Understanding Barriers to Critical Health Services in the Borena and Jimma Areas of Ethiopia: A Gender, Youth, and Social Inclusion Analysis Conducted by EngenderHealth's REACH Project

Background

EngenderHealth's Reach, Expand, and Access Community Health (REACH) project builds upon the successes and lessons learned from the preceding A'Ago project, both funded by the Kingdom of the Netherlands. The REACH project aims to improve individual health-seeking behaviors and increase community demand and support for comprehensive sexual and reproductive health and rights (SRHR); menstrual hygiene management (MHM); water, sanitation, and hygiene (WASH); and nutrition services in the Borena and Jimma zones of the Oromia region in Ethiopia. Working in partnership with Amref Health Africa and DKT Ethiopia, our goal for this project is to ensure women's and young people's SRHR, MHM, WASH, and nutrition needs are fulfilled through integrated programming.

To ensure the health of the community through SRH, MHM, WASH, and nutrition, REACH has four objectives: (1) improve women and young people's agency by engaging them in comprehensive life skills training and interventions; (2) improve intervention schools' and communities' support for women and young people to demand services; (3) ensure the availability of high-quality services, products, and infrastructures in intervention schools and communities; and (4) support learning, scale up best practices, and enhance the enabling environment to ensure public and community accountability. This report presents the results of a gender, youth, and social inclusion (GYSI) assessment conducted by the REACH project with the objective of better understanding the intersectional factors that affect access to and uptake of SRHR, MHM, WASH, and nutrition services.

Study Purpose and Objectives

Recognizing that gender, youth, and other social characteristics critically affect access to health information and services, the REACH project commissioned a study to understand how these determinants impact health service utilization in the Borena and Jimma zones. Specific objectives of this study are listed below.

- To understand what resources and assets individuals in these two intervention zones have access to and control over and how that affects uptake of SRHR, MHM, WASH, and nutrition services
- To understand common knowledge, beliefs, and perceptions and related social and gender norms that affect health-seeking behaviors as well as interactions and relationships between men and women in the two intervention zones
- To understand gender roles and decision-making processes in the two intervention zones, including which groups are included or excluded, and why
- To identify institutional barriers to participation in REACH activities and utilization of project services and to understand how different genders are likely to benefit from the project

Methodology

EngenderHealth conducted a formative assessment in February 2023 to explore the local context and identify barriers to project-supported health services.

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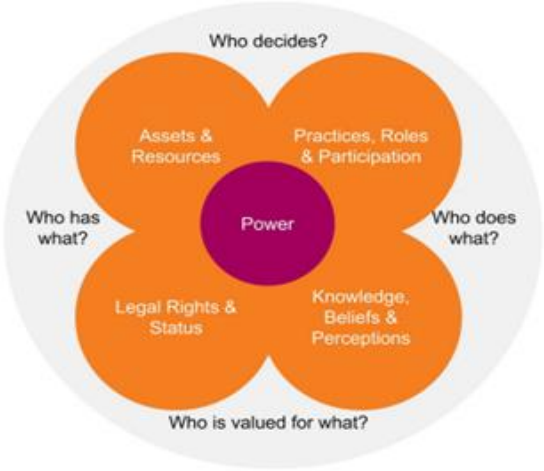
Sample

Researchers identified study participants from *kebeles* (lower administrative units) in the project implementation zones. Researchers then facilitated focus group discussions (N=21) with young women ages 15 to 19, women ages 20 to 24, young men ages 15 to 19, and men ages 20 to 24. The team worked deliberately to engage people with disabilities—including those who have long-term physical, mental, intellectual, or sensory impairments that may hinder their full and effective participation in society on an equal basis with their able-bodied counterparts. The study team also conducted 53 in-depth and key informant interviews with community gatekeepers, religious leaders, kebele administrators, school directors, and government representatives from health and education bureaus, zonal health and education offices, and the women and social affairs bureau.

