extent the research participants internalized their knowledge in their real lives (what the level of the individual awareness is). The second limitation concerns the data collection process represented by the bilingual nature of the research – even though the research assistants were trained in data collection techniques (in English), the vast majority of the data collection occurred in Amaharic. The 'translation dependency' may have influenced particularly the FGDs outputs where not only the content of the information matters, but also the style of communication. This 'lost in translation' status quo is considered as the major limitation of the research by the author since there were numerous challenges with translation of FGDs' outcomes faced. As the majority of the FGDs outcomes were finalized a short time before the researchers' departure, there were no possibilities to discuss or consult the outcomes.

The nature limitation of this study lies in its case study approach. Whereas its internal validity achieves high level providing a profound understanding of this case (Vaus, 2001), external validity is lacking. There is no basis for generalizing to a wider population beyond this case. A statistical generalization is also not possible either since the researchers had not used representative random sampling[108]

4.5. Conclusion

This chapter documented the whole research methodology of the study while discussing both the qualitative and the quantitative methods applied, the sampling logic and the analytical process were introduced. Ethical considerations with the main study limitations closed the chapter.

[106] Utilized only as one categorical variable with no clarifying variables following

[107] Who have just been found at the starting point of their careers and might better keep this topic for more advanced stage of their professional career

[108] This turned out to be practically infeasible

5. Research Sites & the Study Population

As explained in the previous chapter, the data collection has occurred in 4 selected kebeles: two of them were purely urban – Kebele 13 and Kebele 17 inside of Bahir Dar town. The remaining two kebeles – Tis Abay kebele & Meshenti kebele are in the Ethiopian context labeled as 'satellite towns' by the local authorities. However after the initial mapping the researchers have decided to deem those kebeles as rural just specifically for the purpose of the study. As the studied population is highly diverse (n=245), its characteristics are going to be presented in kebele-disaggregated manner in this chapter in order to follow the case study approach supporting the internal validity of the data. In the following chapters which will be presenting major findings, only two categories are going to be used for the comparison: *rural* (referring to kebeles Tis Abay and Meshenti) and *urban* (referring to kebeles 13 and 17 in Bahir Dar town).

5.1. Kebele 17 – Urban

Kebele 17 is situated in the southern part of Bahir Dar town; it has been merged with Kebele 7 during the field research period, but the data collection itself took place predominantly in former kebele 17. It is resided by approximately 10.000-12.000 inhabitants (Kebele Belay Zeleke administration, 2009). Since this kebele has been newly established, most houses have no official house numbers given by the local authority. This is worrisome because the illegal status may cause difficulties in the future. All the street life of the kebele was affected by a huge road construction[109] during the data collection period. That construction caused an excessive dust and noise, which was very characteristic for all of the kebele during the research period. At the side road directed to Tis Abay there is a large cattle market which attracts the attention of farmers and herders from many neighbouring rural kebeles. There is a small fresh fruit market with household equipment kiosks; those are not significantly large but for the life of the kebele quite important. There is one public health centre (*Han Health Centre*) which is one of the biggest in town, and one private higher clinic. In the very southern part of the kebele there is a large campus of Bahir Dar University, the Social Sciences Faculty called *Peda*. The area of the campus was excluded from the sampling because university students living in dorms there are not registered as Bahir Dar citizens.

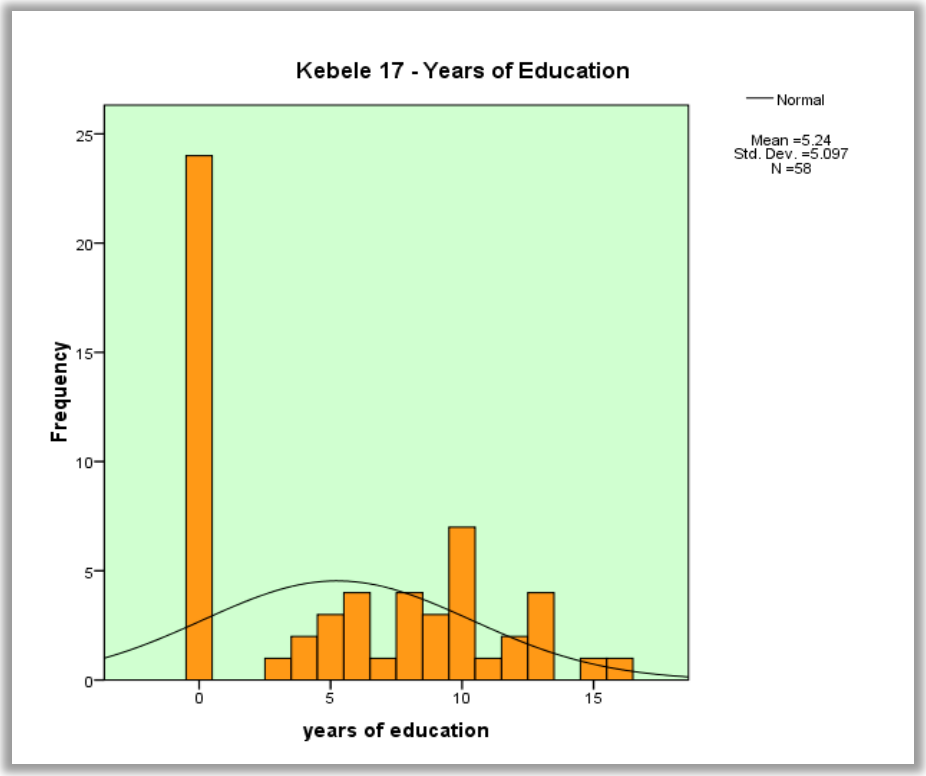
Figure V.A: Neighbourhood Next to the Road Construction – Kebele

Source: author, fieldwork 2011

[109] Figure V.A

5.1.1. Population Characteristics (n=58)

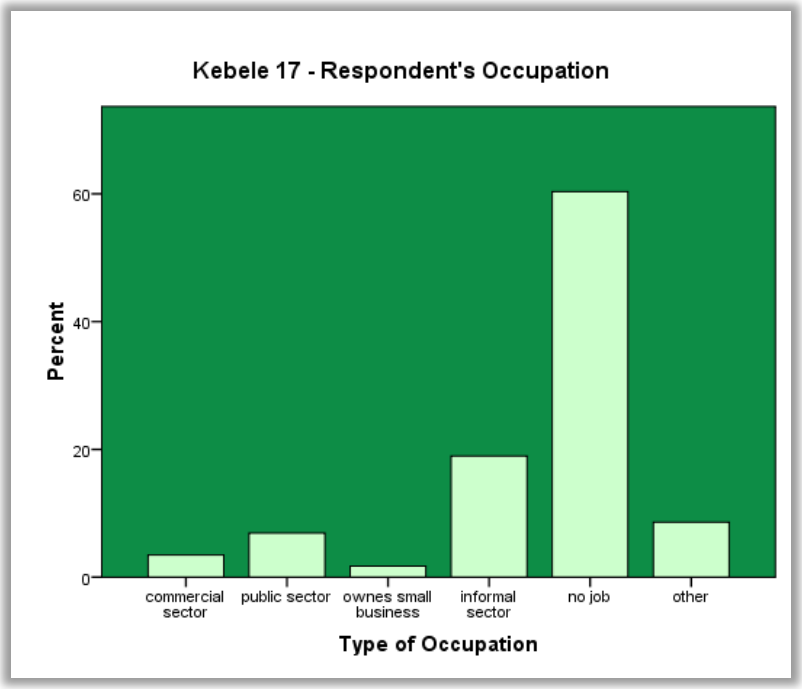
Figure V.B: Educational Level Attained in Kebele 17



Source: fieldwork, 2011

The mean age of the population sample in Kebele 17 is 30.98 years varying from 20 to 47 years age, which applies to the category of women reproductive age (15-49 years). The sample of Kebele 17 has been ethnically homogenous – 98.3% of women reported Amhara ethnicity. The religious structure favours Orthodox Christians with 82.8%, followed by Muslims (15.5%). More than four fifths of women in Kebele 17 lived with their husbands at the moment[110] of the data collection (86.2%) whereof 63.8% lived in arranged marriages. Mean of living children per one woman is woman has been 2.4 in Kebele 17. The level of education of the vast majority of respondents does not exceed primary schooling level although 27.6% of women passed 10 or more years of education. Oppositely, there have been 41.4% of women with no education at all (Figure V.B), which also relates to the proportion of women who can neither write nor read (37.9% are illiterate).

Figure V.C: Economic Activity by Occupation in Kebele 17



Source: fieldwork, 2011

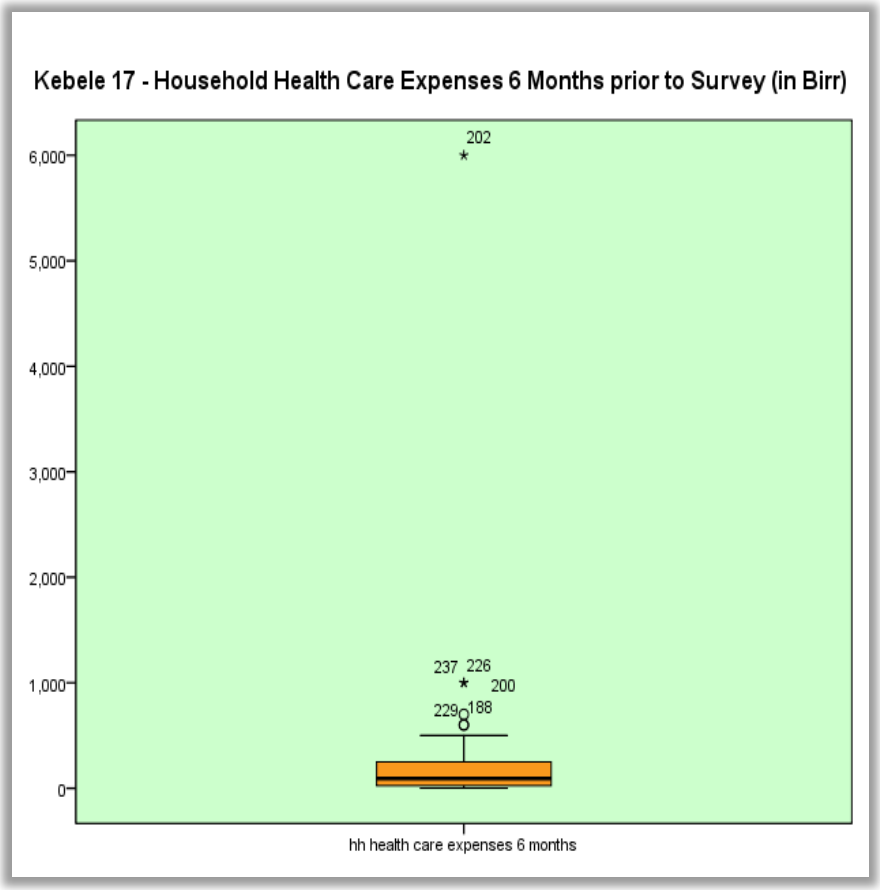
The fact that the most prevalent economic activity in Kebele 17 is informal business is reflected also in our data: most economically active women are involved in the informal sector (19.0%), like preparing and selling local drinks (tela, araki)[111], making traditional clothes or tailoring curtains, bed sheets etc. Further on 6.9% of the sample work in the public sector. Small businesses (e.g. tiny coffee & tea places) sustain livelihoods for 1.7% in the

[110] Note – does not mean the same as 'married' since some of the respondents were married but their husband had been on duty e.g. in the army and did not participate on a daily household life

[111] The women who prepare and serve these drinks it are also often known to work unofficially as commercial sex workers.

sample. However, more than half of the total population is unemployed (60.3%). See the Figure V.C. Economic situation of the households expressed by their monthly income varied as well: from 200 Birr to 5.000 Birr, median household monthly income in kebele 17 is 850 Birr. Monthly income per capita[112] in kebele 17 is 173.2 Birr although with extremes at both the lowest and highest levels – 75 Birr and 1.333 Birr. Concerning household health care expenses, median household spending on health during six moths prior to the survey was 92.5 Birr, which makes it 15.4 Birr spent on health care in kebele 17 per month. However, extremes such as 0 spending per 6 moths and oppositely 6.000 Birr occurred (See the Figure V.D).

Figure V.D: Health Care Expenses by Household in Kebele 17



Source: fieldwork, 2011

Examining the access to livelihood assets, this study is selective to the ownership of means of transportation and mass media channels. Media exposure was enabled mostly due to radio and television ownership: 75.9% of the population has had a radio compared to 55.2% of TV owners. Cell phone ownership has been prevalent amongst 69% of women in keble 17.

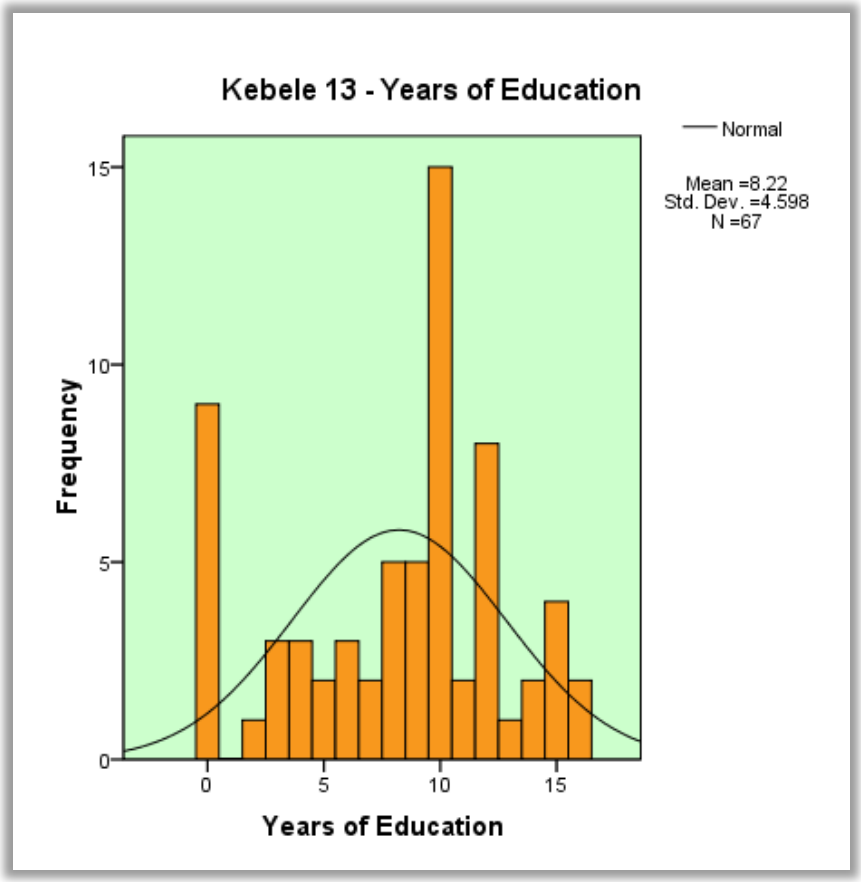
5.2. Kebele 13 - Urban

Kebele 13 is situated in the western tail of Bahir Dar town, adjacent to shores of Lake Tana. It has circa 20.000-25.000 inhabitants (Kebele 13 administration, 2009), which makes it one of the most populous kebeles in town; the kebele is also one of the largest in terms of the surface area. Kebele 13 is very special for the presence of the Felege Hiwot Referral Hospital which serves to almost 7 million people not only from the West Amhara but also from Oromo and Beninshangul Gumuz regions. Apart from the referral hospital there is one public health centre and one public health post situated together with 5 small private clinics and one higher clinic[113]; there are 2 health private colleges. There are

[112] Calculated as a division of the total household income between all the household members per each single household
[113] None of the private health facilities in kebele 13 provides reproductive health services because of high competition with Felege Hiwot Referral hospital or a public health centre.

several public offices, namely: the Police Commission, the Justice Bureau Supreme Court of the Amhara Region and the Immigration Bureau. At the edge of the kebele there is an old marina which attracts prospective foreign investments[114].

Figure V.E: Educational Level Attained in Kebele 13

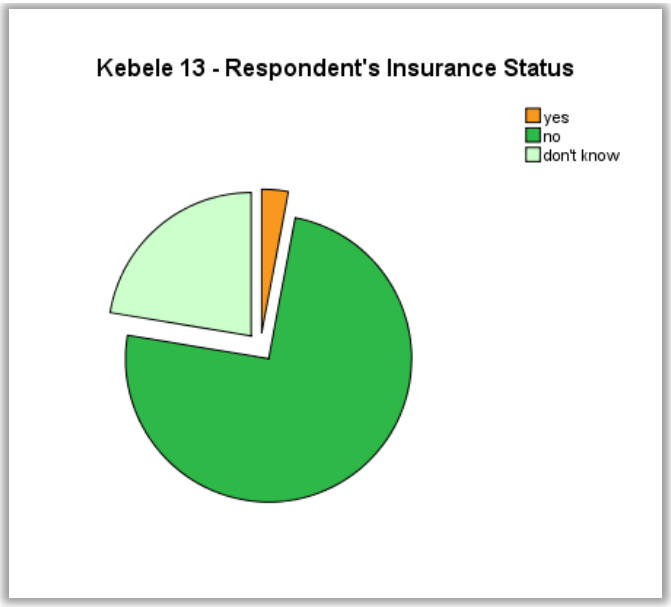


Source: fieldwork, 2011

5.2.1. Population Characteristics (n=67)

The age structure of Kebele 13 varied from 20 to 46 years constituting the mean age of 31.25 years. Even though in this kebele we can find the most ethnically diverse population (apart from Amhara also Tigraway & Oromo), the Amhara still represents 95.5% of the sample population. The religious structure also varied more than in other sampled kebeles[115]; however, the primacy of the Orthodox Church was obvious (82.1%). Again, the vast majority of respondents lived with their husbands (86.6%). Interestingly Kebele 13 is unique for its high prevalence of marriages by love - 49.2% of the population got married that way, which was exactly the same proportion of arranged marriages. Each bore on average (mean) 2.07 children, which is absolutely the lowest figure. The level of education also exceed the other kebeles – 50.7% of women in Kebele 13 have had more than 10 years of education compared to 13.7% with no schooling (see the Figure V.E). This also has wide impact on the overall illiteracy level which is the lowest compared to other kebeles (only 14.9%). Women of Kebele 13 hold one more primacy: there have been found the only insured women in the whole sample – 3% (see Figure V.F). Compared to Kebele 17 this kebele is very diverse in the economic status of its population which could already be judged from the appearance of the

Figure V.F: Distribution of the Kebele 13 Population by Insurance Status



Source: fieldwork, 2011

[114] The researchers have witnessed the visit of one of the potential Asian investors during their kebele observation mapping
[115] Presence of Catholics, Orthodox, Protestants and Muslims was recorded.

neighbourhood[116]. From those who have been economically active (62.7%) most respondents have been employed in the public sector (19.4%), followed by the informal (16.4%) and commercial sectors (10.4%)[117], which might reflect the high presence of petty entrepreneurs' workshops and kiosks. Kebele 13 households' economic situation was the most privileged amongst our sample: 1.000 Birr median household income with variations from 140 Birr to 5.000 Birr. The monthly income per capita consequently mirrored this situation (median 300 Birr). Household health care expenses were also higher: median household health spending six months prior to the survey was 120 Birr (20 Birr spent on health per month. Media exposure is reflected in Table a5.

Table a5: Media Exposure by the Possession in Kebele 13

Kebele 13 - Media Exposure by Possession		
Type	**%**	Frequency
Radio ownership	**74.6**	50
TV ownership	**70.1**	47
Cell phone ownership	**77.6**	52

Source: fieldwork, 2011

5.3. Tis Abay Kebele – Rural

Tis Abay kebele with the total population of 11.656 inhabitants (Tis Abay kebele administration, 2009) is situated approximately 26 -30 km Southeast of Bahir Dar town. Due to the presence of the Blue Nile Falls, which is one of the most visited tourist sites in Ethiopia, this kebele is more exposed to the tourist flow than other kebeles in Bahir Dar Special Zone. The accessibility of Tis Abay kebele is a bit difficult on the score of topography and its underdeveloped infrastructure. The side road to Tis Abay is very dusty without any stable bottom layer; also the transport availability is a bit limited for its population due to public buses schedule[118]. There are a few public district offices, such as the Ethiopian Electric Corporation and Agricultural Institution; there is also a small dairy office of USAID. Regarding health care, there is one public health centre and two private clinics. Tis Abay Health Centre has been reconstructed during the period data collection.

Figure V.G: A Public Bus to Tis Abay

Source: author, fieldwork; 2011

[116] One can find rich middle class inhabitants working for NGOs or as civil servants, living in villas with a huge fence as well as underclass inhabitants sustaining their livelihoods by begging, living in straw huts or shelters built of plastics and other waste material around the Orthodox church compound.

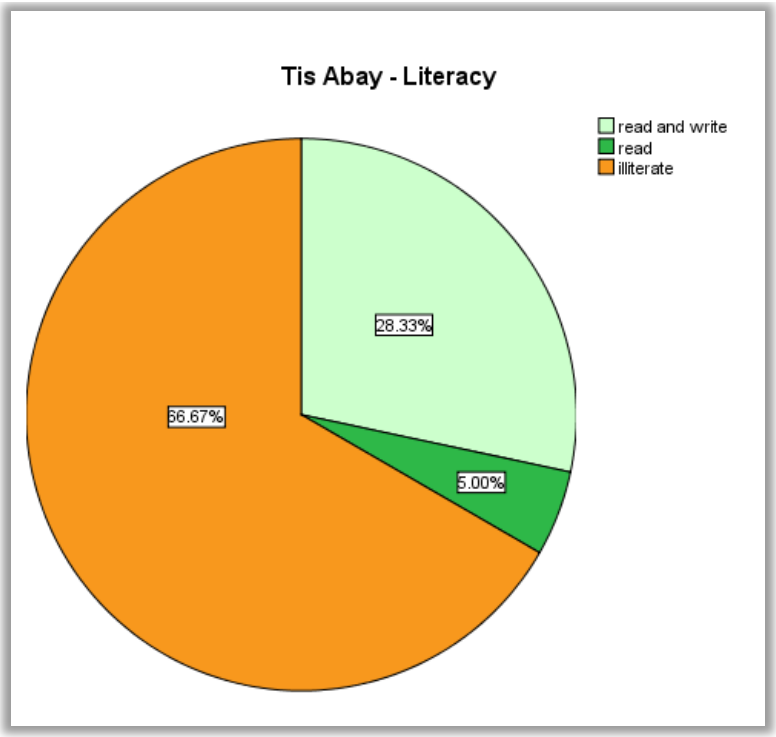
[117] See Appendix A5 – Distribution of the Population by Occupation, Kebele 13

[118] The latest public bus to Bahir Dar leaves at 4 pm - Figure V.G.

5.3.1. Population Characteristics (n=60)

Age dispersion of the Tis Abay population ranged from 19 to 45 years while generating mean age of 31.52 years and being ethnically homogenous (98.3% of women reported Amhara ethnicity). Although the major religion was Orthodox Christianity (78.3%) there was a significant Muslim minority present (20%). In Tis Abay we found the highest proportion of single living mothers (25% living without a husband) among the whole population sample. Additionally, the highest prevalence of arranged marriages was indicated in Tis Abay (89.7%)[119]. Women in Tis Abay bear the highest number of children compared to the other kebeles: they raised on average 3.02 (mean) children ranging from 1 to 9 kids (see Table b5). Tis Abay women also reported the lowest educational level among our sample: 70% of the population sample indicated zero school attendance; mean of schooling was 1.82 years. Consequently, 66.67% of the population sample are illiterate (see the Figure V.H).

