

Communication for Health Project
Johns Hopkins Center for Communication Programs
**Exploring Sociocultural Determinants of Health
Service Use and Health Behavior in Ethiopia**



Sociocultural Study Report
September 2018

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ACKNOWLEDGMENTS

This qualitative study was a collaborative effort of many individuals. The following individuals were involved at the various stages of the study.

Douglas Storey, PhD, Principal Investigator, Johns Hopkins University Center for Communication Programs (CCP), guiding the study at all levels. Nandita Kapadia-Kundu, PhD, Co-Investigator, CCP, led the study design, data collection, data analysis, and report-writing phase of the study. Kim Dam, MPH, Co-Investigator, CCP, made significant contributions in designing the study, supervising the data collection, analyzing data, and writing sections of the report. Habtamu Tamene, MA MPH, Co-Investigator, CCP Ethiopia, contributed to the design of the study, supervised data collection, conducted data analysis and writing sections of the report. Minyahil Ayele, MSc, Co-Investigator, CCP Ethiopia, supervised data collection and contributed to data analysis and report writing. Feleke Dana, MPH MSc, CCP Ethiopia, supervised data collection; and Andargachew Eniyew, MPH, lead researcher from Le Monde consulting firm coordinated field supervision, contributed in the analysis, and report writing activities.

We acknowledge the following individuals for reviewing the study proposal and/or report and providing valuable comments: Simon Heliso, MA, Chief of Party and Country Representative of CCP/Ethiopia; Tsega Berhanu, MA, Senior SBCC Specialist at CCP/Ethiopia; Betemariam Alemu, MA, Director of Capacity Building and Coordination at CCP/Ethiopia; Fitsum Girma, MD MPH, Senior Public Health Advisor for John Snow Inc.; Esete Getachew, MA, Gender Specialist at CCP/Ethiopia; Tegbar Achamyaleh, MA, SBCC Specialist at CCP/Ethiopia; Biruk Melaku, MA, Associate Director at CCP/Ethiopia; Guda Alemayehu, MA, SBCC Specialist at United States Agency for International Development (USAID)/Ethiopia; Sanjanthi Velu, PhD, Team Leader, CCP; and Lindsey Leslie, MSPH, Program Officer II, CCP.

We extend our gratitude to the following organizations for their valuable contributions to the study: USAID for financial support of the study; Le Monde Health and Development Consultancy PLC for the professional assistance in undertaking the study; Regional Health Bureaus of Amhara, Oromia, Tigray, and Southern Nations and Nationalities Peoples' (SNNP) regions and Woreda Health Offices for facilitating the overall fieldwork; the Ethiopian Public Health Institute, for their technical review of the study protocol and for providing valuable comments and supervision of data collection.

We are grateful to all study participants for sharing us their perceptions, perspectives, and experiences and for devoting their time to helping us learn from them. We would like to thank all individuals involved in data collection (team leaders and data collectors), transcription, and coding of data.

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ACRONYMS

ANC Antenatal Care

CCP Johns Hopkins Center for Communication Programs

FGD Focus Group Discussion

HDA Health Development Army

HEW Health Extension Workers

IDIs In-Depth Interviews

IUCD Intrauterine Contraceptive Device

JSI John Snow Inc.

KII Key Informant Interview

PMTCT Prevention of Mother-to-Child Transmission

PNC Postnatal Care

RA Rapid Assessment

RMNCH Reproductive, Maternal, Newborn, and Child Health

SBCC Social and Behavior Change Communication

SEM Socio-Ecological Model

SNNP Southern Nations Nationalities and Peoples'

TB Tuberculosis

USAID United States Agency for International Development

WASH Water, Sanitation, and Hygiene

EXECUTIVE SUMMARY

The Ethiopia Communication for Health Project is a five-year United States Agency for International Development (USAID)-funded project implemented by the Johns Hopkins Center for Communication Programs (CCP), in collaboration with John Snow Inc. (JSI) and the Federal Ministry of Health of Ethiopia. The project focuses on six health areas: reproductive, maternal, newborn, and child health (RMNCH) and family planning; malaria; nutrition and immunization; tuberculosis (TB); prevention of mother-to-child transmission (PMTCT) of HIV; and water, sanitation, and hygiene (WASH) in four regions: Amhara, Oromia, Tigray, and Southern Nations, Nationalities, and Peoples' (SNNP) regions.

The overall goal of this study was to identify sociocultural determinants that influence health service use and behavior in the six health areas in order to inform project health interventions. Increasingly, SBCC policymakers and practitioners need to look beyond the individual as the unit of analysis, as household, community, society, and health systems play a major role in improving health outcomes. Because it enables analysis at multiple levels, the socio-ecological model (SEM) is an appropriate model for understanding the processes of complex interventions.

The study was conducted in August 2017 in a total of eight woredas (districts) in Amhara, Tigray, Oromia and SNNP regions of Ethiopia. Qualitative data were collected using in-depth interviews (IDIs) with mothers of a child under two years of age [n=16], focus group discussions (FGDs) with female and male community members [n=16], key informant interviews (KIs) with Health Extension Workers (HEWs), Health Development Army (HDAs) and religious leaders [n=24], and rapid assessments including a short interview with kebele administrators [n=8].

Key Findings

Community perceptions of health and health services

Malnutrition, delivery-related complications, diarrhea, malaria, and cough/TB were reported as common health problems in the community in four study regions. Shortage of food items at the household, workload on mothers, unemployment, and poor hygiene and sanitation practices were mentioned as causes for malnutrition. Similarly, prevalence of home delivery in remote areas, low health seeking behavior of rural women, and poor quality of health services in health facilities were indicated as contributing factors for delivery complications. Low health-seeking behavior of pregnant women was attributed to the norm that a pregnant woman only needs to go to the health facility if she feels physically unwell.

Maternal Health Behaviors

Early Antenatal Care

Only three of the 16 interviewed women visited a health facility for their first ANC checkup during the first three months of the gestational period of their most recent pregnancy. Women's descriptions of ANC services were often general and focused on procedures such as getting a urine test to check pregnancy, checking the health condition of the fetus, and receiving medicines

and vaccinations. Although few women reported that the health workers advised them about women's nutrition during pregnancy, the majority of them said they did not receive counseling during their ANC visits.

The prevalent social norm for the first ANC checkup across all four regions is at 16 weeks (four months). This norm needs to shift to the recommended "early ANC (<12 weeks) visit".

Delivery at a health facility

The social norm related to place of delivery has shown a shift over time from home delivery to health facility delivery. Women who delivered at home said their short labor time and lack of household support to manage their other children were the main reasons for not delivering at health facilities. HDAs and HEWs believed women's resistance to change was a major barrier to not delivering at a health facility, but suggested the reason for that was some women have no one to manage their household and children when they go for delivery. Focus group participants emphasized that the long distance to health facilities and poor quality of health services were the main barriers to health facility delivery.

POSTNATAL CARE

Women do not commonly visit health facility within seven days of delivery because of the social norm that a woman should not leave her home within a month after delivery. Women do not usually visit health facilities after delivery unless the mother or newborn are having health problems. No regional variation was found regarding PNC social norms and practices. Only five of the 16 IDI participants (women with a child under two) reported that they have received PNC from either HEWs or health facility within seven days of delivery.

Recommendations for maternal health

- SBCC activities should emphasize informing women about early signs of pregnancy and going for first ANC visit within the first 12 weeks of pregnancy.
- SBCC on the first ANC visit needs to be prioritized, as it is a gateway way behavior.
- Male involvement in household chores and gender-equity norms about men's work in the household need to be promoted.
- The SBCC program should emphasize the overall concept of birth preparedness, where both money and transportation are planned in advance in case of an emergency and/or labor.
- SBCC on PNC should be provided during a pregnant woman's ANC visits.

Contraceptive Use

Perceptions about side effects were reported as the main reason for a woman's choice of contraceptive method. Responses about decision making varied among the female IDI participants and HEWs. Most female IDI participants claimed that they decided together with their husbands to use contraceptives, although they said some couples in their communities do not discuss family planning use and some men do not allow their wives to use contraceptives. In contrast, HEWs reported that husbands were mostly the ones who decided if their wives would use family planning. Hence, the claim by women about deciding with their husbands to use contraception may not reflect general decision-making practice within the community. The data on gender inequity indicates a strong male bias when it comes to decision making. Several women reported using contraceptives secretly.

The required normative shift related to family planning is that couples should start using contraceptives earlier, in order to space their first four children. Currently, the prevalent norm is that of couples using contraceptives after the birth of four or five children. The SBCC program needs to shift this norm to initiate the use of contraceptives earlier in a woman's childbearing experience.

Recommendations

- Depict postpartum family planning as an important component of the family planning program.
- In radio and digital media, show women using contraceptives after the birth of their first child.
- Show nulliparous women using contraceptives in radio and digital media.
- The social norm of using contraceptives after the birth of four to five children needs to be shifted.

Child Nutrition

Almost all participants reported that an infant should start taking additional food at six months of age. However, challenges surfaced related to key complementary feeding practices, such as dietary diversity, frequency, and quantity of food. Although caregivers across regions appeared to understand that complementary foods need to be diverse, very real constraints, such as availability and affordability of foods like meats and vegetables, were evident.

We have discussed the issue of food insecurity during the food scarcity season in this report. Study participants stated that adults often deprive themselves to ensure that children get enough (or something) to eat.

The study participants identified local food models based on the pile sort exercise. These local food models should be studied in detail to develop a locally relevant and culturally acceptable nutrition promotion strategy.

Recommendations

- The program needs to provide context specific options for promoting food diversity.
- The nutrition education strategy should be built on local foods and their seasonal availability instead of promoting the “six food groups,” a categorization not understood by study participants. The final local food model presented in the report should be the foundation of the nutrition promotion strategy.

WOMEN’S NUTRITION

Responses to women’s nutrition during pregnancy showed that the practice of special nutrition-related care for mothers during pregnancy is low. Rather, feeding during pregnancy is shown to be negatively affected by cultural beliefs. Fears of a ‘big fetus/baby’ and the practice of fasting during pregnancy are culture-related factors that must be addressed.

Gender inequity was evident in the type of nutrition offered to pregnant versus lactating mothers, indicating that a newly delivered mother is prioritized over a pregnant women.

Recommendations

- Health service contact points, such as ANC in health facilities and birth preparedness in maternal waiting homes, can be used to promote special and reasonable nutritional support to pregnant and lactating mothers.
- The SBCC program should prioritize pregnant women for additional nutritional intake. Pregnant women require more attention and care by their families.

COORDINATION WITH WOREDA AUTHORITIES TO FACILITATE BEHAVIOR CHANGE

The study participants reported that “directions” can reach every member of a one-to-five network through a well-set communication chain. If Communication for Health can provide a list of behaviors, such as early ANC care (<12 weeks), four ANC check-ups, and starting contraceptive use after the birth of the first or second child to the woreda authorities with a Family Health Guide for each one-to-five network leader; perhaps behavior change can occur more widely. Similarly, the HDA provides a system through which planned SBCC inputs can create an environment for behavior change.

Recommendations

- Engage primary health care units in health promotion activities through a community outreach program.
- Providing training to HEWs and HDA leaders will enhance the effort of HEW and HDA activities.

FAMILY HEALTH GUIDE

Most households do not have a copy of the Family Health Guide. There seems to be a shortage of the guides and, therefore, they are primarily given to pregnant women. Many women reported that the guides do not last long due to improper use or storage.

Recommendations

- SBCC efforts should be made to improve the practice of handling and storing the Family Health Guide at home. Here, the lesson from HEWs in Tigray in preparing bags to hold the guide should be replicated in other areas.
- HEWs and HDAs need to encourage educated children to support their mothers to use the guide.
- There is a need to sensitize HEWs to regularly use the guide while providing health education and counseling during home visits.

WASH PRACTICES

Availability of a handwashing station near a latrine positively influences handwashing with soap of women, as they can easily access water and soap/ash. However, not all households have handwashing station; most women take water in a jug to the latrine for handwashing purposes. The main insight from the handwashing data was that almost all participants spoke about 'handwashing' and not 'handwashing with soap.' Establishing handwashing stations in households can be a precursor to regular handwashing with soap.

Recommendations

- Interventions should focus on increasing access to latrine facilities with handwashing station at the household level, as it improves handwashing practice after latrine use.
- The use of soap or ash should be emphasized in handwashing promotion efforts.

HANDWASHING STATION

Overall, availability of a handwashing station at the household level is limited. Handwashing stations also appear to have a limited lifespan. Many participants reported frequent damage and lack of regular maintenance as reasons for the short life of handwashing stations.

Recommendations

- The handwashing station must have soap and water.
- Interventions should focus not only on installing handwashing stations but also ensuring sustainable functionality through regular maintenance.

SOCIAL CAPITAL

The presence of new and traditional social structures in Ethiopia is widespread, and these structures work directly with and for community members. One-to-five networks and HDAs are present in all eight kebeles included in this sociocultural study. These social structures can be

leveraged for the specific purpose of promoting health behavior change and creating a conducive social environment that supports behavior change at the community level.

Recommendations

- The Communication for Health project should work with woreda and regional administration to collaborate with HDAs to prepare guidelines on how to use digital SBCC resources.
- Narrowcasting relevant portions of the radio episodes to the mobile phones of one-to-five leaders will ensure coverage of a large number of households.
- Digital health resources such as the Hulu Betiena app and relevant radio content can be provided to the iddirs to increase coverage.
- Iddirs can also be used to create new social norms.
- Iddirs are a good space to promote gender-equitable norms.

