



REPORT

PROGRESS AND CHALLENGES TO SEXUAL, REPRODUCTIVE, MATERNAL, NEWBORN, CHILD AND ADOLESCENT HEALTH (SRMNCAH): FINDINGS FROM THE PROGRAMME ON WOMEN'S EMPOWERMENT (POWER) ACTION RESEARCH IN GAMBELLA



With funding from



Progress and Challenges to Sexual, Reproductive, Maternal, Newborn, Child and Adolescent Health (SRMNCAH): Findings from the Programme on Women's Empowerment (POWER) Action Research in Gambella



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TABLE OF CONTENTS

SECTION 1: INTRODUCTION	1
1.1 Background	2
1.2 Rationale of the programme	2
1.3 Action research	3
1.4 The purpose of the action research	4
1.5 Objectives of the action research	4
1.6 Methodology and approach	4
1.6.1. Study setting	4
1.6.2 Study design	6
1.6.3 Target population	6
1.6.4 Sample and sampling for household survey	6
1.6.5 Sampling procedure	6
1.6.6. Inclusion/exclusion criteria	7
1.6.7. Household survey data collection procedures	7
1.6.8. Qualitative data collection methods and procedure	7
1.6.9. Sample and sampling for qualitative data collection	7
1.6.10. Data collection instruments	8
1.6.11. Field supervision and data quality assurance	9
1.6.12. Data management and analysis	9
1.7. Ethical issues	9
SECTION 2: FINDINGS OF THE STUDY	10
2.1 Introduction	11
2.2 Sociodemographic characteristics of respondents	11
2.3 Access to SRMNCAH information, and the knowledge, attitudes and behaviour of women and men	12
2.4 The SRMNCAH services in the health facilities	17
2.4.1. Available FP services	17

2.4.2. Sexually transmitted infections	18
2.4.3. Management of sexual and gender-based violence	20
2.5 Access to SRMNCAL services	21
2.5.1. Access to youth-friendly SRMNCAL services	22
2.5.2. Abortion in Ethiopia	23
2.6. Factors/barriers affecting SRMNCAL service utilization	24
2.6.1. Supply- and demand-side barriers	25
2.7 Logistic regression analysis on access to and utilization of SRMNCAL services	31
2.7.1. ANC service access and utilization	33
2.7.2. Access to delivery services	35
2.8 POWER progress and promising practices	36
 SECTION 3: CONCLUSIONS AND RECOMMENDATIONS	 41
3.1 Conclusions	42
3.2 Recommendations	44
3.2.1. General recommendations	44
3.2.2. Programme-related recommendations	44
 ANNEXES	 47
Annex 1: Household survey questionnaire	48
Annex 2: Focus group discussion	54
Annex 3: Key informant interview guide	56
Annex 4: Health facility assessment checklist	57
 REFERENCES	 64

ABBREVIATIONS

AIDS	acquired immunodeficiency syndrome
ANC	antenatal care
AOR	adjusted odds ratio
ART	antiretroviral therapy
BCC	behavioural change communication
CD4	cluster of differentiation 4
CI	confidence interval
COR	crude odds ratio
EDHS	Ethiopian Demographic Health Survey
FGD	focus group discussion
FP	family planning
GBV	gender-based violence
HCT	HIV counselling and testing
HIV	human immunodeficiency virus
IEC	information, education and communication
IMC	International Medical Corps
IUCD	intrauterine contraceptive device
KII	key informant interview
NGO	non-governmental organization
PMTCT	prevention of mother-to-child transmission
PNC	postnatal care
POWER	Programme on Women's Empowerment in Sexual and Reproductive, Maternal, Newborn, Child and Adolescent Health (SRMNCAL) Rights
RCC	refugee central committee
RRS	Refugees and Returnees Service
SDG	Sustainable Development Goal
SGBV	sexual and gender-based violence
SPPS	Statistical Package for the Social Sciences
SRHR	sexual and reproductive health and rights
SRMNCAL	sexual, reproductive, maternal, new-born, child and adolescent health
STI	sexually transmitted infection
UN	United Nations
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
WHO	World Health Organization



SUMMARY

INTRODUCTION: The United Nations Entity for Gender Equality and the Empowerment of Women (UN Women), in collaboration with the International Medical Corps (IMC), with the generous support of the Austrian Development Agency, implemented the Programme on Women's Empowerment in Sexual and Reproductive, Maternal, Newborn, Child and Adolescent Health (SRMNCAH) Rights (POWER) in refugee and host communities in Gambella Region. POWER was designed to contribute to UN Women's overall goal: every woman, every child, every adolescent girl everywhere demands her rights to quality SRMNCAH services, particularly in humanitarian settings.

This action research aimed to document the progress of the programme's implementation and lessons learned, identify barriers and challenges to accessing the services, and inform humanitarian partners of the programme's progress in improving future SRMNCAH services for the refugee and host communities.

STUDY METHODS: The study employed a cross-sectional design with a mixture of qualitative and quantitative data collection approaches. The primary target population of the study was women and men in the age category of 15–49 from the targeted refugee camps and host woredas (districts of Ethiopia). Participants were involved in the study voluntarily. No one was obligated to respond to any questions if they did not want to respond. Consent was taken from study participants, and parental consent for minors involved in the research was also taken.

For the household survey, a total sample size of 404 households was used. The survey data were collected using electronic mobile tablets, and the mode of data collection was face-to-face interviews. To complement the household survey, qualitative data were collected using focus group discussions, key informant interviews, case studies and health centre assessments. Data from the household survey were organized and processed using the Statistical Package for the Social Sciences (SPSS), version 20. The data collection was conducted from 20 November to 15 December 2021 in selected refugee and host communities in Gambella Region.

FINDINGS: Overall, 64 per cent of respondents reported that they had knowledge of SRMNCAH. About 62 per cent of women and girls and 66 per cent of men and boys had information about SRMNCAH. The most widely available and preferred sources of SRMNCAH information for both women and men were community workers (68.1 per cent); health facilities (57.2 per cent); printed information, education and communication materials (33.9 per cent); schools (29.7 per cent); and peers/friends (25.3 per cent). In general, the community members have negative attitudes towards family planning (FP) services. The main factors that prevented respondents from using the SRMNCAH services were cultural beliefs (53 per cent), husband's influence (22 per cent) and fear of the community (25 per cent). The use of FP services was mainly decided by husbands (43 per cent), followed by women themselves (35 per cent). Multivariable logistic regression analysis showed that education, participation in SRMNCAH programme training and workshops, accessibility of health facilities, and community dialogues and discussions had statistically significant associations with FP service utilization.

Access to antenatal care (ANC) services was mainly decided by husbands (47 per cent), followed by women themselves (23 per cent). About 33.5 per cent of pregnant women had attended ANC more than four times. The result of multivariable logistic regression analysis showed that, in the refugee community, husband participation in an SRMNCAH programme, access to health facilities and type of health-care provision had statistically significant associations with the recommended level of ANC attendance. The study shows that a significant proportion (70 per cent) of female refugees deliver their children in health facilities. According to the 2016 Ethiopian Demographic Health Survey (EDHS), the percentage of health facility deliveries in Gambella Region was 45 per cent. This shows that there is better institutional delivery culture in the refugee community than in the host community.

Similarly, the qualitative study identified the main challenges and barriers to access and use of SRMNCAH services on the supply side, demand side, and both demand and supply sides. Various barriers related to gender roles and sociocultural norms, the awareness level of the community and dowry-related challenges are categorized as demand-side challenges. Inability to get quality service at night, lack of client-friendly services, providers' unpleasant behaviour, prohibition of abortion services, shortage of medication and health-care providers, substandard health facilities (inadequate stock of medicines, supplies and equipment), long distance and lack of transport facilities, and difficulty in getting health-care providers when needed were identified as the main supply-side challenges.

The POWER activities were reported as effective, and promising practices were identified. Based on the multivariable logistic regression analysis result, women's and men's participation in SRMNCAH programmes was found to have a statistically significant association with FP and ANC service uptake. This is indicative of the programme's effectiveness in meeting one of

its objectives. The programme's progress and perceived changes were also recognized and observed by household survey participants. Among this progress that occurred as a result of POWER, 47 per cent of the respondents confirmed that there is increased access to SRMNCAH information in the community. The qualitative study also identified the progress of the programme and its effectiveness. This progress included: increased awareness of and access to information, ANC and delivery services in the refugee camp thanks to ANC follow-ups linked with nutritional support for pregnant women and newborn registration; increased demand for FP services; and a somewhat less negative community attitude towards FP. The existing community-based structure of refugee and returnee services, the community referral system through community outreach agents, and the absence of female genital mutilation in both the refugee and host communities were identified as enabling factors and promising practices in the study communities.

RECOMMENDATIONS: Based on the findings, the following programme interventions are recommended for future implementation:

- activities to raise awareness of and create demand for SRMNCAH services;
- working closely with the community to address gender norms and dowry-related barriers;
- building additional health facilities; providing client-friendly services;
- making sufficient medication available in health facilities;
- arranging locally appropriate transportation; and
- strengthening the community-based referral system.

Section 1: Introduction



1.1 Background

Despite the unprecedented improvements in the lives of women, adolescents and children in less developed countries, women and girls are particularly vulnerable to sexually transmitted infections (STIs), unwanted pregnancy, sexual and gender-based violence (SGBV) and maternal illness and death. Among the deaths that occur due to conflict, displacement, and natural catastrophes, 60 per cent of maternal fatalities, 53 per cent of under-5-year-old mortality and 45 per cent of newborn deaths are preventable.¹

Health challenges are particularly acute among mobile populations, refugees, those in temporary camps, internally displaced communities and adolescents. Reports show that people under 25 years old constitute almost 60 per cent of the 1.4 billion people living in humanitarian settings, and often face diverse sexual and reproductive health and rights (SRHR) challenges.²

Unequal gender norms, attitudes and practices contribute significantly to negative outcomes linked with maternal health and the realization of sexual and reproductive health and rights, as part of broader SRMNCAH issues. These make it difficult for women and girls to get contraception, family planning (FP) and other reproductive health services. In Ethiopia, only 52 per cent of married women or women in unions have the freedom to choose their own sexual relations, contraception and health care. This figure is even lower in humanitarian settings, making it difficult for them to fully engage in society and seek health care. Around 15 million adolescent girls (aged 15 to 19) have been subjected to forced sex (forced sexual intercourse or other sexual activities) at some point in their lives, a problem that is worsened in crisis situations.³

In many cases, it is difficult to obtain an essential package of health-care services in humanitarian settings. As a result, well-planned and focused approaches to and strategies for sexual, reproductive, maternal, new-born, child and adolescent health (SRMNCAH) services are required, particularly in humanitarian circumstances. According to the United Nations Office for the Coordination of Humanitarian Affairs assessment

of humanitarian needs in Ethiopia,⁴ refugees require SRMNCAH interventions because women and girls are frequently subjected to abuse and prejudice.⁵

1.2 Rationale of the programme

The United Nations Entity for Gender Equality and the Empowerment of Women (UN Women) was established to accelerate progress on meeting women's needs worldwide, to be a global champion for women and girls, dedicated to gender equality and the empowerment of women. UN Women supports the UN Member States as they set global standards for achieving gender equality, and works with governments and civil society to design laws, policies, programmes and services needed to ensure that the standards are effectively implemented and truly benefit women and girls worldwide. UN Women also coordinates and promotes the UN system's work in advancing gender equality and in all deliberations and agreements linked to the 2030 Agenda. The entity works to position gender equality as fundamental to the Sustainable Development Goals (SDGs) and a more inclusive world. It works globally to make the vision of the SDGs a reality for women and girls and stands behind women's equal participation in all aspects of life with its four strategic priorities: i) women lead, participate in and benefit equally from governance systems; ii) women have income security, decent work and economic autonomy; iii) all women and girls live a life free from all forms of violence; and iv) women and girls contribute to and have greater influence in building sustainable peace and resilience, and benefit equally from the prevention of natural disasters and conflicts and from humanitarian action.

In line with its vision and strategic priorities, UN Women, in collaboration with International Medical Corps (IMC), has been implementing a Programme on Women's Empowerment in Sexual, Reproductive, Maternal, Newborn, and Child and Adolescent Health (SRMNCAH) Rights (POWER) in humanitarian settings in Gambella Region.

1 These data are calculated for 50 fragile states based on OECD 2015. The maternal mortality data are based on WHO et al. 2014.

2 UNFPA 2014.

3 WHO, on behalf of the United Nations Inter-Agency Working Group on Violence Against Women Estimation and Data 2021.

4 OCHA n.d.

5 Cassaniti 2018.

The programme works to address the barriers that are preventing women, children and adolescents from demanding and realizing their rights to SRMNCAH services and seeks to achieve the following three outcomes (results):

- establish rights-based national and local SRMNCAH frameworks;
- improve promotion of equal gender norms, attitudes and practices regarding women's rights to SRMNCAH;
- empower women and girls to exercise their SRMNCAH rights and seek services.

POWER was implemented in Gambella Region in both host communities (Itang, Laree and Gambella woredas (districts)) and refugee camps (Jewi, Nguenyyiel and Kule), where the population is predominantly women, adolescents, and children, and has increased vulnerabilities in the humanitarian context.

The action research was conducted in Jewi and Nguenyyiel refugee camps and the Itang woreda host community in Gambella Region. The study population is disaggregated by sex in Table 1.1.

TABLE 1.1:
Population of camps and host community

Community	Male	Female	Total
Jewi camp	25,419	32,845	58,264
Nguenyyiel camp	40,433	42,189	82,622
Itang woreda	17,955	17,731	35,686

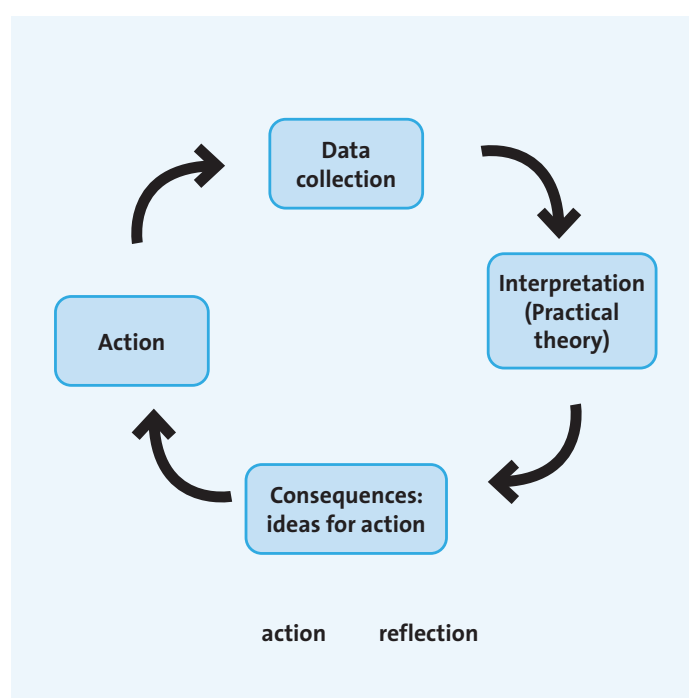
Sources: CSA 2007; UNCHR n.d.

To ensure that women, children, and adolescents have equal access to reproductive health services, understanding the existing gender biases in the social, cultural, institutional, legal and economic structures is vital for informed action. Therefore, this action research is important to derive evidence from the existing programme implementation and propose further interventions in the study area. Evidence from the action research can inform design of new programmes to ensure that sexual, reproductive, maternal, newborn, child and adolescent health rights are addressed well.

1.3 Action research

Action research is a philosophy and methodology of research generally applied in the social sciences, development and humanitarian intervention to seek transformative change through the simultaneous process of taking action and doing research, which are linked together by critical reflection to solve the observed problem (Figure 1.1).⁶

FIGURE 1.1:
Action research flowchart



⁶ Burns 2007.

UN Women preferred this research methodology to investigate problems and challenges during the implementation of POWER, and to recommend practical solutions to address SRMNCAH-related problems in the refugee and host communities of the intervention areas.

1.4

The purpose of the action research

The purpose of the action research is to document the progress on the SRMNCAH programme implemented in the humanitarian setting, lessons learned from it, gaps in it and efforts required for it. The findings will better inform UN Women and partners working in a humanitarian setting on the current progress and the efforts required to improve SRMNCAH services in the refugee and host communities.

1.5

Objectives of the action research

The specific objectives of the action research are:

- to analyse progress on implementing the current SRMNCAH programme, lessons learned and promising practices for ensuring the services in the target communities;
- to assess the project's progress (recorded outcomes) and recognized changes due to the SRMNCAH programme's implementation in the target community;
- to access the existing challenges and gaps in realizing the rights to SRMNCAH information and services;
- to provide recommendations for improving the access and utilization of SRMNCAH services in the refugee and host communities.

1.6

Methodology and approach

1.6.1. Study setting

The action research was undertaken in Gambella refugee camps (Nguenyiel and Jewi) and selected host communities (Itang Agnuak and Itang Nuer communities), where POWER activities were implemented. The programme's activities focus on women's empowerment in SRMNCAH in both refugee and adjacent host communities. For this study, two refugee camps and one host community were selected.

In both Nguenyiel and Jewi refugee camps, all refugees are individually registered with ration cards. A total of 68 per cent of the population is under the age of 18. Schools at both primary and secondary levels operate in the camp, run by the Refugees and Returnees Service (RRS) and World Vision respectively. Early-childhood schools are available, including child-friendly schools run by Save the Children.

Nguenyiel Refugee Camp (Figure 1.2) is the newest and largest camp in Gambella, opened to accommodate the renewed refugee influx from South Sudan following the escalation of conflict in the world's youngest nation in July 2016. It has a total population of 82,654.⁷

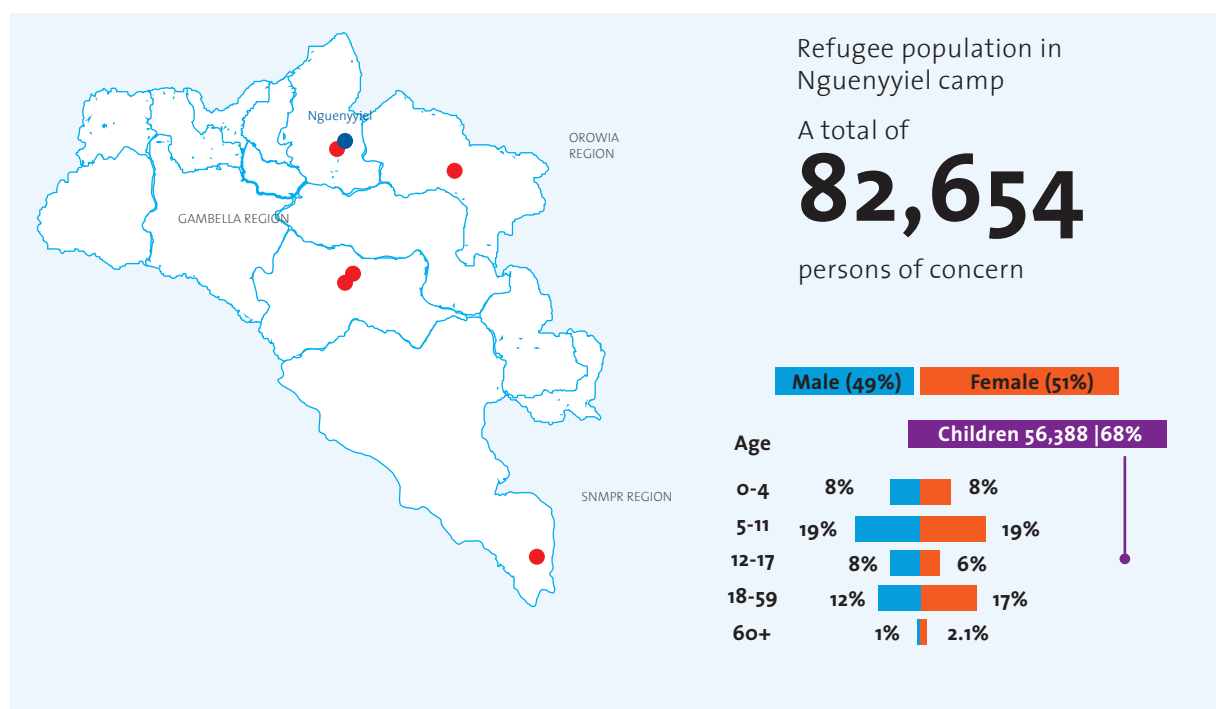
According to the United Nations High Commissioner for Refugees (UNHCR), **Jewi Refugee Camp** (Figure 1.3) was established on 15 March 2015. The total population of Jewi refugee camp is 58,267.⁸

Itang is a woreda in Gambella Region, Ethiopia. Because Itang is not part of any zone in the region, it is considered a special woreda, an administrative subdivision similar to an autonomous area. It is bordered on the south and south-east by Anywaa Zone, on the west by Nuer Zone, on the north-west by South Sudan and on the north by Oromia Region. Nuer, Anuak and other ethnic groups reside in the woreda.