Framework

Researchers employed EngenderHealth's GYSI Analysis Framework and Toolkit to assess sociocultural factors and other barriers and facilitators that affect girls' and women's abilities to access and adopt services. We assessed the four dimensions of power defined in the GYSI framework (see Figure 1) at individual, community, institutional and system, and policy levels that may help or hinder access to and uptake of SRH, MHM, WASH, and nutrition services. This includes specifically:

Figure 1: GYSI Framework



- Resources and assets available to women and girls, particularly those related to access to health services, access to income generating activities, and access to and control over financial resources and services
- Practices, roles, and participation of women and girls related to gender equality and rights, including decision-making powers
- Knowledge, beliefs, and perceptions related to gender and social norms as well as health information and access
- Legal rights of women and girls in relation to SRHR

Data Analysis

Professional transcribers familiar with the local context and dialect transcribed audio recordings from the focus group discussions and key informant interviews and then translated them into English. The study team coded the transcripts using a content analysis method based on the four dimensions of power. For ease of reference, the study refers to all participants aged 15 to 24 as "young women and men" but identifies differences observed by geography or sex with specific mentions. The team analyzed data under each dimension and across each level to identify gaps and disparities at individual, community, institutional and system, and policy levels. We obtained ethical clearance from the Ethiopian Society of Sociologists, Social Workers, and Anthropologists, as documented in letter number IRB/ESSSWA/030/2022. The team also secured support letters from EngenderHealth's Ethiopia Country Office and the Oromia Regional Health Bureau. The study team informed all respondents of the purpose of the study, ensured confidentiality, and obtained consent before convening any discussion or interviews.

Findings

The section presents sociodemographic profiles of participants and findings organized by the four domains of the GYSI framework.

Availability of SRHR, MHM, WASH, and Nutrition Resources

To understand the context for this assessment and the availability of SRHR, MHM, WASH, and nutrition resources, we first explored access to and the intersectionality between these resources and services.

> "Because of the nomadic nature of the community, it is difficult provide health services. For example, a pregnant woman may start antenatal care this month and when the household moves to another location, they are lost follow-ups. We try to link them with other facilities in the zone but sometimes they move very far, even crossing the border with Kenya."
>
> *Key informant from a health facility, Borena*

Broadly, we found that women and girls in rural areas do not typically access health services. In Borena, this is due to the lengthy distances to health facilities, the nomadic lifestyles of women and girls in this area, and the negative perceptions within the communities—all of which are exacerbated by frequent and extended droughts that prevent women and girls from accessing water supply for sanitation purposes. In Jimma, we observed that women had limited access to SRHR information and services in general and that young women had even less access to SRHR information and less awareness about the negative consequences of harmful practices, such as early marriage. For instance, key informants reported that while antenatal care uptake has been improving, the dropout rate before delivery remains high. Additionally, participants from Jimma cited increasing unemployment among young men who were exposed to alcohol, khat, and illegal drugs, which they believed increased the risk of SRHR problems for young people in the community.

There is critical shortage of clean water across Borena, which affects overall personal hygiene and sanitation practices, including MHM. Respondents described the situation as critical, especially in rural communities, and young women reported typically using old cloths and leaves as menstrual pads. Girls attending school in both zones reported having better access to sanitary pads through school programs and gender clubs; however, these programs are vulnerable to shortages. Further, the study found that school- and community-based toilet facilities are essentially nonexistent in most rural communities and schools, and while the availability of toilets and handwashing facilities in schools is better now than in prior years, these facilities are often not used due to lack of water and poor personal hygiene practices.

> "Currently there is a serious drought problem. Water is the main problem for the community, to address the issue of nutrition, WASH, and other services addressing this problem is the first and most important. Water is basic requirement for agricultural and livestock farms. The government should respond to the problem."
>
> *Young male focus group participant, Borena*

Finally, while we discovered an overall food shortage in Borena due to the ongoing draught, we also learned of a school program in certain *woredas* (districts) that aims to improve the nutritional status of children. Respondents cited this program as critical to keeping students in school as well as supporting their nutrition.

Access to and Control over Resources: Who Has What and Who Decides

Respondents from focus group discussions and key informant interviews in both zones identified fertile land, water points, housing, livestock, and employment opportunities as major tangible resources. Access

to education and health facilities and services is limited in both zones, but particularly in Borena. In Jimma, people grow coffee and khat in addition to grains.