GENDER NORMS AND INEQUITY

This sociocultural study examined several dimensions of gender in detail. These included decision making, son preference, gender-based violence, male involvement, and gender-based roles. The study also explored local narratives and idioms that illustrated these gender-inequity norms. The data indicate that any gender strategy needs to emphasize a general respect for women as decision makers, as pregnant women, and as mothers. Women carry a disproportionately high burden of the child bearing, child rearing, and farming responsibilities.

Most participants in all interview types acknowledged that some form of gender-based violence exists. A few participants stated that gender-based violence is an issue that should be dealt with in the household. Several HEWs and HDAs felt that husbands' involvement in household chores and support during pregnancy was not as dominant.

Gender-inequity norms need to change by promoting compassion, male involvement, and positive role models. The social structure of HDAs and one-to-five networks can ensure that the 'nudge' for behavior change occurs at the got (village) level, as HDAs are in regular contact with its members at least once or twice a month. The follow up required at the community level for health behavior change can be provided through HDAs. Gender-equity norms will be an important crosscutting issue.

Recommendations

- Recognize women's significant contributions in and outside of the household.
- Show examples of husbands and wives making decisions (both harmonious and non-harmonious).
- Male support during and beyond pregnancy can be modeled in programming.
- Incorporate major themes of gender-based violence into programs. Issues related to food, resources, and money underlie most conflict in the household. These conflicts tie into other forms of gender-based violence, such as physical and sexual violence.'

COUPLE COMMUNICATION

Couple communication was common at most study sites except for the Adaba woreda of Oromia. Religious beliefs were cited as the reason for this. Although the data on couple communication indicated that couples do discuss issues among themselves, it is not enough. Findings from the decision making data show that the man is the ultimate decision maker in most instances, even if the woman initiates discussion. The consequences of a woman not agreeing with a man's decision can lead to conflict and even physical violence.

Participants also reported that couples rarely discuss maternal health issues, such as ANC and PNC. Most participants highlighted the role of fellow women—both in the community and in the family—in sharing a woman's concern and influencing her decisions regarding maternal health. Neighbors also play a decisive role in settling disagreements among couples and influencing husbands in promoting health decisions.

Recommendations

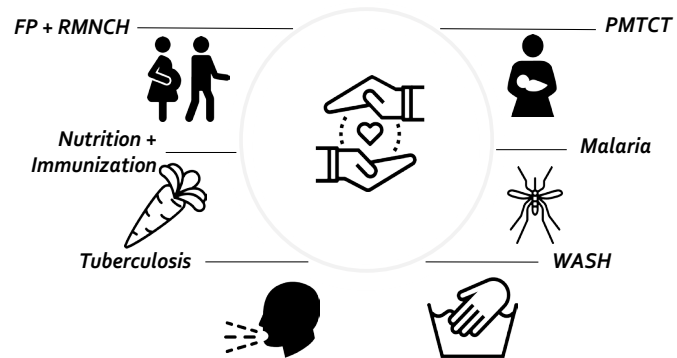
- The SBCC program should identify couples where a woman has a strong decision-making role and model the interaction of such couples.
- Couple communication in the Ethiopian context needs to be promoted as an equitable decision-making process.
- Couple communication promotion activities should be integrated with gender interventions

CHAPTER I. INTRODUCTION

Introduction to Communication for Health Project

The Ethiopia Communication for Health Project is a five-year United States Agency for International Development (USAID)-funded project implemented by the Johns Hopkins Center for Communication Programs (CCP), in collaboration with John Snow Inc. (JSI) and the Federal Ministry of Health of Ethiopia. The purpose of the project is to address structural-, systemic-, and community-level constraints to the science and practice of social and behavior change communication (SBCC) in Ethiopia to support the Government of Ethiopia's vision of a healthy Ethiopia through increasing knowledge and health practices of individuals and communities.

Figure 1: Six Health Areas of Communication for Health



The project focuses on six health areas: reproductive, maternal, newborn, and child health (RMNCH) and family planning; malaria; nutrition and immunization; tuberculosis (TB); prevention of mother-to-child transmission (PMTCT) of HIV; and water, sanitation, and hygiene (WASH) in four regions: Amhara, Oromia, Tigray, and Southern Nations, Nationalities, and Peoples' (SNNP) regions.

Overall Study Goal

The overall goal of this study was to identify sociocultural determinants that influence health service use and behavior in the six health areas in order to inform project health interventions.

Specific Study Objectives

The study objectives centered on understanding family dynamics, gender norms, and social capital in the context of health behavior change in rural Ethiopian communities. The study was conceptualized and based on using the socio-ecologic model (SEM), which considers different level factors that influence behavior. The five key study objectives were:

1. To assess community perceptions of health, access to and use of health services, and sources of health information
2. To identify barriers and facilitators to “gateway behaviors” identified in the baseline survey, including registration for early antenatal care (ANC) during the first 12 weeks of pregnancy, Family Health Guide use, and ownership of a handwashing station

3. To explore the social dimensions related to health, identification of social norms, community strengths and challenges, social capital, and community networks or groups, such as iddirs, local saving groups (equbs), and youth groups
4. To understand and identify the mechanisms through which gender discrimination operates at the community and household levels
5. To identify patterns of couple communication and family communication at the household level

Using the Socio-Ecological Model to Design the Sociocultural Study

The key objectives of the sociocultural study were considered while selecting a conceptual framework. The objectives span individual, household, societal domains and the socio-ecological model (SEM) was selected for the study. The SEM is applied to global health interventions due to its multi-dimensional perspective that includes the individual, community, and the health system.¹ The SEM also guides interventions for the Ethiopia Communication for Health project. Increasingly, SBCC policymakers and practitioners need to look beyond the individual as the unit of analysis, as household, community, society, and health systems play a major role in improving health outcomes. Because it enables analysis at multiple levels, SEM is an appropriate model for understanding the processes of complex interventions. The model guided the design of this sociocultural study. For this study, we explored layers within the community, from households to community networks to religious leaders, to understand the dynamics of health behavior. Our primary aim was to understand the microenvironment at the household level and the sociocultural environment at the community level. To that end, we did not include the larger the policy dimension.

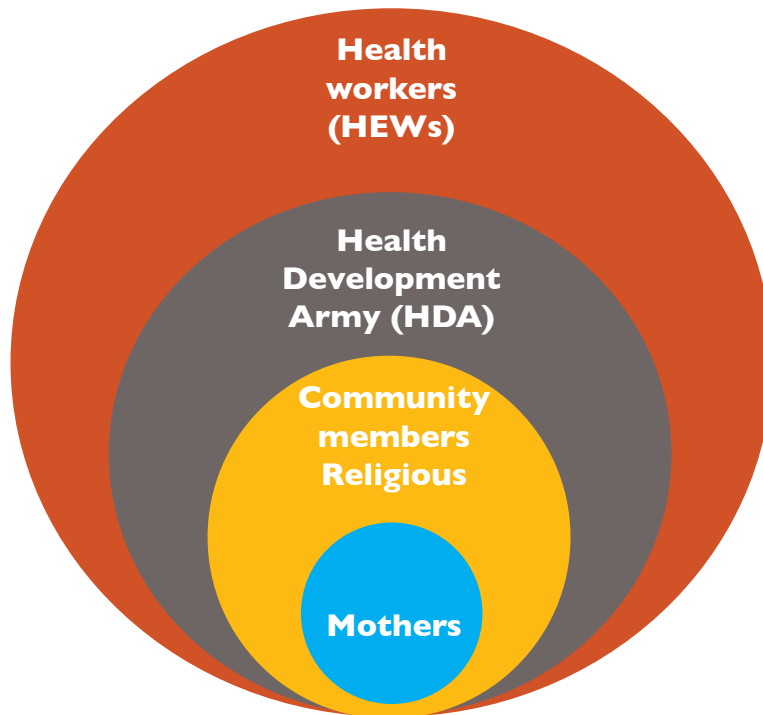
SEM enables examination of the different levels of influence on communities that combine to create a composite picture of SBCC program settings. Given the study objectives, getting perspectives from different stakeholders was crucial. Stakeholders ranging from individuals/household members to health system workers and community members and leaders were interviewed for the study.

Interviews and focus group discussions (FGDs) were conducted at the following levels (Figure 2):

- **Health system:** key informant interviews (KIs) with health extension workers (HEWs)
- **Community:** KIs with health volunteers, such as the health development army (HDA)
- **Community:** FGDs with community women and men
- **Community:** KIs with religious leaders
- **Individual/household:** in-depth interviews (IDIs) with mothers

¹ McLeroy, K. R., Bibeau, D., Steckler, A., & Glanz, K. (1988). An ecological perspective on health promotion programs. *Health Education Quarterly*, 15(4), 351-377.

Figure 2: Socio-Ecological Model (SEM)



A subset of questions related to social norms, couple communication, gender inequity norms, and barriers and facilitators of key health behaviors were asked to all study participants. The data related to these questions address all levels of the socio-ecological model. The SEM model can structure analysis by different stakeholders and assess if they are similar or different according to their perspectives, norms, and perceptions.

The aim of a sociocultural study is to provide guidance for the development of an effective health behavior change intervention. The SEM model enables us to plan a multilevel study that includes perspectives of stakeholders at household and community levels (Figure 2).

CHAPTER 2. METHODOLOGY

Geographic Areas of Study

Data collection for the study occurred in August 2017 in eight woredas (districts) in four regions of Ethiopia: Simada and Sayint in Amhara, Adwa Rural and Tahtay Koraro in Tigray, Adaba and Jeldu in Oromia, and Dale and Damot Sore in SNNP. Qualitative data were collected from eight kebeles, one kebele² within each woreda (Appendix A).

Sample Selection Procedures

The study combined several qualitative data collection methods, including 16 FGDs with female and male community members (n=153); IDIs with women aged 15 to 49 years with children under two years of age (n=16); and KIIs with HEWs, HDAs, and religious leaders (n=24). A rapid assessment (RA), including a short interview with kebele administrators (n=8), was also conducted. The RA gathered contextual information about social groups, marginalized households, food insecurity, maternal deaths, and access to health services, and included a transect walk through the village.

A purposive sampling technique was used to identify study participants. Upon arrival at the study kebele, the study team submitted a letter of introduction to kebele administrators and HEWs. They then established working relationships with HEWs and HDAs, and collected basic information about the kebele and the study communities. Working with the HEWs and HDAs, team leaders followed recruitment scripts³ to determine if potential participants met the inclusion criteria.

Women with a child under two (IDIs): In each kebele, the team randomly selected two women with a child under two, who had resided in the kebele for at least six months. The sampling was done using the HEWs' registers that listed all women in the community with a child under two. Team leaders carefully selected rural women who typically represent the community.

Community members (FGDs): Working with HEWs and HDAs, team leaders selected 8-10 female and 8-10 male community members per FGD. Only community members aged 18 years and above and currently residing in the kebele for at least six months were identified and invited to join a group discussion.

HEWs and HDAs (KIIs): Team leaders selected one HEW and one HDA per kebele. Experienced HEWs and HDAs aged 18 years or above who had been in their current position for at least one year were eligible to be chosen to participate.

2 Kebele is the smallest administrative unit.

3 Four types of recruitment scripts were used: one for women, one for community members, one for HEWs and HDAs, and one for religious and kebele leaders.

Religious leaders (KII): Team leaders, with support from HEWs and HDAs, identified one religious leader per kebele to interview. To be chosen, the religious leader had to be from the predominant religion of their kebele, be aged 18 or above, and currently residing in the kebele for at least six months.

Kebele administrator (short interview): The kebele administrator from each selected kebele was chosen for a short interview. To qualify, they had to be aged 18 years or above and currently residing in the kebele for at least six months.

Final Sample of Study Participants

A total of 201 individuals participated in the study: 8 in the RA, 16 in IDIs, 24 in KIIs, and 153 in FGDs. The table below shows the number of study participants by region and type.

Table 1: Final sample size, by region and type of participants

Type of Participant	Number of IDIs/KIIs/FGDs/RA					Total number of participants				
	Amhara	Oromia	SNNP	Tigray	Total	Amhara	Oromia	SNNP	Tigray	Total
In-Depth Interviews (IDIs)										
Woman with child under two	4	4	4	4	16	4	4	4	4	16
Key Informant Interviews (KIIs)										
HEWs	2	2	2	2	8	2	2	2	2	8
HDAs	2	2	2	2	8	2	2	2	2	8
Religious leaders	2	2	2	2	8	2	2	2	2	8
Rapid Assessment (RA)										
Kebele administrator	2	2	2	2	8	2	2	2	2	8
Focus Group Discussions (FGDs) with community members										
Male	2	2	2	2	8	20	18	16	21	75
Female	2	2	2	2	8	19	19	19	21	78
Total	16	16	16	16	64	39	37	35	42	153

Data collection instruments

The study used the following data collection instruments:

IDI guide: Designed for women with a child under two, this guide focuses on perceptions of health issues in the local community as well as perceived barriers/facilitators of health practices. The guide has sections on “activity clock” or listing daily life; media exposure and other sources of health information; family planning and reproductive, maternal, newborn, and child health; early ANC registration (less than 12 weeks), delivery, and postnatal care (PNC); couple communication; gender

inequity; and pile sort. Pile sort involves grouping 20 picture cards of food into local categories and labeling these categories using existing cultural constructs (Appendix B).

FGD guide: This guide includes sections on community resources, social norms, nutrition, gender norms and inequities, social relationships and couple and family communication, and pile sort. It focuses on collecting information from female and male community members about general health issues and health behaviors practiced in the community and sociocultural determinants (barriers and facilitators) to health service use.

KII guide for HEWs and HDAs: This guide focuses on describing major health issues in the kebele, trends in health-seeking behaviors, determinants that influence health service use and behavior, and the role of HEWs and HDAs in improving the community's health behaviors. The guide captures information about counseling and SBCC; family planning and RMNCH; immunization, nutrition, malaria, and WASH, and includes sections on gateway behaviors, such as having a family health guide and handwashing station; social norms, village/social groups, and community traditions; and the use of mobile phones.