7 United Nations High Commissioner for Refugees (UNHCR). 2020. UNHCR Ethiopia | Gambella Camp profile - Nguenyiel refugee camp January 2020: <https://data2.unhcr.org/en/documents/details/73873>

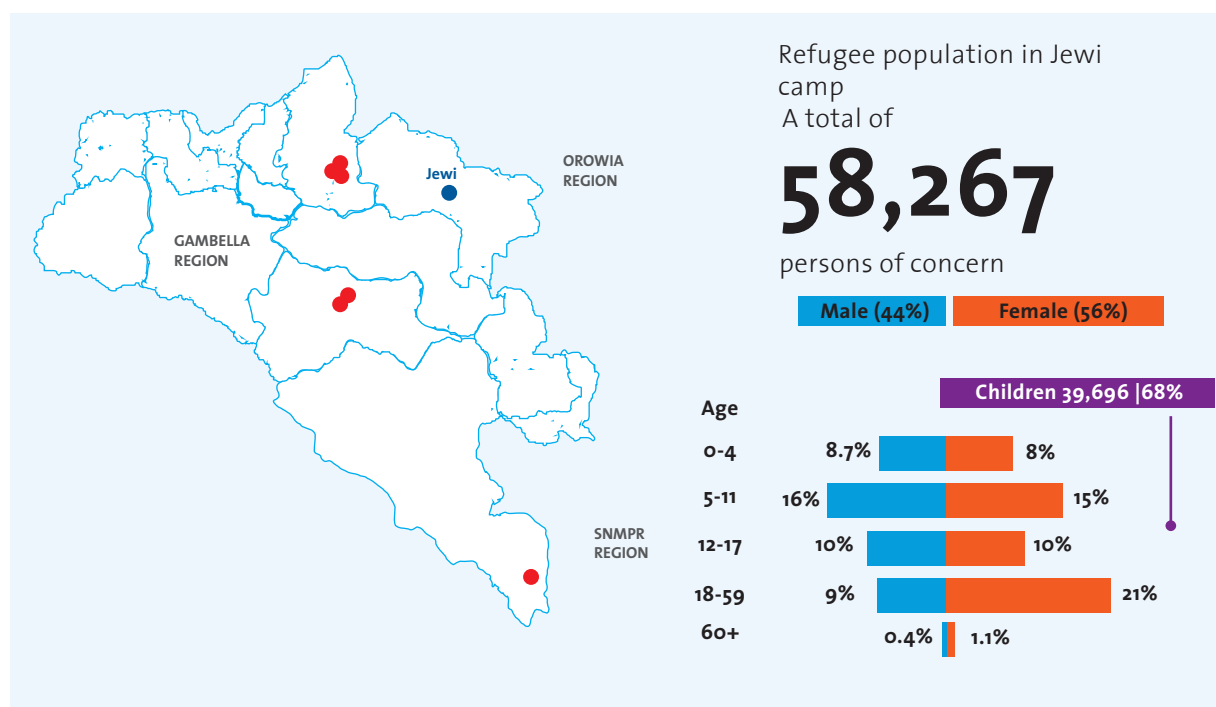
8 United Nations High Commissioner for Refugees (UNHCR). 2020. UNHCR Ethiopia | Gambella Camp profile - Jewi refugee camp March 2020: <https://data2.unhcr.org/en/documents/details/75367>

FIGURE 1.2:
Map of Nguenyyiel Refugee Camp



Source: UNHCR, January 2020

FIGURE 1.3:
Map of Jewi Refugee Camp



Source: UNHCR, March 2020

1.6.2 Study design

This action research employed a cross-sectional study design combining qualitative and quantitative approaches. Both primary and secondary data were collected, analysed and interpreted to derive practicable recommendations. The qualitative data collected from officials, leaders and experts working in relevant governmental and non-governmental organizations were used to complement the quantitative data.

1.6.3 Target population

The primary target population of this study was women and men in the age category of 15–49 from the target refugee camps and host woredas. The evidence generated from these target populations could be generalized and applied to the refugee and host communities where this study was undertaken. Moreover, the similarities in the setting and population composition of other refugee camps can make the study indicative of the overall SRMNCAH utilization, gaps and existing progress in similar refugee and host communities in Gambella Region.

1.6.4 Sample and sampling for household survey

Sample size calculation

The sample size for the quantitative survey was calculated using the following formula, which is used to estimate a sample from a large population:

$$n = \left(\frac{Z}{E} \right)^2 p q$$

where:

n = sample size required to assess all study variables

Z = the value associated with a confidence level of 95 per cent = 1.96

E = the level of precision = 0.05 (5 per cent)

p = population proportions for the variables of interest = 50 per cent (with the purpose of obtaining the

maximum sample size because of involvement of multiple variables in a single study)

$$q = 1 - p = 0.5$$

The specific values given for these variables are those used for this quantitative study.

The resulting sample size of 385 is adjusted for an expected non-response rate of 5 per cent, yielding a sample size of 405. The sample size is allocated proportionally to each target camp and host woreda based on its population size.

1.6.5 Sampling procedure

A two-stage sampling method was employed (Table 1.2).

1. A random selection of blocks⁹ from the list of the targeted refugee camps and host woredas was made. Among the three intervention refugee camps and three host woredas, two sample refugee camps and one host woreda were selected based on population size and convenience for data collection. The population size in Nguenyyiel refugee is the largest, and Jewi is accessible and relatively secure. From the host woredas, the one with Anuak and Nuer ethnic groups (two of the largest ethnic groups in Gambella) was selected. Accordingly, Jewi and Nguenyyiel refugee camps and Itang woreda were selected for this study. Furthermore, blocks were also selected from the refugee camps. Note that the blocks in each of the refugee camps have a high level of homogeneity in their socioeconomic and cultural characteristics and in their inhabitants' life experiences. Therefore, two blocks from each of the two refugee intervention camps (a total of four blocks) were selected for this study.
2. Households were selected from each sampling zone using systematic random sampling techniques. The number of households in each block was divided by the sample size allocated to obtain the sampling interval. As a result, every fifth household was selected for the interview. Once the study households were identified, one eligible member was identified for the interview. In each selected household, women or men aged 15–49 years were interviewed. If there was no woman/man in the specified age range, the adjacent household was

⁹ In the refugee context and according to UNHCR vocabulary, a refugee camp consists of settlements, sectors, blocks, communities and families. Sixteen families make up a community, 16 communities make up a block, 4 blocks make up a sector, and 4 sectors are called a settlement.

taken for an interview. The next household after that was the one initially selected. If there was more than one woman or man aged 15–49 in the selected household, a lottery method was used to

select one respondent for the interview. To have more women in the study population, one man was interviewed in the next household after two women had been interviewed.

TABLE 1.2
Sampling procedure for the survey

Target areas	Sample woredas/ camps	Sample population	Male	Female
Host community (Itang)	1	231	93	138
Refugee camps (Jewi and Nguenyiel)	2	174	75	99
Total	3	405	168	237

1.6.6. Inclusion/exclusion criteria

Women and men in the age range of 15–49 years were eligible for the action research. Potential respondents with limited experience of community life (less than one year in the community) and those who were too sick to complete an interview were excluded.

Similarly, for the qualitative study (key informant interviews (KIIs) and focus group discussions (FGDs)), translators were used, and those who had very good English, Nuer and Anuak language skills were selected. They translated the local language into English for the expert leading the discussion.

1.6.7. Household survey data collection procedures

The quantitative data were collected through face-to-face interviews using a structured questionnaire. Particular attention was given to the selection and training of data collectors, getting the consent of respondents prior to interviews, and the collection of the data. Such attention is valuable for maintaining the quality of data. This was important, considering the length of the survey questionnaire, the harsh weather conditions in the target community, the low level of literacy and the motivation levels of the community. The household survey data collectors were selected from members of the refugee and host communities who spoke the local languages, which are Nuer and Anuak. They had experience in collecting data using Kobo online data collection tools. Moreover, they received training on how to collect data and ensure that they considered ethics during the data collection process. Accordingly, the data collectors gained participants' consent and fulfilled ethical considerations during data collection.

1.6.8. Qualitative data collection methods and procedure

This study applied various qualitative techniques and procedures. These include KIIs, FGDs, case studies, and health facility assessment and observation with a checklist.

1.6.9. Sample and sampling for qualitative data collection

Twelve FGDs were held with girls and boys (14–17 years old), women and men (18–45 years old), women council members (30–48 years old) and religious/clan leaders (over 45 years old). Thirteen KIIs were also conducted (with five women and eight men). The key informants were from service providers (health institutions, RRS, non-governmental organizations (NGOs) working in the refugee settings, and governmental organizations working in the host community). In addition, four case studies and three health centre assessments were conducted, as shown in Table 1.3.

TABLE 1.3**List of respondents in the qualitative study**

Respondents	Target number
FGDs Nguenyyiel refugee camp <ul style="list-style-type: none"> • FGD with adult women (19–45 years old) • FGD with adult men (18–45 years old) • FGD with girls (14–17 years old) • FGD with boys (14–17 years old) Jewi refugee camp <ul style="list-style-type: none"> • FGD with women (18–45 years old) • FGD with men (18–45 years old) • FGD with girls (14–17 years old) • FGD with boys (14–17 years old) Itang host community <ul style="list-style-type: none"> • FGD with women (18–45 years old) • FGD with men (18–45 years old) • FGD with girls (14–17 years old) • FGD with boys (14–17 years old) 	12
KIIs KII with Jewi refugee health centre KII with Nguenyyiel refugee camp health centre KII with Itang health centre KII with IMC KII with RRS KII with staff from the Ministry of Women and Child Affairs KII with RRS health centre KII with RRS	8
Case studies	4
Health facility assessment	3

Semi-structured KII and FGD guides were used to collect the qualitative data. Trained field researchers were deployed to collect the qualitative data. All qualitative interviews were audio-recorded and assigned unique identifiers. Qualitative data from each interview were transcribed and translated into English.

1.6.10. Data collection instruments

The following three main types of data collection tools were developed and used.

1. **Survey questionnaire:** A standardized survey questionnaire (reproduced in Annex 1 of this report) was used to collect the household data. It has a section for female respondents only and another for male respondents only according to the nature of the questions. The survey was carried out using an electronic form on tablets.
2. **FGD and KII tools:** Interview guides were prepared for relevant respondents who had a better understanding of the programme. The interview guides for qualitative assessment are in Annexes 2 and 3.

- 3. Health facility assessment:** Health facility assessments were conducted with the two refugee health centres and the host community health centre to analyse the available SRMNCAH-related services from the perspective of the service providers.

1.6.11. Field supervision and data quality assurance

Data collectors, supervisors and consultants met each day during the data collection period to discuss and address the challenges they faced. The completed questionnaires were checked daily for consistency and accuracy. On-site spot-checking was conducted by supervisors to take corrective measures. At the end of each day, enumerators produced backup files and saved them on a hard disk for safety reasons.

1.6.12. Data management and analysis

Data were transferred to Statistical Package for the Social Sciences (SPSS) and Stata software for further cleaning and consistency checks. Data from the quantitative survey was processed using SPSS, version 20. Descriptive analyses were made from quantitative data to generate frequency tables, graphs and charts to illustrate results. Logistic regression was used to explore factors associated with the utilization of essential services.

The qualitative data generated through KIIs and FGDs were transcribed. A thematic approach was applied to the process of qualitative data analysis. The text data were thematically sorted by major report outlines.

After critical review, all transcripts were coded in a codebook form using Microsoft Excel and NVivo software. Then, detailed quotes from interviews were taken to show a range of perspectives from different categories of respondents.

Findings from qualitative methods, quantitative surveys and observation were triangulated and discussed in the final report to provide a full picture of progress and challenges in the target communities.

The findings were presented to UN Women and revised based on input and comments obtained on the challenges to and progress of the intervention. Recommendations for future interventions were made as a result.

1.7.

Ethical issues

Permission to conduct the survey was obtained from a governmental body concerned. Confidentiality and privacy were ensured in all the interviews conducted. Before interviews started, the participants were informed of the purpose of the survey, and interviews were conducted only after their consent was secured. Efforts were made by the study team to identify interview venues that ensured privacy and prevented any interruption. Anonymity was maintained throughout this study, from the data collection to the writing up of the report. To ensure the privacy of the respondents, all the names mentioned in the case studies, KIIs and FGDs of this research are changed.

Section 2: Findings of the study



2.1

Introduction

This section of the study report contains the findings of the action research conducted on the progress and challenges of POWER, UN Women's programme to enhance SRMNCAH service provision in the target host and refugee communities in Gambella Region.

2.2

Sociodemographic characteristics of respondents

A sample size of 405 was targeted for the household survey, with 404 respondents interviewed: a response rate of 99.8 per cent. In terms of their geographical coverage, nearly 230 (57 per cent) of respondents were from the Itang host community, and about 174 (43 per cent) were from refugee communities (Figure 2.1). Most of the household survey participants (more than 299 (74 per cent)) belonged to the Nuer ethnic group. A total of 242 (60 per cent of respondents) were female, and 162 (40 per cent) were male (Table 2.1). More than 178 (44 per cent of respondents) were women household heads.



Photo: UN Women

TABLE 2.1

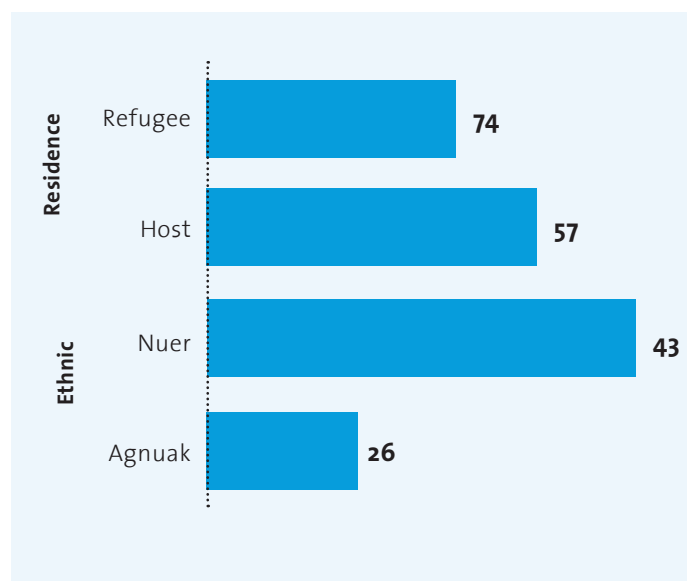
Characteristics of the respondents

Community	Male	Female	Total
Refugee	70 (40.2%)	104 (59.8%)	174
Host	92 (40%)	138 (60%)	230
Total	162	242	404

Source: Own computation from primary data, December 2021

FIGURE 2.1

Respondents by residence and ethnicity (%)

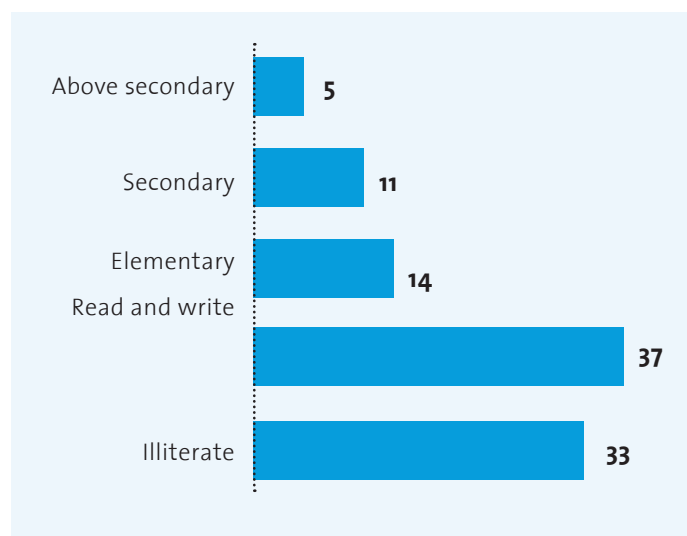


Source: Own computation from primary data, December 2021

According to the household survey, 149 (37 per cent) of the respondents had no formal education but could read and write by themselves (Figure 2.2). Another 133 (33 per cent) of respondents were illiterate and could not read and write at all. In total, 57 (14 per cent) and 44 (11 per cent) of the total number of respondents had completed their elementary and secondary school education, respectively. Only 20 (5 per cent) respondents had education beyond secondary school.

FIGURE 2.2

Educational characteristics of the respondents (%)

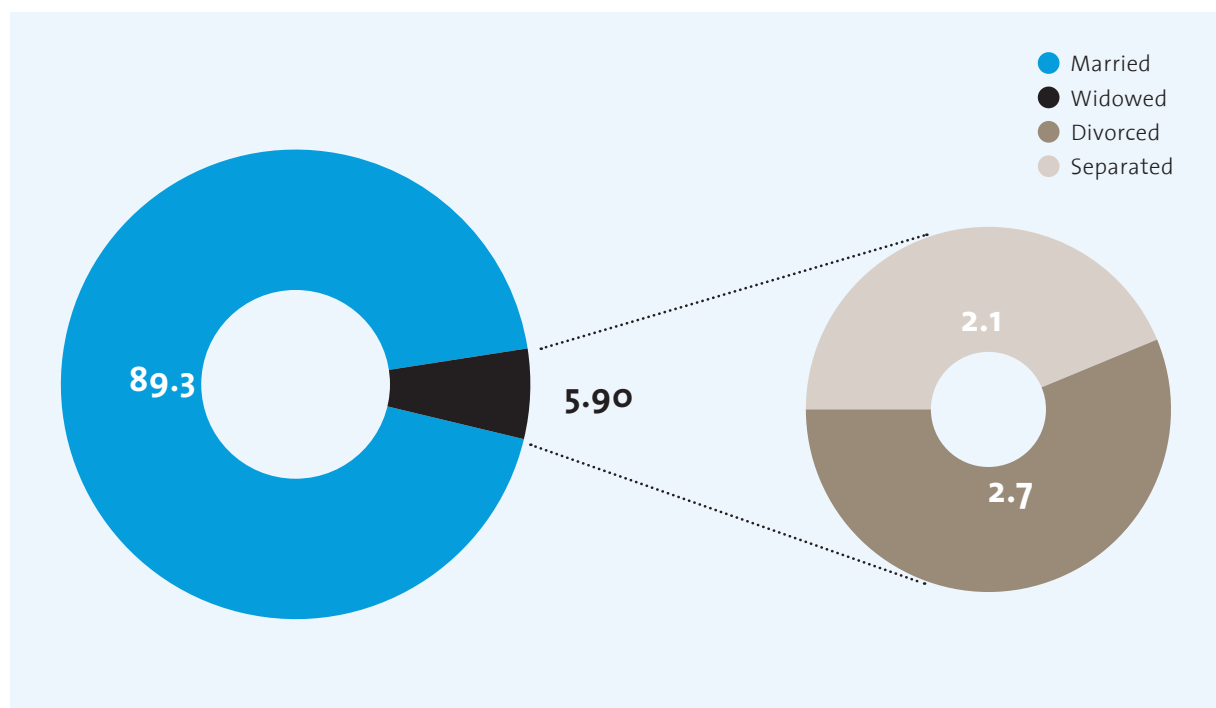


Source: Own computation from primary data, December 2021

As expected from household data collected, 359 respondents (89.3 per cent) were married, 24 (5.9 per cent) were widowed, 11 (2.7 per cent) were divorced and 8 (2.1 per cent) were separated from their spouses/

partners (Figure 2.3). The mean age of the household survey respondents was 30.5 years, with a standard deviation of +7 and an age range of 14–50. Most respondents were in the age category of 25–45.