Young women and men participating in focus groups agreed that men have the primary decision-making power. Adult males (particularly husbands) make the final decisions on key household matters such as managing family properties, selling livestock, supporting children's education, determining girls' marriages, and allowing access to health services. Further, young men have greater opportunities than young women in accessing income generating activities; they can also inherit land and participate in livestock rearing and other farming activities in both zones. In Borena, young men can also inherit camels and cattle.

> "As far as I know, in our society, young unmarried women do not have the right to own, decide, and sell any property if they live with their families, except for going to the market and buying and selling any family property. We young women can't be allowed by our husband to do any work like men."
>
> *Young female focus group participant, Borena*

Women have some decision-making authorities, but these powers are primarily limited to the purchase of food and resolution other small matters. Study participants also mentioned that there is a difference between urban and rural areas— women from urban areas may have more control over some decisions. Further, in some cases, women who head households may have exclusive rights related to property decisions. However, young unmarried women have limited decision-making power and minimal access to and control over resources; they are dependent on their families in every aspect of their life.

> "If I asked my parent to buy something, for example a mobile phone, they will buy for me, but if my sister asks, they will not buy for her thinking that she does not know anything."
>
> *Young male focus group participant, Jimma*

Division of Labor: Who Does What

Focus group participants from both zones consistently identified the role of women and girls as confined to household and community activities. Women and girls are involved in cleaning the house and barn, fetching water, preparing food, collecting firewood, feeding and herding livestock, milking livestock and processing milk, tending to sick animals, going to the market, and—in some cases (particularly if there are no male children) keeping chickens and goats. Young women are unable to participate in community activities, particularly in Borena; however, young women with some level of education, may participate in health development army structures in leadership roles.

> "Girls' roles and responsibilities affect menstrual hygiene management. Most of the time, girls are expected to perform household activities all the time, even during the menstruation period girls are asked to fetch water and collect firewood, and she may bleed on the way to this work."
>
> *Key informant, Borena*

Study participants from Jimma explained that women, both married and unmarried, struggle to visit health facilities for various reasons, including due to lacking time because of household responsibilities. For girls, household demands also affect school attendance and performance.

> "Women and girls are responsible for all household activities mainly preparing food, collecting firewood, and fetching water every day. They are hard workers. Boys and men engage farming activities, which require physical labor and girls rarely participate in such activities. Compared to us, men have better time to rest and enjoy with their friends."
>
> *Young female focus group participant, Borena*

Men and boys in Jimma engage in various farming activities, including rearing livestock, and other income generating activities, while in Borena they focus mainly raising cattle and camels. Study participants from both zones also mentioned that married men play primary roles in community activities.

Norms, Knowledge, Beliefs, and Perceptions: Who Is Valued for What

Young men and women from both zones define the "ideal girl" as the one who has good character; completes household chores well; participates in community activities; is virgin before marriage; obeys, respects, and listens to her father or husband; does not talk back to and lives in peace with her father or husband; and respects those around her. In contrast, young men and women from Borena define the "ideal man," as one who is smart, knows about current issues, has many cattle, is sociable, supports his family in times of crisis, is respectful to elders, and adheres to the community culture. Participants also explained that boys are "real boys" when they love adventure, are determined to make long trips across the desert, and follow their fathers' footsteps. In Jimma, an "ideal man" is one who makes decisions, is a good father, is committed to supporting his children, is disciplined, and is dedicated to his work. He should advise a "wrong doer" to correct their ways, adhere to local culture, respect elders, and support poor persons and people with disabilities.

> "Ideal behavior for women in our community is all about fulfilling their husband's will and act according to his command, not arguing with him and accepting his idea. Unmarried girls are expected to be silent, not appear in public places, even if she appears her heads should be looking down. They show respect and support to their families. If they [go] against these behaviors, they will be considered as rude, will not find a husband, and everyone sees and talks bad about them."
>
> *Young male focus group participant, Borena*

The study respondents also perceived that there are negative perceptions toward people with disabilities and that people with disabilities are viewed by some as not needing sexual and reproductive health services and support. One key informant from Borena noted that such perceptions are improving and mentioned that there are some schools in construction for persons with disabilities and some schools employ special needs teachers to support students with disabilities.