KII guide for religious leaders: This guide focuses on the main health issues in the kebele and cultural and religious determinants of health service use and behavior. The guide has sections on the role of religious organizations and leaders on the health of women and children, nutrition and WASH, and family planning and RMNCH.

RA tool: This tool includes a short interview with a kebele administrator to identify and map social groups, access to health services, availability of food, and villages with the most vulnerable households. The tool also has a straight line (transect) walk component at the village level to observe the WASH environment, mapping exercise, and local market.

Training and Pretest

A five-day training was conducted for four team leaders and eight data collectors (four men and eight women) from July 25 to 29, 2017 in Addis Ababa. Researchers from CCP Baltimore and Le Monde provided the training. Team leaders and data collectors had BA/BSc or MA/MSc degrees and prior experience in qualitative data collection. They were fluent in both English and local languages of the study area, including Amharic in Amhara, Afan Oromo in Oromia, Tigrigna in Tigray, and Sidamegna and Wolaytegna in SNNP regions. The training covered topics such as study methodology, research ethics, informed consent, qualitative research methods, data collection tools, audio recording and note taking, and transcription. The training was provided through interactive presentations, role-playing sessions, and review of data collection tools.

The study instruments were pretested in Sundafa woreda of Oromia region. The team conducted interviews with five women with a child under two and undertook a transect walk during the pretest. The study team identified and documented issues in the selection of study participants and data collection tool elements, and held a discussion session after the field test. The pretest allowed the research team to clarify issues in the selection of study participants and restructure sequence of questions in the data collection tools.

Data Management and Analysis

Data collection was tracked daily using a “master tracking sheet.” Team leaders compiled demographic data of study participants daily in an Excel database. Kebele and village maps were prepared using data from rapid assessments. All interviews and FGDs were recorded using digital audio recorders. Recordings of the interviews and FGDs were then transferred to and stored on a password-protected hard drive. Team leaders labeled each recording with a unique identification code⁴ describing the region, kebele, and type of interview.

Individuals experienced in transcribing qualitative data transcribed and translated⁵ the recorded data into English. The transcribers had MA/MSc degrees and were fluent in local languages and English. Transcripts of interviews were given the same unique identification code as the recordings and stored on a password-protected hard drive.

The study team prepared a codebook with 13 thematic areas and 76 codes, which were used to code the English transcripts using NVivo version 7 software for Windows. For quality assurance purposes, one transcript from each type of interview was double-coded by CCP and Le Monde researchers then compared to identify codes or coding areas requiring revision. Le Monde researchers coded the data.

CCP researchers prepared a data analysis plan based on the six study objectives. The analysis employed thematic analysis technique, which describes and interprets participants’ views based on emerging themes. The technique involves identifying patterns related to knowledge, social norms, and practices as well as the sociocultural determinants influencing health behaviors. It also includes identifying the differences between sociocultural determinants by region in order to assess priorities for SBCC programming. A socioecological analysis was carried out to compare patterns of perceptions at four levels: household (women), community (men and women community members), community health volunteers (HDAs), and frontline government health workers (HEWs).

Ethical Considerations

The Johns Hopkins Bloomberg School of Public Health Institutional Review Board and the Ethiopian Public Health Institute Scientific and Ethical Review Committee provided ethical approval for the research. A one-day training for data collectors and team leaders was conducted by the lead researcher from CCP on research ethics and procedures, including informed consent, study participant privacy, and confidentiality. A field visit was made by an expert from the Ethiopian Public Health Institute Scientific and Ethical Review Committee to check the data collection teams’ adherence to ethical standards.

4 A master codebook of unique ID for all interviews was prepared and given to team leaders.

5 Interviews conducted in Amharic, Afan Oromo, and Tigrigna were directly transcribed and translated into English, while the interviews conducted in Sidamigna and Wolaytegrna were transcribed to Amharic and then translated to English.

The study followed standard ethical procedures. Oral consent was obtained from all study participants before interviews, using the approved consent scripts. The trained local study team members administered oral consent to potential participants. FGD participants consented individually at a private location before the FGDs began. Data collectors signed a copy of the consent forms declaring they read the consent to the study participant and study participants voluntarily agreed to participate in the study. Data collectors gave a copy of the signed consent form to each study participant and kept another copy for the study records. Data on personal identifiers was not collected or recorded.

CHAPTER 3. COMMUNITY PERCEPTIONS OF HEALTH PROBLEMS, BEHAVIORS, AND SERVICES

The study findings are presented in five chapters based on the study objectives. Broad findings for the four regions are described first in each chapter; followed by regional variations and differences across the socioecological levels. Chapter 3 analyzes the sociocultural determinants of health service use and health behaviors from the perspectives of study participants.

The study explored how different community members (mothers, villagers, religious leaders, HDAs, and HEWs) perceive health problems and how people access and use health services, including contraceptive services. Contraceptive use patterns—duration, side effects, and dropouts—and household practices related to nutrition and WASH were also explored.

Perceptions of Health Problems

Common Health Problems And Their Causes

Understanding the rural community's perceptions on common health problems and their knowledge about causes of health problems helps in designing effective SBCC interventions. When asked to identify health problems, malnutrition, delivery-related complications, diarrhea, malaria, and cough were common answers across the four study regions.

Malnutrition

Malnutrition was reported as a major health problem across the four study regions. Study participants described malnutrition from different perspectives based on signs of malnutrition, such as stunting and weakness, and/or causes of malnutrition, such as being unable to eat three times a day. A few study participants also linked malnutrition to shortage of animal products, such as meat and eggs, especially for young children and lactating women. Most study participants acknowledged that malnutrition is more severe in women and children in their community.

No regional variation was observed, except in the perceptions of the causes of malnutrition. Study participants from Amhara and SNNP regions associated the causes of malnutrition with the workload on women, while study participants in Oromia emphasized poverty as the main cause of malnutrition. Women in rural Ethiopia have diverse responsibilities, including household chores, caring for their family, and supporting agricultural activities. Some study participants said woman have to give more attention to farming and other activities and lack sufficient time to care for children, which results in child malnutrition. *“In our community, our focus is on our agricultural activities; no one gives attention to taking care of children. Therefore, children mainly get malnutrition.”* [30, Female, IDI, Simada, Amhara]

Poverty: On the other hand, poverty, which is manifested through shortage of food items in the household, was reported as the main cause for child malnutrition. Such problems were worse in female-headed households since their household income was lower than male-headed households. *“Since I divorced my husband, I don’t get enough money to buy all necessary materials for my child and feed appropriately. As a result, as you see, he is very thin.”* [30, Female, IDI, Simada, Amhara]

Food insecurity: Focus group participants from chronically food insecure woredas associated the cause of malnutrition with insufficient distribution of ration/food aid. They said the government distributed food aid to vulnerable households, however, the amount distributed was not sufficient to meet their family’s need. A high number of dependent family members within the household and high unemployment rate contributes to the imbalance. Additionally, the distribution also did not cover all vulnerable households. *“[T]here are many economically poor women and men. When the government brings support programs such as PSNP [Productive Safety Net Program] and the direct support program, it does not reach all households. There are also many young people, who have no farmland.”* [24, Female, FGD, Adwa Rural, Tigray]

Children and lactating mothers as primary victims: Some study participants identified children and lactating mothers and as the main victims of malnutrition. They compared the current nutrition situation for lactating mothers with that of previous experience and concluded that the problem of malnutrition continued to worsen. *“In the past, it is said that mothers had no problem of malnutrition because they can get whatever they need, such as butter and meat. Because of that, they do not face much problem while giving birth. Now, there are different health problems related to malnutrition.”* [46, Male, KII Religious Leader, Adaba, Oromia]

Similarly, study participants identified children as main victims of malnutrition. Children in rural communities do not get sufficient food, which, coupled with lack of clean drinking water causes stunting and wastage on children. *“Since the community is poor, children do not get sufficient food to eat. There is problem associated with water as well.”* [30, Female, IDI, Adaba, Oromia]

Delivery-related complications

Most study participants reported maternal and child mortality in their locality. They recognized delivery-related complications, such as excessive bleeding, as a major causes of newborn and maternal deaths in rural communities. Except in Tigray, study participants reported delivery complications as a major health problem in the community. Some study participants in Jeldu woreda of Oromia region linked women’s low health-seeking behavior with a low quality of health care services in the health facilities. Home delivery and low ANC attendance were indicated as common practices in the rural community that contributed for delivery complications.

Home delivery (excessive bleeding and elongated labor): Home delivery is common in rural communities, especially remote areas. It can cause serious health risks, including excessive bleeding and elongated labor that can result in the death of a mother and a baby. *“When they [rural woman] give birth at home; they bleed; some die because of complicated labor. This is the main problem in our area.”* [30, Female, IDI, Jeldu, Oromia]

In some cases, even though people may take pregnant women to a health facility for delivery, they take them very late—after labor has already progressed. Such practices can cause the death of the child and/or mother. *“During labor, our community members do not have the habit of taking women to health facilities early.”* [24, Female, IDI, Adaba, Oromia]

Poor quality of health services: Shortages of medicines at the health center and low-quality health care services at the health facilities were among the reasons study participants mentioned that adversely affect health-seeking behaviors of the rural community. *“The policy is good. It says that a mother shouldn’t lose her life while giving life. However, there is shortage of medicines in the health center. When women go for family planning, they say that there is no chosen method of family planning at the time and women may get pregnant as a result. When mothers go for delivery, there is no full care for the mother. The reason they present is shortage of medicines. We need solution for these problems.”* [30, Male, FGD, Jeldu, Oromia]

Low uptake of antenatal care checkups: Pregnant women do not regularly attend ANC services, and do not take the tetanus toxoid vaccine during pregnancy. Rural pregnant women do not feel ANC attendance is important unless they have a health problem. *“In our community, maternal death is a big problem. The reason is that pregnant women do not go to health center on time for checkup during their pregnancy.”* [42, Male, KII Religious Leader, Simada, Amhara]

Diarrhea

Study participants identified diarrhea in children among the common health problems in all the study regions. Most study participants stated that flies were transmitters of diarrhea. Lack of clean water and poor hygiene and sanitation were also considered contributing factors for the spread of diarrhea.

Lack of clean water: Focus group participants in Oromia region indicated families spend a significant part of their income on medication due to persistent diarrheal diseases associated with lack of clean drinking water in their community. *“Regarding the lack of clean drinking water, our people are suffering a lot and exposed for different diseases. People go to health facilities for medication daily because they get diarrhea due to drinking unclean water. They spend most of their money on medication.”* [42, Male, FGD, Adaba, Oromia]

Poor hygiene and sanitation: Open defecation was reported as a cause of diarrhea. *“The cause of disease [diarrhea] that means bacteria source is from open defecation or unable to use latrine properly. So, we advised them [community] to use latrine properly.”* [43, Male, KII Religious Leader, Dale, SNNP]

Misconceptions about the causes of diarrhea: A few study participants (including religious leaders) had misconceptions about the causes of diarrhea. For example, a 61-year-old religious leader said diarrhea might be transmitted through wind. *“I don’t know causes of diarrhea, but they were saying it was its time. It spreads easily at that time (epidemic). Like the cause is the wind.”* [61, Male, KII Religious Leader, Tahtay Koraro, Tigray]

Malaria

Study participants identified malaria as one of the common health problems. Children and pregnant women were identified as the main victims of malaria. *“Malaria is the most common disease in our community. It affects children the most.”* [61, Male, KII Religious Leader, Tahtay Koraro, Tigray]

Poor malaria prevention activities, such as the low coverage of insecticide spraying at mosquito breeding sites, and low use of insecticide-treated nets were the contributing factors that increased the risk of malaria infection. Shortages of antimalarial drugs for small children was also reported as common problem in rural communities that worsen the effect of malaria. *“Ambulance was said to be arranged in this kebele, but while spraying against mosquito, it is done along the roadsides leaving some other parts, which further contributes to unfair distribution of anti-mosquito medicine to all places.”* [44, Male, FGD, Simada, Amhara]

“There is no medicine for small children in drug stores. Small children do not take injections; they will be seriously ill when medicines do not work well” [49, Male, FGD, Simada, Amhara]

Most study participants did not know the causes of malaria. They believed that malaria is caused by cold weather. *“If the weather is cold and if you don’t eat enough food you can have malaria.”* [30, Female, IDI, Tahtay Koraro, Tigray]

Cough/Tuberculosis

Study participants in Tigray and SNNP regions identified cough/TB as common health problems in the community. Study participants could not identify the causes of TB. Exposure to cold air and eating foods made from wheat were suggested as possible causes of cough/TB. A few study participants said that TB is hereditary. *“There are also people who are exposed to (‘ሕማም ባባይ ሰዓል’) tuberculosis. They cough nonstop. The cause of the nonstop cough that exposure to cold air.”* [31, Female, IDI, Adwa rural, Tigray]

“We think it is hereditary and also if you only eat foods that are made from wheat you can have TB.” [61, Male religious leader, KII, Tahtay Koraro, Tigray]

Health Facility Deliveries

DELIVERY CARE

Proper health care and ensuring hygienic conditions during delivery can reduce the risk of complications and infections that may lead to serious illness or death for the mother, baby, or both.⁶ According to the 2016 Ethiopian Demographic Health Survey, nearly one in four (26 percent) live births in the five years preceding the survey were delivered in a health facility.⁷ Identifying the

⁶ World Health Organization (WHO). 1999. Reduction of Maternal Mortality: A Joint WHO/ UNFPA/UNICEF/World Bank Statement. Geneva: WHO.