Figure V.H: Distribution of the Tis Abay Population by Literacy



Even though this kebele is well-known for its economic agricultural base[120], most of the economically active women have been employed in the informal sector (25%) – sometimes in fabrics making and leather tanneries, more often in preparing local alcoholic drinks[121] for Saturday markets. Additionally 18.3% of women have owned their small businesses of a similar kind. However, traditionally, most of the women were unemployed (46.7%). Household median monthly income in Tis Abay indicated the lowest economic standard in the whole sample: 500 Birr ranging from 150 Birr to 3.000 Birr, monthly income per capita logically reflected this situation: the median amount of 100 Birr sustained living per each household member sampled in Tis Abay (see Appendix B5).

Table b5: Tis Abay - Number of Living Children

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	**<= 1**	15	**25.0**	25.0	25.0
	2 - 3	28	**46.7**	46.7	71.7
	4+	17	**28.3**	28.3	100.0
	Total	60	**100.0**	100.0	

Source: fieldwork, 2011

[119] Abduction has been also prevalent.
[120] Particularly on cattle
[121] Tela or tej

Health care expenses in Tis Abay were found the lowest in the whole sample: the households spent (median) 50 Birr on health during 6 months before the survey which makes it 8.3 Birr spent on health care per household per month. General media exposure is lower although radio ownership is pretty high even in Tis Abay (71.7%) in opposite to TV possession which was absolutely the lowest in the sample (8.3%). Cell phone possession was prevalent amongst 38.3% of the population.

Figure V.I: Women's Hard Labour in Tis Abay

Source: author, fieldwork 2011

5.4. Meshenti Kebele – Rural

Meshenti kebele with th total population of 3.061 inhabitants (Meshenti kebele administration, 2009) is situated circa 17 km Southwest from Bahir Dar town. The physical accessibility of Meshenti is much better than in the previous case because of its strategic position on a quite a new main road which connects Bahir Dar with the central part of the country. Health care in Meshenti is provided by one public health centre and three private clinics. There is also a traditional healer present in the kebele[122].

5.4.1. Population Characteristics (n=60)

The mean age of Meshenti kebele population was 31.13 ranging from 20 to 47 years. Ethnically, the population was 100% Amhara; oppositely to the other kebeles Islam[123] was reported as the major religion amongst 56.7% of the population, followed by Orthodox Christianity (41.7%). Noticeable proportion of women lived without a husband (23.3%) while every fourth woman in Meshenti got married by love (26.7%). Each woman in our sample was raising on average (mean) 2.50 children, interestingly women bearing maximum one child constituted 40% of the Meshenti sample. The level of education was higher than in Tis Abay but still lower than in urban kebeles in our sample (mean in Meshenti was 3.15 years of schooling) while women with no schooling at all constituted 48.3% of the population sample. The literate proportion of the population constituted the same figure as the illiterate proportion – both 48.33%.

Compared to all the other kebeles the smallest proportion of unemployed women was found in Meshenti (36.7%). Meshenti women from our sample contributed to their households' incomes through involvement in various economic activities (see Table c5).

[122] He advertises his services on the main road and was also visited by the researchers.

[123] Meshenti kebele is well-known for its special religious composition compared to the other kebeles in BDSZ

Table c5: Distribution of the Population by Economic Activity

Meshenti - Respondent's Occupation					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agriculture and fishery	1	1.7	1.7	1.7
	Commercial sector	6	10.0	10.0	11.7
	Public sector	2	3.3	3.3	15.0
	Owns small business	13	21.7	21.7	36.7
	Informal sector	16	26.7	26.7	63.3
	No job	22	36.7	36.7	100.0
	Total	60	100.0	100.0	

Source: fieldwork, 2011

Figure V.J: Araki Seller in Meshenti

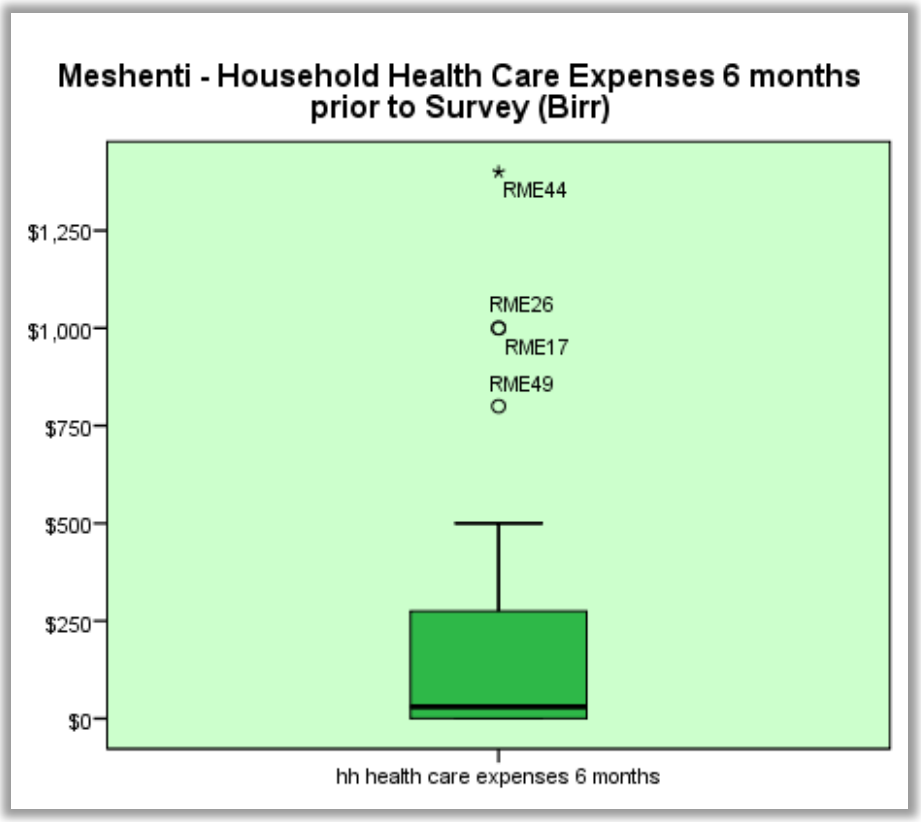
Source: author, fieldwork 2011

The most typical income generating activity in Meshenti is predominantly the cash crops trade[124] that together with other items, such as leather goods or local alcoholic drinks, are regularly merchandised on Wednesday and Saturday markets which attract hundreds of people from more distant kebeles. Women often contribute to those markets either through informal sector activities (26.7%) or by their own entrepreneurship (21.7%). Household median monthly income reached the same level as in Tis Abay (500 Birr, ranging from 120 Birr to 4.000 Birr). Nonetheless, median monthly income per capita was higher than there: 130 Birr.

Sampled households in Meshenti spent the lowest amount from the whole on their health care (median): 30 Birr per six months (ranging from 0 to 1.400 Birr) prior to the survey, which constitutes 5 Birr spent on health of the whole household per month (for overview see Figure V.K). The Meshenti population was also least exposed population towards media: again, the most prevalent mass media channel was radio (61.7% owned a radio), television was possessed by 25% of the population. A cell phone was owned by 46.7% of the sampled population in Meshenti.

[124] Coffee beans, lentils, onions and tomatoes

Figure V.K: Meshenti Household Health Care Expenses



Source: fieldwork, 2011

5.5. Conclusion

The selected demographic and socioeconomic characteristics per each kebele presented in this chapter support the fact of enormous diversity in Ethiopia, which has been the case even within one administrative zone (BDSZ). One can obviously conclude that the overall environment is much favourable towards urban women in the majority of aspects (even though there were some interesting differences found between urban kebeles). For instance there was a significant correlation[125] between the type of kebele (urban/rural) and the level of education of our respondents (years of schooling). It is also interesting to observe the changing patterns of the marriage while choosing one's own husband (marriage for love) is more likely to be attributed to urban settings. On the other hand, there have been also some common phenomena found both in rural and urban kebeles: for instance the level of monthly household health care expenses (as a percentage of monthly income) has been almost identical in all sampled kebeles – around 4.2% (ranged from 3.7% to 4.7%).

[125] -4.27 at p 0.01

6. Lessons Learned from the Health System Structure & Communication Strategies

This chapter is going to provide a reader with an insight into reproductive health service structure in BDSZ with special focus on the provision modalities of selected services under the decentralized framework. Special attention is paid to implementation of the Health Extension Programme in BDSZ. Secondly it will present the mapped communication and targeting strategies towards demand and awareness creation in Amhara and BDSZ. The chapter attempts to identify challenges as grasped by key-informants and FDG participants in both urban and rural areas of BDSZ.

6.1. Where It All Begins: Planning & Financing

"Decentralization is a very challenging exercise for this country" (key informant interview, 2011)

The key regional institution regarding health resource allocation both human and financial, planning and supervision in Amhara is the Amhara Regional Health Bureau (ARHB) based in Bahir Dar. Since the structure has been decentralized (as described in Chapter 3), the main responsibility in terms of annual planning and its implementation lies on woredas following the priorities issued by the MoH while preparing their annual development plans. However, priority setting within the decentralized system turned out not to be that clear. Several key informants (2011) reflected the on-going national discussion on priority settings in health planning, which also concerns Amhara. Summarizing the main views, expressed, there have been three main views regarding the priority settings & planning:

- ✓ Preferring *resource-based* planning – woredas should undertake proper annual resource assessment and plan with respect to resources available in order not to spend energy on huge planning followed by a disappointment from a huge resource gap between the plan and the resources allocated by the ARHB.
- ✓ Favouring *needs-based* planning – even though the resources would not allow, the planning of primary health care regarding the basic needs should be kept needs-based, especially with focus on maternal and reproductive health.
- ✓ Balancing both *needs-based* & *resource-based* – strategic and 'road map' documents such as the National RH Strategy should stay needs-based and ambitious as a vision; however, the issue of communities' ownership (woredas) is crucial, taking into account the communities' resources & administrative capacities.

The planning starts at the bottom - at the facility level when facilities located at different tiers of the service delivery system prepare their annual plan reporting their needs for both human and financial resources. They submit these to their Woreda Health Office. Woreda Health Office further balances the requirements of the facilities based on the scope population of the served and their evaluated performance. Finalizing their proposals, woreda health offices submit them to the Zonal Health Office in Bahir Dar. The Zonal Health Office performs more administrative role compiling the different woreda proposals and submitting them to the ARHB. Most of the key informants indicated the unclear mandate and competencies of the Zonal Health Office, which is apart from the management of physical extension such as such as supervising the health centres construction & equipment[126] not clearly stated even in the HSDP IV (MoH, 2010a).

[126] Equipping the health facilities also includes distribution of supplies provided by donors/NGOs which makes the whole procurement less efficient. For instance a facility in a satellite town is officially supported in supply by a certain NGO. However, this

6.1.1. Woredas + NGOs = Transparent Partnership?

The key actor that interferes into 'Woreda Health Office - AHRB' planning relation are NGOs, both local and international. Those NGOs, as critically reflected by one key informant (2011), have a lot of interaction with AHRB, MoH and other government actors with the aim to "push their own priorities within the health system" (key informant interview, 2011). Advocacy and lobbying are considered as legitimate ways in order to procure certain policy improvements but - as also pointed out by another key informant - the woreda health offices may feel overwhelmed. Joint planning of woredas and NGOs in order to come up with development plans has been understood by the majority of key informants as an ideal situation. Since woredas most likely lack both human and financial resources they hardly refuse NGOs that often work with more resources than woredas themselves operates with (key informant interview, 2011). From the NGOs' perceptive it has to be mentioned that the practical implementation of common activities is hampered by a high turnover even at administration positions. Insufficient information sharing at both sides, lacking transparency about utilization of resources and alignment of activities were also reported.

Before an NGO is allowed to start implementing its programmes or projects, there is a certain administrative procedure which involves another stakeholder – the Regional Bureau of Finance & Economic Development (BoFED). Since BoFED coordinates all funds flowing into the region, it becomes one of the signatory powers of the joint agreement between an NGO[127], ARHB and the Woreda Health Office (where the activities are to take place). According to the NGO's focus the agreement specifies the scale and duration of the programme/project activities. ARHB and BoFED are primarily responsible for monitoring the project/programme performance while delegating the mandate also to the Zonal Health Office and Woreda Health Office. There is often an advisory committee formed to follow the contribution of the programme/project to development of a kebele/woreda or zone where implemented.

Since the range of activities implemented by NGOs in reproductive health and related issues is enormous, it should be briefly mentioned what exactly NGOs implement both in BDSZ and in the whole of Amhara.

6.1.1.1. Activities Run by NGOs in BDSZ & Amhara

The scope of activities managed by NGOs in reproductive health in Amhara is wide. Starting from technical suppor,t such as drugs and appliance supply, through capacity building, research with evidence-based advocacy and lobbying, resource mobilization, comprehensive service provision, awareness raising or social marketing campaigning, community-based reproductive health service provision or government programmes support. Even though the scope is large, the competition amongst NGOs has also been identified by several key informants. In order to grasp the main idea of each of the category of activities mentioned, the Table a6 presents & summarizes them particularly for Amhara and nationwide additionally.

NGO still has to deliver the drugs and equipment through the Zonal Health Office, which extends the waiting period for the facility. Sometimes NGOs deliver the supplies directly while giving a notice to the Zonal Health Office. Unfortunately, according to several key informants this is more an exception confirming the rule.

[127] Or a group of NGOs if it is their joint programme, which is often the case

Table a6: NGOs' Activities in BDSZ and Amhara

Capacity building	Training organization for both health providers and health officers - strengthening public health capacities, best practice sharing
National advocacy & lobbying	Achievement of taxation abolishment on imported contraceptives under the National Advocacy Network, prioritizing the issue of RH at the national level
Research & evidence-based advocacy	Research conducted across the country on RH, gender & poverty; the evidence is used as a tool for advocacy & policy improvement
Technical support	Medical appliance & drugs supply, development of various RH curricula for providers
Resource mobilization	Grouping around thematic areas and developing joint resource mobilization proposals later submitted to donors
Comprehensive service provision	Comprehensive clinical RH service provision with focus on both long-term & short-term FP methods, HIV/AIDS prevention and STIs within comprehensive packages
Awareness raising & BCC	Activities targeting different population segments in order to influence positively their health care seeking behaviour together with knowledge, attitude & practice
Social marketing	Marketing approach (4 Ps) applied particularly to short-term FP methods distributed through marketing channels at the subsidized price while involving small private entrepreneurs
Government programmes support	Financial, labour and material assistance to government extension programmes in terms of facilities construction
Community-based programmes	Recruitment & training of volunteers assisting to HEWs providing house to house counselling and services and using available referral linkages

Source: fieldwork, 2011

Regarding ways forward in terms of NGOs' implementation modalities, only one key informant expressed a necessity to consider a sort of holistic approach to development through issues integration. This means an attempt to come up with joint programming, monitoring and evaluation in order not to 'confuse' communities and support their involvement. Practically it would mean a lot of efforts and challenges ,such as decreased competition but also no longer existence of separate programmes on RH, HIV/AIDS, malaria, TB, etc. (key informant interview, 2011).

6.1.2. Health Care Financing

Combining government and donor's contribution (vide Chapter 3) both general and reproductive health cares in Ethiopia still suffer from lacking financial resources (MoH, 2010b). Regarding HIV/AIDS programmes they have been heavily donor dependant. As shared by one key informant, as soon as Ethiopia wants to become a middle income country by 2015/2020 "*more responsibilities should be taken for paying for health services and HIV/AIDS programmes*" (key informant interview, 2011). The fact is that some financing modalities have already been initiated (MoH, 2010b; several key informant interviews, 2011) and their testing in Amhara was on-going at the moment of data collection. As the most praised financial schemes turned to be social health insurance and community-based health insurance (Chapter 3) also reacting upon the fact that out-of-pocket model did not generate the required budget (key-informant interview, 2011). The role of insurance schemes was perceived by a lot of key-informants as the key income generating technique in order to sustain 'free of costs' primary health care services, especially with regards to reproductive health. Insurance schemes have also been seen as a promising tool to increase the quality of public health services (several key informants interviews; MoH, 2010a; MoH, 2010b). There were two valid questions regarding insurance schemes obtained during the in-depth interviews (2011):

1. Would people consider this system as reliable and would they trust that it brings the promised quality improvement?
2. Would people be willing to accept the system of payment for deferred health service consumption?

Considering the quantitative population sample of this study, there were only 2 research respondents (out of 245) who claimed their active insurance status[128]. It is interesting to point out that those participants lived in the wealthiest studied area (kebele 13 in BDSZ) with the highest median income per capita for that kebele[129]. Overall, the key informants showed very positive attitude towards health financing reform in Ethiopia, especially towards the health insurance schemes. There was only one key informant showing a certain doubt about the implementation which turned out to be lagging behind already during the testing phase (key-informant interview, 2011).

Box 6.A

Indigenous Savings & Insurance Systems

There are numerous types of indigenous voluntary associations where Ethiopians gather in their communities in order to help each other and/or celebrate. Two of those systems – *iddirs* and *iqqubs* resemble the system of modern commercial or public insurance most. *Idders* are established primarily to provide mutual aid in burial matters but also to address community concerns. When a death occurs among its members, the association raises an amount of money depending on internal directive and handles the burial and related ceremonies. Additionally, designated members are delegated to stay at the house of the bereaved for couple of days and assisting the household (Pankhurst & Hailemariam, 2000). In the opposite, behind *iqqubs* establishment stands the idea of starting an income-generating activity. *Iqqubs* are traditional savings associations where members make regular contributions and then allocate the money to individual members on a rotating basis through a lottery system (Mequanent, 1998). A few of our key informants reported a cooperation of their NGOs with those associations on the community basis in order to involve them in awareness raising activities regarding reproductive health & HIV/AIDS (key-informant interviews, 2011).

[128] The respondents were instructed not to report the traditional type of insurance briefly described in the Box 6.A
[129] 500 Birr and 366.6 Birr respectively

6.2. Reproductive Health Service Provision in BDSZ

"Sometimes the workload makes nurses aggressive. So many patients come here on daily basis. Due to the workload, they are sometimes aggressive" (an urban key-informant interview, 2011)

"Most likely I am satisfied but I have complaints about some supplies like ART. There is no ART drug here so people are suffering due to lack of medicine. Most of them are using holy water…" (A rural key-informant interview, 2011)

6.2.1. Clinical Services

The public health facilities[130] providing RH services included in this study were as follows:

- ✓ Felege Hiwot Referral Hospital – based in kebele 13, serving 7 million patients (key informant interview, 2011) not only from Amhara but also from other neighbouring regional states.
- ✓ Han Health Centre – situated in kebele 17-7 covering totally the area of three kebeles (Belay Zeleke, Gimbot Haya and Keshabay).
- ✓ Meshenti Health Centre – the only public facility in the kebele, serving the population of 3.061 inhabitants.
- ✓ Tis Abay Health Centre – serving the population of 11.656 inhabitants and covering in total three kebeles (Tis Abay Zuria, Hasra and Majj). This health centre also supervises two health posts in Hajera and Maji.

6.2.1.1. Urban RH Service Delivery

Felege Hiwot Referral Hospital

As already mentioned, this facility plays a special role in the whole regional state of Amhara being the largest, most equipped and specialized facility available. Its mostly curative role logically results from the position within the health tier system which also reflects RH services provision available. Apart from 'standard' RH services, such as ANC & PMTCT, FP, HCT & ART, child delivery & safe abortion, it also provides cervical cancer screenings and treatment[131] (key informant interview, 2011). Both key informants interviewed at this hospital reported the 'standard' RH service provision as free of costs apart from child delivery (Chapter 7). This appeared to be valid for several other key informants (2011) and also our household survey data. Moreover, since *Felege Hiwot* is designated to deal with more complicated cases of deliveries and general surgical intervention costs there

around 300 Birr there while adding 4 Birr per day of hospitalization and card registration (key-informant interview, 2011), it is more likely to happen that a child delivery in *Felege Hiwot* requires spending. The transport arrangement is fully the user's responsibility (key-informant interview, 2011). The child delivery department has been also recognized as the most overloaded RH service in the hospital (ibid) while indicating that prospective mothers who were able to deliver at health centres in their kebeles preferred the hospital even on the account of higher spending (ibid). The same key-informant reported the quality of their service as the main reason of their clients' trust. As the second, more

[130] Private health facilities were not included for several reasons, mainly because in urban areas they do not provide RH services in kebeles sampled because of the competition with public facilities. In rural areas they provided only some services such as FP short term methods.

[131] For more serious cases going beyond their expertise or equipment they refer to either Gonder hospital or Black Lion hospital in Addis Ababa even though the communication channels within those facilities almost do not exist (key-informant interview, 2011).

implicit reason was reflected the incidence of malfunctioning referral system when both health service providers from lower levels' facilities and (prospective) patients themselves skip one or more tiers in the system and seek health care straight away in *Felege Hiwot.* As one key-informant (2011) indicated, the facility defends against this excessive patient inflow by charging more those coming without a referral document (25 Birr compared to 4 Birr).

Han Health Centre

Figure VI.A: The New Wing of Han Health Center, kebele

Source: author; fieldwork 2011

This health centre offers both short-term and long-term FP methods, ANC, HCT (VCT, PICT & PMTCT), assisted child delivery & safe abortion are also provided (key-informant interview, 2011). All RH services including card registration and child delivery were reported as free of costs. FP was reflected as the most required service, at the momentum of data collection the health professionals were trained by one NGO on IUD provision. Shortages of supply regarding FP methods were not reported, the main distribution of equipment and drugs through the Zonal Health Office was confirmed as well as incidental direct procurement by the NGO, which even built a special room for FP within the health centre compound (Figure VI.A). The shift in focus from short-term FP methods to long-term FP methods was highlighted even though the key-informant (2011) admitted the greater popularity of short term methods. The health centre has attempted to reverse this trend by promoting more long-term methods. The recent training on safe abortion care was organized by the same supporting NGO. There was quite high incidence of abortions reported (approximately 70 per month) specifying Bahir Dar University students[132] as the most frequent users, mostly reporting rape (key-informant interview, 2011), which partially supports the statement of another key-informant from urban health settings that people tend to misreport in order to get the service (key-informant interview, 2011).

6.2.1.2. Rural RH Service Delivery

Figure VI.B: Showing the Plans & Targets in Meshenti

Meshenti Health Centre

Source: author, fieldwork 2011

All of the classical RH services were available in Meshenti Health Centre: ANC, FP short-term and long-term methods, assisted child deliveries; the abortion service was about to start since the health providers were passing the safe abortion training at the moment of data collection.