FIGURE 2.3
Marital status of the respondents (%)



Source: Own computation from primary data, December 2021

For the qualitative study, a total of 66 beneficiaries (39 female, 27 male) were involved in a total of 12 FGDs from Jewi and Nguenyiel refugee camps and the Itang host community. About 8–12 participants were included in each FGD. Of these FGD participants, 44 were married and 18 were single. Nine were illiterate. Most participants had children ranging from 1 to 16 in age; 18 had no children. Study participants in the camps had resided there for about eight years. The age range of FGD participants was between 10 and 45 years old.

Similarly, 13 KIIs were also included from Jewi and Nguenyiel refugee camps, Gambella and the Itang host community. The education levels of key informants varied from school grade 12 to medical doctor and MSc. The KII participants had served as heads of refugee central committees (RCCs); outreach workers; supervisors supporting health extension workers; community health agents and health-care providers; officers; coordinators; heads of NGOs; RRS representatives; and staff of health centres.

2.3

Access to SRMNCAH information, and the knowledge, attitudes and behaviour of women and men

Overall, 260 respondents (64 per cent) reported that they had received information about SRMNCAH. Among the respondents who reported having information about SRMNCAH, 62 per cent were women and girls, and 38 per cent were men and boys. This shows that women have more information about SRMNCAH than men. As Figure 2.4 shows, the most widely available sources of SRMNCAH information for the study population are community workers (68.1 per cent), health facilities (57.2 per cent), information, education and communication (IEC) printed materials (33.9 per cent), schools (29.7 per cent) and peers (25.3 per cent). They are also the preferred sources (Figure 2.5).

The background features a collage of African art. On the left, there are vertical panels with circular patterns and silhouettes of people. On the right, there are panels with geometric patterns, a face with sunglasses, and a profile of a person with a large earring.

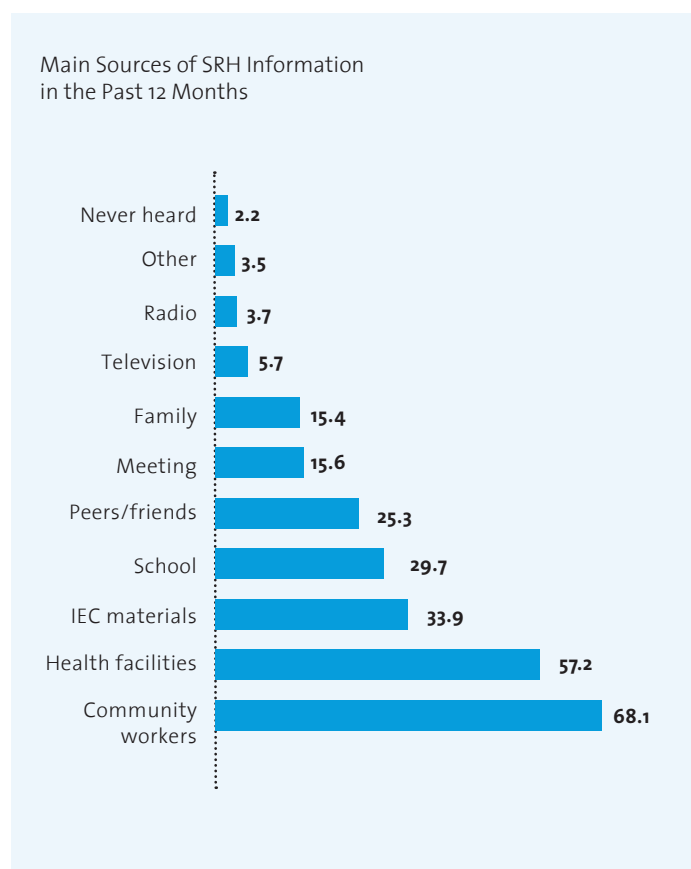
260 respondents (**64 %**)
reported that they had
received information about
SRMNCAH.

62 % were women and girls:
38% were men and boys

However, reporting having information about SRMNCAH might not indicate that knowledge of SRMNCAH helped respondents to have better understanding and know-how to practise better maternal and child health. FGD participants and key informants pointed out that they may have only some information about SRMNCAH, not the kind that is helpful for behavioural change and improved SRMNCAH service utilization.

One FGD respondent from Itang town responded that “I have information about SRMNCAH.” However, she had no experience using institutional delivery, antenatal care (ANC), postnatal care (PNC) or the use of birth control methods, partly because she did not know enough about the services and partly because of other sociocultural barriers.

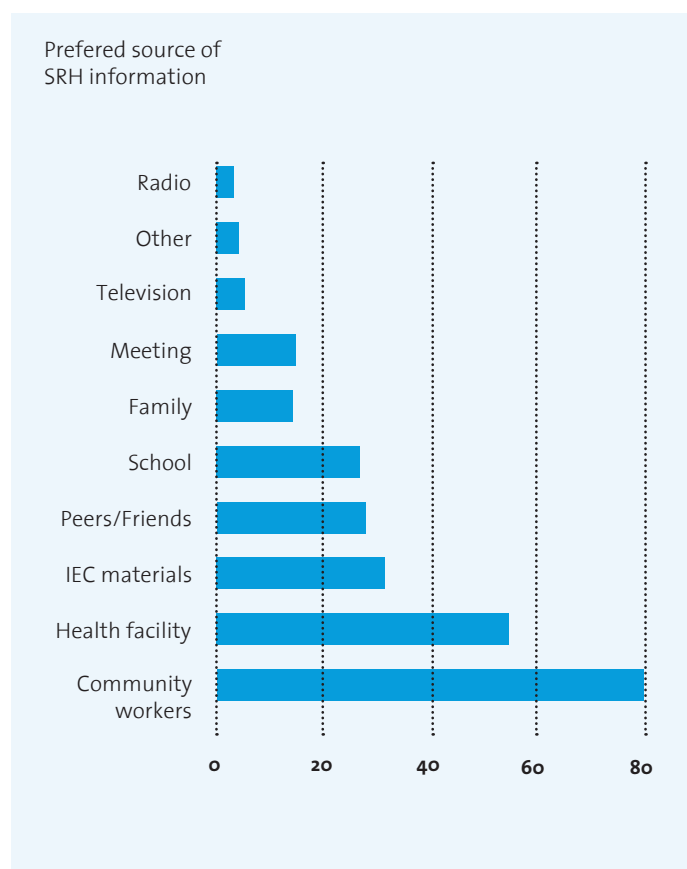
FIGURE 2.4
Main sources of information (%)



Source: Own computation from primary data, December 2021

Similarly, findings from the qualitative study showed that women residing in remote villages have limited information about and awareness of SRMNCAH and services compared with those who are close to areas where service providers are located (Table 2.2). In addition, men and boys in remote villages have very limited knowledge and understanding of SRMNCAH compared with women and girls in remote villages.

FIGURE 2.5
Preferred sources of information (%)



The study also revealed that the general community has a negative attitude towards FP services and products. Judging from the responses of FGD participants, only a few educated women and girls, in both the refugee and host communities, are aware of FP and willing to use it.

TABLE 2.2
Knowledge and awareness of SRMNCAH

FINDINGS	QUOTES
<p>Women in remote villages have limited knowledge and awareness</p>	<p>“Though most of the community members don’t have enough understanding about the importance of reproductive health, women who live in a remote village, which is far from the health facilities in the camp, have very limited awareness of reproductive health.” (FGD with adult women in Jewi and Nguenyyiel refugee camps; P1, P2, P9)</p> <p>“In the refugee camp, adolescent girls have unmet SRMNCAH service needs. Their awareness level is low, as most of the interventions do not target adolescent girls for SRMNCAH services.” (KII with health centre in Jewi refugee camp)</p> <p>“Most community members in rural areas of Itang woreda don’t have enough awareness about ANC, PNC, institutional delivery and FP services.” (FGD with adult women in Itang host community; P4, P2)</p>
<p>Men and youth have limited knowledge of SRMNCAH</p>	<p>“Adult men have less knowledge in SRMNCAH than adult women. As a result, men don’t support their wives for accessing SRMNCAH services.” (FGD with adult women in Jewi refugee camp; P4, P5, P9)</p> <p>“Most of the adolescent girls don’t have enough understanding of SRMNCAH, and they were challenged due to the unmet needs for SRMNCAH services. Though IMC has a youth-focused programme through youth centres, the number of adolescent girls who can access the youth centres are limited. Moreover, adolescent girls are not reached through schools, where youth (girls and boys) can be reached or are easily accessible, for various reasons.” (FGD with adult women in Nguenyyiel refugee camp; P4)</p> <p>“The knowledge of the refugee community on SRMNCAH is low, especially among men and young boys.” (KII with health centre in Jewi refugee camp)</p> <p>“The knowledge of men about SRMNCAH is low. As a result, men don’t allow their wives to use SRMNCAH services. Especially men don’t want to accept women using birth control (FP) to limit the number of children, as they always want a big family.” (FGD with adult women in Itang host community)</p>
<p>The general community has a negative attitude around FP use Education and awareness increase use of SRMNCAH services</p>	<p>“Generally, the culture prohibits the utilization of some of the SRMNCAH services, especially FP services. As a result, the community doesn’t have a positive attitude towards family planning, and men and elders don’t want their wives to limit the number of children. As a result, most of the refugee community (more than 90 per cent) don’t use FP services.” (KII with health centre in Jewi refugee camp)</p>

“Some women use FP services for child spacing without the knowledge of their husbands. However, they couldn’t continue using the FP service for a longer period, as they were afraid of negative consequences and fear of their husband and the community’s reaction.”

(FGD with adult women in Nguenyyiel refugee camp; P2)

“Women who have received more education and who have awareness have begun to use all SRMNCAH services, including FP, institutional delivery, STI treatment, ANC and PNC.”

(FGD with adult women in Jewi refugee camp; P3, P2)

“Because of the SRMNCAH programme, women have a better understanding of the importance of SRMNCAH services in general and are interested in using FP services. However, men are very conservative about it. Some women started using FP without telling their husbands. Though FP coverage has increased (from 4 per cent to 9 per cent) for the last two years in the refugee camps, it is very low compared with the rate of discontinuing FP utilization discontinuity.”

(KII with health centre in Jewi refugee camp)

BOX 2.1

Case study

My name is Puruel, and I am a 16-year-old girl. I am living in Nguenyyiel refugee camp and a grade 7 student. I got married at the age of 15. I got pregnant, and my family received the dowry from my husband’s family.

My husband was 19 years old when we got married. He was not a student, and he didn’t have work either. He was living with his family. He wouldn’t have had a means of income to support me if I had been living with him. Thus, I had to decide to stay with my family, but I gave birth at the age of 15. Now it is difficult for me to be active in schools like I used to be before while I am caring for my baby. If I had been aware of the FP method by then, I would have used it. Nobody told me about birth control and other FP services. My family thought only about the amount of dowry they received and ignored my future life. Three of my classmates have also dropped out of their education with a similar problem like me. Younger students start sex at the age of 13 or 14, but they don’t know how they should prevent unwanted pregnancy; and despite the fact that our parents and elders are aware that adolescent girls start sex at an early age, they are reluctant to coach them to use birth control to avoid pregnancy.

Students who participated in SRMNCAH programmes at the IMC SRH centre are more likely to get adolescent-friendly health services. Thus, youth-focused interventions in SRMNCAH programmes could contribute to the use of adolescent-friendly health services and ultimately prevent negative SRMNCAH outcomes among students.

Regarding the trend of participation in community dialogues and discussions, out of all the survey participants, more than 70 per cent of women and girls

and 60 per cent of men and boys said that they had engaged in community dialogues and discussions on SRMNCAH organized in different ways over the previous three years. According to the response in the FGD and KII discussions, although the number of community members participating in the SRMNCAH awareness-raising programmes has increased, there should be further efforts to bring about changes in attitudes and practices to improve mothers’ health and their children’s well-being.

According to the household survey response, although only 3 per cent of women reported that they had the ability to negotiate safer sex with their partners or husbands, while 53 per cent of male survey respondents had a belief that women had the ability to negotiate with their partners about safer sex and fertility.

Regarding the decision on the number of children, 67 per cent of female respondents said that men and women decide jointly. However, overall, 64 per cent of respondents (men and women combined) said that men are the decision makers on the number of children. Only 26 per cent of women respondents said that women can decide on their fertility by themselves.

Hence, it can be inferred that the decision regarding fertility is dominated mainly by the husbands. This finding is also in the line with the findings from KIIs and FGDs, which state that most men in both the refugee and host communities have the ultimate power to decide on the number of children and the overall fertility of their wives. Nevertheless, women in the refugee camps have better SRMNCAH utilization for the following reasons:

- Both men and women in the refugee camps have better access to SRMNCAH-related training, awareness-raising programmes and home visits by health extension workers for the SRMNCAH outreach programme.
- ANC follow-up is a pre-requisite for registering a new baby and for nutritional support to a pregnant woman in the refugee camp. Thus, pregnant women are motivated to follow up on their ANC and related services, and to participate in awareness-raising programmes.

From the FGDs conducted with men participants, the study tried to analyse the existing efforts to engage men in promoting their wives' and daughters'

utilization of SRMNCAH services. The finding shows that most men respondents were not targeted by the existing governmental and non-governmental SRMNCAH service promotion efforts. According to their responses, most of the SRMNCAH interventions focused on adult women. Women usually attend the training and awareness-raising programmes at the health centres or get knowledge and information from the community outreach workers. The only men who have access to SRMNCAH-related services are community outreach workers and a few members of the RCC.

2.4

The SRMNCAH services in the health facilities

2.4.1. Available FP services

The health centre at Nguenyi refugee camp provided a better range of FP services and products than the health centres in Jewi refugee camp and the Itang host community (Table 2.3). In Nguenyi health centre, at the time of the study, female and male condoms, intrauterine contraceptive device (IUCD) insertion, oral pills, injectable contraceptives and emergency contraception were available to users; only vasectomy and tubal ligation were not. Only four methods (emergency contraception, pills, injectable contraceptives and male condoms) were available in Jewi health centre. In the Itang host community health centre, only oral, injectable and emergency contraceptives were available.

According to the KIIs with health centre experts, the local and international attention given to refugee communities meant that the services provided to the refugee community were better than those of the host community, which is congruent with the findings of the facility assessment.

TABLE 2.3**Types of FP available in the study communities**

Services and products	Nguenyyiel	Jewi	Itang
Male condoms	Yes	Yes	No
Female condoms	Yes	No	No
Oral pills	Yes	Yes	Yes
Injectable	Yes	Yes	Yes
IUCD insertion	Yes	No	No
Emergency contraception	Yes	Yes	Yes
Tubal ligation	No	No	No
Vasectomy	No	No	No

Source: Own computation from primary data, December 2021

2.4.2. Sexually transmitted infections

According to the 2016 Ethiopian Demographic Health Survey (EDHS) report, the percentage of people aged 15–49 who were infected with HIV in Gambella Region was the highest in the country, at 4.8 per cent, compared with a national average of 0.9 per cent.¹⁰ Judging from the records of health facilities and responses of FGD participants, the prevalence of STIs, including HIV/AIDS, in the refugee community is very high. More than 60 per cent (62 per cent female and 38 per cent male) of the refugees have had STIs in the last five years. According to the interview with the health

expert, in one month, 53 per cent of refugees receiving ANC follow-up had STIs, and 42 per cent of outpatients in the camp health centre had STIs. This indicates the high prevalence of STIs in the refugee community.


As Table 2.4 shows, almost all the targeted health facilities provided diagnosis and treatment of STI, provide drugs used to treat common STIs (antibiotics), HIV counselling and testing (HCT), antiretroviral therapy (ART) and prevention of mother-to-child transmission (PMTCT) in the health centres. The health centres also provide cluster of differentiation 4 (CD4) testing and viral load services through referral to Gambella hospital.

TABLE 2.4**STI and HIV service availability**

STI and HIV	Nguenyyiel	Jewi	Itang
Syndrome diagnosis and treatment of STI	Yes	Yes	Yes
Drug supply to treat common STIs (antibiotics)	Yes	Yes	Yes
HCT	Yes	Yes	Yes
ART	Yes	Yes	Yes
PMTCT	Yes	Yes	Yes
CD4 testing	Yes	No	No
Viral load	Yes	No	No

Source: Own computation from primary data, December 2021

10 Central Statistical Agency (CSA) [Ethiopia] and ICF. 2017. 2016 Ethiopia Demographic and Health Survey. Addis Ababa, Ethiopia, and Rockville, Maryland, USA. CSA and ICF, p. 247.



The percentage of people
aged 15–49 who were
infected with HIV in
Gambella Region was the
highest in the country, at
4.8 per cent, compared
with a national average of
0.9 per cent.

2.4.3. Management of sexual and gender-based violence

Sexual and other forms of gender-based violence (SGBV), including rape, is a problem throughout the world, occurring in every society, country and region. Refugees and internally displaced people are particularly at risk of SGBV during every phase of an emergency.

Emergency contraception, STI diagnosis and treatment, presumptive treatment, post-exposure prophylaxis and tetanus vaccine were available in refugee and host community health centres to deal with SGBV (Table 2.5). Psychological support/counselling and legal referral services for SGBV survivors are also available in the refugee camps, but only through referral to IMC and RRS protection centres.

Although the refugee community is expected to include a higher proportion of SGBV survivors, only three SGBV cases were recorded in public health centres in the Nguenyyiel refugee camp in 2021. However, no case was referred to legal services, as the SGBV survivors were not willing to take the cases to the legal system. According to the key informants from IMC, the psychosocial services provider, seven SGBV survivors at Nguenyyiel refugee camp received psychosocial support in 2021.


The experts mentioned that most of the SGBV survivors were not interested in getting legal support. Consequently, most of the SGBV cases were not reported. Most of the time, cases are mediated by community representatives, including the RCC. Girls in the age range of 10–14 are the group most vulnerable to SGBV, which is perpetrated by individuals in the bush, during firewood collection and in the community. The main contributors to SGBV in the host and refugee communities are the lack of access to information about and knowledge of the impact of SGBV, widespread acceptance of SGBV in the community as ‘normal’, dowry-related factors, gender inequality, and poor justice and law enforcement when SGBV cases are reported.