⁷ Central Statistical Agency (CSA) and ICF. (2016). Ethiopia Demographic and Health Survey 2016. Addis Ababa, Ethiopia, and Rockville, Maryland, USA: CSA and ICF.

barriers and facilitators for health facility delivery and understanding the social norms related to the place of delivery will help SBCC programs to design tailored and relevant program content. This section presents findings related to experiences, perceptions, social norms, barriers, and facilitators of institutional delivery.

Social norms on delivery

Of the 16 women who participated in an IDI, 12 reported they delivered their last child at health facility and other four reported they delivered at home. Most of the deliveries took place at public health centers and hospitals. Focus group participants also reiterated that health facility delivery is becoming a norm in rural Ethiopia. *“There is no woman who delivers at home. It was our mothers who used to deliver at home. Currently, women go to ANC and deliver in health center. We call for an ambulance and it takes them to the health center so that they deliver there.”* [32, Female, FGD, Adwa rural, Tigray]. For more details on social norms and delivery, please refer to Chapter 5.

Facilitators For Health Facility Delivery

Access to ambulance service: Women who live within walking distance to a health facility or those who have better access to ambulance services often deliver at health facility.

Birth preparedness: Women who have good birth preparedness; who plan their place of delivery ahead of time, including having the phone number of ambulance services; and who prepare everything they need to deliver at health facility in advance often deliver at health facility.

High-risk perceptions about delivery complications: Women with a high-risk perception about delivery complications resulting from home delivery and know about health services tend to choose to deliver at a health facility. *“The reason is that if we deliver at home, there may be too much bleeding and placenta delay; but if we deliver at health facility, they give us an injection to stop bleeding and they keep our hygiene and support us very well in the health center.”* [31, Female, IDI, Adwa Rural, Tigray]

Antenatal care: Most women who attended ANC services had delivered at the health facility. This is justified by the counseling services provided by health care workers during ANC checkups. *“I delivered at the health center. I went there because I was told to deliver at the health center during checkups.”* [19, Female, IDI, Damot Sore, SNNP]

Positive attitude about the quality of health services: A few women from the Tigray study site who delivered in a health facility had a positive attitude about the quality of health services in their health facility. *“Even, the delivery service in the health center (ሓኪም) is very good; it has good quality and sanitation; and it is good to treat too much bleeding.”* [31, Female, IDI, Adwa Rural, Tigray]

Counseling: Some women reported that the counseling by HEWs and HDA led to a better understanding of the importance of health facility delivery. *“I didn’t have that much problem but they [HEWs and HDAs] told me not to deliver at home. So, I delivered at a health center.”* [20, Female, IDI, Dale, SNNP]

Barriers To Health Facility Delivery

Reasons why women do not deliver at health facility varied across women who delivered home and the HEWs and HDAs. Women who delivered at home said their short labor time and lack of support were the main reasons they chose not to deliver at a health facility. In contrast, HDAs and HEWs said that the primary barrier to having an institutional delivery was “women’s resistance to change.” One HEW said that short labor time was not an adequate reason for a woman to deliver at home because labor takes an average of eight hours. Focus group participants emphasized distance to a health facility and poor quality of health services as the main barriers for health facility delivery.

Risk perception, fear, and lack of power

Low risk perception: Some women are more confident and comfortable with home delivery. They only decide to go to health facilities if the labor is taking a long time. *“Some mothers do not like to give birth at health facility. They prefer to give birth at home. When the labor is prolonged they may be forced to go to health facility.”* [55, Female, KII HDA, Jaldu, Oromia]

Fear: In some cases, HEWs and health care providers in the health centers counseled pregnant women to complete the recommended number of ANC visits and to deliver at the health facility. However, some pregnant women were unable to comply with the recommendation, they experience guilt and were afraid to go back to see the health-care providers. They did not want to go to health facility again. *“There is a woman in our area who didn’t attend the ANC checkup. Finally, she went to labor and called for people. When we reached her, we told her to go to health center and have her baby there. But she refused. She was afraid that the nurses might ask her why she didn’t attend the ANC checkup.”* [51, Male, FGD, Jaldu, Oromia]

Women who get pregnant outside of marriage are often scared to talk about their pregnancy with people they do not know, including health-care providers. They tend to feel shame, hide themselves, and prefer not to use health services, including facility delivery. *“If somebody who has a wife but goes to someone outside the marriage and impregnates her, no such discussion takes place. She feels shame. She usually comes accompanied by her sister or one of her relatives discuss with us.”* [55, Female, KII HDA, Jaldu, Oromia]

Lack of decision-making power: The decision about where a woman should deliver is sometimes made by other family members—such as a husband, mother-in-law, or children (mainly students)—rather than the woman herself. The decisions these family members make may vary depending on their risk perceptions and knowledge about health services. A few mothers-in-law reported they prefer home delivery to health facility delivery. They based their belief that home delivery has low risk on their own home delivery experiences. *“There are few mothers-in-law [who] sometimes resist health care setting delivery because they say that delivery at home had been used for long period of time, and they assume that nothing is changed.”* [19, Female, KII HDA, Simada, Amhara]

In contrast, students often have good awareness about the importance of health facility delivery and the risks associated with home delivery. They encouraged their mothers to deliver at the health facility. *“For example, for my family I have my own daughter who is in grade six. She decided for me to deliver at health facility. She confronts others by saying, ‘is there anything you pay when she gives birth at health facility? So, why you want to her to deliver at home, where there is no health care.’”* [43, Female, KII HDA, Adaba, Oromia]

Poor infrastructure

Lack of transportation and discomfort with traditional bed/stretchers: For villages far from a health facility, the lack of transportation is a major barrier for health facility delivery. In distant villages, people often use traditional bed—a local stretcher used to transport people, living and dead—to take pregnant women to health facility. However, many women are not comfortable using a traditional bed, which then discourages them from delivering at health facility. *“There is difference based on our location; those who are near the health center use ambulance because they are near, they may also take her with bed. But ours is far; it is beyond the river that you saw. Because of the discomfort when they carry her long distance, some women give birth at home, hiding when labor starts.”* [37, Female, FGD, Adaba, Oromia]

Absence of water in some health facilities: Some health centers in Oromia region have no water. Mothers cannot get water to wash their body, even after delivery. *“When we reach there [health facility], we give birth, but as it is already said there is no water, after we give birth, we come back the following day to our house without washing our blood there. Think about someone carrying you with that blood and take to home.”* [35, Female, FGD, Adaba, Oromia]

Absence of maternity waiting room: Some health centers in Oromia region also do not have maternity waiting rooms, which are rooms dedicated to mothers who are approaching to give birth and to wait for sometime after birth. Women are discharged from the health facility a day after delivery and sent back to home. This timing creates a serious problem for women who come from distant villages where there is either no transportation or traditional beds are used to carry the woman home. Use of the traditional bed can be very painful because the woman's body has not yet recovered from the trauma of labor and delivery. *“When we give birth at health center they send us home the following day; we do not rest well, we do not have food to eat, and we come home troubled. When we decide not to go to health center to give birth, we put our life to risk of death. We try to give birth at home just to avoid going there, and the trouble of carrying us with bed. We do not have money to go health center ahead of time, take hotel rooms and stay there until we give birth.”* [35, Female, FGD, Adaba, Oromia]

Poor mobile network: For distant villages, a phone call is the only means to access ambulance services in time of labor. However, some study participants reported that poor quality of the mobile network sometimes limits access to ambulance services. *“I know recently a woman who*

delivered at home. Labor started early in the morning, and we called for an ambulance. However, the phone number of ambulance did not work. Then neighbors prepared traditional bed to take her to health center. But before they could take her to health center, she delivered at home.” [38, Female, FGD, Jaldū, Oromia]

Poor-quality or limited health services and support

Health care provider’s unfriendly approach: Some focus group participants mentioned that some health care providers in health facilities are unfriendly to rural women. They are disrespectful and sometimes insult pregnant women about their poor hygiene. Such practices discourage women to go to health facility. “Some health professionals have a discipline problem. They do not give equal attention for rural and urban women. If women from rural area go there for service, the nurses may treat them badly. They ask them why they didn’t wash their hair or clothes and so forth.” [28, Male, FGD, Jeldu, Oromia]

Health centers do not work over weekends: In some cases, a health worker’s residence is far from the health center, so they decide not to work during the weekend. “There is a woman at a nearby to health center. She started labor on one Saturday. Health workers are not expected to be at the health center on Saturday. This is because the workers have no residence here. They frequently travel every day to come and serve here since it is not far away. There was only one midwife and health officer for the health center but none of them were there at the time. She could not get assistance for delivery in health center. Then, she went back and gave birth at home. Unfortunately, her baby died. Other women raise this and similar cases to prefer to give birth assisted by traditional birth attendant.” [35, Female, KII HEW, Jeldu, Oromia]

Lack of support by family or neighbors: Some study participants indicated at the time of labor, especially if the labor is at night, they may not find people to support them to go to the health facility. As a result, they are compelled to deliver at home. “It was not my decision; I felt the pain of labor at midnight and my husband was not around because he is security guard so that he spends the night out of the house. I always sleep with my little children and I was telling them that they would call out our neighbors if it becomes serious, but God helped me, and I gave birth to my child in good health condition.” [25, Female, IDI, Dale, SNNP]

Short labor time

Some mothers experience short labor time. The labor doesn’t wait until they go to health facility. However, health extension workers do not support such reasons. HEWs said it is a pretext by mothers to defend their home delivery. “When I tried to call the ambulance, my labor has already begun, and I was not able to go to health center, they arrived late and blame me for not reporting the case early. But it was emergency.” [37, Female, IDI, Sayint, Amhara]

Postnatal Care

Prompt PNC for both the mother and the child is important to treat any complications arising from the delivery, as well as to provide the mother with important information on how to care for herself and her child. Safe motherhood programs recommend that all women receive a check of their health within two days after delivery. However, the 2016 Ethiopian Demographic Health Survey indicates that less than one in five mothers receive PNC services within two days after delivery.⁸ This section explores social norms, perceptions, barriers, and facilitators for the uptake of PNC services.

Social norms

Women do not commonly visit health facility within seven days of delivery because of the social norm that a woman should not leave her home within a month after delivery. Women do not usually visit health facilities after delivery unless the mother or newborn are having health problems. No regional variation were found regarding PNC social norms and practices. Only five of the 16 IDI participants (women with a child under two) reported that they have received PNC from either HEWs or health facility within seven days of delivery.

Beliefs⁹: In some areas of Oromia and Amhara region there is a belief that a woman who gives birth and leaves the house within one month of delivery will be attacked by an evil spirit. *“No, I didn’t attend PNC in seven days. In our culture, the mother who currently delivered a child does not go to anywhere until one month. There is one belief called harasaa in our locality it is believed that, if the mother is go outside home, the devil may beat her.”* [24, Female, IDI, Adaba Oromia]

Postnatal care after home delivery

Some remote communities believe that if a woman safely delivers at home, the mother and newborn should only go to a health facility if either has a health problem. Their first visit would be for immunization 45 days after delivery. In some cases, during their home-to-home visits, HEWs or HDAs reported they identified women who deliver at home, advised them to come to the health facility for PNC, and provided their phone number to the woman to call if she had an emergency. *“If a woman delivered at home, the baby will be taken to health center after a month for vaccination. But the mother will not go to the health center; she stays at home with her relatives.”* [19, Female, KII HDA, Simada, Amhara]

8 Central Statistical Agency (CSA) and ICF. (2016). Ethiopia Demographic and Health Survey 2016. Addis Ababa, Ethiopia, and Rockville, Maryland, USA: CSA and ICF.

9 Beliefs are assumptions individuals make about things around them. For example colostrum is “bad milk” and needs to be thrown away. Social norms on the other hand are “accepted standards of behavior within defined social groups. For example, the social norm of number of children is 4-5 in Ethiopia and could be 1 in Japan.