The RH services were reported as free of costs including the card registration. As the only payment regarding RH services were indicated drugs provided during ANC investigations (key-informant interview, 2011). The same NGO as in urban health centres was providing them with IUD training and contraceptive supply[133]. The privacy and confidentiality were ensured through

[132] The university *Peda* campus is situated in the same kebele.
[133] The same mechanism of procurement as described for urban health centre

the room rotation system while almost each service has its own room available (due to health centre expansion). The time-effective approach was demonstrated towards ensured informed FP choice of women (and sometimes their husbands) when lecturing them en bloc on methods & their side effects during waiting in a queue for treatment or counselling. These 'lectures' were later followed by individual sessions with clients already having some background FP information (key-informant interview, 2011). Depo Provera was reported as the most popular method due to its duration[134] while condoms were picked up only by men. Even though the ANC utilization was reported as quite high, skilled child delivery utilization was poor. The key informant (2011) reflected that out of 106 women who came for ANC to health centre there were only 5 who delivered at the facility. As well as other health facilities, Meshenti health centre attempts to achieve the targets given by the Zonal Health Office as a part of the annual and quarterly plan where exact figures are indicated per each service (Figure VI.B). Meshenti health centre also showed a proactive approach to increase the utilization rates of HCT when organizing outreach programmes by themselves. Consequently, the utilization rate increased several fold (ibid).

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Tis Abay Health Centre

Figure VI.C: Physical Extension of Tis Abay Health Centre

Source: author, fieldwork; 2011

Similarly in Tis Abay Health Centre, both long term and short term FP methods are provided with the planned shift towards long term methods, a referral linkage with Felege Hiwot Referral hospital for permanent methods[135] was also mentioned (key-informant interview, 2011). Privacy is ensured thank to separate rooms. HCT (VCT, PICT & PMTCT) is also provided. There is no payment related to RH services in Tis Abay neither for child delivery nor for ANC drugs nor a registration card. However, if a drug is not available in the centre, the client gets a prescription and has to purchase it somewhere else, which is then non-refundable (ibid).

The health centre attempts to improve its difficult financial situation through charging 3 Birr for a card registration and other non-RH services to generate some revenues for health centre quality improvements, they mostly buy the needed medicine & equipment. Lacking laboratory equipment[136] was reflected challenging, incidental medicine donations were usually distributed to the Tis Abay population for free. The key informant (2011) also reflected upon the annual budget allocation to their health centre as insufficient support highlighting that even if the Zonal Health Office was in surplus, the resources available were usually equally distributed among all health centres in the whole Zone (key-informant interview, 2010).

6.2.1.3. Reflection on Clinical Service Provision in BDSZ

Numerous key-informants reported significant improvement regarding the geographical access of reproductive health services in BDSZ. However, quality still stays a pressing issue as one key informant (2011) argued: "*I should not say like I do have such amount of Health Centres, such amount of Health Posts…obviously, there are many health centres these days the expansion is so enormous, so huge. But in terms of adequacy…the government has to clearly see what has to be done, it*

[134] Some women living in remote kebeles supervised by Meshenti health centres have to walk around 1,5 hours therefore they do not have to come often

[135] Vasectomy and female sterilization

[136] After the finished interview the head of the head centre proudly showed us the new freezer for laboratory specimen storage.

has to assess quality and has to clarify where the gaps are & those gaps should be filled… if the government does not give you the green light, everybody continuous in the same vicious circle" (key-informant interview, 2011). See the Appendix A6 on VCT quality observation carried out in urban facilities of BDSZ.

Regarding the RH service adequacy experienced by FGD participants, there have been differences in quality regarding urban and rural health centres. Whereas in urban health centres as the main quality issue was reflected staff overload & mistreatment (urban FGDs, 2011), in the rural context the burning issue is inadequate supply of drugs and medicine (rural FGDs, 2011), which points out at the inadequate procurement and logistics management. Considering the qualifications of health centres' heads, all of them reported clinical nurse diploma, one of them also indicated employment at a private health institution. This was also reflected by several urban FGD participants as an unfavourable phenomenon. As a positive move towards relief of nurses' workload, employment of FP & VCT counsellors appeared. Their engagement in RH service provision represents a task-shifting direction in health service delivery (several key-informant interviews, 2011). Ensuring 100% privacy turned out to be challenging especially in both urban health facilities due to the enormous inflow of medical students performing their internships (several key-informant interviews, 2011)[137].

6.2.2. Community-Based Services

As described in Chapter 3, reproductive health services are provided at the community level by Health Extension Workers (HEWs) assigned by the Zonal Health Office supported by volunteers (often former CBRHAs) supported by various NGOs (several key-informant interviews, 2011). The vast majority of our key-informants expressed very positive attitude towards their deployment, some of them referring to small scale studies attributing recent CPR increase just to HEWs. On the other hand, a lot of key-informants doubted their capacities and confidence particularly in regarding their attendance of child deliveries (ibid). Since the modality of urban HEWs has been implemented, the nature of the training also differs. Urban HEWs are usually graduated nurses who additionally pass only 3 months training on all 16 packages to become a HEW, unlike rural HEWs pass 1 year training conditioned by high school graduation (key-informant interview, 2011). Trainings with various focuses as well as in-service practice are usually highly supported by NGOs, which brings both benefits and shortcomings. A few key-informants disapproved the quantity of trainings targeted on HEWs (key-informant interviews, 2011); oppositely the alignment of those trainings is often an issue – as an urban HEW highlighted: *"It has been two weeks since we learned about FP counselling method. Before we only used to tell them to use Depo or pills. The training is bringing a difference"* (FGD, 2011). Interesting is also the feedback given by the general society of Bahir Dar on HEWs. Through FGDs organized with both urban and rural participants it resulted that people in relation to HEWs envision first environmental health issues such as latrines, hygiene, household management or malaria prevention. The experience differed across gender and type of settlement indeed[138]. Overall, their work was generally accepted as beneficial and socially responsible (several FGDs, 2011). Additionally, some key-informants admitted that HEWs can hardly meet the communities' health demands, especially related to RH. All female participants of a rural FGD concluded: *"Hews? They do not have supplies! All they have is Coartem.[139]"* (rural FGD, 2011).

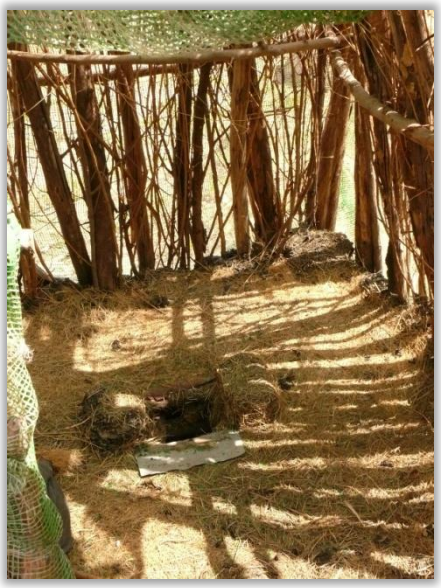
[137] Although a client has the right not to approve the presence of an intern during her/his investigation, particularly in *Felege Hiwot* Referral Hospital this was reflected as an issue.

[138] For instance an FGD with urban males revealed that they were very well informed about the programme from mass media but had no notion of existence of this programme in their own kebele.

[139] Malaria treatment drug

6.2.2.1. Health Extension Workers in BDSZ

Figure VI.D: A Pit Latrine Interior in Tis Abay Built by a HEW



Source: author, fieldwork 2011

According to the Zonal Health Office (2011) there were totally 43 HEWs assigned in BDSZ. Regarding the studied areas sampled, the status quo was during the data collection as follows:

- ✓ There were 3 HEWs working in kebele 13 at the momentum of data collection.
- ✓ There were 8 HEWs operating in kebele 17-7 covering totally the area of three kebeles (Belay Zeleke, Gimbot Haya and Keshabay), they were supervised by the Han Health Centre.
- ✓ There were no HEWs available in Meshenti at the momentum of data collection.
- ✓ There were 9 HEWs assigned for Tis Abay Zuria kebele, Hasra kebele and Majj kebele. Two of them were available right for Tis Abay Zuria kebele. All of them were supervised by Tis Abay Health Centre.

Box 6.B

A rural HEW's Narrative

"I was giving to this new woman the contraceptive when her husband accidentally showed up. The man was already suspected that she used contraceptives because he found her registration card. One day he stopped me on the road and wanted to talk to me. He asked me if I was the one who had given his wife an injection. He also added that he would initiate a fight with me if I kept doing this. I had also ran into a man with a stick in his hand to hit me. He also implied: 'you have made my wife not to conceive by injecting her and now you have to reverse the situation by injecting me!." (A rural HEW at the FGD, 2011)

The monitoring & evaluation system of HEWs is based on reporting supported by regular field visits of designated supervisor who is directly subordinated to health of a health centre (key-informant interview, 2011). According to HEWs their supervisor tests in their communities the quantity of households covered by each as well as the progress of model households (FGDs, 2011). As obvious, there were more HEWs available in sampled urban kebeles of BDSZ than in the rural ones. This mirrors the high turnover issue (key-informant interviews, 2011) especially in rural areas where difficulties to overcome both topographical and social barriers in order to cross a family's threshold play a role. HEWs (FGD, 2011) also identified an important population segment while visiting people door to door – maids. Those domestic workers often very young spending almost 100% in their employers household hardly find time and financial resources to visit a health centre (key-informant interview, 2011). It seems that HEWs reached one underserved population segment.

Being a Health Extension Worker…

Both urban and rural HEWs identified numerous challenges faced through their job performance. Particularly in rural areas certain 'resistance to change' was identified since people (mostly farmers) do not internalize the teachings even after several regular visits so persistence and consistence are necessary. It was also suggested to involve community gatekeepers more since they often serve as a model to the society and people would easily accept new models of behaviour from them. As another pressing issue identified in rural FGDsis to mention the power imbalance experienced while addressing men and initiating a discussion on reproductive health of their wives. Read the Box 6.B on power imbalances encountered at HEW's job performance. In urban areas HEWs reported the general public attitude as more

distant while sending HEWs to rural areas where they should 'better teach the farmers' (several FGD participants, 2011). Regarding child deliveries, none of the participating HEWs (both urban and rural) reported their own assistance at a child delivery (FGDs, 2011). This again confirms the worries expressed doubting their confidence. Moreover at the momentum of data collection, child delivery training was organized for urban HEWs unlike the rural ones, which unfortunately proved the assumption on cumulating the services in certain (urban) clusters.

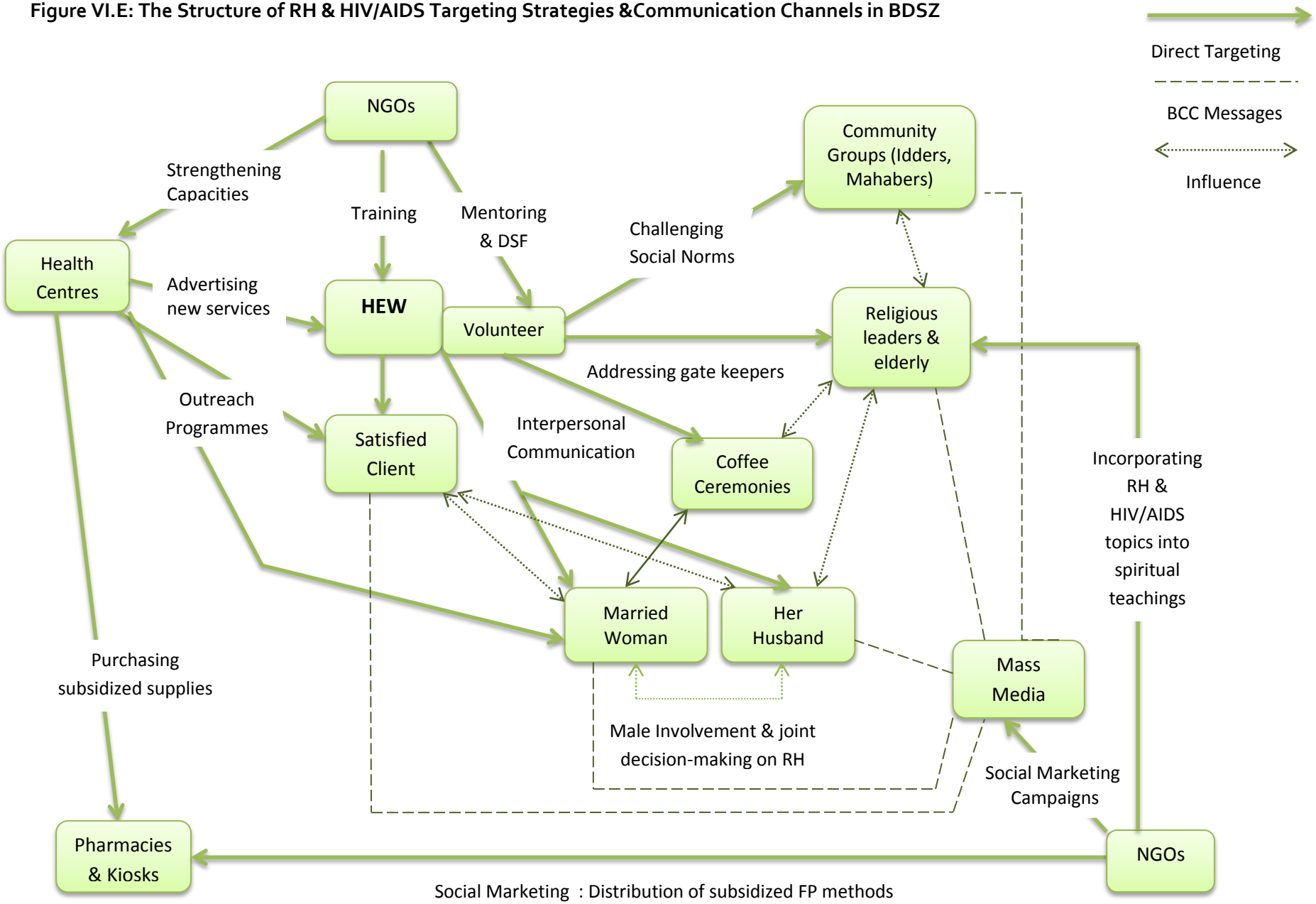
6.3. Communication Strategies towards Greater Awareness & Utilization of RH Services

"Awareness nowadays is becoming better but not adequate. As we know reproductive health is women-oriented: services, mobilization. Everything is female-focused and males are forgotten. They are not supported regarding maternal health so they do not know about health of their partners nor about their own reproductive health. " (A key-informant interview, 2011)

Communication messages designed to raise awareness on reproductive health issues and to stimulate the demand for reproductive health services have dramatically changed during the past decade (Salem et al., 2008). Ethiopia is not an exception and since some of the maternal health outcomes and services utilization rates have not changed so dramatically as expected, development practitioners had to come up with more innovative communication mix which does not only target the populations but which also enables their participation in a message development process. Contemporary strategies as investigated in BDSZ vary across settlement settings, age and gender. On the other hand, as the quote implies, the majority of strategies still target on married women, especially in connection with family planning (several key-informant interviews, 2011). The good sign is that population groups requiring special attention in both behavioural change communication (BCC) and service user-friendliness have been officially identified (Amhara MARPs survey, 2010; MoH, 2010a; Erulkar & Muthengi 2009; Population Council & UNFPA, 2010) and more efforts were undertaken to 'get them on board'. Even though NGOs have played a crucial role in design and dissemination of BCC messages challenging especially gender imbalances & unequal power relations, there are other important actors who have been executing various strategies to create demand for reproductive health services while promoting a positive social change. As observed in BDSZ, the communication structure created by various actors is not simple and involves many channels, social institutions and individuals. The key role is again played by HEWs who are positioned in the heart of the whole structure of different awareness raising strategies taking advantage of their social and spatial proximity towards the communities. On the other hand, traditional channels, such as mass media or satisfied clients of particular reproductive health service still play a role, even though more passive. Male involvement obviously becomes a 'buzz phrase' in the reproductive health sphere, which was also concluded by many key-informants in BDSZ(2011); however, there are few effective targeting strategies which would address the men's reproductive knowledge, attitude and practice not only in an important but limited relation to their wives' health (key-informant interview, 2011).

On the other hand, the fact that various actors have acknowledged the importance of joint decision making on either women's or men's health is positive. Desirable factors of contemporary communication strategies mapped in Amhara and BDSZ is their focus on the social changes and community empowerment (Cabaňero-Verzosa, 2003) rather than on simple BCC. Secondly, their higher credibility is also ensured due to the engagement of stakeholders, such MoH & ARHB (through HEP) and very recently religious leaders and institutions enjoying enormous respect amongst the whole society (several key-informant interviews,2011).

Figure VI.E: The Structure of RH & HIV/AIDS Targeting Strategies &Communication Channels in BDSZ



Source: fieldwork, 2011

Figure VI.E provides a comprehensive scheme of RH and HIV/AIDS communication channels and targeting strategies as mapped through in-depth interviews and FGDs in BDSZ. This scheme should not be understood as a fixed status quo. Moreover, it would certainly look differently for high school youth or different segments of HIV/AIDS most-at-risk-populations. The main aim of this scheme is to grasp the major channels between various communicants with a common aim to influence women's health care seeking behaviour positively. As the structure is very much interconnected, the main targeting and communication strategies will be presented in categories.

6.3.1. Financial Mechanisms

As financial mechanisms are understood those which attempt to increase access to reproductive health care through monetary mechanisms: a) demand side financing in health and, b) social marketing.

6.3.1.1. Demand-side Financing in Health (DSF)

Even though this mechanism has been reflected in a very limited manner, there were interventions reported by key-informants (2011) from one research-oriented NGO. This system reflects the barriers faced by limited financial resources and geographical and social access when "placing purchasing power and ideally the choice of provider directly in the hands of beneficiaries" (Gupta et al., 2010:2). In the context of this study the intervention reported was small-scale livelihood environment change which caused the positive behaviour change[140]; additionally, the NGO subsidized the cost of registration cards at a health facility for married adolescents targeted. Another intervention implemented by the same NGO was characterized by a voucher system with a network of participating RH providers offered to a targeted population of urban domestic workers. This DSF system is rather small scale in BDSZ and according to a few key-informants it has not been favoured by the ARHB because its potential of a dependency creation (key-informant interview, 2011).

6.3.1. 2. Social Marketing

This strategy utilizes the social marketing approach of '4 Ps' (Product-Price-Place & Promotion) focusing on financial accessibility and availability of short-term FP methods, in Ethiopian context especially condoms which are distributed through marketing channels. For instance as observed and checked with several pharmacists in BDSZ, one specialized NGO was the major distributor of condoms to pharmacies, private clinics, motels and kiosks (several opportunity discussions; key-informant interview, 2011). The price of the short term FP methods is subsidized; however, some price policy reconsiderations have been made (key-informant interview, 2010) – for instance in 2010 the price of a package of three condoms was 1 Birr, at the momentum of data collection it was 2 Birr. Even this system targets primarily private providers & wholesalers; supplies for subsidized prices are often purchased by public facilities when facing shortages (key-informant interview, 2011).

[140] A family received a goat each year in which it did not wed off a daughter before her legal marriage age (key-informant interview, 2011).

6.3.2. Bridging the Spatial Distance

6.3.2.1. Outreach Programmes

Outreach programmes were organized by both NGOs and Health Centres in BDSZ, or combined by both (key-informant interviews, 2011). The main aim was often health promotion and as the main tool they used a van, most likely providing VCT, equipped with audio-video utilities promoting HIV prevention (key-informant interview, 2011). An interesting element of this 'traditional approach' was targeting military camps and the Police in their compounds (ibid).

6.3.2.2. Mass Media Channels

Figure VI.F: BCC Material for Posters & Billboards on VCT

Source: FHI, 2011; * "Trusting before testing is like a playing on a cliff"

This traditional communication channel is still frequent. An NGO purchases some air time on TV or the radio, produces billboards, posters and flyers which are distributed at various places (key-informant interview, 2011). In order to support the FP informed choice decision they produce the materials where all options are compared (ibid). Concerning the dissemination through television since there is only one state media in Ethiopia the information has potential to reach more people than it would through different fragmented TV channels (ibid). The NGO that specializes on mass media RH advertising is present up to 5 times a day in the national TV (ibid). Perhaps not surprisingly television and radio were reported as two main sources of information on reproductive health amongst household respondents (TV-34.3%, radio – 28.2%, n=245). Those communication channels were also reported as the continuously preferred ones. The role of information disseminated through media was also identified by female FGD participants especially in relation to decrease of HTPs and FGM/C in particular [141](FGDs, 2011). According to the household survey 16.3% of women in BDSZ would let her daughter circumcised[142]. There was also a moderate[143] association found between radio ownership[144] and knowledge of abortion status which supports the assumption that media exposure plays a positive role in RH knowledge in general.

6.3.3. Narrowing Social Distances

This section of targeting strategies and communication channelling presents the most progressive approach with high potential to address the issues such as stigma, exclusion from a service while opening a discussion on cultural norms and barriers. The role of HEWs has already been discussed; however, the following sub-sections are more or less directly related to their job performance.

[141] Quotes such as: "*I heard from the radio that even the science and religion proved it is a bad practice*". "*Our parents mutilated us because they lacked the knowledge*" or "*I circumcised my first daughter because there was no law & education at that time*" (urban FGD participants, 2011)
[142] In case they have or would have one
[143] V=0.226, phi = 0.226 at p=0.006 (Sig. ≤ 0.05) (n=245)
[144] It was owned by majority of the study population – vide Chapter 5

6.3.3.1. Volunteers & Mentoring

In many kebeles there are often volunteers often working aside of HEWs very closely with the communities. Their 'recruitment' may differ from being a former CBRHA hired by an NGO, performing traditional birth attendance and having a strong position in that particular community or being selected by an NGO as a mentor for initiated community meetings (several in-depth interviews, 2011). Both mentors and volunteers are usually trained by NGOs in order to perform a certain task related to a job of a HEW. Sometimes the voluntary job is not tight to HEW's performance – for instance: an NGO 'contracts' a health provider who voluntarily reaches the remote communities for investigation, he is not on anyone's payroll but his expenses on food and fuel are covered by that NGO (key-informant interview, 2011). Volunteers are most likely expected to fully participate in community life while following the important occasions such as holidays, market days, coffee gatherings where in a friendly and informal way disseminating various messages regarding RH, HIV/AIDS, HTPs, etc. (several key-informant interviews, 2011). In order to acquire access to excluded populations such as to married adolescents or female domestic workers the mentors are selected in the way so that their status would enable their negotiations with e.g. a husband or an employer to permit the attendance of a targeted woman or a girl (key-informant interview, 2011). Similarly mentors who are respected in communities are selected for male involvement groups (non-participant observations & key-informant interviews, 2011). The aim of male involvement groups is to mobilize communities and to create some space for open discussions on the issues of household duties sharing, family planning, women's & children's health, caring for elderly, early marriages or alcohol abuse (non-participant observation, 2011). Since audiences are often illiterate, mentors often use illustrations, flipcharts and posters which can stimulate the discussion (ibid).

Figure VI.G: Male Involvement Group with a Mentor in Woreta

Source: author, fieldwork, 2011

Figure VI.H: Mentor's BBC Material

Source: Population Council, 2011

6.3.3.2. Involving Religious Leaders

Religious leaders in BDSZ are usually targeted in two ways: a) informally during holidays and feast celebrations by volunteers or b) they are formally addressed by NGOs. The importance of religious leaders involvement to bring the desired behavioural change in the desired manner was also recognized by HEWs: *"Involving highly accredited people especially religious leaders and the elderly. I think after their intervention people might have accepted that. So making*

them participate on special meetings can be effective" (a rural HEW, FGD, 2011). Recently more international NGOs have started to cooperate with religious leaders more systematically, especially through their implementation partners, often local NGOs. Even though the initiatives have been in smaller scale, one intervention which incorporates RH issues, gender inequalities, HIV/AIDS or HTPs in the previously strictly spiritual teachings has already been approved by the patriarch. Since the federal state is secularized from the Orthodox Church, the negotiations on scaling up the programme to the national level were "*in the full swing with no need to ask the state for the permission*" (key-informant interview, 2011) at the moment of data collection.