Informants understood that the community outreach programme financed by UN Women tried to persuade SGBV survivors to trust the system through which the psychological, clinical and legal support services are provided. Moreover, an attempt was also made to treat them with dignity, ensure their security, respect their privacy and the confidentiality of the case. However, the study found that most of the SGBV survivors need only clinical treatment and psychological support and do not want legal support.

TABLE 2.5
Management of sexual violence

Method	Nguenyyiel	Jewi	Itang
Emergency contraception	Yes	Yes	Yes
Presumptive STI treatment	Yes	Yes	Yes
Post-exposure prophylaxis	Yes	Yes	Yes
Hepatitis B vaccine	No	No	No
Psychological support/counselling	Yes	Yes	No
Referral for legal support	Yes	Yes	No

Source: Own computation from primary data, December 2021



Psychological support/counselling for SGBV survivors in the refugee camps is provided by IMC as an implementer of the SRMNCAH programme. IMC has a strong community structure for SRMNCAH and SGBV service provision. For instance, in Jewi refugee camp, it has more than 48 community outreach health workers. The SGBV survivors receive integrated services through a referral system. The community outreach health workers refer the SGBV survivors to the IMC health centre and the RRS protection centre for clinical treatment, legal support and psychological support.

As shown in Table 2.5, when looking at the SGBV services and case management in the host community, it can be concluded that they are very poor compared with the refugee community. At the time of the study, the only service available for SGBV survivors in the Itang community was clinical treatment. There were no psychological or legal support services for SGBV survivors in the host community. It was reported that the district office of the Ministry of Women and Child Affairs (the Bureau of Women and Child Affairs) does not have a strong system for referring SGBV survivors and linking them with legal and psychosocial support. The mandated governmental body, including the district office of the Ministry of Women and Child Affairs and the police office, are reluctant to seek psychological and legal support for SGBV survivors. According to the responses of key informants from the district office of the Ministry of Women and Child Affairs, lack of budget, lack of knowledge, poor coordination among service providers, absence of NGOs in the host community, and lack of accountability and responsibility on the part of governmental agencies and staff are some of the reasons for poor SGBV services.

For instance, IMC does not have a psychological service in the host community as it does in the refugee community. The type and quality of service given to the host community, including the SGBV care, are far worse than the services in the refugee camps. Organizations such as RRS, UNHCR and NGOs are the institutions primary responsible for providing, coordinating and making services available for the refugee community. However, the local government is the only body mandated to provide services to the host community. NGOs provide selected services to the host community at their own discretion, if at all. A key informant from an NGO stated that, as the refugee community has international attention, and there are many humanitarian organizations providing services, the services

available, including health, legal and psychological services, are far better for the refugee community than for the host community.

2.5.

Access to SRMNCAH services

Of the total 237 women who participated in the survey, 51 per cent have had access to health facilities. Half of the study participants perceived that adolescent girls had access to SRMNCAH information and services. Nearly 45 per cent of the study participants reported that adolescent girls had access to and use of SRMNCAH services without the permission of their family members. And about 32 per cent of women and girls reported that they were comfortable while accessing and using SRMNCAH services from the health centres.

Although 55 per cent of male respondents (72 per cent in the refugee camps and 28 per cent in the host community) reported that they had supported their wives to use SRMNCAH services, especially to have access to ANC, health centre delivery and childcare, 39 per cent of women respondents stated that they do not have their husbands' agreement to use contraceptive methods and other SRMNCAH services. The household survey results show that, among the male household survey participants, close to 35 per cent of husbands were unwilling to send their wives and children to access and use SRMNCAH services at any health centre or health programme.

The FGDs and KIIs explored the reasons for husbands' refusal to support their wives to use SRMNCAH services. Some of these reasons are sociocultural influence, including husbands being proud of having large numbers of children; low acceptance of SRMNCAH services in the community; the culture not allowing men to accompany their wives when the wives visit health facilities to access ANC, PNC, institutional delivery and other health services; and a lack of awareness among husbands of the benefit of SRMNCAH.

According to the KIIs with experts at the health centres and the FGDs with adult women, it was understood that various FP options are available to the study population. Given their lack of awareness and their fear of their husbands, most women prefer short-term options such as the pill or injection for child spacing.

2.5.1. Access to youth-friendly SRMNCAH services

Although implementing SRMNCAH services has gained momentum in most countries, young people typically remain underserved by these services despite their demonstrated need. According to the WHO Recommendations on Adolescent Sexual and Reproductive Health and Rights, adolescent and youth-friendly health services should be designed to address the barriers faced by youth in accessing high-quality SRMNCAH services.¹¹ These barriers include:

- **structural barriers** such as laws and policies requiring parental or partner consent, distance from facilities, costs of services and/or transportation, long waiting times for services, inconvenient service hours, lack of necessary commodities at health facilities, and lack of privacy and confidentiality;
- **sociocultural barriers** such as restrictive norms and stigma about adolescent and youth sexuality, harmful gender norms, and discrimination by communities, families, partners and providers;
- **individual barriers** such as incomplete or incorrect knowledge of SRMNCAH, including myths and misconceptions around contraception; limited self-efficacy and individual agency; constrained ability to navigate internalized social and gender norms; and lack of access to information about what SRMNCAH services are available and where to seek services.

In 1994, the International Conference on Population and Development identified adolescent-friendly health services as a key strategy for meeting adolescents' health needs, especially those related to SRMNCAH. To be adolescent-friendly, SRMNCAH services should be affordable, accessible, appropriate, acceptable and provided by trained health professionals. Adolescent-friendly SRMNCAH services include counselling, FP, voluntary counselling and testing, and treatment of STIs.

From the health facilities assessment in both the refugee and host communities, it was observed that there is no adolescent-friendly SRMNCAH service provision in the health centres. As a result, adolescents continue to face several unmet needs related to SRMNCAH services, such as the use of contraceptives.

They face barriers to accessing these services, such as lack of knowledge and experience of available services, lack of confidentiality, ignorance, low quality of care, inconvenient times, location of youth-related service centres, and wrong judgment on the part of health-care providers. The existing SRMNCAH services meant for youth are small scale and not well organized to meet the needs of adolescents in the study population. The existence of a clear mismatch between the available services and SRMNCAH needs of the youth population was also observed in the refugee and host communities.

The qualitative data indicated that adolescent girls have a high unmet need for SRMNCAH services due to the poor access to SRMNCAH services. The health expert key informant at RRS summarized the situation of adolescents as follows:

“On one hand, adolescent girls are vulnerable to various SRMNCAH-related problems such as unintended pregnancy, HIV or other STIs, and unsafe abortion. On the other hand, they have less access to SRMNCAH because of the demand-side factors such as lack of knowledge, poor attitude and practices, fear of the community, and supply-side factors such as lack of youth-friendly services like SRMNCAH counselling, contraceptive services, treatment of STIs and abortion-related services. Parent–adolescent communication about SRMNCAH also prevents adolescents from adopting unhealthy SRMNCAH practices. However, its association with the utilization of SRMNCAH services is less known.”

During the FGDs, young people felt that the absence of friendly services (such as lack of privacy) at the health centres was the main hindrance to access to SRMNCAH services, especially FP services. Furthermore, they stated that lack of information, absence of the services and lack of friendly services exposed them to unwanted pregnancy, abortion and school dropout.

11 WHO recommendations on adolescent sexual and reproductive health and rights. Geneva: World Health Organization; 2018.

FGD responses of adolescent girls at the refugee camps are quoted and summarized as follows:

“Though we can get SRMNCAH-related information and education from the IMC SRH centre, it is difficult to access the FP services from the health centre. Because, when adolescents visit the health centre, the community imagine that they are looking for FP services and discriminate against them, as FP use is not encouraged by the community”. Relatively adult mothers may have access to SRMNCAH services at health centres when they visit the health centres seeking maternal and child health services, including vaccination, ANC, PNC and related services. (P1, P9, P11)

“Most adolescents prefer to use a condom as contraceptive method because travel out of the camp to use other FP services from a private centre is not legally allowed.” (P1, P5)

“The health centres are not willing to provide abortion services when the girls want to avoid unwanted pregnancy. However, the health centre gives post-abortion services only after we have developed complications because of unsafe abortion that is conducted in the bush or at home.” (P4, P2)

“Emergency contraceptive methods should be made available in an accessible and friendly way to the adolescent girls to prevent unwanted pregnancy. The services are available in the refugee health centres. However, it is not accessible for adolescents.” (P9)

2.5.2. Abortion in Ethiopia

In Ethiopia, unsafe abortions cause an estimate 6-9 per cent of maternal deaths, a sharp reduction from the estimated 32 per cent of deaths from unsafe abortion before 2005.¹² For much of Ethiopia’s modern history, safe abortion services were unavailable. In fact, abortion was only allowed when pregnancy physically put the woman’s life at risk. Motivated by

the growing death toll from unsafe abortion and other related causes, advocates, providers and policymakers sought legal reform. In 2004, the Ethiopian Parliament voted to approve a new, progressive law. However, the new Criminal Code of the Federal Republic of Ethiopia maintains the legal prohibition of abortion. In 2005 Ethiopia expanded its abortion law, which had previously allowed the procedure only to save the life of a woman or protect her physical health. Following this, Ethiopia allows women to obtain a safe and legal abortion under some conditions, which include cases of rape, incest or fetal impairment. In addition, a woman can legally terminate a pregnancy if her life or physical health is in danger, if she has physical or mental disabilities, or if she is a minor who is physically or mentally unprepared for childbirth.¹³

Since the enactment of the new law, efforts have been undertaken to improve access to abortion-related care, such as constructing more health centres and training more mid-level service providers. In 2006, the government published national standards and guidelines on safe abortion that permitted the use of medications (misoprostol with or without mifepristone) to terminate pregnancies, in accordance with WHO clinical recommendations on safe abortion.

The liberalization of the abortion law in 2005 and the establishment of technical guidelines served as an essential step in supporting the practice of safe abortion services. However, eradication of morbidity from unsafe abortion has not yet been achieved. There are still challenges in Ethiopia with regards to unsafe abortions given the restrictions in the law. For example, the health centre could not allow legal abortion if the condition under the abortion law was not fulfilled.

During an FGD with adolescent girls aged between 14 and 17 it emerged that nine of the eleven were sexually active. Six of them had used condoms, and three had used injectable contraceptives. Moreover, the families of seven were not aware of their children’s sexual activity. The girls also asserted that the girls and boys could get condoms in the camp, as there is free condom distribution in various corners of IMC service centres. Sometimes girls were also found to be using emergency contraceptives to avoid unexpected pregnancy. The girls fear pregnancy more than the risk of STIs, including HIV and other SRMNCAH-related issues.

12 Federal Democratic Republic of Ethiopia Ministry of Health. 2014. National Norms & Guidelines for Safe Abortion Services in Ethiopia second edition (moh.gov.et)

13 Ethiopia 2005; Ethiopia, Ministry of Health 2006.

As adolescent girls are at school, they reported that they do not want to get pregnant and face complications due to unsafe abortions. As mentioned above, abortion is not allowed in the health centres, and FGD respondents said that it is common to carry out abortions in the bush, at home or in private health centres outside the camp.

Based on the qualitative data, it was found that adolescent girls in the host community are not much more at risk of unsafe abortion than adolescent girls in refugee camps. In the host community, most adolescent girls accept teenage pregnancy, as the community accepts it, but they must drop out of school. In contrast, in the refugee community, most of the adolescent girls do not want to stop their education and cannot tolerate discrimination at the hands of the community, which forces them to prefer unsafe abortion.

In general, for both the refugee and host communities, there are no youth-friendly SRMNCAH services. Therefore, youth-friendly services such as counseling services, HIV testing, contraceptive provision, STI diagnosis and management, pregnancy testing, PNC, abortion care and other youth-targeted services should be integrated with non-health-related services, such as library and internet services and recreation centres, so that youth are not identified as SRMNCAH users and avoid the stigma.

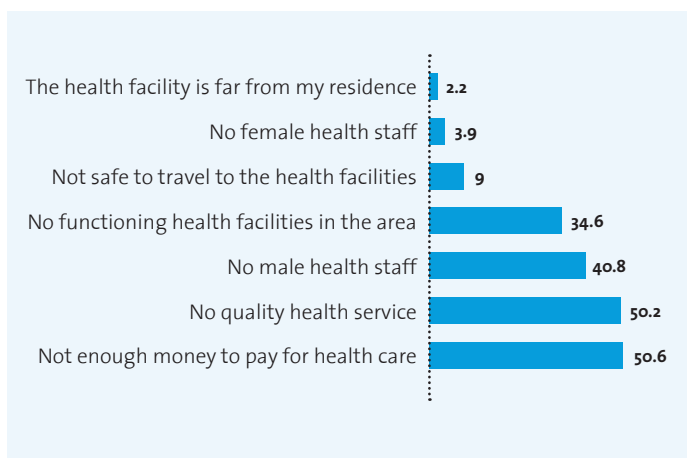
2.6.

Factors/barriers affecting SRMNCAH service utilization

Socioeconomic status was found to be a significant factor in the utilization of SRMNCAH services. Thus, the qualitative findings showed that poor socioeconomic status was one of the barriers to the utilization of SRMNCAH services among women in refugee and host communities. Socioeconomic status was also linked with access to information, education, decision-making power and control over resources.

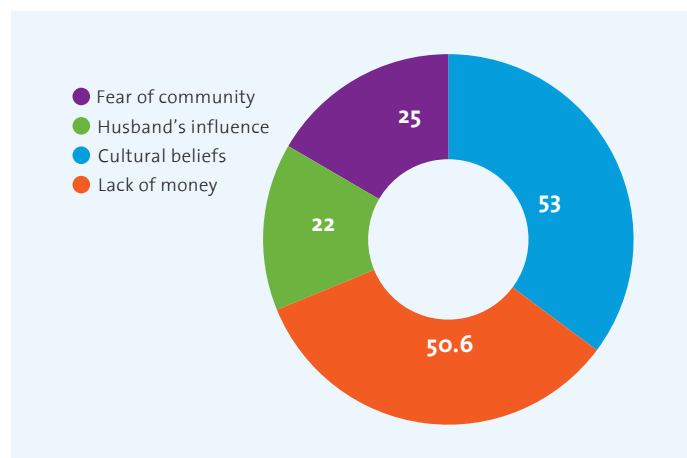
The household survey participants were asked about the factors or barriers that affected their SRMNCAH service utilization. As shown in Figures 2.6 and 2.7, the respondents described social and cultural factors and poor health service provision (supply side) as major challenges to service utilization. Consequently, according to the women household survey respondents, poor quality of service (50.2 per cent), lack of male health-care providers (40.8 per cent) and lack of some of the SRMNCAH services (34.6 per cent) were among the main factors limiting access to health facilities. Moreover, the decision-making power imbalance between men and women and lack of free discussion between women and men were identified as the main gender role-related challenges and barriers to access and use of SRMNCAH services. The main sociocultural factors for not seeking SRMNCAH services are cultural beliefs (53 per cent), lack of money (50.6 per cent), fear of community (25 per cent) and husband's influence (22 per cent).

FIGURE 2.6
Reasons for not accessing health facilities (%)



Source: Own computation from primary data, December 2021

FIGURE 2.7
Sociocultural barriers to accessing SRMNCAH services (%)



The qualitative study findings also identified three main categories of challenges and barriers: the supply and demand sides, the difference in gender roles, and sociocultural norms. Specifically, the main supply- and demand-side challenges were identified as difficulty in getting quality services at night, lack of client-friendly services, providers' unpleasant behaviour, prohibition of abortion services, shortage of medication, shortage of health-care providers, distance and lack of transport facilities, and difficulty in accessing health-care providers on duty.

2.6.1. Supply- and demand-side barriers

Based on the UN Women SRMNCAH Programming Guide: Promoting Gender Equality in Sexual, Reproductive, Maternal, Newborn, Child and Adolescent Health, supply-side and demand-side/sociocultural challenges to SRMNCAH service utilization are categorized as follows:

Supply-side challenges

Limited staff and health facilities

A key informant from the health centre in the Jewi refugee camp explained that, because of the high need for SRMNCAH services among the refugee population and the limited number of health experts and facilities in the health centre, the SRMNCAH services are not client-friendly and satisfactory for mothers.

The key informant stated that a standard health centre is expected to serve a population of about 25,000. However, currently, the health centres in Jewi refugee camp provide services for more than 62,000 people.

On the other hand, the refugee community has a high need for ANC, institutional delivery, PNC and child health-care services. As a result, the health experts are forced to prioritize providing services for those clients who need urgent treatment. Other women who attend SRMNCAH and regular services and need ANC in the first trimester (one to three months pregnant), vaccination, PNC and STI services are forced to wait longer. Priority is given to women in their third trimester (seven to nine months pregnant).

This situation results in poor-quality service delivery and unfriendly client services, and discourages clients from using the services. The picture below shows a queue of women waiting for maternal and child health services at a health centre.



Women and children waiting for SRMNCAH services at Nguenyiyel refugee camp during the assessment. Photo: UN Women

FGD participants from the Jewi refugee camp explained the situation as follows:

We have a better awareness of maternal health, including ANC. Moreover, at least one visit for ANC services is required to get nutritional support for pregnant women from humanitarian organizations, including UNHCR and other NGOs. However, we are not happy with the health centre's services. (FGD with adult women in Jewi refugee camp)

Professional health experts are not available to give health services, particularly during the night. Health services are delivered by traditional and local birth attendants. (FGD with adult women in Jewi refugee camp; P2, P4)

The services at the health centre are not client-friendly, and we wait for more than half a day or the whole day seeking a treatment, and many other people are treated in the same way. (FGD with adult women in Nguenyyiel refugee camp; P1, P4, P6, P8)

The key informant from the health centre confirmed that the above-mentioned challenges are valid claims and stated that:

There is a limited number of staff and shortage of budget, drug, delivery kits and chemicals. For all these reasons, the health centre couldn't provide the expected services for the target community. At the MCH [maternal and child health] ward, there are eight midwives (four women and four men) as per the standard, but the community to be served is beyond the capacity of the health centre. For example, during the morning shift, 40–50 mothers may visit the health centre for ANC follow-up, whereas the capacity of the health centre is designed only for 15–20 mothers per day. Because of the high workload, the ANC follow-up prioritizes a pregnant mother whose gestational period is six months and above. In addition, there are 8–18 health facility deliveries expected per day in the refugee community. In this regard, it is estimated that more than 95 per cent of the refugee women deliver at the health centre to get registration for their newborn baby. The refugee community is also challenged by the limited access to drugs from the health centre. For instance, at the time of the study, some of the chemicals and delivery kits were out of stock. (KII with health service providers in Jewi refugee camp health centre)

The findings of the study also show that capacity of the health facility is not an issue in the host communities because the health centres are built to provide for 25,000 people each as per Ethiopia's health facility standards. Hence, the health facilities are aligned with population size, and the health facilities are not using their full capacity because of lack of awareness of SRMNCAH services in the community.

b. Shortage of trained SRMNCAH service providers

The health facilities assessment found that capacity-building training was provided in the three health centres visited during the study. Accordingly, a total of 14 staff members in Jewi, 33 in Nguenyyiel and only 4 in Itang had been trained in SRH-related topics in the previous two years. A higher portion of staff members had received SRMNCAH-related training in Nguenyyiel health centre than in Jewi and Itang health centres. The training was on basic FP (IUCD), contraceptive implants and basic emergency care provision after abortion. However, the training did not cover HIV or other STIs, gender-based violence (GBV) prevention and response, or youth-friendly SRH service provision.

c. Geographical inaccessibility of health centres

The study found that geographical inaccessibility is one of the factors limiting access to SRMNCAH services. According to a key informant from the Itang woreda health office, the health posts in rural areas do not provide primary health-care services.