Postnatal care after delivery in a health facility

Some rural women who gave birth at health facility and were discharged after 24 to 48 hours following delivery did not come for a second PNC visit, since they felt that they had already received all the necessary care. The case also depicts poor quality of counseling services at the health center. *"I delivered my last child at health center. I did not come again for PNC since I believe I had got whatever I required during the delivery care."* [22, Female, IDI, Jeldu Oromia]

Some mothers did not receive PNC after they were discharged from the health facility. *"No, it was only at the time of delivery, they treated the child otherwise nothing was done after I came back home."* [30, Female, IDI, Simada, Amhara]

The above findings contradict responses from most HEWs, who stated that they visit mothers within 48 hours of delivery. *"We visit within 48 hours of delivery then again visit on the third day of delivery. If we see danger sign, we will give gentamicin (antibiotic). If the newborn is healthy we follow up and give vaccination until he or she completes the routine."* [28, Female, HEW, KII, Dale, SNNP]

Services provided by health extension workers during postnatal care visit

HEWs provide various health services during their PNC visit to a woman's home, including examining the newborn and mother; providing medicines, and counseling the mother to take the child for vaccinations. *"HEW came to my home once when the baby was seven days old. At the time, she told me to bring the baby to the health center for immunization when it was 45 days old. She checked my belly and told me to call her if the bleeding doesn't stop."* [19, Female, IDI, Damot Sore, SNNP]

Family support to a mother after delivery

Data indicates that household support of female relatives is necessary for the well-being of the new mother. *"If a woman has grown girl or mother, they help her at time of her delivery. If she has mother-in-law, she can also support her. Husbands also support in collecting of firewood; but they do not help in household chores due to cultural issues."* [27, Female, KII HEW, Adaba, Oromia]

Contraceptive Use Patterns

Contraceptive Use And Choice Of Method

Twelve of the 16 interviewed women with a child under two were using modern contraceptive methods at the time of data collection. Two of the remaining four women reported they had used injectable previously, but discontinued use due to side effects. Of the two, one woman was using calendar method, while the other one was not using any method. *"I encountered health problems; gradually my stomach was getting bigger because of the family planning method. So, I stopped to use the method and shifted to calendar method."* [24, Female, IDI, Adaba, Oromia]

Among the current contraceptive users, seven women used injectable and five women used implants. The majority of women using implants were previous injectable users. Although one reason for switching to implants could be the shortage of injectable at health facilities, the women stated that their primary reason for switching was the side effects of injectable. *“My experience of using Depo-Provera (injectable) was not good. My body was itchy; I had a problem with anemia, lump on my face and burning sensation on my body. While I switched to implant, I feel peaceful. I have been using implant for three years. So far, I have not encountered any problem.”* [19, Female, IDI, Damot Sore, SNNP]

Except for two women, current implant users said that they did not encounter severe side effects from using the implant. They described the method as comfortable and good. Current injectable users reported experiencing side effects such as irregular menstruation, missing menses, excessive menstrual bleeding, extended menstruation period, abdominal distention, loss of appetite, headache, hair loss, and hypertension. *“It (the injectable) is fine, but I lost much hair and had hypertension. When I give birth to my last child, I have lost much blood because I have never seen my menstruation during the five years of using a contraceptive. Because of it, I lost a lot of blood during delivery.”* [32, Female, IDI, Tahtay Koraro, Tigray]

Injectables and implants are the commonly used family planning methods among married women in the communities across the four regions, according to female IDI participants, HDAs, and HEWs. Women who have many children and those who want to use contraceptives secretly without the knowledge of their husband prefer injectables, while newly married women who want to delay birth and those who want to space their children prefer implants. *“Because the one for three years is essential for our health. Also, it is better to come to the health center in every three years than in every month. Also, the one with three month cause headache and the injection is painful when injected into the arm.”* [25, Female, IDI, Simada, Amhara]

Oral pills, intrauterine contraceptive devices (IUCDs), and condoms are the least chosen family planning methods across all study communities; none of the study participants mentioned them as their preferred method. Here, beliefs and misconceptions about side effects are the reason for not preferring these methods. Additionally, most study participants stated that they do not like using condoms.

We found no regional differences related to contraceptive choice. However, some participants in Oromia and Tigray reported that HEWs tend to advocate for the use of certain types of methods. One woman in Tigray reported that health workers told women that injectable and oral pills are outdated, have many side effects, and the women should not take them because women do not get adequate food. A HEW in Tigray also said that they advise women to use the implant because its hormone dose is lower than injectables. A woman in Oromia said that the HEW told her she would lose weight and have irregular menstruation if she used an injectable. Another woman in Oromia also said the HEW told her not to work on heavy tasks for five days after using the implant. *“When we go to the health center for the contraceptive method, the health workers tell us not to choose oral pills and injections because they are getting outdated. They tell us we mothers should*

not have to use the oral pill because it hurts our hearts because we do not eat food properly, we only drink coffee. Therefore, they do not give us oral pills. Currently, they also tell us to avoid the injection. As alternatives, they tell us that plastic (implant) is better for us or the one that is inserted into the womb [IUCD]. They are the ones who know its side effect, and they tell us so.” [25, Female, FGD, Tahtay Koraro, Tigray]

Family Planning Barriers

Husband’s refusal: When asked about decision maker for family planning use in their community, female IDI participants acknowledged that there are some men in their communities who do not allow their wives to use contraceptives. The majority of HEWs said that husbands are the ultimate decision makers for contraceptive use.

Traditionally, husbands have had control over their wives and made all decisions on household issues. Because of this, they usually have significant influence on the decision to use contraceptives as well as what method to use. There are reports that, even when the husband and wife discussed and decided on the type of method to use, the women were not allowed to change the method, since the husband’s decision prevails. A few study participants noted that husbands do not allow their wives to use contraceptive unless they have many children. Men believe that a wife’s primary role is to give children, and some husbands use religion as an excuse for not allowing their wife the choice, according to some study participants. As a result, some women use contraceptives secretly. *“I have decided to use family planning alone. I have used without letting my husband (know) ... I know the importance of family planning method. If I have many children, I know the primary victim is me. I decided to use because I know how difficult it is to feed them (children) and how difficult it is to take care of them. Even if my husband is educated [religious education], he does not let me use family planning method because he believes that using family planning is haram.”*¹⁰ [24, Female, IDI, Adaba, Oromia]

Disapproval of parents: A couple’s parents may disapprove of contraceptive use. They tend to follow the old trend—having more children is an asset—and want to have many grandchildren. Few women participants also noted that their mothers-in-law do not allow them to use contraceptives. *“Our father and mother tell us not to use family planning because they think we have to follow their old trend.”* [38, Female, FGD, Jeldu, Oromia]

Distance and unavailability of choice of contraceptive: Clients having to travel a long distance to a health facility and health facilities not having modern methods in stock can be barriers to contraceptive use. Women reported that they often do not get their choice of contraceptive method, especially injectables, due to supply problems. *“Let me tell you my experience. Last year I was there in the health center, a woman came and asked the health professionals to give her contraceptive, Depo (injectable). Unfortunately, at the time other methods like implant were available but not Depo. Even though the professionals told her about the advantage, she did not accept. Later she*

¹⁰ In the Muslim religion, ‘haram’ means forbidden.

became pregnant. After having that experience, now she has started to use implant right after the 45th date of birth.” [29, Female, KII HDA, Saint, Amhara]

Local beliefs: There are many local beliefs in the study communities that have a negative effect on family planning use. People associate use of contraceptive with infertility, health problems from side effects, increased food intake, convenience for work, and religion. Although participants noted that they knew women in their communities who gave birth after they stop using contraceptives, there is a belief that contraceptive use can lead to infertility. The risk of infertility is believed to be high for unmarried and newly married women who do not give birth to the first child. *“Personally I do not support it (using contraceptive). I am seeing many women who are unable to have children because of it [contraceptive] ... They (referring to specific women as an example) were using family planning methods, and they want to have children. But, there was a side effect of the method, and they were unable to get pregnant even though they have tried to solve the problem by visiting different health facilities.”* [60, Male, KII Religious Leader, Adwa rural, Tigray]

People believe that for a woman to use a contraceptive, specifically implant and injectable methods, she needs to eat more food and a balanced diet; therefore, these methods are not suitable for poor women. The implant is considered to cause a feeling of hunger, and, if a woman who uses the method does not eat adequate food, it will ‘burn’ her body and irritate her sex organ. People also believed that a woman should eat balanced diet/nutritious food if she uses injectable. *“In order to take Depo (injectable), we have to eat a balanced diet. Women who are living in urban areas can get a balanced diet. However, the rural women cannot get a balanced diet. The rural women eat one or two times a day. Since the Depo (injectable) needs food, it can cause a health problem.”* [24, Female, IDI, Adaba, Oromia]

The common beliefs associated with side effects are:

- Oral pills cause a gastric burn, stomach discomfort, ‘burns’ the body, and emaciates the woman.
- Injectables cause unwanted weight gain, excessive fat, hair loss, and infertility, and the injection is painful.
- Implants cause severe pain during insertion, results in hair loss, ‘doesn’t match with body system of the woman,’ and ‘sucks blood.’ Woman using an implant will be overweight/ fatter and it will change her physical appearance. Implant ‘burns’ the body and irritates reproductive organ, and a woman who uses an implant cannot get pregnant in time (immediately) after stopping use. The implant will move from the arm and bury itself deep in the body.
- The implant is not convenient for work. A woman who uses implant cannot do heavy work as it will easily tire her.
- The IUCD causes a problem during sexual intercourse, this hindering women from having sexual intercourse with their husbands. IUCDs could move deep into the uterus during

work and get lost in the body. *“They say that ... the one which is inserted in the womb [IUCD] also prevents ... sexual intercourse with their husbands. I also believe this, and the rest women also believe that way.”* [31, Female, IDI, Adwa rural, Tigray]

There is a traditional belief called Zar in some parts of Amhara. It is an evil spirit that causes fear, and some people are believed to have the spirit. Some people believe that if they do things the spirit does not like, the spirit will be unhappy and make them sick. For example, they believe that if a woman with Zar uses an injectable contraceptive, the spirit will get upset and she will become sick. They believe the spirit will affect her potential to have a pregnancy, and the woman may not give birth again.¹¹ *“They (the community) have a traditional belief called Zar. They think it [the Zar] will be upset if they use the (contraceptive) method and something bad will happen to them. They said it would disturb their pregnancy and that they will not be able to give birth again.”* [42, Male, KII Religious Leader, Simada, Amhara]

Religious beliefs are another barrier to contraceptive use. A few participants reported that religion prohibits contraceptive use. Some believe that preventing pregnancy is a sin because God gives children and, because of that, they do not need to limit the number of children they have. A few participants also reported that some women do not want to use contraceptives because they are afraid their religious leaders will judge them if they know they are using a contraceptive. *“As a religious leader what I say is that, according to our religion, it is impossible to quit having children because it is what God gives. It is forbidden by the law of God to use family planning. It is God who gives children to people according to his wish. Preventing the gift of God using different kinds of mechanisms is forbidden in our Sharia Law.”* [46, Male, KII Religious Leader, Adaba, Oromia]

There are slight variations in responses to family planning barriers among study participants. FGD participants mostly mentioned disapproval of husbands and couples' parents as a reason for not using contraceptives. HDAs stressed women's lack of knowledge, and blame women who pretend to accept advice during education sessions but do not practice what they learn. HEWs highlighted misconceptions, husbands' refusal, injectable contraceptive supply interruptions, and fear of religious leaders as the primary barriers they encounter. Most religious leaders mentioned traditional and religious beliefs as reasons for not using a contraceptive.

Household Health Practices

Women Daily Routines

Most study participants reported that rural women usually wake up early in the morning to do household chores such as preparing food, cleaning their house, caring for children, fetching water, collecting firewood, and taking care of the cattle. During the day, they also assist with farming activities in the field, such as weeding. They usually sleep late at night. *“I wake up early in the*

11 If a person who is considered having the Zar becomes sick and the illness is believed to be due to the spirit, the family will buy hen or other things for the Zar to make it happy so that the person will get well.

morning, and use to prepare food for my child including milk, which is prepared from milk powder. The other activity is taking animals to outside, communal grazing areas. In addition, I also work in weeding seasonally.” [30, Female, IDI, Simada, Amhara]

There is no regional variation on the main work of rural women. While rural women in all study regions were involved in household chores and out-of-house farming activities, the type of farming activities varied depending on the context. Also, depending on their economic status, in some cases, rural women with low incomes were also involved in daily labor and commercial activities to generate income. “I wake up in the morning and clean the house, prepared coffee and after we had our morning coffee, I again cleaned the house. Then I chopped fuel wood and prepared lunch. After that in the afternoon, I went to the house where I was hired to prepare enset (false banana). Then I washed my baby, feed her breast milk and I let her to sleep. Then I washed clothes and prepared dinner for my family. Finally, I went to bed.” [25, Female, IDI, Dale, SNNP]

Women’s Nutrition

Maternal feeding during pregnancy and within days after delivery

In general, consumption of special foods—foods different from daily use—was not common at any of the four study sites. The variety and amount of food consumed by pregnant women in the study sites was reported to be affected by two broad categories of beliefs: food beliefs associated with fear of ‘big fetus,’ and ‘other’ beliefs.

‘Big fetus/baby’-related beliefs: Some women fear that increasing food intake and eating some types of food during pregnancy will result in producing a ‘big fetus.’ This fear is a major factor that affects eating habits during pregnancy and after delivery. The belief was prevalent at all study sites, even though there were some variation in scale. “[T]hey [the family] do not allow her [pregnant mother] to eat meat because of fear of a big baby. Now they do not prevent her from eating specific food [milk, butter, honey], pregnant women need to avoid eating much since that lead the baby to become very big and makes giving birth difficult.” [27, Female, KII HEW, Adaba, Oromia]

Loss of appetite: In some cases, a mother may avoid some foods due to a lack of appetite for specific types of foods or inadequate access to food or due to abdominal discomfort. “When we ask them [pregnant mothers] why they do not eat well, they say I do not have an appetite. They complain about abdominal discomfort. Most of them are affected by malnutrition because of inadequate food.” [27, Female, KII HEW, Adaba, Oromia]

Maternal nutrition after childbirth

Mothers across all of the study communities received special feeding care after childbirth. After giving birth, mothers are commonly served soft foods, mostly in the form of porridge or soup prepared from cereals, and drinks such as gruel, juice, tella (the local beer), and soft drinks.