6.3.4. Quality Improvements at the Facility Level

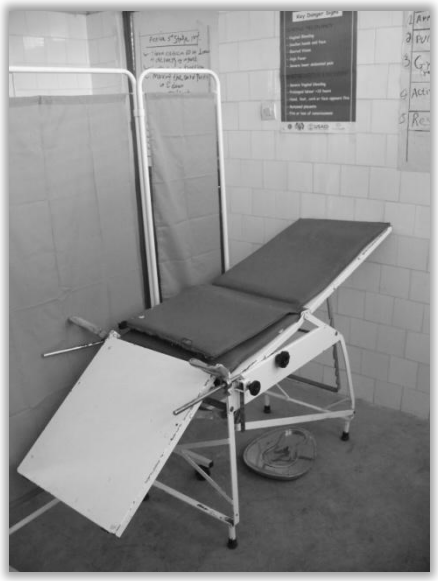
As their targeting strategy towards higher utilization of RH services, several key-informants labelled the quality improvements since the "*strengthening of existing institutions will have a positive impact on people's interest*" (key-informant interview, 2011). The strengthening is usually executed by NGOs through both supplying with equipment[145] & drugs and providing trainings to health providers as described, Box 6.C provides a practical example of a tool for quality improvement being implemented at the health centre level in BDSZ. As soon as HEWs serve as an extended channel of health centres they advertise new available services and equipment(key-informant interview, 2011). Health centres were also reported as the third most frequent channel which household respondents gained the RH information through (21.2%, n=245).

Box 6.C

COPE: Client-Oriented, Provider-Efficient Services

The process of improving quality in health facilities implemented by one NGO in several health centres of BDSZ. COPE encourages service providers & other staff at a facility to assess the services they provide jointly with their supervisors. This system of self-assessment identifies problems, attempts to find root causes and makes the participants aware of good practices. This assessment approach also includes client interviews to increase staff's understanding of the users' perspectives. COPE also tries to include the services and the community overall (EngenderHealth, 2011).

Figure VI.I: Delivery Room in a Rural Health Centre



Source: author, fieldwork, 2011

Service integration was also reflected as a strategy towards increased service utilization which is legitimate; however it only concerns people who are already users (of another service indeed) so it definitely functions in terms of coverage increase, nonetheless, the issue of positively influenced health seeking behaviour is not fully addressed by service integration. The HEW position already integrates lot of services (16 packages), however since HEWs 'do not have a mandate to make prescriptions' (key-informant interview, 2011), the issue of supply availability stays open. As the greatest achievement in terms of integration key-informants indicated PMTCT availability in all health centres, generally the integration of RH and HIV/AIDS was not appreciated (several key-informant interviews, 2011)

[145] Figure VI.I

6.3.5. Sexual & Reproductive Health Education

Sexual and reproductive health and HIV/AIDS education is not yet fully institutionalized in Ethiopia as already described in Chapter 3. This gap was not only recognized by a few key-informants (2011) but also concretely demonstrated by 300 unwanted pregnancies in one high school in the centre of Bahir Dar town for the duration of six months prior to the data collection period (key-informant interview, 2011). Sharing the worries of one key-informant: "*People talk a lot about HIV/AIDS with young people. But they do not talk a lot about reproductive health… the thing is 'you do not do it, and if you do it you use a condom'. There is too much focus on HIV infection. It is not the focus 'if you have sex you can also become pregnant or you can make a girl pregnant'*" (key-informant interview, 2011). Female FGD participants in both urban and rural areas admitted that discussing RH issues with their daughters is not common, although some participants reported they shared their own experience with their children (FGDs, 2011), which contrasts with the striking finding revealed by the household survey (2011) when 31.4% of women in BDSZ stated that they did not talk to anyone about RH issues[146]. Many both male and female FGD participants highlighted the role of school in RH information dissemination to adolescents and youth, especially in relation to STIs and unwanted pregnancies (ibid). Considering the quantitative study population, 79,6% of women reported the full agreement with incorporating sexual and reproductive health education into school curricula for adolescents whereas only 1,2% completely disagreed (n=245, fieldwork, 2011). In practice lacking sexual and reproductive health education is often substituted by fragmented NGOs' initiated *peer-support groups*.

6.3.5.1. Peer Support Groups

NGOs often combine the mentor approach with the peer approach to identify and form relatively homogenous groups in order to establish them on a peer-to-peer basis with a mentoring leader. The mentors first train the peer leaders and then, with support of training manuals, they disseminate the information among the group (several key-informant interviews, 2011). The manual is developed in a progressive manner so while the group is followed by a mentor and after passing through all the topics in the manual, the group 'graduates'. The peer approach is used especially in HIV prevention programmes, additionally it relies to a large extent on youth's social networks. Those are, perhaps surprisingly, often weaker than stronger, especially as far as girls are concerned, due to their attributed gender roles (Population Council & UNFPA, 2010).

Box 6.D

Bahir Dar University Gender Club

It was established at the university to support female students and to create awareness of gender equality. The club has its own executive organs, accounting and PR. It is formally supported by the Bahir Dar University Gender Office. The club attempts to address male students to support female students and treat them equally as well as provide technical support to female students to prevent dropouts (e.g. separate library and computer services during exam periods). Considering the reproductive health female students receive confidential support while dealing with unwanted pregnancies as well as STI prevention counselling, which is given especially to students of lower grades (head of the club interview, 2011).

6.3.5.2. Gender Clubs

[146] A person whom the respondent talked to about RH issues three months prior to the survey

Gender clubs are usually established at universities in order to support their female students and promote gender equality. However, their role does not emphasize the educational aspect, this study considers gender clubs as complement in SRH education. Gender clubs' mandates also vary across universities therefore only gender club established at Bahir Dar University, Peda Campus is presented in Box 6.D

.

6.4. Conclusion

Summarizing the level of reproductive health public service provision in BDSZ there were substantial efforts indicated towards increased financial and spatial access to the services. However, the quality of clinical services provided still remains a burning issue although in different ways for urban and rural areas. User-friendliness towards specific population groups, such as sexually active youth or widows was indicated as insufficient. Health Extension Programme seemed to prove its strengths, however, weaknesses in addressing high turnover, brain drain and potential burnout represented major challenges in the management and supervision of HEWs. The inefficient allocation of human resources was indicated as the major shortcoming of HEP implementation in BDSZ. This practically meant high concentration of HEWs in urban areas where availability of clinical services was ensured, whereas in rural areas, where the HEWs' service is needed the most, their presence lagged behind. Regarding the communication channels and different strategies towards increased awareness and demand for SRH services in BDSZ there was no single intervention applied which would not theoretically increase the chance for further success. However, this process remains NGOs-driven, partially fragmented and relying to a large extent on Heath Extension Workers. Despite the significant progress in making PMTCT service widely available in BDSZ, the synergy of RH and HIV/AIDS agenda in terms of programming seemed underestimated.

7. Dimensions of HIV/AIDS Awareness

This chapter is going to present the state of HIV/AIDS awareness in BDSZ at both individual and community level utilizing the data from household survey and opinions expressed during FGDs. First the individual assessment of comprehensive HIV knowledge obtained through the household survey disaggregated by different socioeconomic characteristics will be presented. Additionally the relation of comprehensive HIV knowledge to practice of selected reproductive health services will be examined. All characteristics are going to be presented for rural and urban areas separately. HIV practice in terms of protection and condom utilization will complement the whole insight. The subchapter will be closed in by major misconceptions identified.

7.1. HIV Knowledge & Practice

Individual comprehensive HIV knowledge (as defined in Chapter 4) in our quantitative population sample varied across selected socioeconomic indicators such as age, the level of schooling, employment status or household monthly income – see the Table a7 (household survey, 2011). However, the overall HIV comprehensive knowledge in BDSZ was 60.4% which means that two out of five women in our sample did not know the ways of HIV transmission (household survey, 2011).

	Table a7: Comprehensive HIV Knowledge by Socioeconomic Characteristics I. (n=245)						
		Age group					
		<= 25	26 - 28	29 - 31	32 - 37	38+	Total*
BDSZ	Count	45	27	20	30	26	148
	% of Total	18.4%	11.0%	8.2%	12.2%	10.6%	**60.4%**
urban	Count	19	17	12	18	15	81
	% of Total	15.2%	13.6%	9.6%	14.4%	12.0%	**64.8%**
rural	Count	26	10	8	12	11	67
	% of Total	21.7%	8.3%	6.7%	10.0%	9.2%	**55.8%**
		Household Monthly Income (in Birr)					
		<= $400	$401 - $600	$601 - $900	$901 - $1,500	$1,501+	Total*
BDSZ	Count	37	35	19	26	28	145
	% of Total	15.4%	14.5%	7.9%	10.8%	11.6%	**60.2%**
urban	Count	15	12	10	19	23	79
	% of Total	12.2%	9.8%	8.1%	15.4%	18.7%	**64.2%**
rural	Count	22	23	9	7	5	66
	% of Total	18.6%	19.5%	7.6%	5.9%	4.2%	**55.9%**

Source: fieldwork, 2011; * total count/ percentage of all respondents with comprehensive HIV knowledge

Regardless of the residence type the youngest age group (≤25) showed greater level of knowledge than their older counterparts (ibid). Perhaps surprisingly, the lowest level of comprehensive HIV knowledge reported women between 29 and 31 years in both urban and rural kebeles. Neither educational level of the respondents nor their employment status proved to be in a relation to comprehensive HIV knowledge. Especially considering no significant difference in regard to educational attainment it may be linked with the very limited level of formal sexual and reproductive health education in BDSZ as mentioned above. Additionally there were some urban – rural disparities present with regards to distribution of education as described in Chapter 5 (vide Appendix A7 for other socio-economic characteristics).

Interesting findings appeared in a relation to practice of selected RH services. Comprehensive HIV knowledge in both urban and rural areas of BDSZ was positively moderately correlated with ANC and VCT utilization[147]. Especially in regard to ANC these findings show availability and especially a certain level of quality of PMTCT service in BDSZ. If those women get counselled on HIV/AIDS during their antenatal care and consequently they were able to prove their HIV knowledge it implies a very positive sign of an integration level of RH services and HIV/AIDS prevention in sampled areas of BDSZ (Table b7).

Table b7: Comprehensive HIV Knowledge by Selected RH Service Practice

		currently using FP method					CD at facility		
		yes	no	Total*			yes	no	Total*
BDSZ	Count	87	61	148	BDSZ	Count	79	69	148
	% of Total	35.5%	24.9%	60.4%		% of Total	32.2%	28.2%	60.4%
urban	Count	53	28	81	urban	Count	57	24	81
	% of Total	42.4%	22.4%	64.8%		% of Total	45.6%	19.2%	64.8%
rural	Count	34	33	67	rural	Count	22	45	67
	% of Total	28.3%	27.5%	55.8%		% of Total	18.3%	37.5%	55.8%
		latest pregnancy used ANC					VCT use		
		yes	no	Total*			yes	no	Total*
BDSZ	Count	111	37	148	BDSZ	Count	125	23	148
	% of Total	**45.3%**	**15.1%**	60.4%		% of Total	**51.0%**	**9.4%**	60.4%
urban	Count	63	18	81	urban	Count	71	10	81
	% of Total	50.4%	14.4%	64.8%		% of Total	56.8%	8.0%	64.8%
rural	Count	48	19	67	rural	Count	54	13	67
	% of Total	40.0%	15.8%	55.8%		% of Total	45.0%	10.8%	55.8%

Source: fieldwork, 2011; * total count/percentage of respondents with comprehensive HIV knowledge

Less encouraging are results which link comprehensive HIV knowledge with practice of an individual HIV prevention. There was only one person in the whole sample (n=245) with comprehensive HIV knowledge who reported correct and consistent condom use as her personal practice in order to prevent HIV transmission. In the contrary 82.6% of women with comprehensive HIV knowledge reported as their main practice of HIV protection faithfulness, adding the figure for abstinence (15.27%) it created 97.9% of the sample who from the proclaimed ABC[148] rule internalized only the first two aspects. Only seven participants (2.9%) declared not to protect themselves against HIV/AIDS at all. This finding brings

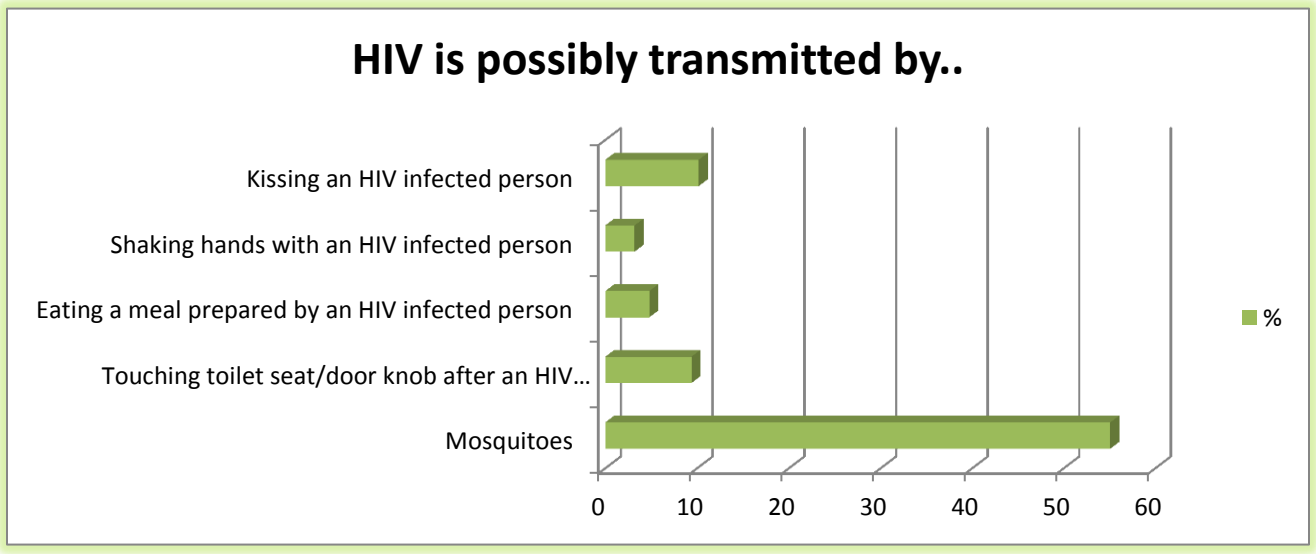
[147] For ANC V=0.381 & p = 0.003 (Sig. ≤ 0.05), (n=148); for VCT V = 0.292 & p= 0.002 (Sig. ≤ 0.05) (n=148)
[148] A – Abstinence, B – Being faithful and C - Condom

the issue of women's trust towards their husbands and vice versa. Why people do not utilize condoms in BDSZ is discussed in the following sub-chapter focused on community dimensions of HIV/AIDS awareness.

7.1.1. Major Misconceptions

As a major misconception identified through the household survey was the possible HIV transmission[149] by mosquitoes: every other woman in our sample (55.1%) reported that HIV could be possibly transmitted by mosquitoes, in rural areas of BDSZ the proportion of women who did not deny this misconception was even higher – 65.0%. The only socioeconomic characteristic which played a role in denying the misconception that HIV could be possibly transmitted by mosquitoes was the level of household income which showed a slightly moderate association[150]. Other misconception prevalence is imaged in Figure VII.A.

Figure VII.A: HIV Misconceptions Identified by Household Survey (n=97)



Source: fieldwork, 2011

In regard to will for further education in HIV/AIDS matters, the vast majority of women showed the desire to learn more about HIV/AIDS (82.3%), in rural areas the figure was even greater: 94.2% which leaves an open door for HEWs counselling. In the opposite, in urban areas there were 26.4% of women who claimed that they needed no more information[151] considering HIV/AIDS (household survey, 2011).

[149] Possibly transmitted was interpreted as a combination of responses: 'yes' and 'do not know', giving such an answer does not indicate knowledge.
[150] V=0.220, phi = 0.311 at p=0.003 (Sig. ≤ 0.05) (n=245)
[151] Combined options "I know all I need to know" and "I do not need to know anything about HIV/AIDS"

7.2. Community Dimensions of HIV/AIDS Awareness

"In previous years the community's awareness about HIV was low. PLWHA were stigmatized and they lost their lives without getting proper care. The community awareness about PLWHA is improving; PLWHA can survive if they get the proper care. In previous years the stigma & discrimination was very huge and PLWHA were even discriminated not to have coffee with their neighbours. But if they get proper care they can survive and live normal life. "(A male FGD participant, 2011)

7.2.1. Prevention & Protection

There was an interesting phenomenon identified through almost all FGDs when participants were asked about the main modes of HIV transmission. Many of them were mentioning 'sharp equipment contact' amongst the first ways of HIV transmission (FGDs, 2011); sometimes related to blood sharing but sometimes without any further clarification – if stated in this context it was identified as a major HIV misconception characteristic indicated through this study. Great difference was shown amongst male and female willingness just to discuss the issue of HIV awareness in general. Urban males were found to be able to discuss this issue more openly including the condom attitude which appeared to be still a sort of taboo for female participants in particular(it will be discussed later). That is why the urban males were identified as the group with rather high level of HIV/AIDS awareness. Regarding the modes of HIV protection, abstinence and faithfulness were mentioned the most amongst female participants whereas condom use was often mentioned at the very last place (female FGDs, 2011) which confirms the results got from the household survey.

7.2.1.1. Attitude towards Condoms

Attitude towards condoms[152] reflected the gender disparities in knowledge related to cultural barriers as identified by female FGD participants (2011) regardless the settlement area:

- ✓ "*I feel shy to talk about it and I think other people have the same feeling. It is something that is alien to our culture, we are not used to it"* (urban female FGD participant, 2011).
- ✓ "*I am shy to talk about it and most of us don't have clear understanding but we heard about it on TV*" (rural female FGD participant, 2011).
- ✓ "*When people find a condom they say: 'this place has been spoiled '*" (urban female FGD participant, 2011)

The lack of women's understanding was also reflected in relation to different age groups. The youth was often indicated by both male & female participants as more progressive society segment in relation to condoms[153] (male & female FGDs, 2011) whereas the 'old society' was referred as more resistant to change (female FGDs, 2011). In the contrary, urban males showed more positive judgments about society of BDSZ and its willingness to change in terms of condom use while being positive about further improvements (male FGD, 2011). The aspect of increased condom availability (in kiosks) was also mentioned (ibid). A reported misconception present in urban kebele on condoms transmitting HIV themselves was rejected during the male FGD (ibid). Even though the urban areas are often

[152] During the FGDs there was no division made between male and female condoms
[153] Read the Box 7.A

considered as more progressive towards change of social norms, the gender discrepancy in attitude towards condoms in urban settings of BDSZ was evident from the household survey and FGDs

7.2.1.2. Most-At-Risk Populations, PLWHA & Impact of HIV/AIDS

As most-at-risk populations of BDSZ in relation to HIV infection were indicated commercial sex workers (CSWs) and people who have unsafe sex with them, followed by the youth and drivers & merchants respectively due to the nomadic nature of their professions (FGDs, 2011). During the urban female FGD the issue of negotiating safe sexual practices was brought up while reported that some men were are not willing to use condoms even if requested (female urban FGD, 2011). Those statements were partially supported by a key-informant from the health professional settings of BDSZ who referred to Amhara MARPs study and own clinical experience pointing out at concurrent partnerships of people despite the proclamation on abstinence and/or faithfulness (key-informant interview, 2011). The suggestion that the whole society of BDSZ is vulnerable to HIV infection was reported only once during all FGDs (2011). Such evidence indicates low perceived vulnerability to HIV which seems to be not largely internalized.

Box 7.A

The Youth as a Vehicle for Change towards Condom Use?

"Awareness about condoms is improving. When someone is seen with condom people think he is promiscuous. In some families if parents see a condom in a pocket of their son they will be angry thinking their child is promiscuous. But now in universities things are changing. Students take condoms freely & there is an improvement. But at the community level there are still some misconceptions" (a male FGD participant, 2011)

7.3. Conclusion

This chapter has shown that there is an interesting dynamics between the individual and community level of HIV awareness in BDSZ. The level of individual HIV comprehensive knowledge showed to be rather unsatisfactory, although with slightly higher levels in urban areas. As more promising finding proved to be the association between ANC and comprehensive HIV knowledge which suggests that access to information on HIV/AIDS leads through reproductive and maternal health services (thanks to PMTCT). Major HIV misconceptions were found to be still prevalent which points out at the quality of counselling which should not only counsel on ways of transmission but also reject major misconceptions. Regarding condoms, the major conclusion implies that women of BDSZ feel comfortable neither using them nor talking about them). Faithfulness as a major mean of protection against HIV infection reflects low awareness of perceived vulnerability to HIV infection. Consequently extreme low condom utilization either as a way of HIV protection or short term FP method was found.

8. Women's Practice Regarding Reproductive Health Services

The chapter is going to provide an insight into utilization and non-utilization (practice) of selected reproductive health services in BDSZ with regard to their women's knowledge based primarily on the household survey and complemented by opinions expressed at FGDs and key-informant interviews. Main drivers of utilization or non-utilization will be presented separately for family planning and ante-natal care. Child delivery knowledge and practice will be presented jointly. A special attention will be paid to HIV voluntary counselling and testing service representing one of the important meeting points in reproductive health and HIV/AIDS programming which is one of the crucial points of this study. Apart from its practice and knowledge also an attitude towards VCT will be presented.

8.1. Family Planning (FP)

"I often come to the clinic for contraceptive injection, but I do not even know if the injection is healthy or not"
(A rural female FGD participant, 2011)

Since the survey targeted married women in their reproductive age and 83.3% of them reported that they 'ever delayed pregnancy'[154], the study explores their knowledge and practice with regards to methods known and methods utilized. Non-users perspective will be also presented while complementing the patterns found.