The main reason is that assigned health extension workers are not available in the health posts, as they spend their time in the towns, and the health posts are not equipped with the necessary kits and equipment to provide SRMNCAH and other health services to the target community. Most of the time, health posts remain closed. Consequently, mothers are forced to travel to the towns to get the service. Nevertheless, most of them prefer to give birth at home, usually because of lack of transport and the long distance from home to health centres in the nearest town.

Similarly, a key informant from the Jewi RCC explained that access to transport and the long distance to reach the health centres are also a problem for women at Jewi refugee camp. The Jewi RCC FGD participants and key informants mentioned that “the ambulance vehicle is not easily accessible to transport mothers from home to health centres in the camp due to challenges with the telephone network and the existence of only one ambulance in the camp. It is also primarily assigned to give transport service from the camp to Gambella referral hospital and is not expected to provide services within the camp.”

d. Weakness in registration of vital statistics

Countries need to know how many people are born and die each year, and the main causes of their deaths, to have well-functioning health systems. According to the KII responses from the health centres and implementing partners, registration of vital statistics, including births, death rate and marriages, is weak in the refugee camps. That has contributed to not having accurate data for an intervention plan to improve the health of newborns, children, adolescents and mothers. Deaths, in particular, are underreported in the refugee camps, to make the population appear larger so that they get more support/humanitarian aid. The one youth key informant reported that she had heard of more than three deaths of adolescent girls due to unsafe abortions in Jewi refugee camp in 2020. However, the families did not report them for fear of reducing the rations they received from UNHCR, which were based on the number of family members.

Demand-side/sociocultural challenges

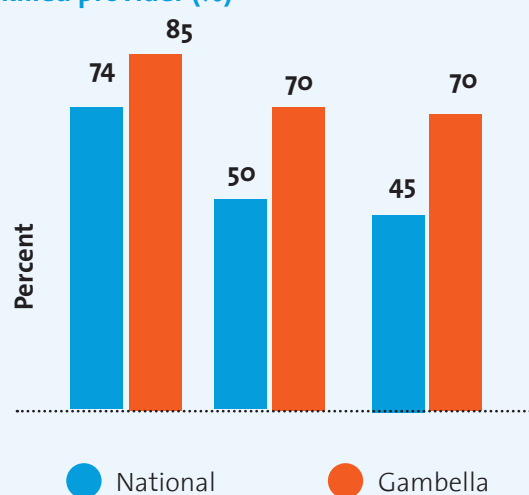
The EDHS found that Gambella Region had made tremendous progress in maternal health indicators between 2011 and 2019. For example, the rate of pregnant women in Gambella who gave birth in the five years preceding the survey and received ANC during their pregnancy from a skilled health provider increased from 54 per cent in 2011 to 86 per cent in 2019. This stands far above the national average of 74 per cent (Figure 2.8). However, the newborn mortality rate has not declined by the expected amount. It fell only from 39 to 36 deaths per 1,000 births between 2011 and 2016.

The rate of skilled attendance during delivery increased from 27 per cent in 2011 to 70 per cent in 2019.¹⁴ In 2016, 12 per cent of women in Gambella did not have any assistance during delivery.¹⁵

14 EDHS 2011, pp. 120–128; EDHS 2019, p. 14.

15 EDHS 2016, p. 150.

FIGURE 2.8:
ANC coverage: one or more visits by a skilled provider (%)



Source: UNICEF 2020

The rate of women who delivered in a health facility increased from 28 per cent in 2011 to 70 per cent in 2019.¹⁶ This rate is also above the national average.

Though progress has been recorded on maternal and child health in Gambella Region for the last 10 years in the host community, this action research finds that most women in the refugee and host communities are vulnerable to food shortages and SRMNCAH-related complications. The most common SRMNCAH-related problems are pregnancy- and abortion-related complications, GBV and harmful practices (including dowry, which add to the husbands' power, and child marriage). As women and men have different social and biological roles, their needs are also different. It was found that the social and cultural norms had greatly affected the SRMNCAH needs of women in both refugee and host communities in Gambella Region.

The gender and sociocultural norms greatly affect the empowerment of women, which influences access to SRMNCAH services. In the study populations, the following aspects reduced women's empowerment to use SRMNCAH services: unequal power and control between women and men at household and community levels, women's low position in the community, the attitude of the community (or husband) in favour of a large number of children, husbands' refusal to use FP and dowry-related gifts when making marriage arrangements. The high prevalence of polygamy in both refugee and host communities has also affected women's empowerment to use SRMNCAH services.

A male adult key informant from the Nuer community in the Itang district stated the following directly:

As long as I gave a dowry, I'm the decision maker on the fertility of my wives. If one of my wives doesn't want to give an additional child, why does she live with me? The use of FP and limiting the number of children is unacceptable in our culture. If she uses any FP service, I automatically go for divorce. Limiting the number of children is not our culture.

Another key informant from Jewi refugee camp also responded as follows:

I never allow my wife to use contraceptive methods. If my wife uses contraceptives, I suspect that she is having a sexual affair with another man because I do not have any mechanism to control her loyalty.

Similarly, most of the women FGD participants in the Itang host community stated their view as follows:

Our husbands are like our children. Instead of supporting the family as heads of the households, they expected their wives to give care and support for them, and when expected care was not fulfilled for them, they beat and physically abuse us. We only recognize their abusive behaviour, and sometimes we wish we would be female-headed households. If we want to divorce, they can claim the dowry, which they gave our families when they requested to marry us, and our family may not be able to afford to repay. As a result, our family members do not accept the divorce, as the dowry is already used. Therefore, we remain to accept it and wait until God gives us justice. Similarly, if the husband wants to divorce his wife, he can demand the dowry to be returned from the wife's family. If she has more than three children, and the divorce came from the husband's side only, the husband may not ask for the dowry, and he leaves it for his children's care. However, after divorce, the father is not responsible for supporting the children; and the mother is the only person responsible for caring for her children. Because of this situation, the wife is forced to give maximum care to her husband to avoid divorce.¹⁷

16 According to EDHS 2016 and 2019, skilled providers include doctors, nurses, midwives, health officers and health extension workers. EDHS 2000, 2005 and 2011 defined skilled providers as "doctors, nurses and midwives".

17 Although the law supports women to get child support from their former husbands after divorce, the culture in Gambella Region does not allow the women to ask for child support through legal processes. In addition, the women are not well informed about the justice system because of their sociocultural status and the high level of gender inequality in the society.

Table 2.6 summarizes the information from qualitative findings about the challenges and barriers to accessing and using SRMNCAH services.

TABLE: 2.6
Barriers to SRMNCAH service utilization

Specific barriers	Discussion points and quotes from FGDs
Difficulty of getting quality SRMNCAH service at night	During the assessment, it was found out that health professionals did not offer health services during the night for the past two months due to the security-related problem. Delivery was provided by traditional and local birth attendants. The traditional birth attendants are not skilled, and mothers are at risk of death. The traditional attendants are expected to provide support for health experts. However, currently, during the night-time, traditional birth attendants are forced to provide delivery services and other health services in the health centres due to the absence of health professionals. The traditional attendants are selected from the refugee camps and trained to support health experts. However, they are not very experienced, the safety measures they use are not the same as those of health professionals, they are not dressed properly as health experts, and mothers are not happy to be treated by the traditional attendants. Moreover, the mothers may be at risk when they are treated by traditional attendants. (FGD with adult women in Nguenyiel refugee camp; P1, P2, P4, P5, P6, P7, P8)
Lack of client-friendly services	<p>The health experts at the health centre do not provide client-friendly services. They mistreat us, and most of the time we wait for half or a full day to get the service. The health facility and the ward are crowded, and many people are admitted into the same ward for different cases. (FGD with adult women in Nguenyiel refugee camp; P1, P4, P6, P8)</p> <p>At the worst, sometimes we may go back home without getting services at all. The health professionals' motivation is low, and they are not friendly, which also pushed the community not to access the SRMNCAH services. (KII with health centre in Jewi refugee camp)</p>
Policy and legal issues affecting abortion service use	Abortion is common in the refugee camps, though it is not recorded in the health centres, since it is not legal. Women and girls are forced to do abortions by themselves using unsafe means. Abortion-related death is common in the village, but it is not reported for reasons such as that the abortion is not conducted in the health centre, and deaths are not reported because, if the family size is reduced, the food aid to the family will be reduced, so the family prefers to stay silent the death of the family member. Usually, any death in the village is hidden and not reported. According to the FGDs, 8–10 abortion-related deaths happen in the camp per year. The health centre may treat the post-abortion complications after unsafe abortions conducted by girls. (FGD with adult women in Nguenyiel refugee camp)
Shortage of medicine and health-care providers	<p>Most of the time, especially for the last two years, there is not enough drugs and kits in the health centre for all types of treatment. For instance, there was a shortage of medication for STI treatment, FP contraceptive methods such as injections, which are relatively often demanded by women, and a shortage of medicines. As a result, the community has been forced to buy the drug from private drug stores. (FGD with adult women in Nguenyiel refugee camp; P2, P5, P1)</p> <p>Owing to budget constraints, price inflation and shortages in the market, the health centre could not obtain all drugs, chemicals and medical kits. Moreover, there is a high workload in the health centre. The health centre is expected to provide services for 25,000 people; however, currently, it provides services to more than 62,000 people. As is standard for health centres, in the maternal and child health ward there are eight midwives (four female and four male), but the community is more than twice the capacity of a health centre. In the morning, 40–50 mothers may come to the health centre for ANC follow-up; however, the health centre can only provide ANC services for 15–20 mothers per day. Because of the high workload, the health centre prioritized mothers who were in the third trimester (six months pregnant and later) for ANC follow-up. In addition, there are 8–18 institutional deliveries a day in the health centre and 1 or 2 home deliveries expected per day in the refugee camp. More than 95 per cent of the refugee women deliver at the health centre to get registration for a newborn (KII with health centre in Jewi refugee camp).</p>

Distance and lack of transport	<p>In the Nguenyyiel refugee camp, a three-wheel motor vehicle (bajaj) was used to transport mothers from remote villages to the health centre, as the refugee camps are very wide. However, the bajaj is currently not functional, and mothers are challenged to travel from distant villages to the health centre and are forced to give birth at their home. (FGD with adult women in Nguenyyiel refugee camp; P1, P2, P4, P5, P7)</p> <p>In the host community, most of the women in the rural kebeles [wards] don't have access to health centre/post-delivery, and there is also a transportation problem to travel to the town health centre. (FGD with adult women in Itang host community; P3)</p> <p>In the refugee camps, women couldn't call the health centre to get transport services due to network problems. As a result, women are forced to give birth at home. (FGD with adult women in Jewi refugee camp; P4, P5)</p>
Men as ultimate decision makers	<p>The gender roles, influenced by the culture, affected the SRH of women and adolescents. Particularly, women's low decision-making position at the household level over resources and decision-making negatively affects their access to the ANC, PNC and institutional delivery services. (FGD with adult women in Itang host community; P8)</p> <p>In our Nuer culture [refugee community], women don't have equal access and control over resources and decision-making power. Men are the ultimate decision makers on important issues, including selling and buying bigger items such as cattle. Women may decide on the low-value household resources, including the utilization of food aid, as women are responsible for managing the whole family. (FGD with adult women in Nguenyyiel refugee camp; P1, P4, P5, P7)</p> <p>In our society, women and men have different roles. Women are mainly responsible for domestic work and childcare. This gender role highly affected the utilization of SRMNCAH services, and women are considered as a purchased object. (FGD with adult women in Jewi refugee camp; P1, P2, P3, P5, P6).</p> <p>Women in the Nuer community have a lower place in the household. (KII with health centre in Jewi refugee camp)</p>
Lack of free discussion between women and men on FP services and STI treatment	<p>There is no free discussion between women and men at the household level regarding FP services and STI treatment. As a result, women use FP services secretly. For instance, out of 10 FGD participants, only two participants discuss FP openly with their husbands, as they are students. In most families, discussing birth control is taboo. (FGD with adult women in Jewi refugee camp)</p> <p>In the general refugee community, as most of them came from rural South Sudan and their educational background is lower, they are afraid to seek STI treatment and afraid to tell their case to their husbands. Most of the husbands don't want to go to the health centre with their wives. (FGD with adult women in Nguenyyiel refugee camp; P4)</p>
Women's low decision-making power on accessing and using SRMNCAH services, particularly FP and STI treatment	<p>Women don't have the power to decide on the number of children, the income that the family generates from selling cattle and cereals, and the money that is brought from the dowry of their daughters. It is the men who are the ultimate decision maker on big issues. (FGD with adult women in Itang host community; P4, P6)</p> <p>Women couldn't decide on the FP services utilization, STI and abortion-related services. The cultural influence and the women's position in the household and the community negatively affected the SRMNCAH of women. (FGD with adult women in Nguenyyiel refugee camp; P1, P3, P4, P5, P6, P9)</p> <p>There is a significant number of STI cases in the camp, but most women are scared of telling their husbands and seeking treatment. Most of the community members, especially men, are unwilling to get STI treatment, and women are terrified to seek STI treatment and afraid to tell their case to their husbands. (FGD with adult women in Jewi refugee camp; P1, P2, P5, P6)</p>
Women's relatively restricted freedom to use ANC, delivery services and child health services, compared with the freedom of women in host communities	<p>Compared with host community, women in the refugee camps are relatively less free to utilize some SRMNCAH services such as ANC, child health, institutional delivery. (FGD with adult women in Nguenyyiel refugee camp; P4, P9)</p> <p>In the host community, especially living in the towns, there is progress in maternal and child health services. Husbands started allowing their wives to deliver in health facilities; however, in Itang woreda rural kebeles, most women don't have access to ANC or PNC and most of them deliver at home. (FGD with adult women in Itang host community; P4)</p>

Women's fear of the community	<p>Some of the refugee women currently need FP services, but many are afraid of their husbands and the community discrimination. (FGD with adult women in Nguenyiel refugee camp; P3)</p> <p>Of 10 FGD participants, 3 were willing to use FP, although they were scared of their husbands and the community's intolerance (FGD with adult women in Jewi refugee camp; P6, P3).</p>
Husbands' refusal to let their wives use FP	<p>Lack of awareness, the need for a large family and keeping the culture are among the reason for husbands to prevent their wives from using the FP services. (FGD with adult women in Nguenyiel refugee camp; P4, P5, P6, P7, P8)</p> <p>As the culture does not support use of contraceptives, women have found it challenging to use it. The mother's health is more affected when having more children, and more women prefer to use FP methods; however, their husbands don't allow them. Therefore, women are afraid of their husbands if they use FP methods, and most of the men prefer divorce if their wives want to use FP services. (KII with health centre in Jewi refugee camp)</p>
Dowries and marriage gifts	<p>The main cause of women's lower position in the community is related to dowry. Because men pay a dowry to women's families, men get ultimate power to control the lives of women, and women can't decide on the number of children and other SRMNCAH-related services. (FGD with adult women in Jewi refugee camp; P4, P7)</p> <p>Men considered their daughters a source of income; they thought that a daughter should bring a huge dowry. Thus, they don't worry about early marriage, teenage pregnancy and the daughter's future life. Because men pay a dowry to the daughter's family men get the ultimate power to control the lives of women after they give the dowry, and women can't decide on the number of children and other SRMNCAH-related services. (FGD with adult women in Itang host community; P2, P9)</p>
Polygamy	<p>Polygamy is very common, and it affects women's empowerment and exposes them to GBV and affects the SRMNCAH of women because they may not have the power and control over their lives. (FGD with adult women in Jewi refugee camp; P4, P7)</p>
High mobility	<p>According to key informants in health facilities, in the refugee camps the prevalence of STIs is estimated in the range of 50–70 per cent. However, most of the husbands are not willing to get treatment for STIs. They split their time between South Sudan and Gambella, so it is difficult to get timely treatment with their wives. In addition, some of them are not willing to visit the health centre for STIs because they are worried about bringing their two to four wives to the health centre. The SRMNCAH unit tried to give pregnant women STI treatment although they couldn't bring their husbands.</p> <p>"However, for non-pregnant women and girls, we requested them to bring their husbands/sex partners for the treatment; otherwise, giving the service only to women is meaningless." (KII with a health centre in Jewi refugee camp).</p>

Source: FGDs and KIIs

2.7

Logistic regression analysis on access to and utilization of SRMNCAH services

Using contraceptives helps women avoid unplanned or unwanted pregnancies and prevent unsafe abortions. In addition, using contraceptives helps women have time gaps between the births of their children, which in turn benefits the health of the mother and children. According to the 2016 EDHS report, contraceptive use among married women was low (35 per cent) in Gambella. Similarly, this household survey found that only about 25 per cent of the women had ever used contraceptive methods. According to the 2016 EDHS, 18 per cent of currently married women whose age was in the range of 15–49 in Gambella Region wanted to have another child soon.

However, the present study finds that about 81 per cent of men and women wanted additional children in the future. As a result, they did not want to use FP methods. Of women respondents who used FP, 18 per cent said that the decision to use it was made jointly with their husbands. Of women who wanted to have another child sooner, 35 per cent had made the decision by themselves, and 43 per cent had the decision made by their husbands (Figure 2.9). This shows that FP service use was mainly decided by husbands, and next most often by the women alone. The main reasons for not using FP methods in the future were fear of side effects (59.5 per cent of the women), opposition from husband/partner (56.8 per cent), religious prohibition (41.3 per cent) and the intention to have more children (26.5 per cent) (Figure 2.10).

According to female FGD participants from Jewi refugee camp, husbands are the primary decision makers on the use of contraceptive methods for their wives. As a result, women could not use contraceptive methods to limit the number of children. Among the 12 female FGD participants, only three women had experience of using contraceptives. However, all of them used

the contraceptive methods without the knowledge of their husbands. As their husbands were not aware of their contraceptive use, those women could not continue using it for more than a year, as their husbands would have grown suspicious if they did not become pregnant for a longer period.