In households that can afford it, starting from few days after birth, the mother also benefits from

eating sheep/goat meat or chicken. *“Commonly they use teff to prepare porridge. In addition, they are also given honey and black seed in the form of hot drink up to 10 days. After that, the husband may slaughter sheep, a goat, or a hen depending on the capacity of the family. Usually, within the first 10 days, the women do not eat food as usual, rather, they prefer to eat vegetables and soft drinks like honey. After 10 days, slowly they start to eat meat. This continues for about 40 days.* [60, Male, FGD, Sayint, Amhara]

While there is a tradition of special nutritional care for women who give birth across regions, the type of foods served to these women right after delivery differs across regions. Mostly families prepare porridge from one type of cereal, often red teff—“as it helps to get more blood,” according to one FGD participant—or a mix of cereals (teff, wheat, barley, or maize) or Bulla. Participants rarely mentioned the addition of pulses or legumes to foods served to recently delivered women. As previously mentioned, families may also provide chicken, sheep, or goat’s meat to a woman after the first few days, in households that can afford it. Honey and oilseeds—such as linseeds, ‘niger’ seeds, and flaxseed—are also reported to be essential ingredients for the physical rehabilitation of a woman soon after delivery. Vegetables are the least mentioned food types offered to a woman after birth across regions. Participants in most communities also reported that they do not believe the care they provide to women after delivery is adequate *“[R]egarding the type of food they take after childbirth, whatever special care is given, it is impossible to say that all women can get adequate food.”* [50, Male, FGD, Sayint, Amhara]

“[W]e are taught that she (a lactating mother) needs to eat food like vegetables, but we do not have that [type of food available].” [27, Female, FGD, Adaba, Oromia]

A study participant from SNNP mentioned that preference for a male child led to discrimination against the girl child. He referred to a local proverb that says, *“when I was pregnant, the best sheep was chosen for me (to be slaughtered when I give birth). Then, I ended up giving birth to a female, and they gave me greens [vegetables].”* [50, Female, FGD, Dale, SNNP]

Child Nutrition

Breastfeeding practice

Early initiation of breastfeeding is closely linked to prelacteal feeding practices; exclusive breastfeeding for the first six months of life and breastfeeding continued to two years and beyond are among the major components of recommended breastfeeding behaviors. Consistent with findings of recent national surveys, which showed the declining trend in prelacteal feeding practices, most participants, across all study sites, reported early initiation of breastfeeding without provision of other feeding. Some participants attributed this departure from past practices to advice from health professionals. *“[T]hey [mothers] have stopped letting newborns swallow butter like in the past. . . . The newborn does not eat anything; it is only breastmilk.”* [28, Female, FGD, Sayint, Amhara]

“We have been advised to give them only breast milk, and so we do.” [20, Female, FGD, Damot Sore, SNNP]

“A newborn is given breast milk immediately after birth. It does not eat anything else.” [32, Female, FGD, Tahtay Koraro, Tigray]

However, newborns are often fed with boiled water and sugar, especially during the delayed release of breast milk; a practice accompanied by discarding of the first milk. *“Mothers boil water and mix it with little sugar, and then they give it to the baby until the breast of the mother gives milk... When the breast of mother starts giving milk, they spill the colostrum to the ground and then give the breast to the baby.”* [38, Female, FGD, Jeldu, Oromia]

Regarding exclusive breastfeeding, responses across the regions revealed a similar understanding of the duration of exclusive breastfeeding. The majority of the participants mentioned that mothers in their community started to add food after six months. However, HEWs reported that even though the women in their communities might know what exclusive breastfeeding is, most did not practice it. Most participants have also reported that when asked about the proper feeding of a child at one year of age, they responded that they continue to breastfeed. *“They do not practice what we have been teaching them. Maybe 20 or 30 individuals from 100 individuals practice what we teach them. Some mothers they sell egg and buy biscuit for the under six months old child.”* [27, Female, KII HEW, Adaba, Oromia]

Complementary feeding practice

Optimal complementary feeding practice comprises the timely initiation of complementary feeding with proper consistency, adherence to recommended dietary diversity, and the frequency and amount of feeding appropriate to the age of a given child. Regardless of the participants' region and gender, most agreed on the need of starting a baby on complementary feeding at six months of age. Porridge is reported to be the most common form of preparation of the first complementary food, although there was a subtle variation in descriptions of the required consistency, as some mentioned of 'thin' porridge or gruel. *“The baby eats soft porridge after he is six months. As my sisters mentioned, he will eat soft ‘Shiro’ after a year. He will eat like other family members after two years.”* [28, Female, FGD, Sayint, Amhara]

“We also prepare foods such as porridge and mix it with oil and butter and give it for the babies. If we do not have it, we do give them Injera with sauce and potato.” [30, Female, FGD, Jeldu, Oromia]

“A baby after six months is fed porridge, gruel, kita [thin local bread] and tea.” [35, Female, FGD, Tahtay Koraro, Tigray]

The type and contents of complementary food can vary among communities. Among food types, a combination of cereals, locally referred as mitin, often constitutes the base for complementary foods in all regions. Participants frequently mentioned adding cow's milk for babies, and including meat and vegetables if or when they were available. They rarely added pulses or legumes.

“Complementary foods for children can be prepared from eggs, different vegetables, meat, oats, teff, barley.” [25, Female, FGD, Sayint, Amhara]

“I prepare complementary food from oat, barley wheat, teff, beans, and eggs.” [22, Female, IDI, Jeldu, Oromia]

Participants in some study sites also noted their contribution to the health sector by influencing complementary feeding practices. *“Based on the education given by the health centers, the food for infants is prepared from the powder of mixed cereals locally called mitin.”* [30, Female, FGD, Adwa Rural, Tigray]

Some participants perceived the type of complementary food to be affected by their residential area, urban or rural. For example, participants in Tigray reported giving processed foods, such as nido (a commercial milk powder), pasta, and macaroni to children. *“In our community, many children start additional food after they become one year and above. They usually give injera. Though our community does not provide such food items as eggs, like those in urban areas do... butter may be added.”* [36, Male, FGD, Simada, Amhara]

“They feed under two children, slightly thin porridge, macaroni, pasta, soft drinks, and oranges.” [27, Female, KII HEW, Adwa Rural, Tigray]

In some areas, participants mentioned that while they have the knowledge about the importance of feeding children various types of food, they could not practice it due to food shortage. *“We do not have food like meat. We do not have pure water; we are giving groundwater to our children.”* [24, Female, IDI, Adaba, Oromia]

In general, although combining cereals and, where available, other food groups to prepare complementary food appears to be a common practice among all study areas, regional variations did appear. The commonly mentioned complementary food types were: chibito (kind of muffin) in Amhara, kocho/bulla in SNNP, bread in Oromia, and qita (bread) in Tigray. However, in all regions, most of these were prepared from a mix of cereals, with little mention of pulses, legumes, or animal products.

The frequency of complementary feeding for infants and young children ranged from two to five times per day, depending mainly on the appetite of the child and the availability of food. During food shortages, participants in most regions, except in Oromia, stated that type of food provided was affected more than the frequency of feeding. *“[I]n any circumstance [even during food shortage] and whatever the issue, the child gets food three times in a day.”* [50, Male, FGD, Sayint, Amhara]

“Children will not be harmed whether there is food shortage because the parents leave their food for children.” [43, Female, FGD, Jeldu, Oromia]

Local models of food categories using pile sorts

Unstructured pile sort exercises were conducted during eight FGDs and eight IDIs with women with a child under two in four regions of Ethiopia. The objective of the pile sort exercise was to uncover local food models that can inform a nutrition education campaign. Typically, nutrition campaigns use the technical “six food groups” categorization, even though it often does not match the local food constructs of the community. Study participants were shown 22 to 25 show/picture cards, representing local foods of the regions, and asked to group the cards based on their

own categorization. Study participants grouped the cards and labeled each group. The data were presented by region and the overall study assessment. We focused the analysis on the “labels” attached by study participants to various groupings. The data reported below are local models based on local knowledge, which do not necessarily match technical nutrition science definitions. There were no right or wrong local constructs.

Amhara

The study participants from Amhara divided the food cards into an average of five categories, with a range from three to seven categories. Table 2 illustrates seven local categories suggested by a group of women in Ashenga kebele. The first category includes injera, which is usually made of teff. Sorghum, barley, and corn are put in the same category under ‘cereal.’ This is followed by wot, which is a sauce that can be plain or with cooked with vegetables and meat. The women in the FGD put peas, lentil, chickpeas, and legumes under wot. Interestingly wot appears in two other categories, indicating that it is a crucial part of the Amhara diet. The “all-round” category refers to the oil and onion that can be used to be prepare alecha wot (without pepper), key wot (with pepper), and shiro (made with peas or chickpeas) wot. Vegetable wot included spinach, tomato, and potato.

The women provided two more local categories of food groupings: mamagiya for drinking milk/ yogurt with a meal and mabaya, which included linseed—an oil or seed that is consumed with porridge after a woman gives birth. Other categories from Amhara included eshet (freshly harvested), kitatiyo (foods that build or strengthen the body), and fasting/nonfasting foods (Table 2).

Table 2: Pile sort of food groupings by women’s focus group discussion, Ashenga kebele, Amhara

	Name of Category	List of Food(s)	Reason
1.	Injera cereal	Sorghum, teff, barley, and corn	They are major proteins and are suitable for cooking and for our body.
2.	Wot (sauce) cereal	Pea, lentil, chickpea, and legume	Because we eat injera with them; they are also eaten when they are raw. Legumes give energy and heat, we learn about them.
3.	All-around	Oil and onion	They have all-round use to prepare alecha wot (without pepper), key wot (with pepper), and shiro.
4.	Foods important for our health and improvement, proteins	Egg, meat, and chicken	They provide protein for the body. People who eat that will be fat and their body will be chubby. People who eat meat and eggs will be fat and will have a beautiful body.
5.	Vegetable wot and alecha (without pepper)	Spinach, potato, and tomato	They are suitable for people and the body. They are not cooked together but the way they are cooked is the same and they are alecha.
6.	Mamagiya (used for drinking while eating)	Milk and yogurt	People drink them while eating — it cools the heart. They cannot be used to prepare wot.
7.	Mabaya (used when we eat) Linseed	It is eaten with injera.	It is a medicine in its own. When a woman give birth, she consumes it with porridge.

Oromia

The Oromia data is presented separately for each kebele due to the differences between the two kebeles. Gardilo kebele has a high proportion of households facing food insecurity during the food scarcity season in Oromia region. Not surprisingly, study participants from this kebele demonstrated a narrow range of food groupings as well as a limited food variety. In contrast, the study participants from the Sariti kebele were able to describe more categories and diverse foods.

A young mother from Gardilo used about three food categories: cereals, food used to cook wot, and raw foods. Cereals cannot be eaten raw and must be cooked, as are foods that can be mixed into wot. In contrast, meat, milk, and sugarcane can be eaten raw.

Table 3: Pile sort of food groupings by a young mother, Gardilo kebele, Oromia

	Name of Category	List of food(s)	Reason
1.	Cereals	Barley, teff, chick peas, and Maize	We cannot eat it raw, which means without processing.
2.	Used to cook wot or meal	Green pepper, beets, carrot, tomato, and potato	We can use those foods to cook wat.
3.	Raw foods	Milk, meat, and sugar cane	We can eat/drink without cooking.

Women from Sariti kebele described seven categorizations of food, some linked to how you eat the food, such as raw, processed, cooked as in wot, or foods eaten together. Another type of categorization was what benefit the food provides the body. For example, foods that build the body, vitamins and energy, and vitamins and disease prevention (Table 4).

Table 4: Pile sort of food groupings by women's focus group discussion, Sariti kebele, Oromia

	Name of Category	List of food(s)	Reason
1.	Food prepared together	Onion, green pepper, and tomato	We eat them together.
2.	Cereals	Maize, teff, and wheat	They are cereals and we eat them together.
3.	Vegetables	Potato, carrot, and cabbage	They can be cooked together, and we eat them together.
4.	Beverages	Milk and yogurt	Both are dairy products.
5.	Vitamins and prevent diseases	Egg	We can eat an egg alone; it prevents diseases.
6.	Foods that build our body	Meat, lentils, and sorghum	It builds our body.
7.	Vitamin and energy	Sugarcane	We can eat this alone; it gives us energy for our body.
8.	Substitutes of 'meat'	Pea, beans, and oats	These foods types can substitute for meat; they give energy and vitamins.

Southern Nations and Nationalities Peoples'

The pile sort data from SNNP indicates that food diversity is highest in this region. Also, most of the study participants were able to provide five to seven food categorizations during the sorting exercise, including kochekecho, which describes foods that benefit the body. The “**main food**” category included potato, sweet potato, pumpkin, kocho, and enset (false banana), which are foods that “*satisfy the belly and is usually eaten for lunch and dinner*” (Table 5).

Study participants in SNNP also mentioned some categories such as wot food, “balanced food,” and foods that prevent disease. This labeling was common in both Amhara and Oromia.

Table 5: Pile sort of food groupings by women’s focus group discussion, Dembezame kebele, SNNP

	Name of category	Lists of foods	Reasons
1.	Fruits	Mango, banana, papaya, and chickpea	They give health and energy.
2.	Kochekecho	Meat, cabbage, green pepper, onion, and oil	Gives common benefit to the body
3.	Wocheegno	Yogurt and cassava	Edible all in one.
4.	Injera	Teff	Eaten with any type of food after grinded and cooking.
5.	Nefero (foods that can be boiled)	Boloke and maize	Cooked and eaten together.
6.	Pan-roasted food	Wheat and chickpea	Foods eaten while drinking coffee (Yebuna kurse).
7.	Main food	Potato, sweet potato, pumpkin, kocho, and enset	Food that satisfy the belly and are usually eaten for lunch and dinner.
8.	Drink	Milk	Can drink after any type of food is consumed.

Tigray

The men's FGD in Maytimket kebele, Tigray provided a separate category for food diversity, "beyainetu or variety foods" that includes green pepper, onion, potato, kale, cabbage, and carrots. These foods can be cooked together and eaten with injera. In another categorization, the men labeled beef, milk, and eggs as "foods which prevent disease."

Table 6: Pile sort of food groupings by men's focus group discussion, Maytimket kebele, Tigray

	Name of Category	List of food(s)	Reason
1	Used for all foods	Edible oil	It is used in all kinds of foods.
2	Energy foods	Flaxseed, teff	They give energy especially for pregnant and women who deliver child. These foods could be eaten together.
3	Variety foods ("beyainetu")	Green papper, onion, potato, potato, kale, cabbage, and carrots	They are used together to prepare beyaynet (variety): it is traditional way of preparing food from different kinds of vegetables and cereals and served with injera together.
4	Food which is eaten raw and alone	Cactus	It is independent food and eaten alone
5	Cereals	Lentils, grass pea, chick peas, corn, wheat, and beans	They could be eaten raw as spike, roasted, and boiled.
6	Foods that prevent disease	Beef, milk, and egg	Because they are proteins.