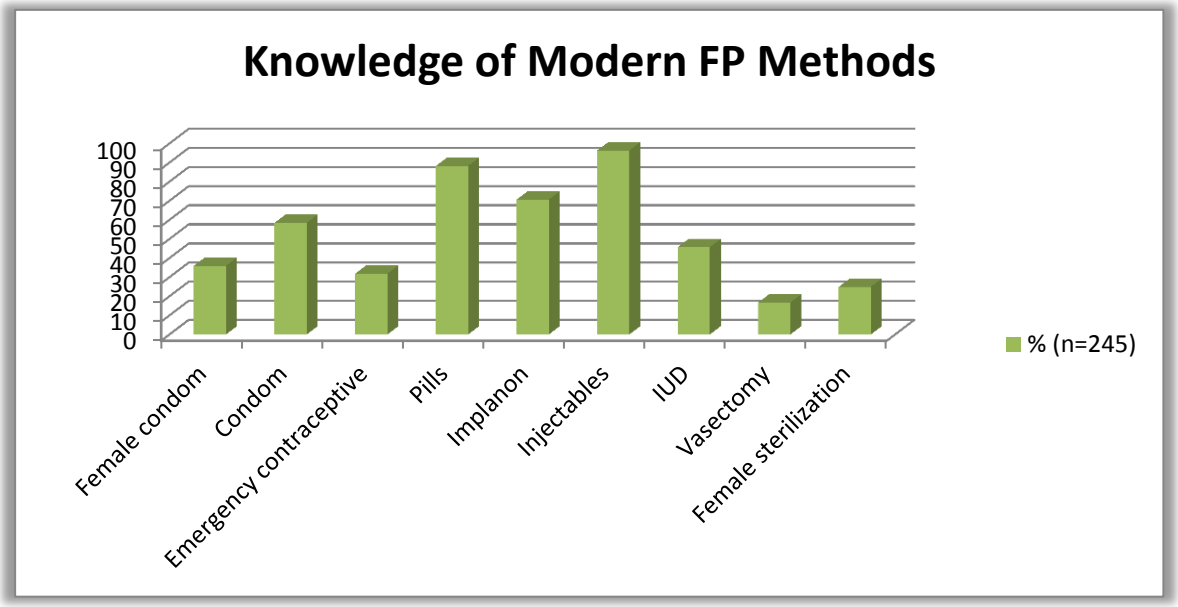
8.1.1. FP Knowledge

Knowledge of family planning methods was originally assessed for both modern and traditional methods. However, according to the targets set by MoH in the National Reproductive Health Strategy which strongly advocates modern FP methods[155], the selection was lately reduced to modern methods. The knowledge was tested per each method separately; the Figure VIII.A reflects the results highlighting that injectables (96.3%), pills (88.2%) and Implanon (70.6%) were the most well-known ones. Attitude towards condoms was discussed in the previous chapter, here should be only added that the level of knowledge is highly correspondent with that. This was confirmed again by the FGDs in rural areas: *"Personally, I do not know what condom is"* (a rural female FGD participant, 2011).
The issue of side effects and misconceptions was revealed as a substantial part of the FP knowledge. The household survey discovered that during one year prior to the survey there were only 18% of women in the sample counselled on FP by a HEW. Moreover, the highest incidence of the counselling took place in kebele 13 where the *Felege Hiwot* referral hospital is based. This reflects again the issue of cumulated services in urban clusters (See the Appendix A8). Experienced/perceived side effects of FP such as anger or gained weight were reported at female FGDs. Infertility misconception was identified only by few key-informants (2011). This proved to be the opposite during the female

[154] Freely interpreted by a respondent, could have also included traditional methods
[155] While shifting towards long-term FP methods

FGDs. HEWs indicated that misconception in relation to rural husbands is linked to lacking knowledge: "*Most of the time men are against women using FP. What we do with the men is meeting them personally at health centres or churches and we give them our focus. When we tell them the benefits there are men who changed immediately and ask if he can bring his wife right away for the package*" (a rural HEW, 2011).

Figure VIII.A: Knowledge of Family Planning by Modern Method



Source: fieldwork, 2011

8.1.2. FP Practice

Slightly more than one in two women used family planning at the momentum of data collection in BDSZ (57.1%) which compared to the national and the regional CPR published in the 2011 EDHS – 34% and 33% respectively exceeded the average. There was a moderate association between woman's age and current FP utilization[156] indicating that the youngest population segment (25 years and below) represented 36.4% of the users whereas the age group of 38 years & above created 12.8% of the population of FP users. The younger a women is the higher probability of her using FP[157]. Rural-urban disparities appeared again whith 51.7% CPR in Meshenti contrasted with 67.2% CPR in kebele 17. Majority of the respondents reported as the main reason of FP utilization spacing of pregnancies (69.3%), 16.4% of the respondents indicated limiting of pregnancies. The most popular FP method amongst users turned to be injectables (72.9%), followed by pills (13.8%) and IUD (4.3%). Condom as a current FP method was utilized only by 4 persons in the whole sample (1.6%, n=245). The possible drivers were already discussed in the previous chapter. There were 79.3% of women using a long-term FP method and, 16.5% short-term FP method which highly correspond with the MoH strategy of the large-scale shift towards long-term methods. Concerning the injectables' surpassing prevalence it leads to comments made by a few key-informants questioning the genuine FP methods availability at the woreda level which certainly hampers the responsible and free decisions about FP methods utilized. This issue was also reflected by urban HEWs (FGD, 2011). Although FGDs did not discuss the topic of informed choice and FP counselling, the household

[156] V=0.283, phi = 0.283 at p=0.001 (Sig. ≤ 0.05) (n=140)
[157] See the Appendix C8.

survey indicated that every other woman using FP (50.7%) was not counselled on side effects of the method used. Moreover, medical staff counselled only 10.7% of FP using women. Concerning the decision making on FP utilization, 72.9% of using women stated that the decision to use FP method was made jointly with their husband.
Concerning FP non-users, the major reasons for non-utilization were indicated as: a) sexual inactivity (36.2%), b) single marital status (9.5%) and c) having not yet achieved a desired family size (9.5%). Especially the second reason indicated may trigger a deliberation on FP user-friendliness towards specific population groups. Several key-informants supported the idea that for single women, widows and youth FP services are still socially inaccessible since everything is targeted on married women which is mutually reinforced by the society and health providers (several key-informants, 2011). Key informant in Tis Abay disclosed that amongst women coming to the health centre for FP methods, 95% of clients were married (key-informant interview, 2011). FGD with non-users in in the same study area supported this idea. Sexual activity and consequent use of family planning in majority of BDSZ remains highly attributed to marital status with the label 'married'. Even though the FP methods were not in practice 'absolutely free of charge' and 45.4% of the users paid for their method (Mean 4.80 Birr)[158] the respondents did not consider this payment as expensive. As one of the urban female FGD participant shared: "*Taking birth control medication is very cheap. Like injection costs 3 Birr or so, it is very easy for a woman to get this unless she is careless. Getting birth control in private or governmental institutions is not difficult and I do not believe that a woman must have a job for that.*"

8.2. Ante-natal Care (ANC)

"I used to not to go for prenatal care in the past but not any longer. These days pregnant women mostly attend health centres to check the condition of the foetus, take the vaccination, keep their health during pregnancy and deliver the child safely, <u>eventually</u> " (A rural female FGD participant, 2011)

8.2.1. ANC Knowledge

There were 82.9% of women in BDSZ who knew ANC, most of them[159] (60.1%) learned about that service at a health centre, secondly in *Felege Hiwot* Referral Hospital (24.2%). Nonetheless, there were 20.8% of rural women who did not know ANC at the moment of data collection (compared to 13.6% of urban respondents). Interesting finding revealed that 16.4% of women did not know any modern FP method during their latest pregnancy which refers to the previous discussion on FP knowledge. Considering the women with ANC knowledge there were 14.7% who indicated the correct number of effective ANC visits (4). Albeit 60.4% of ANC knowledgeable women declared five or more visits as necessary, the interpretation should not be taken as a complete knowledge (which is four visits). In order not to judge that result so arbitrary we have to take into consideration 2 aspects. First the individual level of ANC follow up which certainly enables more visits if necessary and, secondly perhaps the general 'laic' view which may assume "more is always better". FGD participants in both urban and rural settings identified many reasons of importance to utilize ANC:

[158] Excluded transportation
[159] In rural areas it was even 80% of women who learned about the ANC in a health centre

general health of mother and child, PMTCT and vaccination were all mentioned. One slight misconception at rural FGD was reported that ANC prevents difficulties during the delivery itself (a rural FGD participant, 2011).

8.2.2. ANC Practice

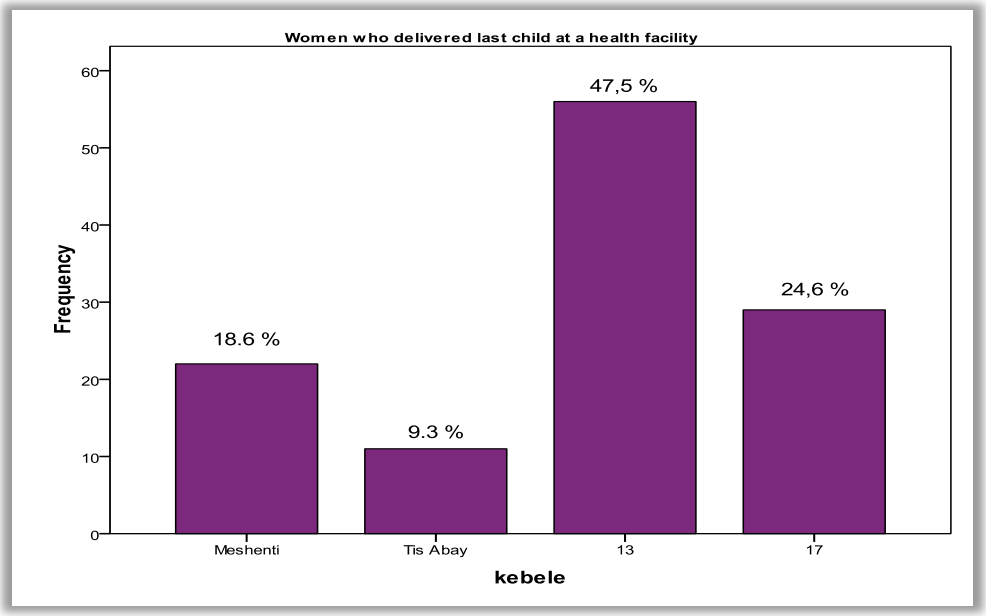
There were 70.2% of BDSZ women who stated that they utilized ANC for their latest pregnancy; urban – rural differences were minimal. Although we cannot disclose whether it was comprehensive ANC or not (the survey did not examine the number of visits) this figure makes ANC the second most utilized RH service of the study and again surpassing the figures from the 2011 EDHS. Health centre was the most frequent facility where women obtained ANC (60.5%), followed again by *Felege Hiwot* referral hospital. In urban kebeles the hospital was at the first place (44.5%) compared to the rural ones (81.3%). Even though ANC is provided only at the health centre level and above tiers in the health provision structure (HEWs at the health posts are not equipped for the appropriate tests, they do not even have the mandate to make prescriptions). Most of the key-informants reported, that the level of ANC utilization in Amhara is one of the most encouraging aspects of RH progress in the country whereas the utilization of skilled child deliveries is one of the most discouraging leaving a large gap which has not been narrowed for decades.

8.3. Skilled Child Delivery Knowledge & Practice

"If we deliver at home and God does not help us, our weakness can expose us to several complications."
(A rural female FGD participant, 2011)

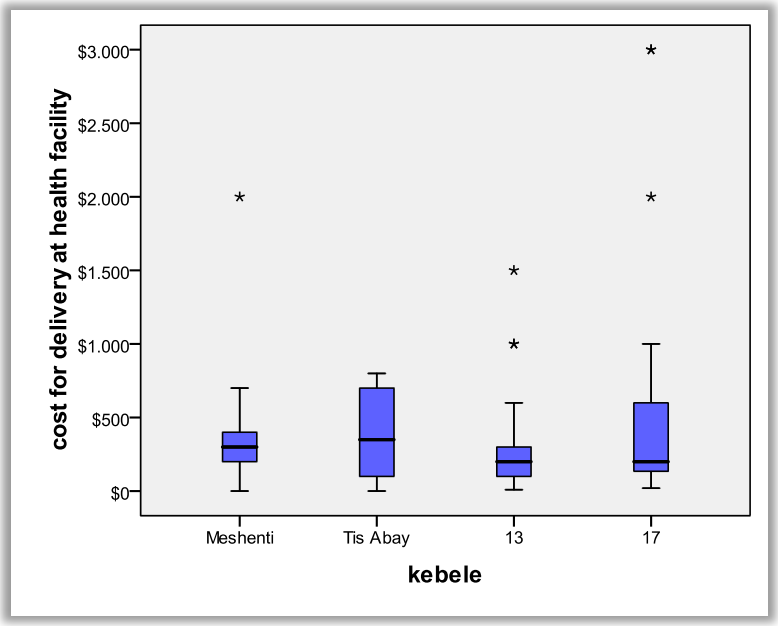
Almost all women in our sample were able to indicate a health facility for a child delivery (96%), but only half of those (49%) delivered their last child at a health facility. *Felege Hiwot* referral hospital was the most mentioned place for a child delivery (59.3%) This is still a more positive result than published by the 2011 EDHS (10%), however, many times mentioned urban-rural disparities are the most prevalent for child deliveries in BDSZ. Out of those who delivered at a facility, the majority came from kebele 13 (47.5%). Tis Abay women had the lowest share of deliveries (9.3%) at a facility level (See the Figure VIII.B).

Figure VIII.B: Distribution of Child Deliveries at a Facility per Kebele



Although the figures seem more or less positive, we have to bear in mind that in one of the kebeles sampled is the largest hospital in the whole regional state. Kebele 13 residents have all the health facilities literally 'round the corner' so the results might be biased in this respect. Despite the geographical proximity, all sampled women had to pay for the transport on average 41.8 Birr (Mean). Since a woman bears the responsibility for her own transport to a facility (no matter what conditions she is in) and the cost of transportation increases the more attendants accompany her, the decision is often made before the labour starts (key-informant interview, 2011). Some prospective mobilization efforts were reported in Tis Abay where the health centre attempted to design own transportation system to *Felege Hiwot* referral hospital for complicated deliveries (key-informant informal discussion, 2011). However, this system was not yet implemented at the momentum of data collection. Cost of delivery (mean) at a health facility differed to a large extent by a place of residence and was heavily influenced by outliers; some extremes indicated amounts between 1.500 and 3.000 Birr, overall mean of delivery cost was 382.6 Birr (Figure VIII.C) One of the reasons for such a high price of delivery was suggested in Chapter 6 while describing the service provision in *Felege Hiwot* referral hospital since slightly more complicated deliveries are considered as regular surgeries which are (related to parity purchase power) costly. Combining expenses for hospitalization, food and 'surgeries' may make the delivery financially demanding[160]. As several key informants admitted, if the supply of the required equipment was shortened, women were often asked to bear the burden of out of their pockets unless they required use of gloves, disinfection or other equipment (several key-informants, 2011). However, this was more likely the case of health centres (ibid).From the women who did not deliver their last child at a health facility (51.8%) the most common reasons were reported as: a) delivery suddenly started[161] – no time to decide (66.4%); b) family custom (16.0%) and c) comfort of their homes (8.8%). Regarding the 'sudden aspect' of delivery it combines many dimensions such as lack of support in family and lack of planning concerning child delivery. In addition, 3.9% of women argued that the facility was too far which possibly leads to the same trend: once the labour starts, reaching the facility is not an option any more due to the distance which bring us back to disproportional percentage of deliveries in kebele 13 and the transportation issues. Cultural barriers/customs were often identified by key-informants as reason not to deliver at a facility which might be also partially combined with the 'sudden aspect of delivery'. A few key-informants from BDSZ also supported the cultural barriers reason: facilities are not friendly towards performing traditional rituals and often do not let any woman's attendants in a delivery room[162] (key-informant interviews, 2011). Home child deliveries were the most common among the women who delivered outside of a facility (98.4%). The women were mostly assisted by TBAs (59.2%) followed by family members or relatives (27.2%). HEWs assisted only at 3.2% of deliveries which reflects the cross-cutting issue of trainings and confidence as discussed in Chapter 6. An interesting opinion was shared by a

Figure VIII.C: Distribution of Child Delivery Costs per Kebele



Source: fieldwork, 2011

[160] A few respondents if the survey indicated that they were forced to run into debts because of their child delivery

[161] This formulation was added later by the researchers due to high incidence of this answer during the data collection

[162] Although 74.4% of women who delivered at a facility were accompanied by their husbands, the survey did not investigate whether they were allowed inside of the delivery room or not.

male FGD participant who suggested including trainings of TBAs into official semi-professional curricula in order to sustain safe deliveries in rural areas. This trend was previously widely supported amongst health professional public, but as admitted by one key-informant since TBAs did not bring any change in maternal mortality decrease; there is no need to include them in official structures. Moreover, there has been still a large attitude towards HEWs who would finally perform delivery assistance. As already discussed, the opposite was still practised and as another key-informant with clinical background argued: "*HEWs have often close bonds with TBAs and they often call them to assist at the first place*" (key-informant interview, 2011).

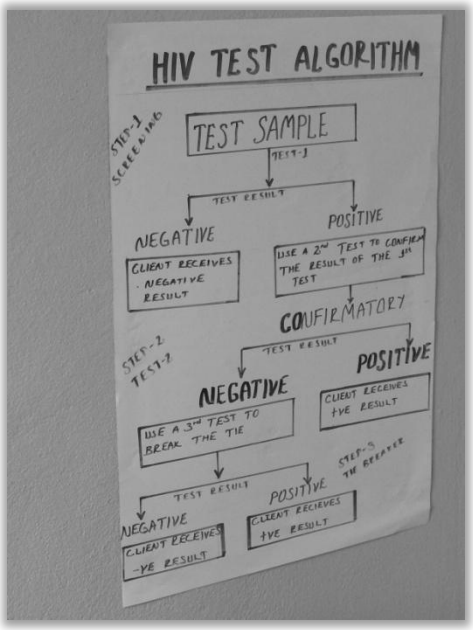
8.4. HIV Voluntarily Counselling & Testing (VCT)

"It is helpful to get to know your status and make decisions afterwards. If I have the disease, then I will join the club of those HIV/AIDS patients and if I am negative, it is going to be great. "
(A rural female FGD participant, 2011)

8.4.1. VCT Knowledge & Attitude

Although several key-informants (2011) expressed doubts about the actual composition of the population who get tested labelling it as most-at-risk-populations (MARPs) the household survey supported by the FGDs proved the opposite. This actually conforms to VCT knowledge explored in the household survey: the vast majority of respondents indicated numerous legitimate health facilities where they would go for their VCT. VCT provision at the health centre was reported the most frequently (40.8% totally, in rural areas even 50%) followed by the *Felege Hiwot* Referral hospital[163] (36.0%). There was no one in the sample who indicated an inappropriate facility. The broad range of facilities indicated with regard to both knowledge and utilization shows high accessibility of this service in both spatial and social manner. Attitude towards VCT showed to be very positive while measuring three aspects of attitude combining the level of stigma, exclusion from the services and negative labelling. There were 75.5% of women indicating the highest positive attitude toward VCT whereas only 2.9% showed the opposite in BDSZ. Perhaps surprisingly, the rural respondents appeared to be more tolerant (with higher positive attitude) towards VCT – 80% compared to 71.2% their urban counterparts.

Figure VIII.D: HIV Test Algorithm Displayed in Meshenti Health Centre



Source: author, fieldwork 2011

[163] After merging the survey categories of district and referral hospital since there is no district hospital in BDSZ

The most significant urban – rural attitude discrepancy was indicated with regard to the payment for the service[164]; when only 5.8% of rural women were either indifferent or positively positioned towards the payment for the service compared to 18.4% of urban female with the same characteristics. The positive attitude towards VCT was also supported by the FGD participants who mostly shared the same opinion about the importance of being tested in order to recognize the status early and if becoming positive to start with the ART as soon as possible (urban & rural female FGDs, 2011). Some participants even showed the desire to get tested during the FGDs.

8.4.2. VCT Practice

VCT practice in BDSZ appeared to be very promising since 80.4% of the survey respondents ever utilized VCT. The utilization rate in urban areas appeared to be about 10% higher than in rural areas (85.6% compared to 75%). The initiation of a decision to get tested was purely voluntary in majority of the cases (54.8%) indicating that a respondent was not referred to the service. There were 18.8% of women who reported being referred to VCT by medical personnel. Additionally, HEWs referred 4.6% of respondents to VCT. This might indicate the utilization of PICT through integrated services. Only 3.6% of women indicated they got tested through other health service while 4.1% stated that they were referred from another health service. As highlighted by one key-informant: "*The current recommendation for each patient who visits the health facility suggests that they should at least hear the advantage of being tested. And they should be somewhat slightly forced to go through that testing process. But it is not mandatory*" (key-informant with clinical experience, 2011). This key-informant also stated that the practice of testing negotiation with a client is largely practised at TB clinics where patients are expected to come for their medications and follow up almost on a daily basis. Then it creates an opportunity window for reflecting the VCT utilization with each patient. The main reasons reported to get tested were: a) health status curiosity (70.6%), b) pre-marital reasons and c) integration or referral (7.7%). Pre-marital VCT represents a special case in VCT utilization – see the box 8.A. If we glance back to the previous chapter where individual comprehensive HIV knowledge was discussed, one interesting comparison comes up: the survey revealed that only 63.5% of VCT users had proved the comprehensive HIV knowledge. So although there was an association found between the comprehensive HIV knowledge and VCT utilization, there is still a gap of 36.5% of respondents who actually got tested but did not have the complete knowledge about the modes of HIV transmission. This slightly undermines such a positive result regarding the VCT utilization in BDSZ in and challenges the quality of VCT counselling. As described in Chapter 3, there is a sort of standardized procedure which should be followed during each VCT counselling session at any facility. This counselling should leave enough room for questions and clarifications of the patient. If we have a look at the Appendix A6 which presents the assessed quality of VCT sessions in urban health facilities of BDSZ, the duration of pre-test counselling at one health centre was recorded as 9 minutes. The question is

Box 8.A

Pre-Marital VCT

The phenomenon of customary HIV testing before marriage was detected by FGD participants, key-informants and also by survey respondents in BDSZ. Especially concerning rural areas this was revealed as a necessary pre-requisite for marriage. Fear from bringing HIV from urban areas was reported by rural FGD participants. Health providers reported that couples often come literally few days before the wedding day. If turns out that when one of the fiancées is HIV positive, the wedding is usually cancelled.

[164] Measuring the level of exclusion from the service through agreement with the statement indicating the out-of-pocket user payment

whether such duration provides sufficient space even for a client who comes to utilize the service repeatedly. The issue of repeated VCT utilization was identified by both key-informants and FGD participants; simultaneously this phenomenon is not yet reflected in the national/regional statistics which also do not provide gender disaggregated data[165]. As a male FGD participant highlighted: "*During the community mobilization on free VCT service, usually those who know their status test again and again. I think those who never got tested do not access the service at all*". As major reasons not to utilize VCT services were reported: a) faithfulness (59.2%), b) sexual inactivity (14.3%) and c) no time to visit/no need[166] (both 8.2%). Additional reason for non-utilization of VCT especially in rural areas was shared with one key-informant who expressed the apprehension that people do not go for testing since they know that there is no ART available in their kebele (which was also the case in one of our rural study areas). Analogically higher availability of ART was indicated as a reason to utilize VCT in urban areas by several FGD participants. This difference brings us to discrepancies in drug supplies in urban and rural areas which will be discussed in the following chapter.