FIGURE 2.9
Decision about FP services

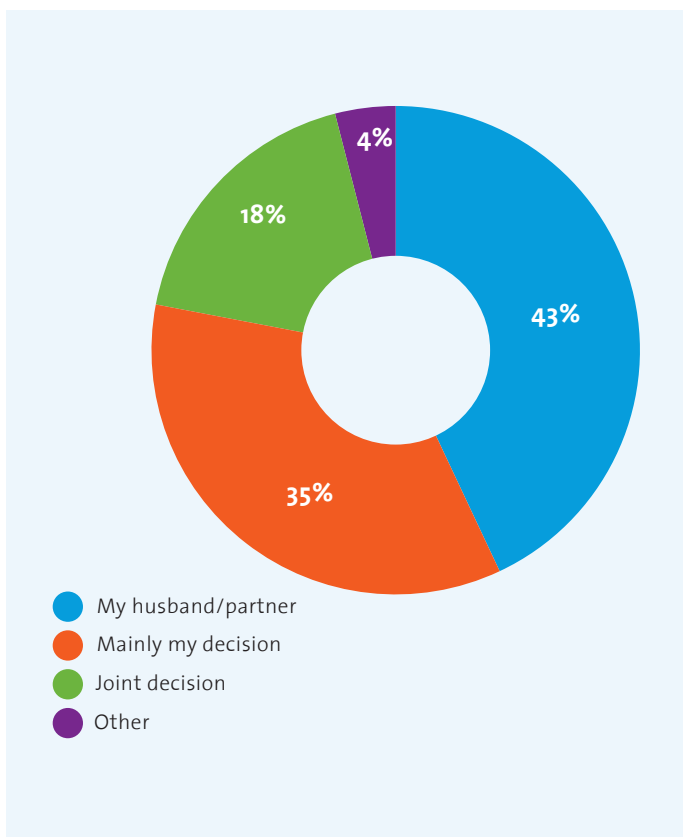
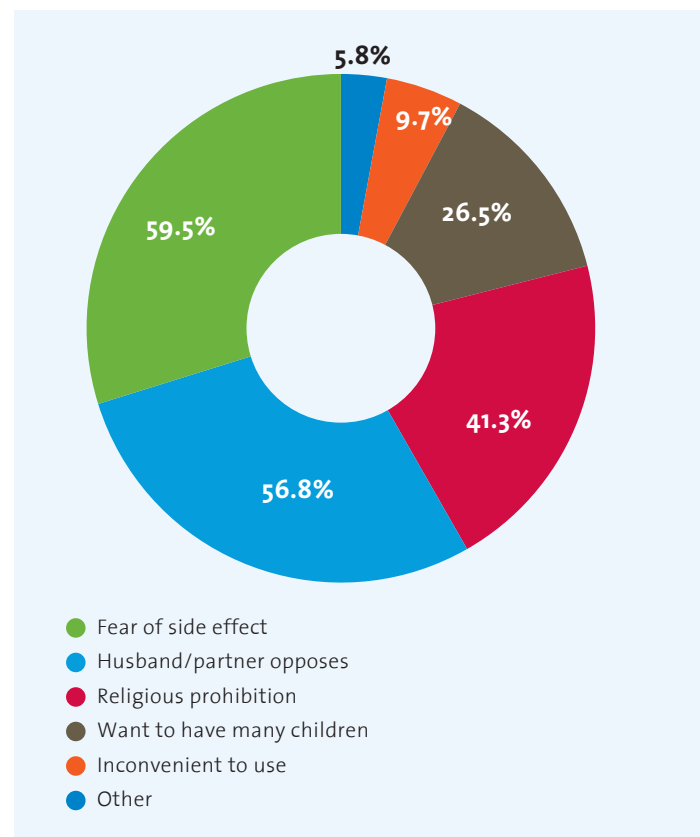


FIGURE 2.10
Reason for not using FP services



Source: Own computation from primary data, December 2021

A multivariable logistic regression analysis showed that formal education, participation in SRMNCAH programmes such as training and workshops, health facility access, and participation in community dialogues and discussions had a statistically significant association with any FP use (Table 2.7). Women who had reached an elementary level of education were 3.7 times more likely to use FP than illiterate women (adjusted odds ratio (AOR) 3.7, 95 per cent confidence interval (CI) 1.37–10.23). Husbands who did

not participate in SRMNCAH programmes, such as attending meetings and workshops, had wives who were 90 per cent less likely to use FP services (AOR 0.3, 95 per cent CI 0.13–0.89). Women who were not involved in SRMNCAH-related community dialogues and discussions were 97 per cent less likely to use FP (AOR 0.03, 95 per cent CI 0.004–0.284). Women who did not visit health facilities were 80 per cent less likely to use FP (AOR 0.2, 95 per cent CI 0.104–0.542).

TABLE 2.7**Factors associated with FP service use from multivariable logistic regression analysis**

Factors	Crude odds ratio (COR) (95% CI)	AOR (95% CI)
Education		
Illiterate	1.00	1.00
No formal education	2.4 (1.15–4.95) **	5.1 (2.17–12.01)
Elementary	2.7 (1.19–6.26) **	3.7 (1.37–10.23) **
Secondary	1.4 (0.49–4.09)	1.8 (0.55–5.81)
Above secondary	4.1 (0.84–20.20)	34.5 (0.98–121.35)
Husband participated in SRMNCAH programme		
Yes	1.00	1.00
No	0.1 (0.06–0.30) **	0.3 (0.13–0.89) **
Women participated in community dialogue and discussions		
Yes	1.00	1.00
No	0.02 (0.003–0.180) **	0.03 (0.004–0.284) *
Women accessed health facilities		
Yes	1.00	1.00
No	0.15 (0.07–0.30) **	0.2 (0.104–0.542) **

Source: Own computation from primary data, December 2021

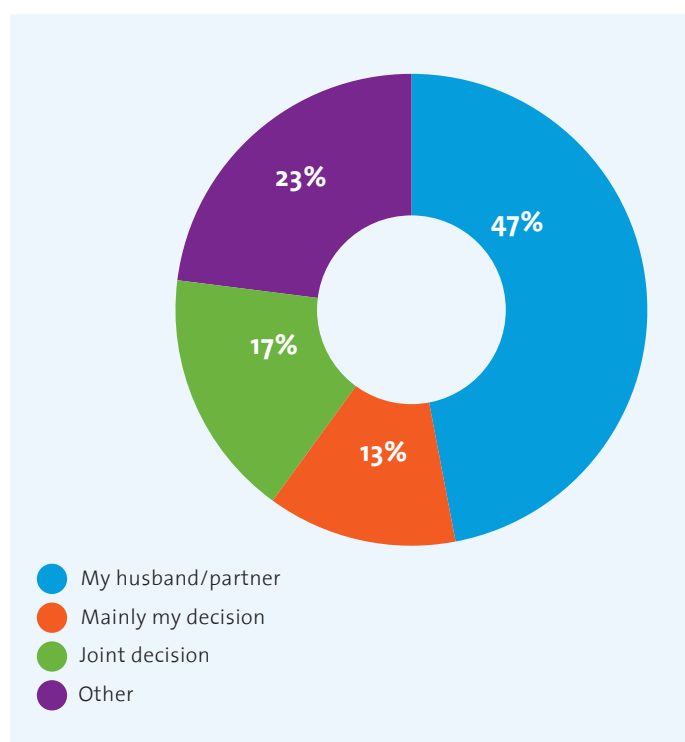
2.7.1. ANC service access and utilization

Health-care services during pregnancy and delivery are important for the survival and well-being of both mothers and newborns. Of all the female study participants, 71 per cent were pregnant before the study and 23 per cent were currently pregnant. Nearly 73 per cent of women study participants visited a health facility to get ANC for their last pregnancy. About 33.5 per cent of pregnant women attended ANC more than four times.


The above result is almost the same as the 2016 EDHS, which showed that 32 per cent of women study participants received ANC from a skilled provider at least four times during their last pregnancy. The largest proportion of pregnant women (43 per cent) received ANC service from female nurses/midwives.

However, according to the response of the study population, 28 per cent and 24 per cent of pregnant women have received ANC services from male doctors and female doctors, respectively. Only 6 per cent of pregnant women obtained ANC services from male nurses/midwives. A total of 47 per cent of the pregnant women said that access to ANC service use was mainly decided by husbands, whereas 23 per cent of them said that it was decided by wives (Figure 2.11).

FIGURE 2.11
Who decided on access to ANC services



Source: Own computation from primary data, December 2021



Of all the female study participants, **71%** were pregnant before the study and **23%** were currently pregnant. Nearly **73%** of women study participants visited a health facility to get ANC for their last pregnancy

A multivariable logistic regression analysis showed that being in a refugee community, husband's participation in an SRMNCAH programme, access to a health facility and type of health-care providers for ANC have statistically significant associations with the recommended level of ANC service use (Table 2.8). Women who reside in refugee camps were 22 times more likely to attend recommended ANC follow-up (four or more visits) than women who reside in the Itang host community (AOR 22.1, 95 per cent CI 4.49–109.23). If husbands did not participate in SRMNCAH

programmes such as meetings and workshops, their wives were 80 per cent less likely to attend ANC (AOR 0.2, 95 per cent CI 0.077–0.46). Women who did not visit health facilities were 70 per cent less likely to attain recommended ANC follow-up (AOR 0.3, 95 per cent CI 0.12–0.60). Those women who received services from male health-care providers were 80 per cent less likely to attain the recommended ANC than those who received them from female health-care providers (AOR 0.2, 95 per cent CI 0.09–0.51).

TABLE 2.8
Factors associated with ANC service use from multivariable logistic regression analysis

Factors	COR (95% CI)	AOR (95% CI)
Community type		
Itang host community	1.00	1.00
Jewi refugee community	6 (3.23–11.21) **	22.1 (4.49–109.23) **
Husband participated in SRMNCAH programme		
Yes	1.00	1.00 n;
No	0.1 (0.05–0.20) **	0.2 (0.077–0.46) **
Women accessed health facilities		
Yes	1.00	1.00
No	0.3 (0.18–0.55) **	0.3 (0.12–0.60) **
ANC provided by		
Female health-care providers	1.00	1.00
Male health-care providers	0.4 (0.20–0.69) **	0.2 (0.09–0.51) **

Source: Own computation from primary data, December 2021

2.7.2. Access to delivery services

Increasing institutional delivery is important for reducing maternal and newborn mortality. However, access to health facilities in rural areas is more difficult than in urban areas because of distance, unavailability of services and lack of appropriate health service facilities. Although institutional delivery has improved in recent years in Ethiopia, home delivery is still common, primarily in areas that are hard to reach because of their remoteness. According to the 2016 EDHS, at national level, 26 per cent of live births were in health facilities. Specifically in Gambella, about 45 per cent of deliveries had occurred at health facilities.

According to the current household survey, a significant proportion (70 per cent) of women delivered at health centres, about 13 per cent of deliveries were performed at home and 15 per cent of deliveries occurred on the

way to health centres. Only 18 per cent of women were not assisted by anyone else during their delivery. More than 90 per cent of women were comfortable being assisted by female health-care providers, only 3 per cent of women preferred male health-care providers, and about 5 per cent of women had no preference whether male or female professionals assisted their deliveries.

A multivariable logistic regression analysis showed that age and access to health facilities had statistically significant associations with institutional delivery (Table 2.9). Older women were 90 per cent less likely to deliver their babies at health facilities than younger women (AOR 0.1, 95 per cent CI 0.01–0.61). Those women who had access to health facilities were 2.5 times more likely to deliver their babies at health centres (AOR 2.5, 95 per cent CI 1.17–5.13).

TABLE 2.9**Factors associated with FP use from multivariable logistic regression analysis**

Factors	COR (95% CI)	AOR (95% CI)
Age group		
14–24	1.00	1.00
25–34	2.6 (1.33–5.08) **	1.3 (0.63–2.81)
35–44	2.3 (0.94–5.53)	0.9 (0.35–2.56)
45+	0.2 (0.04–1.19)	0.1 (0.01–0.61) *
Access to a health facility		
No	1.00	1.00
Yes	1.6 (0.91–2.70)	2.5 (1.17–5.13) **

Source: Own computation from primary data, December 2021

2.8 POWER progress and promising practices

As a result of POWER, changes were recognized by household survey participants. Among the reported changes, 60 per cent of the respondents said that they are aware of the possibility of limiting the number of children and spacing them, and want to do so, 48 per

cent said that the current SRMNCAH intervention has helped reduce early marriage, 47 per cent said that boys and girls are able to access SRMNCAH-related information from the programme and 38 per cent reported that women have started to discuss safer sex because they have obtained SRMNCAH-related information from the programme. Similarly, 27 per cent of respondents said that women have started to use FP services, and 25 per cent indicated that women are able to discuss SRH-related issues with family members.

The qualitative study also identified results that support the effectiveness of the programme intervention. Among the most often acknowledged improvements mentioned by qualitative study participants were increases in awareness and access to information; in ANC and facility-based delivery service utilization; in FP service utilization; in demand for service; and in willingness to use FP services. For instance, FGD participants from the Jewi refugee camp explained the situation as follows:

Since UN Women started the SRMNCAH programme in refugee camps, we have had access to education and training through the mother-to-mother group training and home-to-home follow-up by community outreach health workers. As a result, we have had better awareness of maternal health, including ANC. However, we are not happy with the health centres' services, as we spent the whole day waiting for ANC service; and they give priority to pregnant women who are on their fourth ANC visit. The bad attitude and poor communication of health-care providers also prevent us from using the SRMNCAH services. Therefore, we sometimes go back to our homes without getting any services; and sometimes refugee women prefer home delivery even though they know that the newborn won't be registered for humanitarian aid if it is born at home. (Woman FGD participant from the Jewi refugee camp)



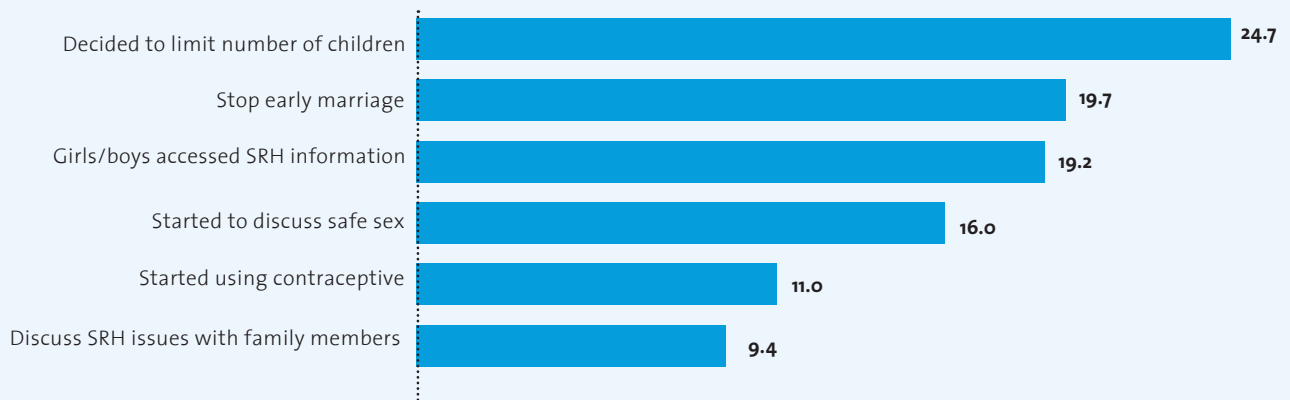
Women receiving SRMNCAH services at Jewi refugee camp during the assessment. Photo: UN Women

The existing structure of IMC within POWER, i.e. education and community referral through community outreach health workers, and the absence of female genital mutilation in Nuer culture were identified as an enabling environment and promising practices for a better future.

The programme's intervention in the target community brought about changes to solve the sociocultural-related problems in accessing SRMNCAH services, which is also acknowledged by the study participants.

Accordingly, as Figure 2.12 shows, 24.7 per cent of the respondents reported that they had decided to limit the number of children, 19.7 per cent had decided to stop early marriage for their daughters, 19.2 per cent had decided to send their boys and girls to health centres for SRMNCAH information, 16 per cent had started safer sex with their partners, 11 per cent had started using contraception for spacing their children and limiting their number, and 9.4 per cent had started discussing SRH with their families.

FIGURE 2.12
Changes brought about by POWER (%)



Source: Own computation from primary data, December 2021

Table 2.10 provides a summary of findings from the qualitative assessment. It focuses on the changes that were observed due to the implementation of the programme. Moreover, it shows certain promising practices that were observed in the study community.

TABLE 2.10
Programme effectiveness and promising practices

Programme effectiveness and promising practices	Discussion points
Awareness has increased, and beneficiaries have got better information	<p>After the POWER programme intervention, our understanding and demand for SRMNCAH services have improved. The only challenge we have is the negative perception of our husbands and the culture of the community about FP services. (FGD with adult women in Itang host community; P3, P6)</p> <p>In the refugee camp, IMC, with the support of UN Women, is providing different SRMNCAH services, including awareness creation and education through community outreach services, counselling services for GBV survivors and referral and links to the nearby health centres for STI services. The mother support groups are also mobilizing women for SRMNCAH services. Due to the UN Women-supported community outreach programme, the awareness level of the community is improving. Most women have a better understanding of all SRMNCAH components, including FP, institutional delivery, STI treatment, ANC and PNC. The awareness of men has also improved, as they are attending different training and meetings through the SRMNCAH programme. (FGD with adult women in Nguenyyiel refugee camp; P2, P3, P5)</p> <p>Most targeted women have a better understanding of all SRMNCAH components, including FP, institutional delivery, STI treatment, ANC and PNC, as women get a better understanding of the benefits of SRMNCAH services. After the POWER intervention, our understanding of SRMNCAH services has improved. However, the perception of our husbands about the FP and the culture of the community about FP services has not changed. (FGD with adult women in Jewi refugee camp; P2, P5)</p> <p>The awareness level of the refugee community has increased as women, men and youth are engaged in training, education and mobilization programmes in the camps. (FGD with adult women in Nguenyyiel refugee camp; P3, P8)</p> <p>The awareness level of the community, especially women, involved in the SRMNCAH programme has increased, and the programme implementation through SRMNCAH youth centres and community outreach programme helped to create increased demand for SRMNCAH services and improved the involvement of men in the SRMNCAH-related programme. (KII with health centre in Jewi refugee camp)</p> <p>The UN Women-supported IMC programme helped raise the community's awareness level on SRMNCAH. The outreach programme through community health workers referred and linked mothers to health centres for the mothers to receive services. Since the programme began, mothers are getting better SRMNCAH services [compared with services in previous period]. (KII with health centre in Jewi refugee camp)</p> <p>Most of the community members are attending the meeting and training sessions organized by IMC and have a better understanding of SRMNCAH. (FGD with adult women in Itang host community)</p>

Utilization of ANC and delivery services in the refugee camp are increasing because they see benefits of FP use	<p>Some men who were targeted by the UN Women-supported IMC training and education started to allow ANC, institutional delivery and PNC; however, they are very reluctant to allow birth control for their wives. Most of the target women have started using ANC, PNC, and some of them have begun FP services. (FGD with adult women in Itang host community; P3)</p> <p>Some of the women have started to use FP methods without the knowledge of their husbands for child spacing. Most of the targeted women started using ANC, PNC and FP services. Currently, the need for FP services has increased especially in young families. Free discussions between the husband and the wife about STI treatment in the young and educated family. (FGD with adult women in Nguenyiel refugee camp; P4, P1, P7, P5, P2)</p> <p>Most of the targeted women have started ANC, PNC; some of the women have begun FP services. Most of the community members who attend the meetings and training have a better understanding of SRMNCAH, and they have started using the FP methods, although their husbands are not willing. (FGD with adult women in Jewi refugee camp; P1, P4, P7)</p> <p>Most of the women use ANC and institutional delivery because the ANC follow-up is linked with the additional nutritional support for pregnant and lactating women, and institutional delivery is also linked with newborn registration. Thus, to get the nutrition support and newborn registration, the refugee women visited at least two ANC follow-ups, and they tried to deliver at a health facility. (KII with health centre in Jewi refugee camp)</p>
Demand for service has increased	As a result of the community mobilization work and outreach programme of SRMNCAH, the demand of the community for SRMNCAH services has increased. However, the health centre couldn't provide the required services for the target community. The POWER programme created demand for SRMNCAH. (FGD with adult women in Nguenyiel refugee camp; P2)
Attitudes to using service have improved	<p>The attitude of the women in the refugee towards SRMNCAH service is improving because most of them are attending community meetings, discussions and training organized by humanitarian organizations working on SRMNCAH in the camp. The attitude of men who attend the meetings also has brought attitudinal change and allowed their wives to access different SRMNCAH-related services, including STI treatments. (FGD with adult women in Nguenyiel refugee camp)</p> <p>The community's attitude about SRMNCAH in refugee camps has been improving during the implementation of the POWER programme. The attitude of men who attended the programme has changed and they started accessing different SRMNCAH-related services for their wives, including STI treatments. (FGD with adult women in Jewi refugee camp; P4)</p> <p>For the last two to three years, the community's attitude towards SRMNCAH, especially ANC, PNC and institutional delivery, has improved in the towns. (FGD P4)</p> <p>The attitude of men who attend the IMC programme has changed and they have started accessing various SRMNCAH-related services for themselves and allowing their wives to do so, including STI treatments. (FGD with adult women in Itang host community; P2, P6)</p>
Existing RRS structure is an enabling environment	<p>RRS has a community structure to mobilize the community on health issues such as SRMNCAH, and the community workers and the refugee structure RCC help to reach the community. (FGD with adult women in Nguenyiel refugee camp)</p> <p>The existence of IMC and other organizations has helped the community to address the SRMNCAH needs. (KII with health centre in Jewi refugee camp)</p>
Education and community referral linkage through community outreach agents is a promising practice	Through UN Women's support, IMC is providing home-to-home education and awareness-raising programmes. The outreach community health workers help to link the service with the health centre. Different SRMNCAH services have been provided in IMC centres for women, men and young adolescents. They are a mother support group programme, counselling programme, referral linkage and education programme in the SRMNCAH centre. (FGD with adult women in Nguenyiel refugee camp; P3, P6, P1, P7)
Female genital mutilation does not happen in Nuer culture	In the Nuer culture of the refugee community, female genital mutilation is not practiced, which is a good cultural practice for women's and girls' SRMNCAH. (KII with health centre in Jewi refugee camp)

Source: FGDs and KIIs



2.9 Lesson learned from POWER

The following lessons can be learned and adopted from the programme, to improve future SRMNCAH programmes in both the refugee and host communities in Gambella Region.