> "Persons with disability are not able to contribute to the community in terms of labor they are lifetime dependent on their families".
>
> *Young male focus group participant, Jimma*

Young women reported that they are expected to support household chores, and as a result, do not have enough time to study (which impacts their school attendance) or to visit health facilities. In contrast, boys have more opportunities to study and are supported in their educational pursuits. In Borena, participants cited beliefs that girls will leave their homes to marry and their education is not worthwhile for family investments.

> "Girls are considered as they belong to another family after they get married. So, they care for boys because they believe that they stay with family and support them in the future, so they prefer sending them to school support them to start small business such as cattle breeding."
>
> *Key informant, Borena*

Young men and women in Borena explained that it is inappropriate for young women, regardless of marital status, to visit to health facilities for SRHR services because they are expected to bear as many children as possible. These respondents cited religious reasons as a primary cause of low contraceptive uptake among women, including beliefs that interfering with conception goes against the will of Allah. Community practices exacerbate this issue further; for instance, in some kebeles, men come together to ban the use of contraception by women and girls.

> "In our community, young women are expected to give birth as soon as they are married. If they use contraception, they are considered as infertile, so they prefer to drop from school stay at home engage in household chores."
>
> *Key informant, Borena*

Polygamy is practiced in both zones and having many children is valued above limiting or spacing births. In Borena, community leaders teach about the importance of having many children to increase clan size. They also say that after childbirth, a husband is not allowed to have sexual relations with his wife for at least two years, promoting postpartum abstinence, and challenge the importance of other family planning methods. However, health workers report that as polygamy is common, a man may acquire another wife after one wife gives birth and continue to engage in sexual activity during those two years with the other wife. Additionally, while it is not necessarily socially acceptable, women may also have extramarital affairs and become pregnant during this period, which can result unintended pregnancies and unsafe abortions.

In Borena, menstruation is a taboo topic and girls are ashamed to talk about menstruation with friends and family. Young women also described experiencing significant challenges with MHM. In Jimma, study participants noted some improvements in awareness and views about menstruation, including describing how menstruation has become less of a secret and parents may be more open to discussing MHM. However, many girls remain hesitant to disclosing issues related to menstruation and are too shy to seek support for pain management.

> "I remember one of my elder sisters got her period for the first time and talked to our mother. Our mother was shocked and said, 'I don't understand this thing, it should be an adult women issue, how come this evil come to you?' and we considered getting period is at young age is wrong. When my age reached and got my cycle, I got ashamed to disclose the issue to my parent, because it is considered as my mistake."
>
> *Young female focus group participant, Borena*

Young men and women participating in focus group discussions in both zones explained that women and girls are ashamed to use toilets in schools and other public areas (where available) because they feel that doing so is inappropriate. Young women further explained that public toilets are not always separated by sex, which contributes to the hesitancy on the part of women and girls to use these facilities. In Jimma, while more than half of schools have separate toilets for boys and girls, none offer MHM cubicles. Yet, respondents noted that some gender clubs are raising awareness around the importance of disposing of used menstrual pads.

Respondents from both zones mentioned that while women prepare food, they eat last and they eat the least. Men and boys receive the "good food" first, and women and girls are left to eat what is not finished afterward. Key informants from both zones indicated access to nutrition services are expanding in the community; yet, as a result of negative gender norms, women and girls are prevented from accessing these services.

> "Toilet facilities, even if available, girls and women are ashamed of using such facilities due to the norms that prevail in the community."
>
> *Key informant, Jimma*

There are select instances of positive deviance, where women and girls depart from the expected norms and engage in healthy activities and practices. However, because of persistent social and cultural norms, community members often regard those who behave in these ways as outliers. More women and girls deviating from these norms are important for serving as role models and catalyzing continued change within their communities and for future generations.