8.5. Conclusion

There were significant disparities found between utilization of four selected services in BDSZ. Urban - rural disparities favouring urban areas were observed in all services, only with an exception of VCT. One of the major findings leads to a confirmation of the quality presumption as in the case of VCT. Enormous improvements of social and spatial access of this service have been made in BDSZ and people seemed to be aware of that. They had a clear view of what is available in their kebele and consequently acted upon that (direct proportion between ART availability and VCT utilization). Pre-marital VCT also provides a good example how easy a concrete service could be incorporated into cultural traditions if accessible and adequate. The opposite example is represented by child deliveries. The chain of cultural barriers, transportation unavailability and financial expenses still make them an exclusive service. The situation about child deliveries does not provide an easy judgement since even the key-informants were not 100% aware of the situation in the field. Theories of total financial accessibility[167] of maternal health services in Ethiopia proved to be false regarding child deliveries in particular. Experts attending the dissemination meeting presentation of the study seemed to be astonished by this finding. Moreover there was no consensus amongst the key-informants on opportunity costs and what is *de facto* included in service provision itself and what should be considered as an opportunity cost.

In the case of child deliveries the shortages of basic equipment loaded a woman with a financial burden of inefficient procurement/logistics if she requested certain quality of the delivery service[168]. Key informants accomplished consensus only in the case of transportation. There were efforts reported which advocated implementation of demand-side financing in health (DSF) strategy, namely vouchers for transportation. Those were according to few key informants reportedly rejected by the ARHB in order not to create dependency. The question is, how much legitimate this reasoning is since the whole health service provision is donor-dependant. Considering FP, the level of utilization of modern methods seems to be promising at the first glance, however after deeper investigation was obvious that the factual method availability mirrored the utilization to a large extend which was also highly related to knowledge of a particular method. Again this reflects the quality of service counselling since women often lacked the basic information such as side effects of FP method they used. Financial accessibility proved not to be an issue any more and even though it was not free of charge, the financial boundaries of FP were widely accepted amongst women in the sample.

[165] For instance *Health Indicators* published by MoH do not provide that information, HAPCO usually releases ANC and PMTCT figures

[166] Could be interpreted as a combination of various reasons such as fear of the result, sexual inactivity or faithfulness

[167] Free of costs

[168] Gloves, disinfect, etc.

9. Demanding & Participating in Reproductive Health

In this chapter, the mechanisms of claiming health needs and participation in own health in BDSZ will be presented. Firstly, the Ethiopian's institutional environment towards rights-based approach to health will be investigated, based on key-informant interviews, and special attention will be paid to access to information on reproductive health. The modes of community and individual participation in reproductive health in BDSZ will be examined presenting the key-informants' opinions supported by the findings from the household survey. Finally, the health accountability mechanisms will be questioned.

9.1. The Institutional Environment

"There are research findings & you present these findings to all relevant government people. We discuss that at all levels: at grass-roots level, at woreda level, at federal level. We discuss all issues that bring attention. That's our advocacy. So although it is not bluntly saying 'rights-based approach', what we are doing is leading to that"

(A key-informant interview, 2011)

The contemporary NGO legislation in Ethiopia (2011) has a specific limitation towards practical implementation of rights-based approach to health (several in depth-interviews, 2011). There are only certain civil society organizations allowed to fully work within this approach which includes only local (Ethiopian) NGOs which receive less than 10% of their funding from foreign resources (ibid). Any other organization is prohibited to use the word 'rights' and to talk, write or anyhow disseminate the information on 'rights.' Although this regulation triggered qualms after its launch between both local and international NGOs about design and practical implementation of their further work, after the re-formulation of their strategic planning documents, re-registration at the governmental agency established for communication with NGOs, most of the organizations could have continued with the implementation of their programmes and projects (several key-informant interviews, 2011). The fact that they mostly could have continued with their programmes lies in terminology – many of the key-informants admitted they nowadays operate with the term 'needs' since in the health terminology it has almost the same connotation as the word 'rights'. However, those key-informants also pointed out that even though rights-based approach to health is not officially proclaimed they have been leading with by their field activities to the same point (ibid). Nonetheless, there have been two rights emphasized by the key-informants themselves: right to information on RH & right to informed FP choice.

9.1.1. The Right to Information & Informed Choice

The right to information on reproductive health, respectively on services available seemed to be widely accepted and proclaimed by several key-informants (2011) who mostly eagerly assented they have been attempting to disseminate this right to the communities. Disseminating the complete information on services and methods available has been advocated with primary attention (several key-informants interviews, 2011). The right to information was also many times mentioned in relation to targeting strategies and communication channels with aiming to ensure that the information really reaches the recipient - i.e. through different materials displayed in different languages in both public and private facilities. This concerns primarily the right to make a responsible decision about family planning method

utilized as one key informant shared: "*We do not force people to use family planning. If they are not willing to use it, it is their right. If they are willing to use it, we need to give them the whole information*" (key-informant interview, 2011).

Figure IX.A: Campaign on Informed FP Choice in Addis Ababa

Source: author, fieldwork 2011.
*Targeting English speaking audience in the centre of Addis Ababa was not clear to the author

On the other hand, the implementation phase of such efforts may look differently at the community level (vide Sub-chapter 6.2.2) where methods availability issues hamper the right to informed choice: "*People see it as an alternative but health professionals teach us that as an obligation*" (urban female FGD participant, 2011).

Another aspect which was identified in direct relation to access to information was focused on body integrity. Especially the right to protection against female genital mutilation/cutting seemed to be widely accepted; all FGDs revealed the knowledge of its illegal status though participants from urban areas identified more reasons against FGM (FGDs, 2011). In connection with the abortion law liberalization through the Penal Code in 2005 one key-informant stressed the need to disseminate the information on right to safe abortion under the existing law[169] especially to the rural communities where he found the level of information dissemination insufficient (key-informant, 2011). The household survey identified the level of knowledge on legal abortion status, revealing significant rural-urban disparities; however, the proportion of women who still think that abortion is illegal remained the same in both urban and rural areas of BDSZ – more than 50% (see the Table a9).

Table a9: Knowledge of Abortion Legal Status

Knowledge of Abortion Legal Status			Percent (n=245)
urban	Valid	Illegal	51,2
		Legal	2,4
		legal on conditions	**24,8**
		don't know	21,6
rural	Valid	Illegal	52,5
		Legal	2,5
		legal on conditions	**7,5**
		don't know	37

Source: fieldwork, 2011

[169] Under 5 conditions which specifies the 2005 Ethiopian Penal Code

9.2. Invited Spaces for Participation on Reproductive Health in BDSZ

"We invite people to participate. To participate – starting from planning, to the evaluation and participate. Health is not just an issue of the Ministry of Health; health is an issue of an individual".
(A key-informant interview, 2011)

There have been several modalities of citizen's participation for reproductive health found in BDSZ although it has to be mentioned that all those processes, as found out through FGDs and key-informant interviews, took place within so-called *invited spaces* (Mohan, 2008; Cornwall 2008)[170]. The existence of a voluntary association formed at the grassroots level in order to influence decisions made about communities' health was not encountered in BDSZ[171]. The 'invited spaces' context in BDSZ means that the communities are invited either by a local or an international NGO or the state/public administration (kebele) often with an assistance of volunteers (Subchapter 6.3.) to participate on various activities at three levels:

a) To participate and gain health and other benefits
b) To participate on implementation of a certain programme
c) To participate in programme activities

Let us describe each of the participation level together with the examples identified.

9.2.1. Three Levels of Participation in BDSZ

As the first participation level ***participation with health benefits*** where communities utilizing health services and/or health education (Rifkin, 1990) was mentioned, which corresponds to a large level with Health Extension Programme (HEP). HEP as a community-based home care initiative which recently started utilized the design of model households through health education. These households not only serve as models to the whole community but they can also gain some benefit from the participation, as a male FGD participant shared: "*That HEW she mobilizes the community and makes them in control of environmental hygiene. When I ask them who did this, my family members tell me it was done by a HEW. She also follows them closely on a daily basis and if the household did not change, it will have an influence on the benefits they get from the kebele* ". Another scheme identified within this level (HEWs' FGDs, 2011) were the *coffee-tea gatherings* organized in kebele 17 by volunteers of HAPCO on a regular basis in a form of *women's group* with the main aim to discuss and educate on reproductive health issues & HIV/AIDS (ibid). The same mode in the same kebele was also applied by an international NGO[172]. In rural areas, namely in Tis Abay health centre there was the establishment of a *mother support group* initiated by another international NGO utilizing the modality of *self-help group* based on social networks. Since the prospective mothers who utilize ANC know each other "*if a woman needs a follow up forgets about the appointment, other group member can go and easily bring her to the health centre*" (key-informant interview, 2011).

[170] If we do not count with indigenous voluntary associations such as iddirs, iqqubs or mahabers which were mostly not found in order to associate for health reasons
[171] Which does not necessary imply that it does not exist, it only was not encountered
[172] This NGO according to the researchers' observations showed to be one of the most well known in town since it also runs a private gynaecological and obstetric clinic which started to provide the abortion care as one of the first in BDSZ.

Figure IX.B: Advertising Mother Support Group in Tis Abay Health Centre

Source: author, fieldwork; 2011

Second level recognized in BDSZ was ***participation on implementation*** which was initiated by several international NGOs in cooperation with some public health facilities with possible initiation in Meshenti (key-informant interview, 2011). This concerns especially the quality improvements described in sub-chapter 6.3.4 when an NGO facilitates a sort of *provider-initiated action plan* which also involves the current or prospective users to gain the 'other side' perspective: particularly in the direction provider → user which also leads to further quality improvement (EngenderHealth, 2011).

Participation in programme activities was identified only once when a local NGO largely supporting the governmental programmes initiated the resource mobilization amongst communities especially in relation to health centres construction & maintaining by labour, kind and finance (key-informant interview, 2011). This was concretely reported in Tis Abay where people were asked for contribution to finish the extension of an existing public health centre (key-informant interview, 2011). In Meshenti people were assembled by the kebele in order to improve the situation with latrines (key-informant interview, 2011). *Participation in monitoring and evaluation activities* running in Amhara were indicated only by one NGO key-informant in Addis Ababa, however, the researchers did not encountered this initiative in the field.

9.2.1.1. Individual Dimension of Participation in BDSZ

The household survey indicated that 17.1% of women in the sample participated at least once at a community meeting organized by the local authorities during one year prior to the survey. In urban areas in 82.1% of the cases the issue of reproductive health was discussed at least once during the meeting(s), in rural area it was even in 90% of the cases (household survey, 2011; see the Appendix A9). The urban-rural disparities in attendance were indicated when urban meetings were attended by 24.8% of women in the sample whereas rural meetings gained attendance of 9.2% of our respondents (ibid). Moderate relation[173] between the knowledge on legal abortion status and community meetings participation was found which mainstays the assumption that access to information may lead to participation. There were 28% of women (in rural areas 30%) who declared attendance at another meeting bringing their health concerns to the local authorities. However, this question was most likely misunderstood since the nature of the responses to the open question indicated more 'educational' meetings attended with focus on legal status of FGM/C and abortion, environmental health, HIV/AIDS treatment & follow up and gender-based violence in general[174] (household survey, 2011). This aspect of 'passivity' was reflected by one NGO key-informant (2011) who sighed about the difficulties of implementation of participatory approach since people are not used to ask questions in general[175]. The key-informant also added that people at community meetings often expect a 'didactic approach' instead of triggering the conversation by themselves (key-informant interview, 2011). Nevertheless, the general understanding of the word

[173] V=0.234, phi = 0.234 at p=0.004 (Sig. ≤ 0.05) (n=245)
[174] Other issues not concerning health were indicated, i.e. in Meshenti there were several women who reported an attendance on a meeting concerning women's entrepreneurship
[175] This was also reflected by the researchers even in office environment and during the work with the data collection team when getting feedback turned to be an enormous challenge

'participation' in BDSZ implied that all participation efforts took place in virtually created spaces by different bodies rather than associating people who have something in common to stand for.

9.3. Accountability Mechanisms for Reproductive Health in BDSZ

"People do not have the courage; everyone complains but there is no one committed to file a charge against the health professionals" (A rural female FGD participant, 2011)

If we consider the access to information as the basic condition for accountability (Yamin, 2008) it can be concluded that in health service provision in BDSZ there have been various steps taken to make the information on reproductive health accessible (several key-informant interviews & HEWs FGDs, 2011). Examining the level of accountability from the same sources, it turned out that there is a certain tendency to achieve service accountability of HEWs, doctors & lower level management in order to 'calm down' users complains which although reported as 'not that common', they happen. Lacking knowledge of the procedure, secondly lacking courage to challenge health providers were indicated as major barriers towards submitting someone's own complaints (male & female FGDs, 2011).

Box 9.A

To tolerate or to complain?

"They do not properly treat everyone. Some time ago, I was in the health centre and one man came after looking for a treatment but they told him that the time has passed. But he confronted them and said: 'this is a government institution, I will go to the proper place and complain'".

An urban female FGD participant, 2011

"They say:' do not argue with her [a health worker], leave her alone and let her keep talking'. They abandoned us and hence we do not have any option but leave".

An urban female FGD participant, 2011

The action of bringing the complaints and concerns to the health centre administration was mentioned more often in urban settings (male & female urban FGDs, 2011) whereas in rural areas the women tended to be more passive in their reactions directing the issues of service accountability towards the government (rural female FGDs, 2011). What was identified only in rural areas was clientelism. FGD participants reported that especially the drug supply is not distributed equally since patients who were not acquainted to health providers had to buy the medicine in a private pharmacy (a rural FGD participant, 2011). Several urban FGD participants conceded that complaints regarding staff mistreatment are accepted and followed whereas complaints concerning medical supply always fall flat since the health centre administration cannot influence the volume and frequency of the medical supply.

The issue of *forward* or *downward* accountability towards service beneficiaries has begun to be promoted by international NGOs in BDSZ in a way of ***patient charters*** (George, 2003) which aim resembles the quality improvement initiatives discussed. However, the added value promoted may be promising in terms of community empowerment when a community monitors a health facility which also allows immediate feedback while utilizing the process of *community score-cards* (key-informant interview, 2011). Such an initiative seems promising although facing a major systematic obstacle: front line health workers in reproductive and maternal health services in BDSZ are not responsible for decisions being made upwards in the hierarchy such as workforce deployment or drug supply.

9.4. Conclusion

This chapter has demonstrated that under the current institutional environment of disseminating the information on health rights/needs, the most stressed health right in the context of reproductive health in BDSZ seemed to be the right to freely choose the time and method of spacing or delaying pregnancies in order to achieve the desired family size. Citizen's participation in own health, as observed, took place primarily within the spaces created by administration units, governmental agencies or NGOs. Health sector accountability mechanisms seemed to be reduced to the administration level; no signs of engaging marginalized groups were recorded or encountered. Administration offices of the health centres appeared to be in the peculiar situation. They got stuck between patients with gradually increasing demands on quality of the service and resistance of the higher levels in the health sector hierarchy, which is constricted by the inefficient resource allocation.

Discussion

This thesis attempted to make a synergy of the reproductive health and HIV/AIDS agendas in order to get comprehensive understanding of HIV/AIDS awareness and reproductive health service utilization while finding their common features. Aside from the direct link in terms of sexual transmission and transmission from mother to child, HIV/AIDS and reproductive health share many of the same determinants, such as gender inequality, poverty, stigma and marginalization of vulnerable groups (Bernstein & Juul-Hansen, 2006). Only quite recently a significant shift towards more comprehensive programming & care combining reproductive health and HIV/AIDS prevention & treatment has emerged. The signs of this paradigm shift are also present in this thesis, which attempted to clear the boundaries between those two phenomena. The main aim of this study was to find out, *what the role of access to information and knowledge is in HIV awareness, reproductive health service utilization and demand articulation within the health system of Amhara focused on Bahir Dar Special Zone (BDSZ).* This chapter reflects the empirical findings addressing the four research objectives while confronting them with contemporary academic literature investigating similar topics.

Reproductive Health Service Provision

Reproductive health and HIV prevention services were found to be planned, financed and provided within the decentralized framework in BDSZ. This study supports the suggestion that decentralization itself does not automatically lead to higher levels of effectiveness and accountability of health service provision (Standing, 2004; Murthy & Klugman, 2004 & Abdella, 2008). Other steps towards health service delivery effectiveness have been taken in Ethiopia, such as community financing for health – the insurance systems schemes for both formal and informal sectors were designed, yet not fully implemented. The spiral of inefficient health workforce recruitment and deployment only deepens urban – rural disparities in access to reproductive health services. Relative profusion of human and financial resources in urban areas (especially with regard to high prevalence of *urban* community-based services) makes the services cumulated in spatial clusters while excluding the majority of the population which resides in rural areas. Inside those clusters, the inefficient functioning of referral systems was observed. The Ethiopian health sector in general was found to be highly donor dependant with influence of other actors, especially NGOs, at the lower administration levels. Their transparency was found to be questionable, especially while advocating their health programmes at concrete administrative areas. In order to address the health workforce crisis in primary health care, the concept of task-shifting strategies to address HIV/AIDS prevention (Lehmann et al., 2009) was found to be present in the form of community-counsellors in both urban and rural areas, which represents one of the promising strategies to sustain primary health care in BDSZ. Health system strengthening activities towards increased service utilization included capacity building efforts which were mostly NGO-driven. Medical and public health skills trainings were the most prevalent ones (also Kebede at al., 2009); most likely service-specific which does not always correspond with integration efforts. Moreover, programmatic trainings often train health workers away from their jobs for several days, leaving their posts vacant, which leads to a significant loss of delivered services (also Travis et al., 2004).

Awareness Raising & Behaviour Communication Strategies towards Positive Health Seeking Behaviour

The study has identified numerous strategies and behaviour communication messages disseminated through different channels with the aim to influence health care seeking behaviour and personal attitude positively; secondly they attempted to address behaviour risk reduction in relation to HIV/AIDS infection. The shift from traditional behaviour communication change disseminated primarily by mass media towards community involvement in message design was found to be conformed to global trends (also Salem et al., 2008). However, this process has been largely NGO-driven. The multi-level approach of strategic communication mechanisms investigated in Bahir Dar Special Zone included knowledge, stigma reduction and access to services (also Coates et al., 2008) while heavily relying on HEWs in the information dissemination process. However, the awareness raising efforts did not indicate the sufficient level of activities alignment from the NGOs' side. Communication strategies were mostly targeting married women whereas some population segments were found to be underserved, such as the youth & adolescents. Adolescent communication strategies were monopolized by peer approach relying on young people social networks, which are often gender-determined (Population Council & UNFPA, 2010). Reproductive health & HIV/AIDS education could potentially make a more significant difference in knowledge if embedded in (at least) compulsory high school curricula; unfortunately, its current status quo is fragmented, insufficient and not monitored. Schools are potentially one of a few communication channels where adolescents can obtain information on reproductive health and related services since the role of health professionals and families as source of information remains low (also Tegegn et al., 2008). The health system strengthening approach was also indicated as a substantial part of targeting strategies (discussed above).

HIV Awareness & Reproductive Health Service Utilization

The levels of individual and community HIV awareness demonstrated dynamic patterns in terms of knowledge, condom attitude and practice of prevention. Some studies examining HIV awareness in Ethiopia did not measure comprehensive individual HIV knowledge (from the latest ones e.g. Deribew et al., 2010) apart from the EDHS. Comparing the results of this study with the 2005 EDHS, comprehensive individual HIV knowledge was found to be considerably higher in BDSZ in 2011 than in 2005 in the whole of Amhara (15.2% and 60.4% respectively). This finding also corresponds with higher utilization level of ANC compared to the 2011 EDHS findings (34% in the whole of Amhara and 70.2%). This study found a positive association between ANC utilization and comprehensive individual HIV knowledge, which signalizes a positive pathway of HIV/AIDS prevention passing through maternal and reproductive health services. This pattern creates a progressive continuum of care which represents a more convenient modality of service delivery (also Kerber at al., 2007; Makokha et al., 2002 or Bernstein & Juul-Hansen, 2006) since a mother who comes for her ANC check-up receives counselling on HIV prevention due to the PMTCT service. Although the individual comprehensive HIV knowledge patterns in BDSZ were found promising, the practice of HIV prevention lags behind in terms of internalization of that knowledge since consistent and correct condom use as a way of HIV protection was found extremely low. Abstinence and especially reported faithfulness amongst both urban and rural women signalized low perceived vulnerability towards HIV/AIDS. which is also reflected in other studies (e.g. Bogale et al., 2010). The same counts for low condom utilization either as a way of HIV prevention or as a short-term FP method. The lack of knowledge together with cultural barriers plays a major role; some studies attribute this phenomenon to certain psychological determinants (Bogale at al., 2010), which was not investigated with this study. Well-known HIV misconceptions were still prevalent but in lower scale than e.g. Deribew et al. (2010) argue. The decrease of HIV misconceptions and increase of positive attitudes towards people living with HIV/AIDS was revealed as a positive sign in

avoiding stigma and discrimination, which was to a large extent reflected by high VCT utilization (80.4%). Nonetheless, the response to HIV and AIDS can only be successful if individuals adapt their behaviour that truly protects against infection (see also Ochako et al., 2011).

Regarding practice of the other selected reproductive health services, such as family planning, this study corresponds with other studies on FP patterns of married women in Ethiopia (e.g. Ko et al., 2010) although indicating lower CPR than this study (51.7% compared to 67% according to Ko et al., 2010). Correspondence in terms of method utilization was also found, favouring injectables and pills compared to other methods. Both studies questioned the quality of FP counselling with relation to the genuine FP informed choice whereas underlining the importance of male involvement in supporting the final decision towards FP utilization. Skilled child delivery practice brought more positive results than the 2011 EDHS (49% in BDSZ compared to 10% in Amhara); however, the bias of proximity of the largest hospital in the region is present. The issue of low birth emergency preparedness combining various aspects, such as transportation constraints or lack of family support were identified as the major determinants of seeking child delivery at a facility level (also Kerber et al., 2007). Cultural barriers towards increased used of skilled care according to this source remain substantial mentioning late recognition of danger signs, decision-making power and community ownership alongside spatial barriers and consequent lacking transportation (also Koblinsky et al., 2010). The issue of quality (both perceived and experienced) was not reflected as the major determinant of utilization as the study of my research fellow Haaij (2011) presents, this was also supported by Kruk et al. (2009).

Accountability and Participation for Reproductive Health

Although this study provides less empirical data on accountability and participation than on awareness and utilization, it conforms to discussion led by Standing (2004), who argues about the implementation of the rights-based approach to health in low- and middle-income countries. According to this study the 'sensitive rights' agenda does not fit in the contemporary institutional settings in the Ethiopian health sector influenced by recent NGO legislation. The 'needs and empowerment' terminology seemed to be accepted in BDSZ and in Ethiopia in general. Participation for own reproductive health in BDSZ was present mostly in the consultation or partnership forms (vide Arnstein, 1969), which refers to a lower-moderate level of participation according to her classification. Reasons for community participation varied from resource mobilization and infrastructure support (the lowest level of participation as defined by Murthy & Klugman ,2004) through efficiency improvement and forward accountability increase (the highest level, ibid). However, this accountability was mostly targeted on the front line health workers, or on their supervisors – the lower level management which supports the view of Yamin (2008), who questions the accountability of the frontline health workers in low- and middle-income countries. In BDSZ it was obvious that the only actors performing forward the accountability towards service beneficiaries/citizens were health administration units at the health centre/hospital levels although the procedures varied. Making health centres/hospitals administrators the only accountable link in the whole health system chain is a worrisome simplification of the accountability mechanisms in the health sector. Those administrators appear in a peculiar situation when losing credibility in the eyes of citizens who seek the service and, simultaneously not being able to influence decisions which are being made upwards in the hierarchy (such as health workforce deployment or drug supply). Since those factors are outside of BDSZ administrators' control the higher management only cause their disempowerment (see also London, 2008). Such a vicious circle only causes the loss of credibility of the whole health sector, which just undermines all the significant efforts which have been done.