- Although it is not possible to eliminate sociocultural influences on health service provision to mothers and children, the UN Women-supported SRMNCAH programme implemented in collaboration with IMC has brought a change in the knowledge, attitudes and practices of the study community regarding SRMNCAH service utilization. This has improved the health of mothers, adolescents and children.
- Currently, efforts to create demand for SRMNCAH services are very encouraging. However, regular, client-friendly and sustainable SRMNCAH service provision is needed at health facilities to realize the expected progress on SRMNCAH service utilization. Multisectoral involvement is also critical to overcome service delivery-related challenges in the refugee and host communities.
- To improve the utilization of SRMNCAH services by women, children and adolescent girls in both communities, the active engagement of men and boys in understanding and promoting SRMNCAH is very important.
- Adolescent girls and girls are vulnerable to SRMNCAH-related problems. Many interventions do not give the required attention to the needs of adolescent girls and girls. Thus, special SRMNCAH services linked to school and youth centres are needed to address the unmet needs of adolescent girls for SRMNCAH.
- Engagement with religious leaders and influential community members is also needed to change cultural barriers and norms related to dowry payment over the long run.

Section 3: Conclusions and Recommendations



3.1 Conclusions

The following conclusions are drawn from the findings of the study.

1. The progress of SRMNCAH programme implementation, and of the status of women and girls, towards access to SRMNCAH services in the target communities

In collaboration with IMC, UN Women has been implementing POWER in the refugee and host communities of Gambella Region. The programme was planned to address the barriers that are preventing women, children and adolescents from accessing and using SRMNCAH services, specifically some of the demand- and supply-side challenges. In this regard, the following progress was observed:

- The awareness of the community, especially women, has improved.
- Initial demand has been created for ANC, FP, institutional delivery and STI treatment, which must be expanded.
- The number of mothers and youth who use FP has increased.
- The number of STI- and GBV-related service users has increased.
- The number of youth who use SRMNCAH services has increased.
- The STI service demand from men and women has increased.
- Psychosocial counselling, clinical services and protection services for GBV survivors have increased thanks to the support of the community outreach health workers, youth centres, counselling centres and referral linkage.

Although there is visible progress in creating demand for SRMNCAH services in the community through the awareness-raising and mobilization activities of POWER, engagement of men and youth and some of the other challenges related to SRMNCAH services have not improved, such as shortage of drugs, high inflation, shortage of funds and decreased support given to the health centres (medical kits, etc.) by humanitarian organizations.

2. Challenges in realizing the rights of women and girls to SRMNCAH services

There are still gaps related to health service provision and community knowledge, attitude and practices that need intervention to ensure that mother, child and adolescent health services improve. Some of these challenges are:

- **Capacity of the health facilities:** The capacity of health facilities in the refugee camps is too limited for the target community because of the small number of health experts, lack of training for experts and limited capacity-building support given to the health centres.
- **Geographical access to health services:** For some communities, both in the refugee camps and in the rural kebeles/villages of the host communities, access to and utilization of ANC, PNC, institutional delivery and other SRMNCAH services have been negatively affected by the geographical inaccessibility of the facilities.
- **Lack of youth-friendly services:** The study revealed that youth from both refugee and host communities have unmet needs for SRMNCAH services, especially for FP services. Moreover, the services are not youth-friendly.

- **Failure to report SGBV cases:** SGBV is prevalent in the refugee and host communities. However, it was found that the community is reluctant to report cases to the police and considers it normal. This has made protecting girls and women from SGBV challenging. The violence is committed by people who are not the victims' regular sexual partners.
- **Child marriage:** As a form of SGBV, this is very common in both the refugee and host communities.
- **Unsafe abortion:** It was reported that the number of abortion cases in the refugee camps is high. Most cases of abortion in adolescents are unsafe and take place in the bush or at home.
- **Negative attitude of men towards FP:** Men's negative attitude towards FP has limited the service utilization in the study communities. The power imbalance between men and women in regard to decision-making reduces women's control over their own bodies, abetted by social norms that prioritize men's authority over women, and the dowry system, which disempowers women and gives them a subordinate position.

3. Gender relations

Involving men is the key to increasing SRMNCAH service utilization in both the refugee and host communities for the following reasons:

Men as decision makers

- Usually, men are the household decision makers and make important decisions regarding health, education, finance, etc.
- Men usually do not make decisions in favour of women, due to limited knowledge and concern for women's SRMNCAH and partly to exert deliberate control over women's bodies.
- The involvement of men in SRMNCAH would improve their understanding of women's health and might encourage them to uphold women's rights and well-being.

Increased partner support

- The involvement of men would lead to better understanding between spouses or partners.
- Men would know about pregnancy, childbirth, birth intervals, and maternal and newborn health.
- This would also provide the opportunity for men to understand the effect of their decisions regarding SRMNCAH matters on their wives or partners and the entire family.
- Male involvement could support women in making and implementing certain decisions.
- Increased uptake of STI and HIV services
- The involvement of men in SRMNCAH would increase the number of people seeking STI and HIV services.
- Because of stigma, men generally do not participate in screening programmes and other health services.
- It is necessary for men to know about the transmission of STIs, including HIV, and SRH-related diseases.
- Women seek and receive STI- and HIV-related services either while seeking FP services or during ANC check-ups, but there is no such provision for men.
- Therefore, the involvement of men would increase service seeking by women, girls and boys as well as men.

4. Decreased burden on women

- The involvement of men in addressing SRMNCAH problems would help families make informed decisions.
- The more men understand, the more supportive they will be.
- The involvement of men would lower the burden on women.

3.2

Recommendations

Based on the study findings, the following general and specific recommendations are proposed.

3.2.1. General recommendations

Stakeholders in the refugee and host communities should create awareness of and demand for SRMNCAH, build additional health facilities in remote areas, provide client-friendly services, provide tailored pre-service and recurrent in-service training for health-care providers, provide sufficient medicine and medical supplies in health facilities, arrange locally appropriate and accessible transport facilities for refugee and host

communities, and secure enough budget to sustain the interventions. There is a need to strengthen the system of community-based referral linkage and to initiate interventions to engage men and boys at all levels of communities, including in leadership and within schools, to transform gender-inequitable attitudes while planning future SRMNCAH programme interventions.

3.2.2. Programme-related recommendations

The following are recommended demand- and supply-side actions for UN Women, IMC and other stakeholders to address the target community's SRMNCAH service needs.

Demand-side interventions

1. Enhance efforts to raise awareness of SRMNCAH through behavioural change communication following a human rights-based approach, and promote a multisectoral intervention to enhance SRMNCAH. Specifically:
 - Strengthen awareness-raising programmes in the refugee and host communities for women, girls, men and boys on SRMNCAH and its impact on their lives, through home- and school-based programmes, and interventions based in youth centres and the general community using innovative approaches.
 - There should be rights-based interventions to enhance the health of adolescent girls in the refugee and host communities, and to secure their right to know about SRMNCAH, their right to be healthy, their right to use SRMNCAH services, and their right to be supported by community partners and health workers.
 - Make advocacy for SRMNCAH rights and service utilization effective by engaging with a range of humanitarian and development bodies.
2. Reinforce strategies for engaging with men and contextualize them to the target community to enhance SRMNCAH service utilization through information, education and communication, skill building and engaging men as champions in advocacy groups. Specifically, the following actions are recommended:

- Strengthen efforts at various levels to engage men in promoting SRMNCAH services for women and girls.
 - Target boys and men through education, training and awareness-raising programmes, with a focus on the importance of SRMNCAH and the well-being of mothers and children. This will contribute to equalizing decision-making power between partners.
 - Initiate a range of programmes that can enhance women's assertiveness, empowerment and decision-making power at household and community levels, including over their fertility, and via interventions engaging with couples and prompting joint decision-making on SRMNCAH service utilization.
 - Encourage men and women to have the same say and engage in family-based dialogue on the available SRMNCAH services and their benefits.
3. Initiate youth-friendly and disability-inclusive services in the host and refugee communities at health centres, at school and in the community (youth centres and SRH centres). There is a need to launch peer-education programmes for boys and girls, and men and women, on the importance of SRMNCAH services for individual, family and community well-being and development.
 4. Promote access to youth-focused SRMNCAH services through health centres, school programmes and community-based SRMNCAH centres in both the host and refugee communities.
 5. Support women's empowerment programmes by placing women's empowerment on the agenda of existing multisectoral steering committee meetings. Specific recommendations are:
 - Address the sociocultural-related problems that prevent women's access to SRMNCAH services.
 - Involve various bodies to empower women and girls, solve dowry-related challenges and eradicate child marriage.
 - Initiate programmes that can empower women economically and socially through life skills and assertiveness training, and activities supporting income-generation.

Supply-side interventions

1. Enhance the accessibility and affordability of health centres and services by building the capacity of health centres

- Fully equip health posts located in remote areas of the host communities with the necessary equipment. Train service providers and assign them on a full-time basis.
- Establish additional health centres and increase the capacity of existing health facilities, to reduce the burden on the existing health centres in providing SRMNCAH services in the refugee camps.
- Ensure strong follow-up and monitoring by the regulatory body to strengthen the health service provision in rural areas.
- Have government health bureaus and humanitarian organizations collaborate to increase access to SRMNCAH services and improve the quality of service delivery in both the refugee and host communities.
- Strengthen the capacity of health professionals through continuous capacity-building training and experience-sharing programmes.

- Strengthen community-based referral linkage to create access to SRMNCAH services.
- Make locally acceptable, sustainable and standard transport services available by creating synergy between government and community.

2. Initiate client- and youth-friendly services at health centres for women, men, and adolescent girls and boys

- Client-friendly services should be promoted in refugee and host communities.
- Health facilities should provide client-friendly services and products targeting young women and girls in the host and refugee communities.
- The unmet need for contraceptive and other SRMNCAH services for adolescent girls should be addressed through adolescent-friendly services in schools, health facilities and youth centres.
- Life skills, negotiation skills and assertiveness training should be integrated with adolescent-friendly SRMNCAH services to enhance the self-esteem of adolescent girls and boys.
- Special consideration should be given to addressing the unmet need for abortion-related services for adolescent girls in the refugee and host communities.
- The application of the national adolescent and youth health strategy developed in December 2021 should be strengthened.

3. Strengthen existing multisectoral and coordinated efforts among different stakeholders

- SRMNCAH programmes should be extended and strengthened to minimize the challenges and satisfy the community's current demand for SRMNCAH services, by involving different sectors and stakeholders to empower women socially, economically and politically, to ensure SRMNCAH service utilization in a sustainable way.
- Strengthen multisectoral integration efforts by involving development and humanitarian organizations, including UN Women, IMC, UNHCR and RRS, in both the refugee and host communities.

Annexes



ANNEX 1: Household survey questionnaire

Action research on sexual, reproductive, maternal, newborn, child and adolescent health rights/ SRMNCAHR – POWER programme in the humanitarian setting

1. Instruction

This structured questionnaire was developed to conduct action research in Gambella refugee and host communities. The purpose of the research is to document the current programme implementation progress, lessons, challenges, gaps and further required efforts on sexual, reproductive, maternal, newborn, child and adolescent health rights/ SRMNCAHR – POWER programme in the humanitarian setting.

The questionnaire takes between 30–40 minutes to complete. Whatever information you provide will be kept strictly confidential. Also, no identifying information such as your name is recorded or needed. Participation in this study is voluntary, and you can

choose not to answer any individual questions or all of the questions. If you have questions or points of clarification, you can ask any time before answering the questions. You may stop participation at any time if you feel discomfort or unhappy by the process or dislike a specific item. However, we hope that you will participate fully in this survey since your experiences and advice are important for the study.

Are you willing to participate in the survey?

Yes >>> If yes, continue the survey

No >>> If no, stop!

Dear interviewer, kindly proceed to the interview only if the respondent is willing (answers yes to the above question) to participate in the survey.

General information

Check eligibility criteria	Age 15–49 (both female and male)	Category 1:	<input type="checkbox"/> Male-headed household
Geographical area:	Camp: _____		<input type="checkbox"/> Female-headed household
	Zone: _____		<input type="checkbox"/> Woman in a polygamous family
	Woreda: _____		
Date (dd/mm/yy):	____ / ____ / ____	Category 2:	<input type="checkbox"/> Female (15–49)
			<input type="checkbox"/> Male (15–49)
Enumerator name and signature:	_____		
Supervisor name and signature	_____		

Section I. Demographic information about the respondent							
1	Please tell us about your demographic background (e.g. your age, gender)	Gender	Age	Marital status	Educational status	Religion	Ethnicity
2		Male Female	_____	1. Married 2. Divorced 3. Widowed 4. Separated 5. Cohabiting	1. Can't read & write 2. Read and write 3. Elementary school 4. Secondary school 5. Above secondary school	1. Muslim 2. Orthodox 3. Protestant 4. Catholic 5. Other	1. Nuer 2. Agnuak 3. Other
3	What is your relationship with the household head?	1. Head 2. Wife 3. Daughter 4. Son 5. Sister of head 6. Brother of head 7. Mother of head 8. Other _____					
4	Is the head of the household a woman or a man?	1. Man 2. Woman					
5	Does your husband have another wife/regular partner? (For married female respondents only)	1. Has wife (wives) 3. Do not have any 2. Has regular partner(s) 4. Do not know					
5.1	Number of pregnant or lactating women in your household	_____					

Section II. Knowledge, attitudes and behaviours of respondents		
6	Do you have knowledge about sexual and reproductive health and rights?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7	Do you think women and girls have enough knowledge of sexual and reproductive health and rights?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8	Do you think men and boys have knowledge of sexual and reproductive health & rights?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9	Did you/your husband participate in IMC's SRH programme's meetings, training to improve the access and use of SRMNCAH services?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10	If you/your husband participates in IMC's SRH programmes, what benefit do you get from the programme?	1. Access maternal health like ANC, PNC, delivery, immunization services 2. Access SRH services like family planning, STI services 3. Access newborn and child health, adolescent health 4. Knowledge on when, how and where to access services 5. I do not access any SRMNCAH services
11	If you/your husband participates in IMC's SRH programmes, what changes have you made regarding SRH?	1. Started using contraceptives 2. Decided to limit the number of children 3. Started to discuss safer sex 4. Sent our girls/boys to access SRH information 5. Decided not to practise early marriage for our girls 6. Discussed SRH issues with my husband & other family members 7. Other (any)-----
12	Is your husband willing to send women and girls to access SRMNCAH services and SRMNCAH information from health centres, community-based programmes?	<input type="checkbox"/> Yes <input type="checkbox"/> No

13	What are the attitude and perceptions of men towards SRH service utilization in your community?	1. Very good 2. Good 3. Neutral 4. Wrong 5. Very wrong								
14	For women respondents	For men respondents								
15	Do you negotiate safer sex and your own fertility with your partner/husband? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you believe women should negotiate safer sex and/or their own fertility with their partners/husbands? <input type="checkbox"/> Yes <input type="checkbox"/> No								
16	If your answer is no for the above question, what factors restrict you from doing so? 1. Fear of husband 2. The culture does not allow me 3. I am not in the position to negotiate (men are powerful)	If your answer is no for the above question, why? 1. Men should decide 2. The culture does not allow women 3. Women don't have power for negotiation								
17	Who decides to seek SRMNCAH services for you? <table border="1"> <tr> <td>1. Myself</td> <td>1. Yes 2. No</td> </tr> <tr> <td>2. My husband</td> <td>1. Yes 2. No</td> </tr> <tr> <td>3. My mother- or father-in-law</td> <td>1. Yes 2. No</td> </tr> <tr> <td>4. Others (in any)</td> <td>1. Yes 2. No</td> </tr> </table>	1. Myself	1. Yes 2. No	2. My husband	1. Yes 2. No	3. My mother- or father-in-law	1. Yes 2. No	4. Others (in any)	1. Yes 2. No	Who decides for your wife to seek and use SRMNCAH services? 1. I decide for her 2. She can decide 3. Mother- or father-in-law decides
1. Myself	1. Yes 2. No									
2. My husband	1. Yes 2. No									
3. My mother- or father-in-law	1. Yes 2. No									
4. Others (in any)	1. Yes 2. No									
18	If your answer for the above question is that you do not decide your SRMNCAH services by yourself, what factors restrict you from doing so? 1. My husband should allow me 2. The culture restricted me 3. I fear the community	If your answer for the above question was that your wife is not in the position to decide for her SRMNCAH services, what factors restrict her from doing so? ----- -----								
19	Have you ever faced any discrimination (losing acceptance) in the household when seeking and using SRH services? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you supported your wife in the household when she is seeking and using SRH services? <input type="checkbox"/> Yes <input type="checkbox"/> No								
20	Have you faced discrimination (losing acceptance) in the household when you need contraceptive use? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you supported your wife in the household when she needs contraceptive use? <input type="checkbox"/> Yes <input type="checkbox"/> No								
21	Do you think adolescent girls have access to sexual and reproductive health services?	<input type="checkbox"/> Yes <input type="checkbox"/> No								
22	If your answer is no for the above question, what is the reason?	1. No service in the community 2. They do not have information 3. They do not want to use the service 4. The service is not friendly to youth 5. Other (specify) _____								
23	Where do adolescent girls and boys get information about SRH?	1. School club 2. Health centre 3. Community-level awareness 4. Radio and TV 5. NGOs								
24	Do women and girls engage in community dialogues and discussions organized by IMC related to their health?	<input type="checkbox"/> Yes <input type="checkbox"/> No								
25	Can adolescent girls use SRMNCAH services without the permission of a family member?	<input type="checkbox"/> Yes <input type="checkbox"/> No								
26	Are women and girls comfortable while accessing SRH-related services from a one-stop centre, in a separate corner?	<input type="checkbox"/> Yes <input type="checkbox"/> No								