Local food categories across four regions

The pile sort exercise facilitated the identification of local food groupings that define how communities label food categories. These local food groupings make a nutrition promotion strategy more robust, as they are intrinsic to the cultural belief systems of rural audiences. The objective of the pile sort was to explore local food "labels" that may not match scientific food groups. The local food models are closer to the perceptions of the community compared to the six food group categories. The commonalities of food groupings across the four regions include, wot foods, balanced food, foods that prevent disease, and so on. Local constructs such as mamagiya (Amhara), mabya (Amhara), kochekecho (SNNP), and beyainetu (Tigray) provide us with "emic¹²" categories that are part of the daily lives of people (Figure 3). The food(s) listed under the various categories are locally available in each region. These data will help in the development of a nutritionally relevant and culturally appropriate strategy in the following ways:

- The concept of wot is relevant to all four regions, as it is Ethiopian food. This food category comprises most of the daily food eaten. If a nutrition communication strategy builds on local foods and constructs—as opposed to proteins, carbohydrates, and so on—

¹² "Emic" is the local perspective or belief system that may be in contrast to the more scientific or academic approaches.

it will lead to a far better understanding of how to develop appropriate messaging. Wot needs to be included in the nutrition education strategy. Food diversity can be promoted by adding vegetables and/or meat to the wot.

Figure 3: A local model of food groupings



- Similarly, the construct of mamagiya can be used for promoting child nutrition. The use of this local term will immediately connect with the audience and enhance the effectiveness of the nutrition communication.
- The categorization of “balanced” food can be used alongside the kochekocho construct in SNNP, which indicates foods that are beneficial.
- Prevention of disease was another category that was common across all four regions. This construct can be used to promote essential foods for women and children.

Handwashing Behaviors

The WASH component of the sociocultural study focused on two behaviors: the presence of a proper handwashing station within the household and handwashing with soap at critical times. Handwashing stations have been defined as a station with the availability of water and soap at a designated place that is convenient for use, such as near a toilet or a food preparation area.¹³ Only seven percent rural households have a proper handwashing station in Ethiopia with the availability of water and a cleaning agent.¹⁴

The Communication for Health baseline survey in four regions indicates that 10.6 percent households have a proper handwashing station, with the availability of both water and soap, although only 65 percent of the participants reported washing hands at critical times. The discrepancy in “reported” handwashing with soap compared with the actual presence of handwashing stations prompted a deeper study of the situation. The sociocultural study explored the feasibility of households preferences for handwashing stations to facilitate handwashing with soap at critical times.

Study participants described their WASH experiences as “handwashing with water” and almost never used the phrase “handwashing with water and soap or ash.” When asked how people washed their hands, a religious leader from Shoye, SNNP said, “They used soap and water if they have, others use water and ash but the rest only with water. They do not have money to buy soap. Most get their food from market even some people buy firewood from market so they do not have money to buy soap.”

A mother from Ashenga, Amhara, in reply to a question about how she prepares food, said, “I did it after washing my hand and I am always washing my hand. There is always water besides me.” The data mostly refer to handwashing with water, indicating that the prevalent social norm is handwashing with water rather than handwashing with water and soap.

Key informants, such as health workers or HDAs, reported they deliver handwashing “messages” to the community but were unable to confirm if people washed their hands with soap or not. “We teach her to use soap to wash her hands if she gets it easily or ash if not. They should always wash their hands especially when they want to feed their children.” [HEW, Rahya, Tigray]

13 Hullah, K. R., Leontsini, E., Drebelbis, R., Unicom, L., Afroz, A., Dutta, N. C., ... Winch, P. J. (2013). Designing a handwashing station for infrastructure-restricted communities in Bangladesh using the integrated behavioural model for water, sanitation and hygiene interventions (IBM-WASH). BMC Public Health, 13, 877.

14 Central Statistical Agency (CSA) and ICF. (2016). Ethiopia Demographic and Health Survey 2016. Addis Ababa, Ethiopia, and Rockville, Maryland, USA: CSA and ICF.

Summary Of Key Findings

Community perceptions of health and health services

- Malnutrition and delivery complications are some of the health problems facing communities in the four regions of Ethiopia. Poverty leading to a lack of food for children, insufficient food aid, and lack of safe drinking water are primary causes of stunting in young children.
- Many people believe that cold weather and hunger cause malaria. A few participants reported that malaria medicine did not reach young children in their kebele.
- Cough is a commonly identified symptom and transmission mechanism of TB. However, many people believe they can get TB by eating food made from wheat, exposure to cold air, or genetics.
- Data from this study indicate that several women chose to have hospital deliveries. Structural factors such as lack of transportation and remoteness of the village were the main causes of home deliveries.
- Community perceptions of postdelivery behavior often influence women to not seek PNC at a health facility seven days after delivery; instead, they often wait until after 45 days to return for their child's immunization.

Barriers to delivery at a health facility

- Women's low risk perception of delivery at home, fear of reaching the health facility on time, low decision-making power.
- Infrastructure-related issues included lack of transportation, poor mobile network connection, and absence of water at the health center.
- Poor quality of health services included unfriendly providers and lack of comprehensive health services at health facilities.
- Inability to find a person to go to health facility with the pregnant woman.
- Experience of short labor time.

Contraceptive use

- Injectables and implants were the most commonly used family planning methods.
- Women in food-insecure households did not choose implants due to the perception that implants require daily intake of nutritious foods.
- Overall, there is a latent demand for contraceptives.

Local models of nutrition and dietary practices

- Local models of nutrition groupings predominated all four regions and categories similar to these local models should be used to promote healthy nutrition practices.

- The technical six food grouping categories are not commonly understood or articulated by rural study participants.
- Wot was a common category listed in all four regions.
- Mamagiya means having milk and/or yogurt with the meal in the Amhara region; kochekecho indicates foods that benefit the body in SNNP.
- Special nutritional care for pregnant women is limited to ceremonies around the childbirth.
- Pregnancy is considered normal and usually women do not consume additional or special foods during this period.

Handwashing practices

- While handwashing with water is a common practice, handwashing with soap was not.
- The HEWs interviewed described the practice of handwashing with soap in terms of the messages they provided to households. They saw their work as “telling people what to do” instead of focusing health behavior change.

CHAPTER 4. GATEWAY BEHAVIORS

The Communication for Health project is integrated to covering six health areas. The project focuses on 16 priority behaviors across the six health areas. A gateway behavior serves as an “entry” toward the adoption of four to five more behaviors along a continuum. The baseline survey identified, through logistic regression analysis, three behaviors as “gateway behaviors.” These three behaviors had a maximum association with other health behaviors. The gateway behaviors are, early ANC care (<12 weeks), owning a family health guide, and having a functional handwashing station within a household.

Three gateway behaviors were explored in the sociocultural study. They were identified as priority behaviors during the baseline data analysis (for details refer Communication for Health, Ethiopia Baseline Report, 2017). In addition to assessing the main barriers and facilitators to the three gateway behaviors, we obtained contextually relevant information about them.

Early Antenatal Care Registration (<12 weeks)

Early Antenatal Care Experiences

Only three of the 16 interviewed women visited a health facility for their first ANC checkup during the first three months of the gestational period of their most recent pregnancy. Six of the women attended their first ANC checkup at three months of pregnancy, and the remaining seven women attended at the fourth month or later. There was no notable difference in attending early ANC (within 12 weeks of pregnancy) across regions. Of the 16 interviewed women, 11 attended four or more ANC checkups, while the remaining visited the health facility for ANC services only two to three times during their recent pregnancy.

The majority of women reported that they decided to go to the health facility for the first ANC checkup without telling their husbands. A few reported consulting their husbands, and some said their husbands accompanied them to their visit to the health facility.

Nearly all—14 of the 16 interviewed women—were tested for HIV during their ANC visits. The two women who did not undergo HIV test during ANC visit were in Oromia. In most cases, health workers initiated an HIV test, while a few women said they requested to be tested for HIV, as they felt sick and want to know their status. *“They [health workers] also told me to do a checkup for HIV, and I did that.”* [30, Female, IDI, Simada, Amhara]

Most women said that they talked with their husbands about the HIV test they take during their ANC visits, and, as a result, their husbands were also tested. The practice of tested couples for HIV during pregnancy is relatively better in Tigray, *“The health workers counseled me that my husband might have sexual contact with other women or he may be infected with other things, so both he and I should check our status. Hence, I discussed it with him, and he agreed and checked his status.”* [29, Female, IDI, Damot Sore, SNNP]

Women’s descriptions of ANC services were often general and focused on procedures such as getting a urine test to check pregnancy, checking the health condition of the fetus, and receiving

medicines and vaccinations. A few women recalled receiving iron supplements and blood pressure measurements as well. Although few women reported that the health workers advised them about women's nutrition during pregnancy, the majority of them said they did not receive counseling during their ANC visits. *"There was no any education except one time during my pregnancy otherwise it was only vaccination."* [37, Female, IDI, Saint, Amhara]

Although health centers and health posts are the main facilities where women attend ANC services, not all women visit these facilities for their first ANC checkup. Some women chose to go to a private clinic for their examination. *"If I know that I have no sickness but pregnancy, I will go to the health post, not to a private clinic. There is service here at health post but I went to a private clinic since I was sick."* [30, Female, IDI, Adaba, Oromia]

In general, women had a positive attitude toward ANC services provided at health facilities. They described ANC services at health facilities as very good and the treatment of health workers as supportive. A few women also said that because health workers prioritized them, they spent less time at health facilities.

However, a few women in Oromia and SNNP regions reported they experienced maltreatment by health workers during their ANC checkups, including being nagged for not coming for an ANC visit when they were in the early pregnancy stage and being asked if they wanted to have abortion. There are also instances in which health workers imposed HIV tests, stating they were a prerequisite to getting other services.

"When I was three months, I doubted and went to a health center for a checkup, and they told me there was a baby in my womb. They asked me whether I want to abort it or deliver it, and I said this is the will of God and I want to give birth." [20, Female, IDI, Dale, SNNP]

"When I went to a health facility, they [health workers] told me to test for HIV to get treatment. They said you do not get treatments unless you are tested, then I decide to get tested." [22, Female, IDI, Jeldu, Oromia]

Social Norms Related To Early Antenatal Care Checkup (<12 Weeks)

The typical timing for the first ANC checkup for pregnant women is at 16 weeks (four months), unless women feel unwell. The current norm of going for the first ANC checkup after 16 weeks is not aligned with the recommended practice of early ANC (<12 weeks) checkup. The main reason pregnant women do not choose to have an early ANC checkup is the strong social norm that women only need to go for a checkup if they experience physical discomfort.

Study participants stated that there is no "fixed" time when they go for their first ANC checkup. Instead, they repeatedly said that women go to the health center only when they feel unwell.

"Unless we are sick, there is no need of go to health center... But if she does not get sick, she goes for medical checkup when she reached at six month of pregnancy." [30, Female, FGD, Jeldu, Oromia]

"If she does not get sick she might not go [to the health center]," said another woman from SNNP, indicating an absence of an established norm related to early ANC-seeking behavior.

“Actually, it depends on your health situation: for instance, if you feel sick during your pregnancy, you could go to the health center starting from two months of pregnancy,” reported one HDA. [23, female, KII, Tahitay Koraro, Tigray]

The lack of a social norm around early ANC-seeking behavior was further reinforced by an HEW from Oromia: “They (women) do not know when they become pregnant, they’re aware about pregnancy when the fetus in abdomen start to move. They came to us when they are four, five or six month pregnant. When we ask them why they delay ... they do not know their last menstrual period. **Most of them know (about their pregnancy) when the child starts to move.** They are not aware of it until then.” The HEW links the late initiation of seeking ANC services to a woman’s confirmation of her pregnancy when the baby starts moving.

Regional differences indicate that while study participants from Amhara reported they had their first ANC checkup at four months, the month of the first ANC checkup varied by region: SNNP participants reported an average of five months and Oromia and Tigray reported a range of four to six months. Data indicate that the “early ANC (<12 weeks)-seeking” norm is nonexistent. Similarly, there appears to be no difference in reporting the norm among the different levels of study participants, mothers, community members, health workers, and volunteers.

Facilitators And Barriers

Facilitators to early antenatal care visits

Health concern: Women usually visit health facility for the first time seeking medical care when they experience illness, not for ANC services. Exceptionally, most interviewed women in Tigray said they visited a health facility for the first time for an ANC checkup. Women also mentioned getting treatment for pregnancy-related health problems and vaccination as reasons for attending subsequent ANC checkups, *“I went to the health facility for the first time due to the pain and discomfort that I encountered.”* [25, Female, IDI, Dale, SNNP]

Desire to have a healthy baby: A woman’s desire to have a healthy baby was a driving factor for subsequent ANC follow-ups. Most women said that they attended ANC follow-ups to know the health status and position of the fetus and ensure the health of the baby.