Conclusion and Policy Recommendations

The study has discussed the role of access to information and generated knowledge in relation to reproductive health service utilization, HIV prevention and participation in own reproductive health in Bahir Dar Special Zone. Access to information was found to be an important condition for all aspects mentioned although in a specific manner to each of those categories. It influences whether women know where to obtain the services, whether they know how to protect themselves against HIV infection or how to complain about health service provision to hold the providers accountable. Internalizing the knowledge towards more positive health-seeking behaviour, responsible HIV prevention and holding health providers accountable is also largely influenced by spatial, social and financial access which this thesis also reflects. The attention was also paid to the ways the information was accessed and further communicated. Numerous traditional and new communication channels targeted a small number of population groups with messages on service and methods availability, lowering risky behaviour or abolishing harmful traditional practices. Community-based communication channels such as religious leaders' involvement or community gatherings' participation appeared to be a promising and innovative way especially in rural areas, yet not fully explored. Urban – rural disparities were found to be present especially in aspects of service delivery, reproductive health service utilization and HIV awareness favouring urban areas to large extent.

Based on the major findings of this study, the author dares to suggest policy recommendations at the following levels: health service provision, awareness raising strategies and behaviour communication change and participation, and accountability for reproductive health. Finally, the opportunities for further research are suggested.

Health Service Provision

- ✓ Avoid unnecessary accumulation of community-based services in urban areas by more efficient health workers recruitment and deployment with special attention paid to rural areas.
- ✓ Strengthen the procurement and logistics of medical supplies and drugs (ART) to rural areas while avoiding the unnecessary mediation via third parties which just prolongs the whole process.
- ✓ Support the clinical health workforce in urban areas in order to face challenges of overload which negatively affects their work performance.
- ✓ Design the remuneration system which rewards health workers who sustain their position for longer period while applying incentive system for those deployed in less attractive rural areas.
- ✓ Align the in-service trainings for HEWs in a manner that still leaves room for the responsible work performance whilst focusing on quality of services provided, not quantity (inflating their packages).
- ✓ Examine the quality of counselling for different reproductive health services: it is the counselling quality which makes the service user-friendly.
- ✓ Make sure that reproductive health and HIV/AIDS policies do not collide with each other, especially with regard to long-term FP methods shift and HIV/AIDS prevention (condom use)
- ✓ Strengthen birth and emergency preparedness while designing alternative transportation strategies at the community level.
- ✓ Achieve consensus on service (opportunity) costs and standardize obligatory guidelines for facilities to follow with aim to prevent patients from bearing the burden of ineffective management[176]

[176] For instance if a woman arrives to a facility to deliver her child and gloves and other equipment are missing and, she gets them from somewhere else, she would be allowed to claim the costs for refund (e.g. at the zonal health office or different body)

Awareness Raising Strategies and Behaviour Communication Change

- ✓ Investigate implementation of new communication channels such as cellular technology while advertising new services at the facility level, saving waiting times while communicating patient's results or referral.
- ✓ Introduce compulsory sexual and reproductive health education at high school level to promote responsible behaviour and advertise existing services.
- ✓ Revise current HIV prevention strategies towards greater knowledge internalization of targeted audiences with special focus on rural women.
- ✓ Address cultural practices towards certain population groups (youth & adolescents, single women and widows) to increase their access to all reproductive health services, especially to family planning.
- ✓ Address power imbalances between female HEWs and husbands of married women while involving more men who would communicate reproductive health and HIV/AIDS messages to undecided husbands.
- ✓ Reconsider demand side financing for health especially in relation to institutionalized deliveries.

Participation and Accountability in Reproductive Health

- ✓ Broaden the accountability mechanisms to higher level of health system since it increases the credibility of services in the eyes of the citizens – e.g. introduce or revise (if existent) the health providers code of conduct and display it in the health facilities.
- ✓ Design rewards for good performance and sanctions for poor performance for both clinical and community-based level within unified guidelines which are publicly accessible.
- ✓ Create an enabling environment for genuine community initiatives which would assist with common health improvements at a various levels.
- ✓ Identify marginalized groups and create affirmative action to increase their participation.

Further Research Opportunities

This study touched upon many issues and topics which are considered by the author as worth exploring through further research. Those include:

- ✓ The roles of community groupings (*iddirs*, *mahabers*, *iqqubs* and others) in health participation in urban areas
- ✓ Other existing or establishing cooperatives addressing the service delivery constraints such as alternative transportation schemes in rural areas
- ✓ Health Extension Programme revision/upgrade based on HEW's experience with rural urban specificaions
- ✓ Supply chain of family planning methods (both long term and short term) and its impact on their utilization in long term perspective
- ✓ Exploring accessibility of reproductive health services of other then 'married women' population groups
- ✓ Public acceptance and implementation of new health financing schemes with its impact on service delivery improvement

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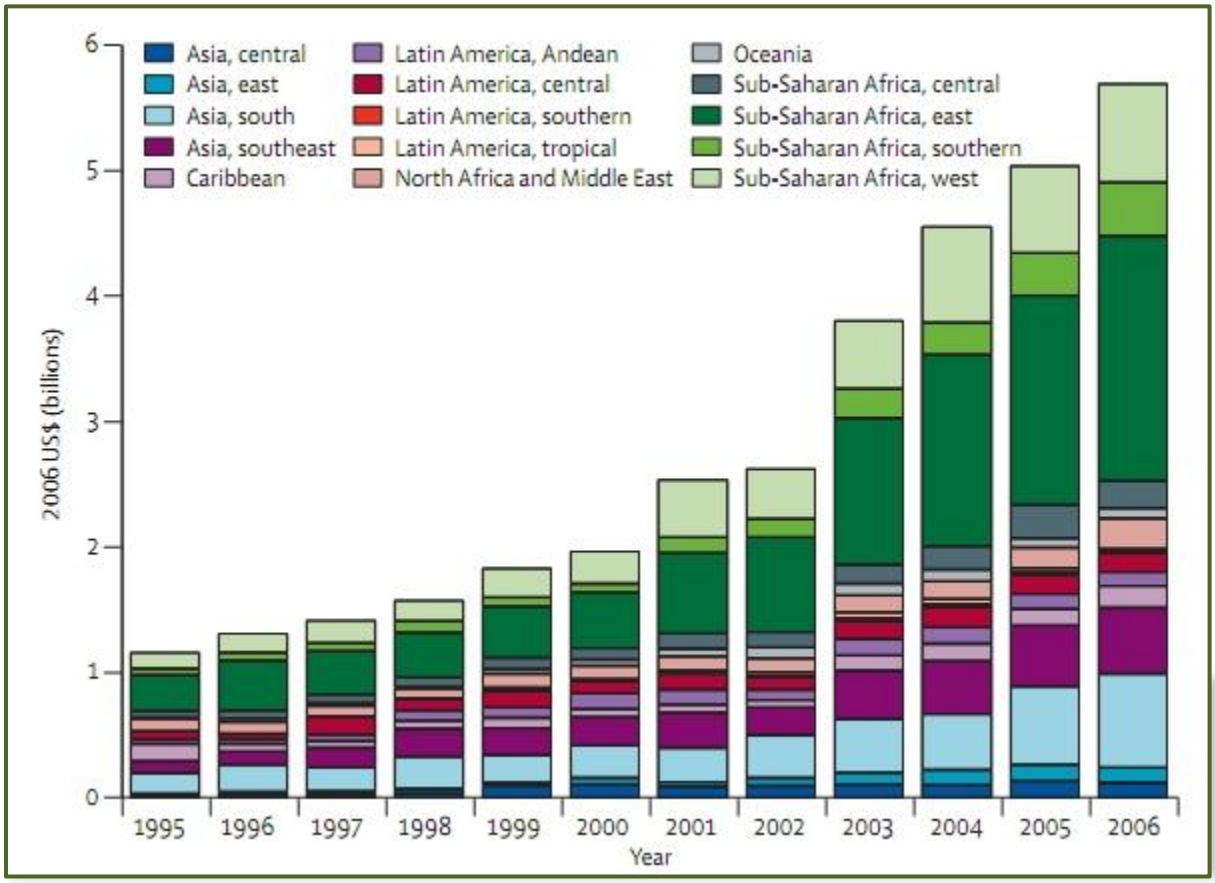
Appendices

List of Appendices

Appendix A1: DAH between 1995 and 2006 by global burden of disease - selected regions



Source: Chunling et al., 2010 (derived from the IMF data

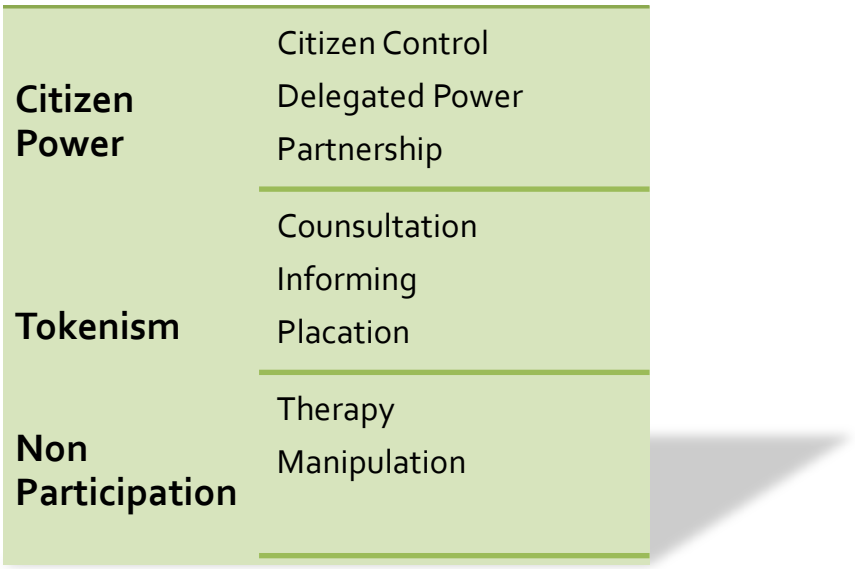
Appendix B1: Selected Characteristics of Major Donors Involved in Global Health

	Group of Actors	Main Examples	Role	Challenges
I.	Multilateral institutions	WHO, WB, UN agencies (UNICEF, UNDP, UNFPA)	✓ WHO - provision of scientific & technical advice with setting international normative standards. ✓ WB - interaction with governments, supporting countries' health systems	× WHO - suffers from inadequate resources, external priorities dependence, cannot be the director of international health work as originally established. × WB - pushes for increased private sector involvement but exclusively supports governments by loans which are often not aligned with national health systems.
II.	National aid agencies	DFID, USAID, GTZ, SIDA	✓ Provision of bilateral aid, sometimes through own initiatives (USAID - PEPFAR), often implementing security/foreign priorities through global health lenses	× No accountability mechanisms to recipients' governments/populations, the only accountability direction goes to tax payers through their elected representatives.
III.	NGOs & their networks	Oxfam, People's Health Movement, IPAS	✓ Campaigning & advocacy[177], complementary role in service delivery & capacity building, often get direct funding from other actors	× Causing internal brain-drain of health workers at the expense of public sector offering better remuneration which threatens health systems' human resources capacities.
IV.	Private foundations	Gates Foundation, Rockefeller Foundation	✓ Funding scientific research with focus on the creation and improvement of health interventions.	× Primary focus on technological innovation, tendency to fund institutions and scholars in high-income countries.
V.	Private sector	Global Fund to Fight HIV/AIDS, TB & Malaria, Stop TB Alliance	✓ Engages through public-private partnerships, bringing expertise on technical norms & standards.	× Following not only public interest, but also the commercial one. Substantial amounts spent on private consultants and auditing companies.

Source: Adopted from Sridhar, 2010

[177] Advocacy broadly includes *campaigning* with main aim to change public opinion and, *lobbying* with goal to change public policy. Both forms of advocacy aim to influence policy formation, especially the policies which could lead to positive impact on peoples' lives (Rugendyke, 2008). Advocacy as a policy formation tool is mostly utilized by civil society, particularly NGOs.

Appendix C1: Arnstein's Ladder of Participation



Source: Arnstein (1969)

Appendix D1: Good Practices of Mobile Phone Use in Sexual and Reproductive Health

SEXINFO – health intervention developed in order to respond to the increasing incidence of STIs among urban youth in San Francisco. Designers looked at high rates of cell phone use among the priority audience: 15- to 19- year old African-American youth. They developed and opt-in text messaging service to provide information about basic sexual health and relationship issues and referrals to youth-oriented services. During the first 25 weeks of offering the service, nearly 4.500 inquiries were made via SMS and 2.500 of those led to requests for more information and/or referrals (Levine et al., 2008).

GPS & HIV/AIDS in South Africa – a mobile phone service in South Africa in 2007 began to provide HIV testing stations location through the use of SMS. By sending an SMS with the term followed by HIV and by the name of their town or postal code South Africans can receive the location of the two nearest travelling HIV testing units (Ramey, 2007).

Appendix A2: International & Regional Human Rights Definitions Tied to Sexual & Reproductive Health

Year	Document & Main Principals
1993	***The International Conference on Human Rights*** in Vienna acknowledged that human rights are universal, indivisible & interrelated, and that women's human rights must be respected in both public and private sphere.
1994	***The Programme of Action*** **of the ICPD** in Cairo, 1994 defined **reproductive rights** as: "certain human rights that are already recognized in national laws, international human rights, documents and other consensus documents. These rights rest on the recognition of the basic right of al couples & individuals to decide freely & responsibly the number, spacing & timing of their children & to have the information & means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decision concerning reproduction free of discrimination, coercion & violence " UN, 1994,Par 7.3
1995	***Platform of Action*** **of the IV World Women Conference** in Beijing re-affirmed ICPD principles and explicitly spelt out the content of women's sexual rights as follows: "The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination & violence. Equal relationships between women & men in matters of sexual relations & reproduction, including full respect for the integrity of the person, require mutual respect, consent & shared responsibility for sexual behaviour and its consequences" UN, 1995, Par. 96
1997	***The Treaty of Amsterdam*** which amended the Treaty of the European Union, considered sexual orientation an unjustifiable basis for discrimination.
2000	*The Council of Europe* requested the inclusion of sexual orientation in the list of unjustified grounds for discrimination in the ***European Convention on Human Rights***.
2000	***The Declaration and Programme of Action*** of the Conference of the Americas in preparation for the International Conference against Racism, Racial Discrimination, Xenophobia & Related Discrimination recognized sexual orientation as a condition aggravating race-related violation of human rights.
2001	The final ***Declaration of United Nations General Assembly Special Session in HIV/AIDS*** called for the promotion & protection of human rights as non-negotiable components of policy responses to the epidemics by: "Recognizing that the full realization of human rights and fundamental freedoms for all is an essential element in a global response to the HIV/AIDS pandemic, including in the areas of prevention, care, support & treatment, and that it reduces vulnerability to HIV/AIDS and prevents stigma and related discrimination against people living or at risk of HIV/AIDS" UN, 2001, Par. 16
2003	The African Union adopted a ***Protocol to the African Charter on Human and Peoples' Rights*** **in the** ***Rights of Women in Africa*** that keeps a series of principles concerning reproductive self-determination: "States Parties shall ensure that the right to health of women, including sexual and reproductive health is respected and promoted…States Parties shall take all appropriate measures to protect the reproductive rights of women by authorizing medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of mother or the fetus " AU, 2003, Par 14

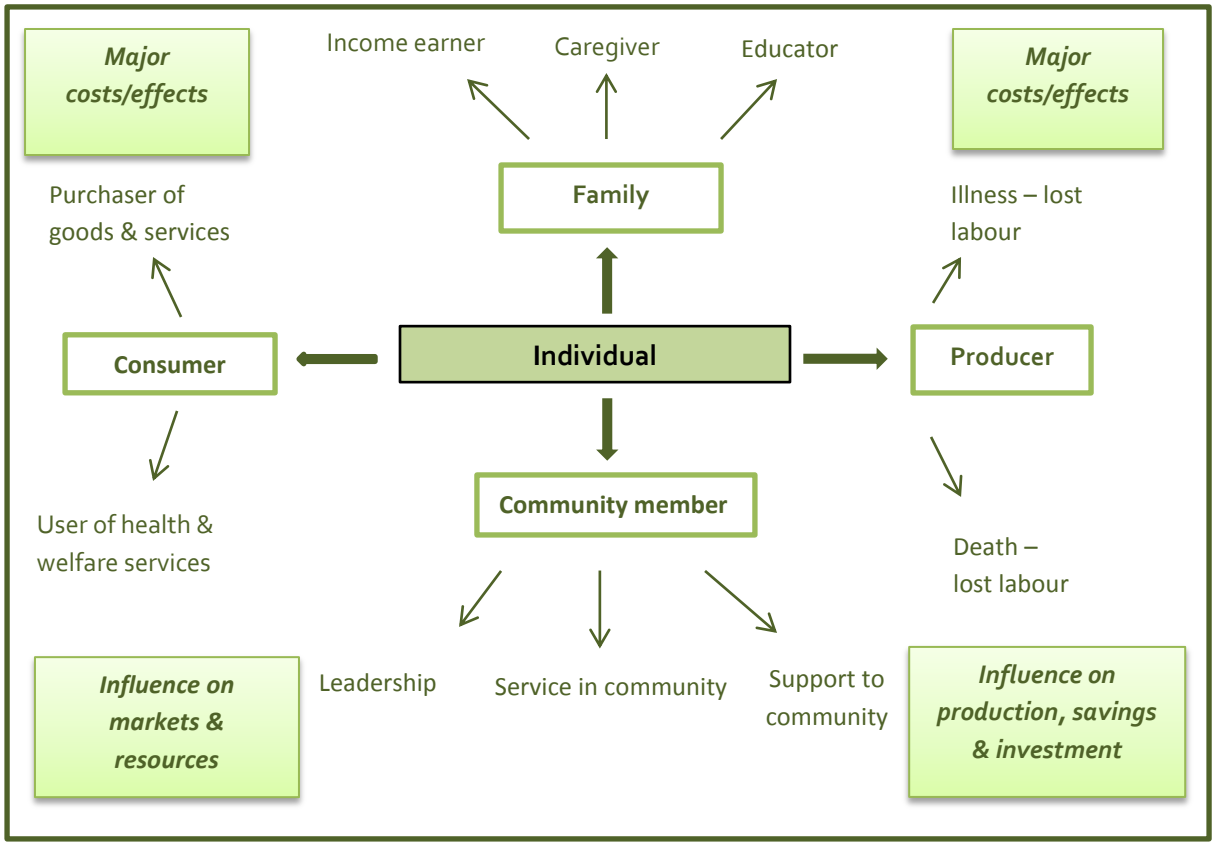
Source: Adopted from Corrêa, 2008

Appendix B2: Quantifiable Targets of ICPD

Goals	Targets
Universal access to primary education	.."countries should…strive to ensure complete access to primary school or equivalent level of education by girls & boys as quickly as possible and in any case before 2015" Par. 11.6
Access to secondary & higher education	"Beyond the achievement of the goal of universal primary education in all countries before the year 2015, all countries are urged to ensure the wildest & earliest possible access by girls & women to secondary and higher levels of education, as well as to vocational education & technical training" Par. 4.18
Reduction of infant & child mortality	"By 2015, all countries should aim to achieve an infant mortality rate below 35 per 1.000 births & under-5 mortality rate below 45 per 1.000. Countries that achieve these levels earlier should strive to lower them further" Par. 8.16
Reduction of maternal mortality	"Countries should strive to effect significant reductions in maternal mortality and morbidity by the year 2015 (…) to levels where they no longer constitute a public health problem. Disparities in maternal mortality within countries and between geographical regions, socio-economic and ethnic groups should be narrowed". Par. 8.21
Universal access to reproductive & sexual health services including family planning	"All countries should strive to make accessible through the primary health-care system, reproductive health to all individuals of appropriate ages as soon as possible and no later than the year 2015" Par 7.6

Source: Bernstein & Juul-Hansen – UN Millennium Project, 2006

Appendix C2 : Radiating Effects of an HIV infection



Source: Sabin & Miller, 2008: 409

Appendix D2: Recent Donor Initiatives in Sexual & Reproductive Health

Institution	Outcome/Document	Characteristics
UN General Assembly	Document '*Keeping the promise: United to achieve Millennium Development Goals* 'as an outcome of the UN Summit on MDGs held in September 2010 in New York	Contains most of the comprehensive SRH services needed to achieve MDGs, it falls short on sexuality education, adolescent needs & unsafe abortion.
UN Secretary-General	*Global Strategy on Women & Children's Health*' established a roadmap to accelerate progress on MDGs 4 & 5 during the UN MDG Summit.	Various international donors pledged over US $ 40 billion for mother & child health, SRH including FP, over the next 5 years.
The World Bank	Released a '*Reproductive Health Action Plan for 2010-2015*'.	Main goals include: increasing contraceptive coverage with family planning, antenatal care, skilled birth attendance, emergency obstetric care & postnatal care.
The G8	Adopted the '*Muskoka initiative on Maternal, Newborn & Under-five Child Health*'.	The main focus is on achieving progress on MDGs 4 & 5, using SRH services including FP. The G8 has pledged to mobilize US $ 5 billion on top of the US $ 4.1 billion annual contribution.
The Global Fund to fight AIDS, TB & Malaria	No outcome document primarily focused on sexual & reproductive health.	It has taken several steps to strengthen health systems in low- & middle-income countries, it explored options for optimizing synergies with maternal & child health. It did not expand its mandate to explicitly cover SRH services, incl. FP.
The European Union	No outcome document primarily focused on SRH. It adopted a '*Plan of Action on Gender Equality & Women's Empowerment in development 2010-2015*'. In the Council conclusions on the '*EU's Role in Global Health*', was adopted on May 2010.	The aim of the first document is to strengthen gender dimension of EU action while the other document focuses on health systems strengthening, with some attention to sexual & reproductive health as one of 4 main challenges. The aid architecture of the EU hinders the specific focus on SRH as it requires agreement in line with aid effectiveness agenda that it is the partner country who determine the policy domains that budget support funds are to be allocated to.

Source: Van Lancker, 2010

Appendix E2: Selected Definitions of MNCH Continuum of Care

"Programmes succeed best when they provide a package of services, including community-based FP, health and nutrition services. Substantial – and sustained – reduction of the risk of dying once pregnant, however, requires a continuum of care from the community to the first referral level, supported by a public education programme."

The World Bank, 1993

"The core principle underlying the strategies to develop MNCH programmes is the 'continuum of care'. This expression has two meanings. First it means care has to be provided as continuum throughout the lifecycle, including adolescence, pregnancy, childbirth and childhood. Second, it indicates that care has to be provided in a seamless continuum that spans the home, the community, the health centre and the hospital."

World Health Report, 2005

"The household to hospital continuum of care approach provides pragmatic steps to ensure the availability of and access to quality maternal and new-born services at peripheral health facilities and district hospitals, while strengthening linkages in between."

Save the Children, 2005

"This encompasses continuum of essential interventions that should be accessible to mothers, new-borns and children at household, community, district and national levels, as well as continuum that follows through the lifecycle of maternal, new-born and child health."