Section III. Access to sexual and reproductive health (only for women)				
27	Do you have access to health facilities?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	If no for Q 27, why?	1. Not enough money to pay for health care 2. No quality health service 3. No functioning health facilities in the area 4. Not safe to travel to the health facilities 5. No female health staff 6. No male health staff 7. The health facility is far from my residence 8. Other _____		
28	Do you have access to the following services?	1. Maternal health	<input type="checkbox"/> Yes	<input type="checkbox"/> No
29		2. SRH/family planning	<input type="checkbox"/> Yes	<input type="checkbox"/> No
30		3 Newborn and child health	<input type="checkbox"/> Yes	<input type="checkbox"/> No
31		4 Adolescent health	<input type="checkbox"/> Yes	<input type="checkbox"/> No
32		5. No, I don't have access	<input type="checkbox"/> Yes	<input type="checkbox"/> No
33	If No for Q 27, why?	1. Not enough money to pay for service 2. No quality health service 3. No functioning health facilities in the area 4. Not safe to travel to the health facilities 5. No female health staff 6. The service is not friendly at the health centre 7. The service I inquire about is not available 8. I was not aware of the services 9. I use traditional alternative medication		
34	Have you ever been pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
35	Are you currently pregnant?	1. Yes 2. No 3. Don't know		
36	Who decides on the number of children you to have?	0. My husband 1. Myself 2. I and my husband jointly 3. Father or mother in-law/family members		
37	Did you visit a health facility for antenatal care during your pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
38	Where and how did you get the knowledge that motivated you for ANC visit during your pregnancy?	0	Before 2020	During 2021
		0. Health centre before year		
		1. IMC POWER programme, outreach programme		
		2. Friends		
		3. Community representatives		
		4. Clubs/youth centres		
		5. Another place		
39	Who decided for you to access antenatal care service?	1. Husband 2. Husband's family 3. My family 4. Myself		
40	Who gave you antenatal care?	1. Male doctor 2. Female doctor 3. Male nurse/midwife 4. Female nurse/midwife 5. Traditional birth attendant/health worker 6. Other (specify) _____		
41	How many times did you visit antenatal care services?	1. Once 3. Two times 2. Three times 4. More than three times		
42	Where did you deliver your most recent baby?	1. At home 2. Health clinic/hospital 3. On the way to the hospital/clinic 4. Other(specify) _____		

43	Did someone help you with your delivery?	1. Yes 2. No [Go to Q 51]		
44	Who helped with the delivery?	1. Relative/friend 2. Traditional birth attendant 3. Midwife, nurse or doctor 4. Other (specify) _____		
45	Who gives you more comfort and freedom during antenatal and delivery services?	1. Male health professional 2. Female health professional 3. Both, I don't have a preference		
Both men and women				
46	Did you have any sons or daughters who were born alive and died, though they lived a short time?	1. Sons who died _____ 2. Daughters who died _____ 3. Total children who have died _____ 4. No response _____		
47	Is there someone who decides on having and not having an additional child for you?	1. Myself 2. My husband and me 3. My husband only 4. My husband's family 5. Others		
48	From what source have you been getting information about sexual and reproductive health services, SRMNCAL and HIV/STI, family planning (contraceptive) in the last 12 months?	Source of information	Yes	No
		1. Radio	1	2
		2. Television	1	2
		3. Print material (poster, pamphlet)	1	2
		4. Health facility	1	2
		5. Community health worker	1	2
		6. Family	1	2
		7. School	1	2
		8. Meeting	1	2
		9. Peers/friends	1	2
		10. Other (specify) _____	1	2
		999. I never heard about SRH		
49	Where is your preferred source of information for contraception use?	Source of information	Yes	No
		1. Radio	1	2
		2. Television	1	2
		3. Print material (poster, pamphlet)	1	2
		4. Health facility	1	2
		5. Community health worker	1	2
		6. Family	1	2
		7. School	1	2
		8. Meeting	1	2
		9. Peers/friends	1	2
		10. Other (specify) _____	1	2
		999. I never heard about SRH		
50	Have you ever used any contraceptive?	1. Yes 2. No		
51	Do you want to have a child in the future?	1. Yes 2. No		
52	Who decides on using contraception?	1. Mainly my decision 2. Mainly my husband/partner's decision 3. Joint decision 4. Other _____		
53	Do you think you will use a contraceptive method to delay or avoid pregnancy at any time in the future?	1. Yes 2. No 3. Don't know		

54	What is the reason that you will not use a contraceptive method in the future? (Circle all that apply)	1. I want to have as many children as possible 2. Husband/partner opposes 3. Religious prohibition 4. Fear of side effect 5. Inconvenient to use 6. Others _____
----	--	---

Section IV. Barriers and recommendations for accessing SRMNCAH

55	What are the key discriminatory attitudes and practices facing women and girls in seeking health care?	1.Lack of awareness of women/girls and men/husbands 2.Traditional beliefs towards SRH 3.Lack of friendly services at health services 4.Using traditional medicine 5.Other
56	What are some social norms related to the status of women and girls which can affect accessing SRMNCAH services?	----- -----
57	What do you recommend to improve utilization of SRMNCAH? (put mark on those that apply)	1. Improve the awareness level of women and men 2. Improve client-friendly SRMNCAH services at the health centre and in the outreach programme 3. Encourage men's involvement in any efforts to provide the service 4. Empower women economically, socially and politically 5. Create client- and women-/adolescent-friendly health services 6. Encourage the involvement of elders and community representatives in providing the service 7. Create access to education and training for women and girls 8. Other (if any) ----- -----
58	What would be the role of men/husbands in creating access to SRMNCAH services for their wives?	0. Encourage and have mutual decisions on sexuality 1. Encourage mutual decision on the number of children they have 2. Encourage and accompany women to use SRMNCAH services 3. Empower women to access information on SRMNCAH 4. Other (please specific) ----- -----

THANK YOU!!!!

ANNEX 2: Focus group discussion

Action research on sexual, reproductive, maternal, newborn, child and adolescent health rights/SRMNCAHR in Gambella Region, Ethiopia



Purpose: Gather information about the opinions, beliefs, practices and attitudes of a group of people towards the SRMNCAH service utilization and barriers to access and utilization of SRMNCAH services.

Tool notes: This tool should be used during small group discussions. The group should be made up of people from similar backgrounds or experiences and should not include more than 8–12 participants. The groups should also be separated by sex and age. The FGD is led by a facilitator who introduces the topics of discussion and helps to ensure that all members participate evenly in the discussions. The facilitator should assure participants that all information shared will remain confidential.

Target: Selected women, men, girls and boys from the target community

CONSENT FORM

Good morning/afternoon: My name is _____ and I work at UN Women Ethiopia as a consultant. We are here to understand the utilization of SRH and barriers to access and utilization of sexual, reproductive, maternal, newborn, child health services in the refugee and host communities.

I would like to now introduce my team. This is _____ (note taker) and _____ (translator).

Your participation is voluntary. No one is obligated to respond to any questions if he or she does not wish.

Your voice will represent the community, but there will be no benefit to you directly from participating in this interview. Do you have any questions regarding the survey? Are you willing to participate in the study?

Geographic location: _____

Translation necessary for the interview: 1. Yes 2. No

Date: _____

Facilitator's name: _____

Note taker's name: _____

Instructions

1. Thank the informants for participating in interview.
 2. Explain the objectives and expectations of the interview.
 3. Outline the session and the amount of time the discussion will take.
 4. Obtain informed consent to record the discussion and/or take pictures.
-

Participant characteristics

	Name	Education (grade)	Marital status	Number of children	Duration of stay in camp
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					

Thematic areas	Guiding questions	Issues to be addressed
1. Gender role and SRMNCAH utilization	<ol style="list-style-type: none"> 1. Do you think the gender role of women and girls at household and community levels affects their access to health services (SRMNCAH)? 2. Are women free to decide and utilize SRMNCAH services by themselves? 3. Do women and girls know about sexual and reproductive health and their rights to them? 4. Can adolescents make the decision to utilize SRMNCAH services without the permission of families? 	<ul style="list-style-type: none"> • Who cares for children, who decides on SRMNCAH, contraceptive use, having children, saving money and using money, selling assets, attending education, etc.? • Are women's and girls' health-seeking abilities and behaviours influenced by their spouse/partner, family and friends? How? • Are there factors that facilitate the ability of women and girls to seek health-care services for themselves and/or their families? If so, what are they?
2. Specific needs of women and men	<ol style="list-style-type: none"> 1. What are the specific needs of women, men, boys and girls? What are the specific SRH needs of girls/women, boys/men? 2. What are the different vulnerabilities of women and girls that affect their SRH? 3. How to empower women and girls to enhance health-seeking behaviour in relation to SRMNCAH services? 	<ul style="list-style-type: none"> • What specific SRMNCAH needs do women, men, girls and boys have? • Are particular age groups more vulnerable? For example, adolescent girls? Why is this, and how can this be improved?
3. Knowledge, attitude and practice on SRMNCAH issues	<ul style="list-style-type: none"> • How do you see knowledge, attitudes and practice regarding SRMNCAH in the community (specifically women in the community)? • Do you know the IMC's SRMNCAH programme? How do you describe the relevance and effectiveness of the programme in improving SRMNCAH? • Is there any visible change on the health facility side in providing better and client-friendly services for women and girls after IMC programme implementation? • What other barriers limit health-seeking behaviour, limit knowledge and increase poor attitudes of the community on SRH? • What SRH-related services are available to men, women, boys and girls in this community? Have SRH-related services improved in the last one year? • If you/your husband participates in IMC's SRH programmes, what change did you observe in SRH service delivery at the health centre? <ul style="list-style-type: none"> o The services are becoming client-friendly services o The waiting time is reduced o Access to the health centre (physical and transport) is improved • The counselling and the treatment are improved 	<ul style="list-style-type: none"> • Do women and girls have knowledge of SRMNCAH? What are the social stigmas around these services? • Do certain demographics avoid health or SRH services for any reason? If yes, why? • Do you know what the solutions are? • What are the main groups to address and engage in the community to improve the situation and reduce barriers?

4. Social norms and barriers	<ol style="list-style-type: none"> 1. What are the social norms related to using the SRMNCAH services? 2. What are some structural barriers restricting women from accessing SRMNCAH services? <ul style="list-style-type: none"> • Gender inequality • Lack of access to services • Traditional practices 3. What are the barriers to health-seeking behaviours for women and men (demand side and supply side)? 	<ul style="list-style-type: none"> • What are some of the discriminatory attitudes and practices facing women and girls in health-care settings? • What are the challenges to accessing the services (please state from the demand and supply sides): policies, laws, etc.?
5. Suggestion and recommendation	<ol style="list-style-type: none"> 1. Please give us any suggestions and recommendations to reduce the current barriers to women's and girls' access to and utilization of SRMNCAH. 2. Please list the recommended SRMNCAH programme interventions to ensure access to SRMNCAH services. 	<ul style="list-style-type: none"> • Sex-disaggregate recommendations at household, facility, legislation, community levels • Women's specific needs

ANNEX 3: Key informant interview guide

Action research on sexual, reproductive, maternal, newborn, child and adolescent health rights/SRMNCAHR in Gambella Region, Ethiopia

Purpose: The purpose of the discussion is to gather information about people's opinions, beliefs and practices about SRH-related problems and their effect on SRMNCAH service access and utilization.

Geographic location: _____ Name of interviewer: _____
Interview date: _____ Place of interview: _____
Translation is necessary for the interview: 1. Yes 2. No

Participant characteristics

Age: _____ Sex: _____ Position: _____ Organization: _____
Profession: _____ Experience: _____ Camp name: _____
Date: _____
Key informant's role in the community: _____

Introduction

1. Thank the participant(s) for the interview.
2. Explain the objectives and expectations of the interview.
3. Outline the amount of time the interview will take.
4. Obtain the informant's consent to record the interview and/or take pictures.

KII guide for health practitioners

General	<ol style="list-style-type: none"> 1. Can you describe the staff, facility and services of your health centre? (Number of male and female staff, quality and availability of service) 2. What is the role of your health centre in creating access to SRMNCAH in the community? 3. Does your organization provide SRMNCAH service to the target community at the expected quality and coverage? How and what?
Demand-/ supply-side challenges	<ol style="list-style-type: none"> 1. What are the key challenges for accessing SRMNCAH service from the community side (demand side)? <ul style="list-style-type: none"> • Awareness of the community • Traditional and cultural norms and practices • Gender inequality 2. What are the key challenges from the supply side for accessing SRMNCAH services? <ul style="list-style-type: none"> • Availability of the services • Availability of supplies, e.g. contraceptives, drugs, medical equipment • Providing client-friendly services • Availability of female service providers • Organizational effort to create demand for SRMNCAH • Promoting and creating awareness on SRMNCAH for the local community 3. What SRH-related services are available to men, women, boys and girls in this community? Is the SRH related improved for the last one year? <ol style="list-style-type: none"> a. If there is a change, what change did you observe in SRH service delivery at the health centre? <ul style="list-style-type: none"> • The services are becoming client-friendly services • The waiting time is reduced • The access to the health centre (physical and transport) is improved • The counselling and the treatment are improved
Cultural norms and beliefs	<ol style="list-style-type: none"> 1. To what extent do the norms and culture of the community affect the SRMNCAH coverage and accessibility? 2. What are the key norms and beliefs that affect SRMNCAH utilization?
Recommendations	<ol style="list-style-type: none"> 1. What are your recommendations to reduce the barriers and influence on accessing SRMNCAH? 2. What are your recommendations to create demand from men and women for SRMNCAH services? 3. What are your recommendations to create more information and access to SRMNCAH for women and girls at the community and health services level? 4. What are your suggestions to reduce barriers from the demand and supply sides (service provision) for SRMNCAH services?

Note: The above questions will be also adapted by the experts to fit other key informants during the interview.

ANNEX 4: Health facility assessment checklist

Action research on sexual, reproductive, maternal, newborn, child and adolescent health rights/SRMNCAHR in Gambella Region, Ethiopia

Name of health facility	
Type (clinic, health centre, hospital)	
Catchment population	
The owner (private, governmental organization, NGO)	
Year of establishment	
Camp	
Assessment conducted by	
Date of assessment	

Part I: Infrastructure and general readiness of facility

Infrastructure

Q#	Characteristic	Response
101	Number of consultation rooms	
102	Total number of inpatient beds	
103	Number of maternity (delivery) tables	
104	Number of maternity waiting beds	
105	Number of beds in female general ward	
106	Number of beds in children's ward	

Basic amenities

Q#	Items	Yes	No
107	Functioning refrigerator		
108	Cold boxes		
109	Computer with internet access		
110	Clean water supply (24 hrs)		
111	Reliable electricity (24 hrs)		
112	Alternative electricity (generator or solar)		
113	Adequate lighting in examination rooms, procedure rooms and operating theatres		
114	Adequate privacy for examination room		
115	Telephone/radio for communication		
116	Television		
117	Emergency transport available and functioning 24 hrs		
118	Handwashing facilities available in examination and procedure rooms		
119	Separate facilities for hand washing and for cleaning (e.g. sinks, buckets, soap, etc.?)		
120	Adequate furniture in all areas of the facility, including client waiting areas, procedure rooms and wards? Is there enough furniture? Is it clean, sturdy and undamaged?		
121	Toilet or latrines, hand wash for both men and women		
122	Safe final disposal of sharps (incinerator or burial pit for sharps)		
123	Safe final disposal of infectious waste (placenta pit)		

Comments _____

Diagnostics

Q#	Items	Yes	No
124	Malaria diagnosis (microscopic/rapid diagnostic test)		
125	Urine test for pregnancy		
126	Urine dipstick – protein		
127	Urine dipstick – glucose		
128	Blood glucose		
129	Syphilis test		
130	Haemoglobin		
131	HIV testing		
132	HIV testing for newborns		
133	Blood typing		
134	Crossmatch testing		
135	Full blood count		
136	CD4 or viral load		
137	Renal function test		
138	Liver function test (alanine transaminase or other)		

Comments _____

Part II: Technical staff

Q#	Professionals	Male	Female	Total
201	Gynaecologist and obstetrician			
202	Other specialists			
203	General practitioners (MD)			
204	Anaesthetist			
205	Health officer			
206	Nurse			
206	Midwife			
207	Lab technician/technologists			
208	Pharmacy technician/technologists			
209	Counsellors/psychologists			
210	Community health workers			
211	All other technical staff			

Comments _____

Training received by staff during the last two years

Q#	Type of training provided	Male	Female	Total
212	FP counselling (basic FP)			
213	IUCD insertion and removal			
214	Implant insertion and removal			
215	Post-abortion care (manual vacuum aspiration, dilation and curettage)			
216	Basic emergency obstetric care			
217	Comprehensive emergency obstetric care			
218	HIV testing and counselling			
219	ART			
220	STI management			
221	Care and support			
222	Infection prevention			

223	Adolescent SRH			
224	CMR (Clinical Management of Rape)			
225	Other SRH-related training			
226	_____			
227	_____			

Comment: Any type of training recommended _____

Part III: Availability of SRMNCAH services

Are the following services routinely provided?

Q#	Services	Yes	No
301	ANC		
302	PNC		
	Basic emergency obstetric care		
303	Administration of parenteral antibiotics		
304	Use of oxytocic drugs		
305	Use of anticonvulsants		
306	Manual removal of placenta		
307	Removal of retained products of the abortion (manual vacuum aspiration or dilation and curettage)		
308	Assisted vaginal delivery		
	Comprehensive emergency obstetric care		
309	Caesarean section		
310	Blood transfusion for obstetric indications		
	FP		
311	Male condoms		
312	Female condoms		
313	Oral pills		
314	Injectable		
315	IUCD insertion		
316	Emergency contraception		
317	Tubal ligation		
318	Vasectomy		
319	Others (specify) _____		
	STI and HIV		
320	Syndrome diagnosis and treatment of STI		
321	Drug supply to treat common STIs (antibiotics)		
323	HCT		
324	ART		
325	PMTCT		
326	CD4 testing		
327	Viral load		
	Management of sexual violence		
328	Emergency contraceptive		
329	STI presumptive treatment		
330	Post-exposure prophylaxis		
331	Hepatitis B vaccine		

Q#	Services	Yes	No
332	Tetanus vaccine		
333	Psychological support/counselling		
334	Referral (legal, support organizations)		
	Adolescent- and youth-friendly service provision centre		
335	Is there a separate corner/unit for adolescents and youth?		
	Which of the following services are available in the centre?		
336	Family planning		
337	HIV testing and counselling		
338	STI diagnosis and treatment		
339	Condom distribution		
340	Recreational activities		
341	List other services provided in the centre		
	1. _____		
	2. _____		
	3. _____		

Comments _____

Part IV: IEC/behavioural change communication (BCC) materials

Q#	Types of IEC/BCC materials	Yes	No
501	FP-related wall charts		
502	FP-related desktop counselling cards		
503	Quick provider reference for FP (job aid)		
504	FP-related brochures/leaflets		
505	FP-related posters		
506	Penile model		
507	Contraceptive displays		
508	ANC-related wall charts		
509	ANC-related desktop counselling materials		
510	ANC-related job aids		
511	ANC-related leaflets		
512	ANC-related posters		
513	STI-related wall charts		
514	STI-related desktop counselling materials		
515	STI-related job aids		
516	STI-related leaflets		
517	HIV/AIDS-related posters		
518	HIV/AIDS-related job aids		
519	HIV/AIDS-related leaflets		
520	HIV/AIDS-related posters		
521	HTP-related IEC/BCC materials		
522	GBV-related IEC/BCC materials		

Comments _____

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