> "One Borena women who is currently engaged in her own business in our city. She drives her own motorbike, while driving motorbike for women is seen as taboo in local culture. Such example in the local women is important to improve the existing perception".
>
> *Key informant, Jimma*

Laws, Policies, Regulations, and Institutions: Who Decides

The family law enacted in 2005 states that the legal age of marriage is 18 years for both boys and girls and includes provisions for divorce and inheritance that treat men and women equally. However, in rural settings, customary laws often prevail, dictating when and how marriage happens, how divorce is concluded, and how inheritance is determined. In Borena, the *Gada* system (a traditional system of governance used by the Oromo people) is practiced more commonly than formal law. In Jimma, formal laws are applied for divorce in some areas, while the Sharia law remains prevalent in many other areas.

All focus group discussion participants indicated that decision-making within formal and informal institutions is controlled by men, but improvements are occurring. Participants cited the increasing participation and inclusion of women in select processes, such as peace building. There are also new committees at the zonal level called "protection teams," which support women's well-being by engaging health, education, law enforcement, and social stakeholders. For example, these protection teams address problems occurring at schools and in health facilities and determine solutions together.

Summary Conclusions and Recommendations

While existing laws and policies support gender equality and awareness among institutional actors, there is a huge gap in implementation and ensuring accountability. Negative perceptions and attitudes are deeply embedded in societal structures preventing girls and women from fulfilling their economic, health, and social rights. Our study highlighted challenges associated with gender norms, cultural traditions, religious beliefs, and community misconceptions that promote male dominance and restrict women's and girl's abilities to make decisions and access SRHR, MHM, WASH, and nutrition resources and services. Specifically, men have more decision-making power than women, enabling them to make reproductive choices and engage in educational opportunities and income generating activities—which are key to long-term health and well-being. These privileges are rooted in the prevailing social norms operating at household, community, system, and policy levels.

Gender norms directly affect SRHR, MHM, WASH, and nutrition outcomes, and there is therefore a critical need for programing addressing these norms. Opportunities exist to promote access to SRHR, MHM, WASH, and nutrition services. These include improving women's and girls' agency and decision-making powers, supporting access to resources and services (for instance, through the country's health extension program), engaging influential religious and community leaders to transform beliefs and perceptions related to gender norms, and facilitating awareness of and adherence to established women's and girls' rights. Such interventions should work at all levels of the socioecological model to promote behavior change and must incorporate a careful balance of male engagement to ensure community support and mitigate potential backlash. Further, understanding the depth of culturally entrenched and structural

gender-related barriers, future programming must be designed and implemented in partnership with local leaders and decision-makers, including particularly male heads of households.

To improve the lives of people with disabilities, interventions addressing negative perceptions must be integrated with interventions focused on improving access to and responsiveness of SRHR, MHM, WASH, and nutrition services specifically for this population. There is also an urgent need to ensure availability of sanitary pads, particularly for out-of-school girls, and to increase the availability of public toilet facilities dedicated to girls and women in school and communities.

Acknowledgements and Suggested Citation

EngenderHealth is grateful to Ethiopia's Federal Ministry of Health—particularly the Maternal and Child Health Directorate, Oromia Health Bureau, and Oromia Education Bureau—for their collaboration and support of the REACH project. We are also appreciative of DAB consulting firm for conducting the formative assessment and preparing the preliminary report. EngenderHealth also acknowledges the generous support of the Embassy of the Kingdom of the Netherlands for funding this important work.

This brief was written by Wonimu Tolera, Gizachew Balew Jembere, Kathryn A. O'Connell, Amy Agarwal, Enkubahri Siyoum Siyoum, Amina Kampise Arero, Teferi Kebede Nurgi, Renu Golwalkar, and Jemal Kassaw Mohammed.

Suggested citation: Tolera, W., Jembere, G.B., O'Connell, K.A., Agarwal, A., Siyoum, E.S., Arero, A.K., Nurgi, TK., Golwalkar, R., and Mohammed, J.K. 2024. *Understanding Barriers to Critical Health Services in the Borena and Jimma Areas of Ethiopia: A Gender, Youth, and Social Inclusion Analysis Conducted by EngenderHealth's REACH Project*. Addis Ababa and Washington, DC: EngenderHealth.

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