Partnership for Maternal, New-born & Child Health, 2006

"The continuum of care for maternal, neonatal, and child health requires access to care provided by families, and communities, by outpatient and outreach services, and by clinical services throughout the lifecycle, including adolescence, pregnancy, childbirth, the postnatal period, and childhood. Saving lives depends on high coverage and quality of integrated service delivery packages throughout the continuum, with functional linkages between levels of care in health system and between service-delivery packages, so that the care provided at each time and place contributes to the effectiveness of all the linked packages."

Kerber et al., 2007

Source: Kerber et al., 2007

Appendix F2: Global SRH Education Initiatives

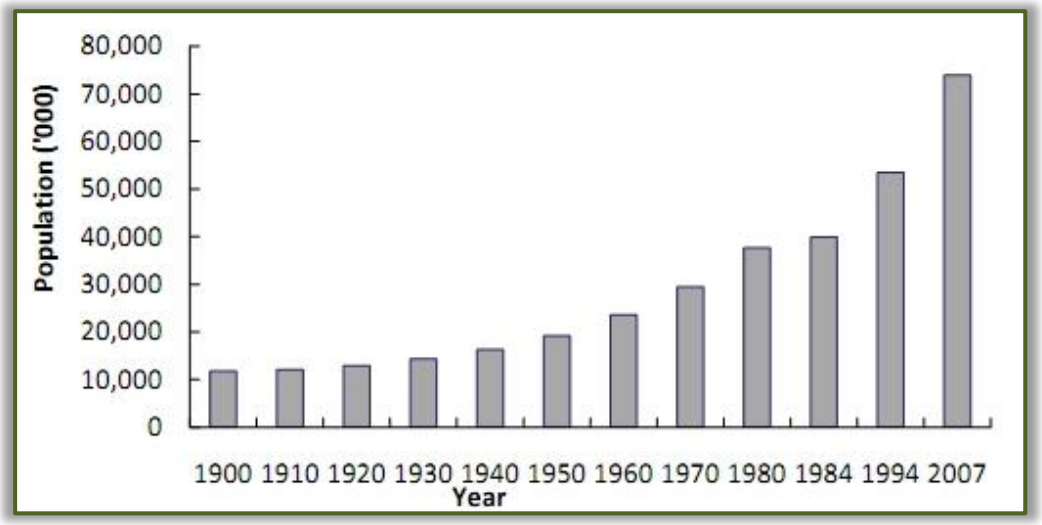
Initiative	Launched	Initiator	Effort
Global School Health Initiative	1995	WHO	Strengthening health promotion & education activities at the local/national/regional/global level. Practically-to increase the number of schools that can be considered as "health-promoting" - to improve the health of students, families, school personnel & communities through crating of healthy school environment, curriculum-based SRH education, provision of referrals to linked services.
Education for AIDS (EFAIDS)	January 2006	Education International/WHO/ Education Development Centre	It combines the efforts of teachers' unions on advocating the initiative *Education for All* at a national level with their commitment to HIV prevention in schools locally. EFAIDS programme also deals with issues such as child labour, developing gender-safe schools & combating stigma & discrimination.
Focusing Resources on Effective School Health (FRESH)	Dakar World Education Forum in April 2000	UNESCO/UNICEF/WHO/ WB/Education International/EDC/ Partnership for Child Development	Formed to develop a basic framework for comprehensive school programming. Four essential components of this framework are: health-related policies in schools, safe water & sanitation facilities, skills-based health education with focus on development of knowledge, attitudes & values and life skills needed to make and act on, decisions to establish lifelong health practices & to reduce the vulnerability to HIV. Key area focus is SRH education including HIV.
UNAIDS Inter-Agency Task Team (IATT) on Education	2002	UNAIDS/UNESCO	To support accelerated & improved education sector programmes to HIV/AIDS by promoting & supporting good practices in the education sector related to HIV/AIDS & encouraging alignment & harmonization within/across agencies.
Global Initiative on Education & HIV/AIDS (EDUCAIDS)	not stated	UNESCO/UNAIDS	It seeks to promote, develop & support comprehensive education sector responses to HIV/AIDS, it attempts to protect the core functions of education system from the worst effects of epidemic. It efforts to promote comprehensive education sector responses to HIV/AIDS.
Ministerial Declaration to promote sexual health to stop HIV in Latin America & the Caribbean	1st Meeting of Ministers of Education and Health to prevent HIV in LA & the Caribbean, August 2008	Ministers of Health & Education of Latin American/Caribbean countries	A *Ministerial declaration* signed by the ministers pledging to provide comprehensive sexual education as a part of the school curriculum in Latin America & the Caribbean. The ministers committed to promoting concrete actions for HIV prevention among young people in their countries. The sexual education should cover broad range of topics incl. biological information with discussion on gender, diversity of sexual orientation & identity along with ethics & human rights.

Source: Adopted from WHO, 2008

Appendix A3: Amhara – Administrative Division by Zone & Woreda

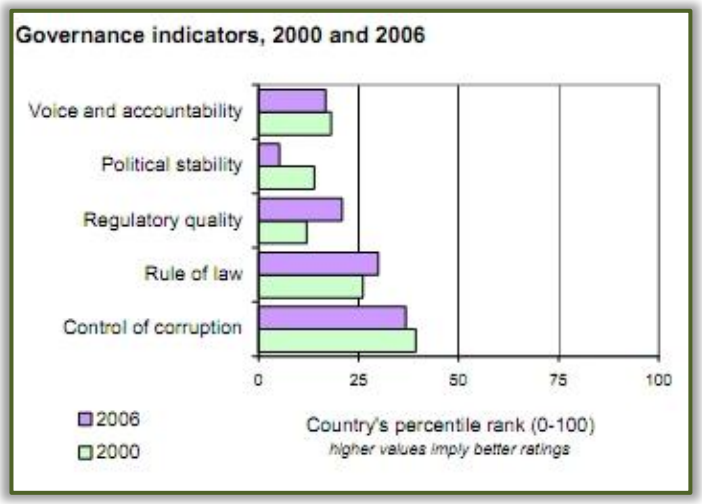
Source: OCHA, 2011, Utrecht University Map Collection

Appendix B3: Trends in population size of Ethiopia from 1990 to 2007



Source: Bekele & Hailemariam,

Appendix C3: The WB's Governance Indicators for Ethiopia 2000 & 2006



Source: WB, 2008b

Appendix A4: Rural Study Area in BDSZ - Meshenti

Appendix B4: Rural Study Area in BDSZ – Tis Abay

Sources: Google Earth CZ; boarders were derived from the field observations

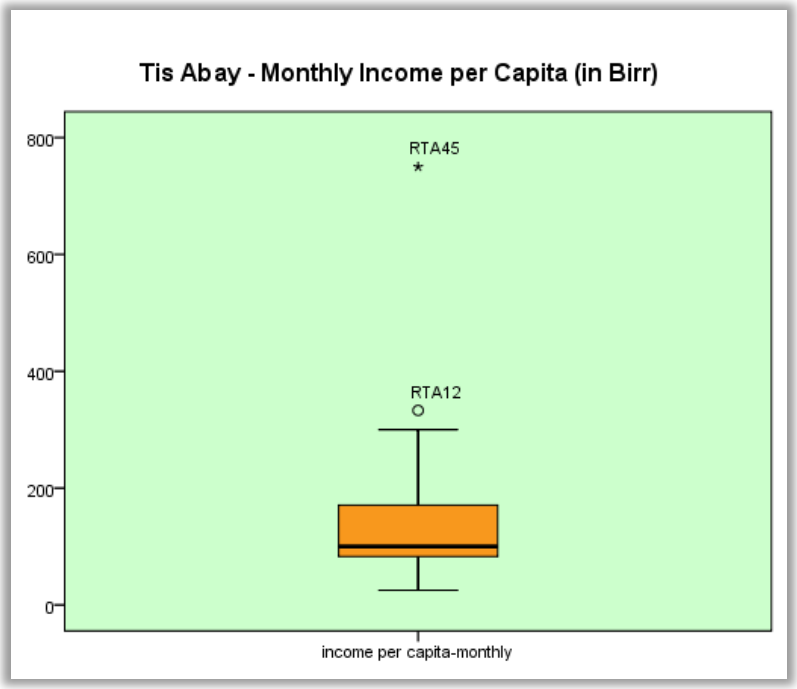
Chapter V

Appendix A5: Kebele 13 by Occupation

Kebele 13 - Respondent's Occupation					
		Frequency	%	Valid %	Cumulative %
Valid	**Agriculture and fishery**	2	**3.0**	3.0	3.0
	Commercial sector	7	**10.4**	10.4	13.4
	Public sector	13	**19.4**	19.4	32.8
	Owns small business	6	**9.0**	9.0	41.8
	Informal sector	11	**16.4**	16.4	58.2
	No job	25	**37.3**	37.3	95.5
	Other	3	**4.5**	4.5	100.0
	Total	67	**100.0**	100.0	

Source: fieldwork, 2011

Appendix B5: Monthly Income per Capita in Tis Abay



Source: fieldwork, 2011

Appendix A6: Quality Observations of VCT sessions in Urban Health Facilities of BDSZ

VCT Session Quality Observation in Urban Health Facilities of BDSZ		
Pre-test Counselling	General Characteristics	Both one-one sessions, in FH* performed by a nurse, in HC** by an HIV counsellor.
	Confidentiality & Privacy, Stigma	In both facilities both secured; stigma & discrimination were discussed.
	HIV/AIDS Explanation & Assessment	In both facilities HIV/AIDS explained, reasons for client's VCT seeking explored, client's knowledge assessed also at both facilities.
	Male & Female Condoms	In HC their use was neither discussed nor demonstrated, they were also not mentioned as an FP method. In FH they were discussed & mentioned as an FP method but not demonstrated.
	Client's Involvement	At both facilities the client was encouraged to ask questions which were lately adequately addressed. In HC a client was asked about benefits of VCT unlike in FH.
	Safer Sex Practices	In FH abstinence was discussed as a prevention mean, mentioning of the safer sex practices. In HC this did not happen.
	Children Care & PMTCT	Were discussed only at FH unlike in HC.
	Duration	It took 9 minutes in HC, for FH it was not recorded.
	Test	Rapid test was performed at both facilities, both clients got their results on that visit, both clients were disclosed negative.
Post-test Counselling	Result	The meaning of the client's test result was explained by providers at both facilities.
	Partner's Involvement	Both HC & FH providers discussed its relation to client's HIV status.
	Male & Female Condoms	Their use was only mentioned at HC whereas at FH their use was mentioned and discussed. None of the facilities performed the demonstration of use.
	Behaviour for Staying Negative	Providers of both facilities discussed abstinence, monogamy & condom use as way of prevention; client's sexual risk was assessed by both FH & HC providers.
	Plan of Action	It was established with both clients, their follow-up was discussed with both providers.
	Referral	Both clients were provided with referral to other medical services & support groups.
	Condom Provision	Neither FH nor HC professional provided the client with condoms (zero male & zero female).
	Duration	12 minutes in HC, 25 minutes in FH.
Overall Emotional Support Skills		Assessed as 10 points (out of 10) in HC and as 8 (out of 10) in FH

Source: fieldwork 2011;* Han Health Centre, ** Felege Hiwot Referral Hospital

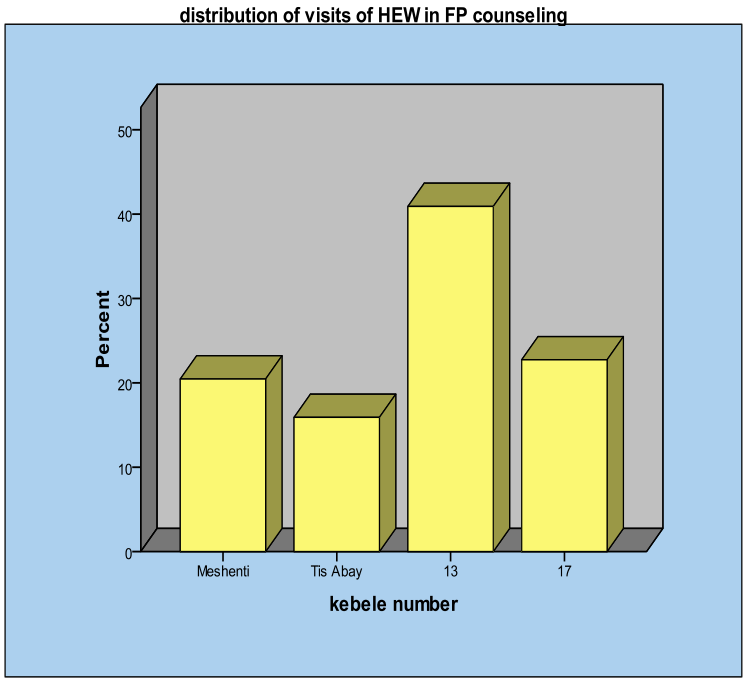
Chapter VII

Appendix A7: Comprehensive HIV Knowledge by Selected Socioeconomic Characteristics

Comprehensive HIV Knowledge by Socioeconomic Characteristics II.						
		Educational Level (years)				
		<= 0	1 - 4	5 - 9	10+	Total
BDSZ	Count	48	18	43	39	148
	% of Total	19.6%	7.3%	17.6%	15.9%	**60.4%**
urban	Count	17	6	23	35	81
	% of Total	13.6%	4.8%	18.4%	28.0%	**64.8%**
rural	Count	31	12	20	4	67
	% of Total	25.8%	10.0%	16.7%	3.3%	**55.8%**
		Employment Status*				
		Employed		Unemployed		Total
BDSZ	Count	73		75		148
	% of Total	29.8%		30.6%		**60.4%**
urban	Count	37		44		81
	% of Total	29.6%		35.2%		**64.8%**
rural	Count	36		31		67
	% of Total	30.0%		25.8%		**55.8%**

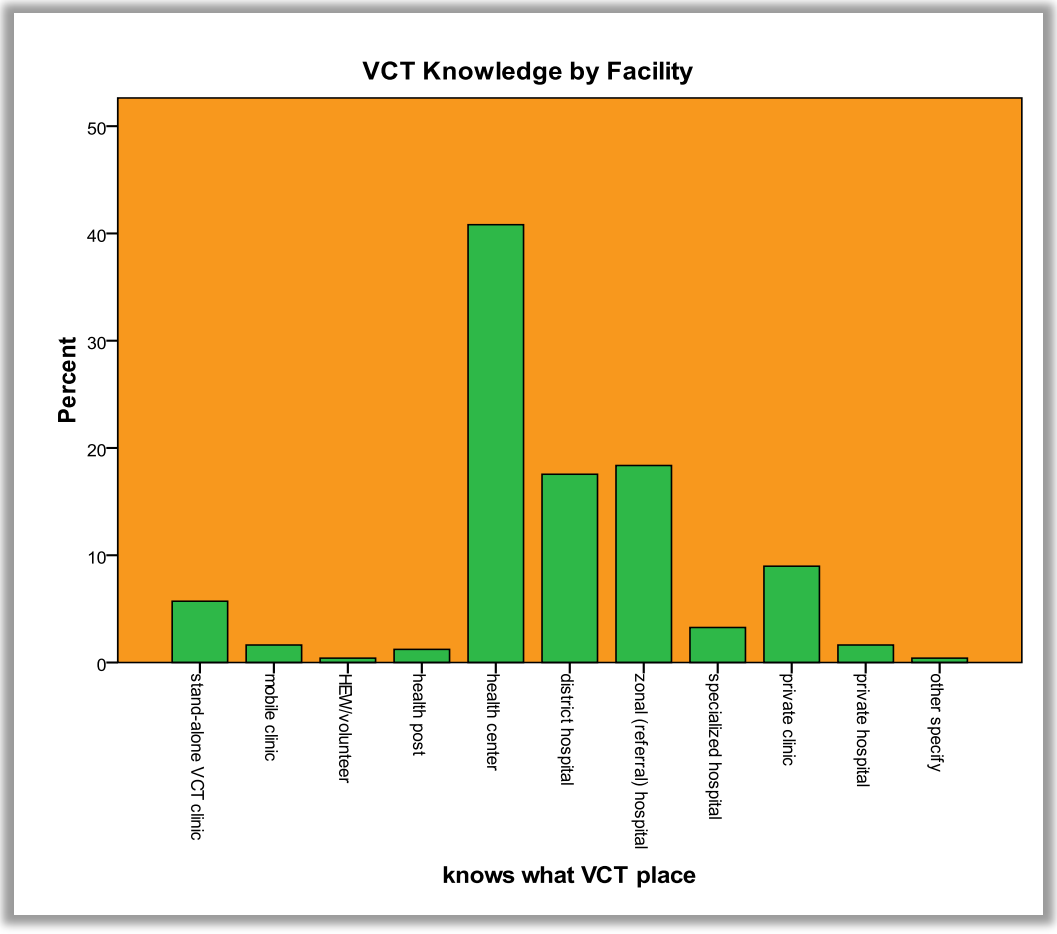
Source: fieldwork, 2011; * earns money herself

Appendix A8: Distribution of HEWs' Counselling Visits on FP by kebele



Source: fieldwork, 2011

Appendix B8: VCT Knowledge by Facility in BDSZ



Source: fieldwork, 2011

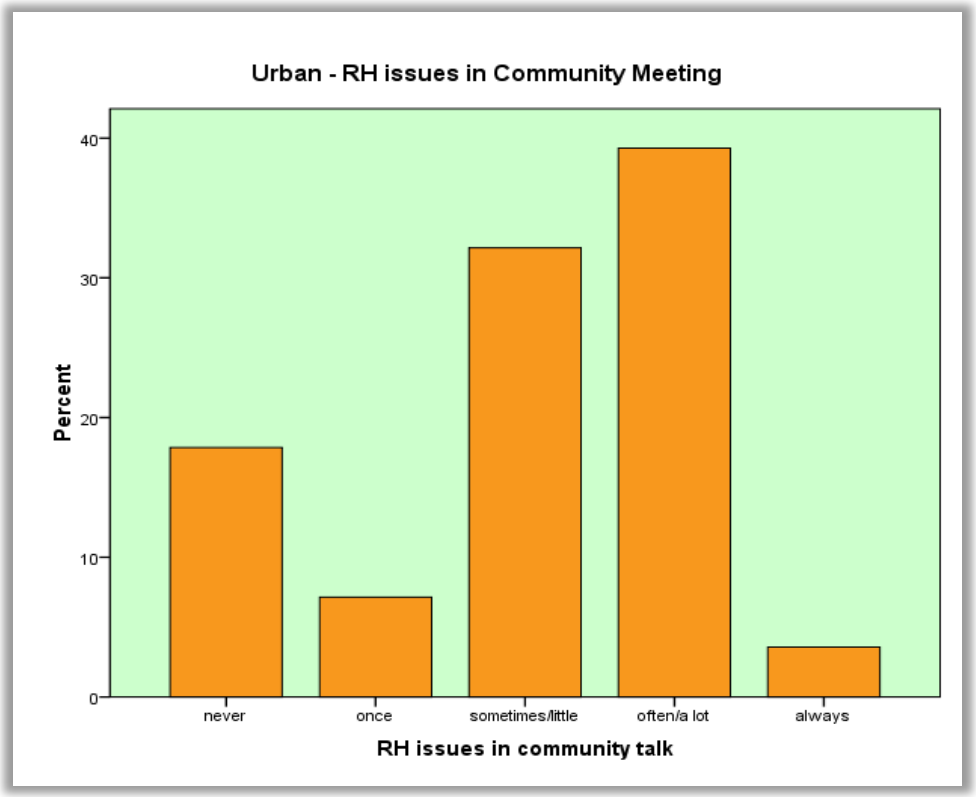
Appendix C8: Family Planning Practice by Age

			FP Practice by Age					
			Age group					Total
			<= 25	26 - 28	29 - 31	32 - 37	38+	
currently using FP method	**yes**	Count	51	27	22	22	18	140
		% of Total	**20,8%**	**11,0%**	**9,0%**	**9,0%**	**7,3%**	**57,1%**
	no	Count	19	13	16	26	31	105
		% of Total	7,8%	5,3%	6,5%	10,6%	12,7%	42,9%
Total		Count	70	40	38	48	49	245
		% of Total	28,6%	16,3%	15,5%	19,6%	20,0%	100,0%

Source: fieldwork, 2011

Chapter IX

Appendix A9: Frequency of Discussing RH Issues at Urban Community Meetings



Source: fieldwork, 2011

Ferenji Doing Research with *Habesha*: A Personal Reflection[178]

During a research briefing at the Dutch Embassy we were asked whether the fact that we got the access to hardly accessible information was not facilitated just by the simple fact of being two young female *ferenji* researchers. I would say [menalbate][179]. Certainly, the officers or health professionals at the health centre level most likely do not meet two female *ferenji* in their 20s every day, but on the other hand, it was our persistence which led us. If we had resigned the first time when being told by the authorities in Bahir Dar there were no population numbers on the kebele level, we would hardly have found ourselves at the point of finalizing our Master thesis. Sometimes we also had the person you call 'Dame Fortune' on our side. Like the situation of interviewing the head of the biggest hospital in Amhara. Even though I hardly ever benefit from my nationality within the international settings since Czechs form a small nation with limited foreign activities, to my big surprise it happened in Ethiopia. Once we found out that the head of Felege Hiwot Referral Hospital obtained his degree in my country, suddenly we had open doors to service provision observations and quality assessments in the whole hospital. On the other hand, sometimes we felt like having bad luck no matter who we consulted or asked for an advice.

As the most demotivating experience turned out to be a male FGD which failed twice due to unrealized promises made to our research assistants mobilizing the male participants in the neighbourhoods. Many times we asked ourselves and the others what we had done wrong or what could have been done better. Later we were provided with some feedback from our host organization: first, some *Habesha* people cannot say 'no' in order not to disappoint you at that moment (no matter you feel more disappointed afterwards) and secondly, the prospective FGD participants were expecting incentives. They expected money as compensation. Especially huge international NGOs operate with a *per diem* system. Both me and my research fellow do understand there is need of valuing people's lost time due to our research which we attempted to cover within our student budget possibilities. But what kind of climate does such *per diem* system create when rewarding people for one hour lasting FGD with the amount equal to half of their monthly income[180]? We faced so many difficulties to explain even to our own research assistants that we had been at the position comparable to theirs in the Netherlands: working hard and having a student part time job combining with demanding studies in order to pay for our research. Those issues were often received with misunderstanding within our research settings. Sometimes we felt so desperate about these *'ferenji = infinite finance'* attitudes even among our research colleagues that we only desired to break this stereotype. If the further 'development culture' is going to be built on such an extortionate *per diem* system, practised especially by the international NGOs and welcomed by both local officers and citizens, we can hardly talk about *autonomous* participation and accountability. The desire to change things has to come from one's own initiative and not in the expectation of incentives of any kind. The only thing which made me hope was meeting a few people who convinced me about the opposite. Instead of waiting for an incentive, they were asking themselves: "what can I do for this community?" They are innovative within their mandate, determined, doing so voluntarily and freely, expecting nothing but a positive change. This is the point where the grass-roots development starts. I strongly believe that Ethiopia stands a chance.

[178] *Ferenji* stands for Amharic expression for a white foreigner, the term is usually associated with wealth and good well-being; *Habesha* is an Amharic word for Ethiopians
[179] Maybe in Amharic
[180] Sometimes even household income