Prior experience: Women with prior experience of pregnancy-related health problems were most likely to know the benefit of ANC attendance and appropriately follow the service. *“When I gave birth to my previous child, the labor was severe. Then, when I asked them why that happened, they said; ‘You should check the weakness and growth of the fetus, it is because it has grown a lot’. Afterwards I go there and check. Even though they do not tell me to come, I go on my own and get checked.”* [28, Female, IDI, Sayint, Amhara]

Health worker’s advice: Often women attended ANC follow-up appointments because health workers advised them to do so and helped them to get an appointment for the next visit. *“When I went to the first time for a checkup, the health worker gave me the card and told me to come back again.”* [20, Female, IDI, Dale, SNNP]

Barriers to early antenatal care visits

Uncertainty about pregnancy status: Uncertainty about pregnancy status was the primary factor for not attending ANC within 12 weeks of pregnancy. Often, women did not know their pregnancy status during the first few months. Women experiencing irregular menstruation went to a health facility early because they thought they missed their menses due to an irregularity, not because they thought they were pregnant. Although a few women said they suspected pregnancy when the encounter symptoms such as loss of appetite, women usually recognized their pregnancy when the fetus started moving in the womb. *“My mensuration is not regular, it sometimes disappears for a year, and sometimes I see it after three months, six months, year. Since I did not see it every month, I did not suspect pregnancy. But when we went to a health facility, they said I was six months pregnant.”* [23, Female, IDI, Jeldu, Oromia]

Not wanting to disclose pregnancy status: Disclosure is a sensitive issue that impacts ANC attendance. Some women who do not want others know about their pregnancy status at an early stage due to concerns of gossip teasing by other people. *“If the women are pregnant they do not want others knew they are pregnant so they stay in the home. Some women exposed themselves after 36 weeks of gestation.”* [28, Female, KII HEW, Dale, SNNP]

Sociocultural influence: For a long time, the community did not have access to a health facility and, therefore, did not develop a habit of using ANC services in the study regions. Consequently, women were not eager to visit the health facility for ANC checkup. There were other beliefs that affected ANC attendance; for example, some people believe that medications, such as injections, hurt women, as they traditionally associate it with evil deeds. In Amhara region, there is a traditional belief related to a spirit called Zar; people believe that a woman who has the spirit should not seek health care because it will make the spirit unhappy.

Family members' influence: Study participants indicated that husbands influence women's ANC attendance. The majority of women reported that their husbands either supported and encouraged them to attend ANC checkups or, at least, did not prevent them from the checkups. They stated that, unlike previous times, currently husbands do not discourage them from visiting health facility for a checkup. On the other hand, HEWs and HDAs said that still there is negative influence from husbands. Negative influence comes from not only from husbands but also from other family members such as the mothers-in-law. *“Family members like the mother-in-law and/or the husband himself often say to the pregnant women ‘you are too early to go to health centers,’ ‘you have to stay at home,’ which discourages pregnant women to not attend ANC.”* [29, Female, KII HEW, Sayint, Amhara]

Inadequate information about first ANC visit: Some participants also reported that women might not know that the first ANC visit should occur before 12 weeks of pregnancy. An HEW said that some women do not have access to information about available maternal health services at health facilities, as they are often engaged in household chores and unable to attend meetings and have community interaction.

Distance and transportation: Long distance to health facilities, coupled with inadequate

transportation, hinders women from attending the full ANC checkups. Although health posts are available at kebele level, only health centers provide ANC services. Since one health center provides service for about five kebeles, women from other kebeles need to travel to the health center located in another kebele. *“When they first visit us, we send them to the health center, since the first ANC should be done there. But, some of them go back to their house instead of going to the health center, because the health center is far from them.”* [27, Female, KII HEW, Adaba, Oromia]

“Those interrupting [ANC follow-up] are due to the distance to the health center. For example, women are mostly attending ANC up to three times, but no women attends four times. When we ask them the reason, they said they are tired of traveling the long distance, as the health center is too far from their home.” [29, Female, KII HEW, Sayint, Amhara]

Except in Tigray, distance and lack of means of transportation are the primary barriers in the three regions. Region-specific barriers included:

- Women do not want other people to know about their pregnancy in Amhara and SNNP.
- Women do not want to expose their body to health workers during a checkup in SNNP.
- Public transportation is not willing to provide service for pregnant women in Oromia.
- Women fear health workers may give them injections (do not want injection) in Tigray.
- Belief associated with an evil spirit called Zar in Amhara impede ANC attendance.

Family Health Guide

Availability Of Family Health Guide

Out of the 16 interviewed women with a child under two, 10 of them own a Family Health Guide. Across regions, none of women interviewed in Saynt and Adwa rural woreda had a copy of the Family Health Guide. Five of the eight interviewed HDAs had a Family Health Guide, while three of them (two HDAs in Amhara and one HDA in Tigray) did not have one. Most women received the Family Health Guide in the past one or two years. Women usually obtain a copy of the Family Health Guide from HEWs or at health centers when they visit the facility for maternal services such as delivery. *“They gave me this book [Family Health Guide] at the health center when I was pregnant.”* [20, Female, IDI, Dale, SNNP]

Regarding availability of the Family Health Guide in the community, it seems most households do not have the Family Health Guide. According to HEWs and HDAs, they only give the Family Health Guide to pregnant women, women with a child under two, and health development groups. They reported shortage as the primary reason for not distributing the guide for all families. Woreda health offices distribute the Family Health Guide based on the number of pregnant women in the kebele, not on the number of all households. *“It was not distributed for all ... Since they were pregnant; it was given to them to aware how to treat themselves as well as their child. We gave them a priority.”* [29, Female, KII HDA, Saint, Amhara]

"The [number of] guides brought to this kebele was based on the number of pregnant women, not [based] on the number of households." [28, Female, KII HEW, Dale, SNNP]

In addition to the limited availability of the Family Health Guide at the household level, women usually do not keep it carefully. When asked where they store the Family Health Guide, only women in Tigray mentioned specific places, such as box, carton, or closet for storing the guide, most of the women just replied 'at home.' According to HEWs and HDAs, the majority of women do not keep the guide carefully: often children drop water on it or it gets lost. HEWs and HDAs also reported some women use the guide as a folder for holding a student's exercise book or as toilet paper. An HEW in Oromia also said that some women rip the guide and post the papers on the wall thinking it is good to see it so that they will not forget the message. *"I keep it somewhere in my house."* [30, Female, IDI, Adaba, Oromia]

"They use this book [the Family Health Guide] for students' bag, or they use as toilet paper, they tear it and use for other purposes." [35, Female, KII HEW, Damot Sore, SNNP]

Family Health Guide Use

Among women IDI participants who did not have a copy of the Family Health Guide, three said they had never seen one. Most women called the Family Health Guide simply the 'book.' Other words for the Family Health Guide in the community included: 'manual' and 'carni' [meaning ticket] in Amhara, and 'health extension book' in SNNP. In Tigray, they called it 'health information,' 'family planning,' or 'medical book.' *"No, I did not see it [the Family Health Guide]. I never saw it."* [23, Female, IDI, Jeldu, Oromia]

All interviewed women acknowledged that the Family Health Guide is important. However, when asked to mention the guide's essential messages, they described them in general terms, such as to keep the body healthy, to keep the health of a newborn baby, and to prevent disease. A few mentioned specific issues, such as sanitation, child feeding, delivery, and child care. *"It has different messages like how to feed a child, how to prevent diseases and how to keep our compound and environment clean."* [24, Female, IDI, Adaba, Oromia]

"It [the Family Health Guide] tells the way how to care for a newly born child, the feelings that pregnant women experience and everything related to mother and children." [25, Female, IDI, Dale, SNNP]

"It is easy to read and understand the pictures in the guide, and it is useful." [32, Female, IDI, Tahtay Koraro, Tigray]

Sharing Family Health Guide messages A few women said they read the Family Health Guide. In Amhara, some women reported that they use the guide for teaching each other during women's meetings. Women in SNNP and Tigray said that their children read the guide for them.

"I use it [the Family Health Guide] to learn about the things that I should do to keep my body healthy and to prevent diseases caused by lack of sanitation." [25, Female, IDI, Simada, Amhara]

"I keep it [the Family Health Guide] in my home and use it for discussion when we have a meeting. We read, discuss, and teach each other." [30, Female, IDI, Simada, Amhara]

"My child is in grade six. So, he can read it to me." [25, Female, IDI, Dale, SNNP]

Being nonliterate and lacking time were among the reasons for not using the Family Health Guide. Women participants also said they do not read the guide because it has few pictures and the content is difficult to understand without health professional support. One woman claimed she does not read the Family Health Guide because the HEW does not tell her to read it.

"I do not use it since I cannot read it." [30, Female, IDI, Adaba, Oromia]

"It [the Family Health Guide] does not contain things to read and understand, most of its content are questions, because of that, there should be health professional that can help you to read." [22, Female, IDI, Jeldu, Oromia]

"I did not need anything from it. Because it is small and had few pictures." [38, Female, IDI, Adwa rural, Tigray]

"I had seen the book again and again when I was pregnant. But, I did not see it after I gave birth because I did not have sufficient time." [25, Female, IDI, Dale, SNNP]

"She said I will teach you coming here every month, keep it in a clean place, and then I keep it. If she told me to read the book, I can read and understand its message." [22, Female, IDI, Jeldu, Oromia]

Some HEWs and HDAs reported that they use the guide to teach women during home visits, during vaccination days, and by organizing meetings for pregnant women. They noted that the guide is helpful to teach women, as the pictures help illiterate women easily understand the messages.

"It has been more than four years since I have been using the family health guide for my job." [29, Female, KII HEW, Sayint, Amhara]

"The community in this area understand pictures easily than words. They understand well about the message in the picture, they explain it correctly ... It is clear to them, instead of teaching them by words; it is helpful to teach them using the picture. When we ask them question depending on the picture that we showed them, they easily understand the message. They easily understand teaching supported by pictures." [27, Female, KII HEW, Adaba, Oromia]

"For example, if you see the guideline, most women do not read what is written there, so we explain it and ask them about their understanding. But, most women understand the picture and able to know what the woman is doing there in the picture." [29, Female, KII HEW, Simada, Amhara]

Feeding practices, complementary food preparation for children, malaria prevention and use of ITN, handwashing, nutrition, hygiene and sanitation, child health, pregnancy and delivery, ANC, family planning, and vaccination are frequently mentioned topics HEWs and HDAs usually address when they teach women using the guide.

"I use it [the Family Health Guide] to teach women about pregnancy ... I also use it to follow up with women who gave birth about their child nutrition. On the other hand, I use it to follow up with women who are neither pregnant nor have child regarding HIV/AIDS and hygiene and sanitation issues." [23, Female, KII HDA, Tahtay Koraro, Tigray]

"Mostly, I've used the book [the Family Health Guide] for the pregnant women. I taught them about malaria prevention, how to use a bed net, and advised men to take mothers to the health center when they have danger signs. We taught about when vaccination should be started, and when infants should

start complementary feeding and how the fathers should support the women. So we show these things when we get the men in meetings.” [35, Female, KII HEW, Damot Sore, SNNP]

However, it seems some HEWs and HDAs do not regularly use the guide for teaching women. A few HDAs, mostly in Amhara and Oromia, reported that they do not use the Family Health Guide for their work. Female IDI participants claimed that even though HEWs promised to come to their home and teach them about the guide, they did so rarely.

“I used this book [the Family Health Guide] since I started my work. However, I did not use last year because these books were not available here.” [35, Female, KII HEW, Damot Sore, SNNP]

“One day she [the HEW] came and taught me using this book [Family Health Guide], she told me she would come again and teach me from the book, but she did not come again.” [22, Female, IDI, Jeldu, Oromia]

“Yes, I ask educated children to read for me. I sometimes call my son during the night when there is light to read for me, and I learn from it. It is to help me to contribute to my community.” [55, Female, KII HDA, Jeldu, Oromia]

Handwashing Station

Availability Of Handwashing Station

Responses to the availability and use of handwashing station differed across regions, although most study participants said that many households do not have a handwashing station. HEWs and HDAs in Amhara region reported that the majority of households have a container, such as a plastic bag or jar, placed near latrine. In Oromia, most households had had a handwashing station in the past; but now, only a few have a handwashing station, as the facilities were damaged according to HEWs and HDAs. They blamed children for frequently damaging handwashing facilities.

Although one HDA in Tigray reported that the government provided plastic containers for handwashing stations to some households, several study participants in Tigray and SNNP said that most households do not have a handwashing station. Jerrycan and plastic containers hanging on a pole near latrines were the common handwashing stations used by households. The containers have an opening to allow water to flow out, and pieces of plastic are used to hold soap near the handwashing facility.

“These days, all the households in the village have handwashing facility near the latrine. But there is no handwashing station inside the house.” [19, Female, KII HDA, Simada, Amhara]

“They wash their hands with soap and water, but they do not have separate [specific] place for handwashing.” [35, Female, KII HEW, Damot Sore SNNP]

“Most households have [a handwashing station], but they may be removed [destroyed].” [35, Female, KII HEW, Jeldu, Oromia]

“When we keep water and soap at the handwashing station, the children open the door and destroy it. That was why we got annoyed and stopped it. When we use the latrine, we use water outside and get

back to our home.” [55, Female, KII HDA, Jeldu, Oromia]

“Even though it [handwashing station] is not available in our household, it is available in some households that are provided by the government.” [56, Female, KII HDA, Adwa rural, Tigray]

Households often do not want to spend money to buy materials for a handwashing station. Just following the old trend is another factor for not having handwashing facility as people have the habit of taking water when they visit latrine for defecation, but not soap.

“Because they do not want to spend money... they do not spend money on it.” [27, Female, KII HEW, Adaba, Oromia]

“No, it is not associated with awareness, it is their habit, and they like to take water to latrine instead of keeping it there.” [27, Female, KII HEW, Adaba, Oromia]

Preferred Type Of Handwashing Station

Table 7: Preferred type of handwashing facility, reasons of preference, and possibility to have in every household

Preferred Type by Region	Reason for Preference	Feasibility to Have in Every Household
Jerrycan with opening at the bottom hung on a pole [Oromia and SNNP]	The materials are locally available, not expensive, and simple to use. Children cannot damage it easily as it is tied to a pole. Convenient to wash hands after latrine use. “Why (we like) this one is that they (people) stand there near the latrine and wash their hands. It is easy to manage and simple to use.” [35, Female, KII HEW, Jeldu, Oromia]	Possible to have because every household has Jerrycan bought with oil. Households can install it with ease.
Jerrycan with opening at the bottom placed on a table-like structure [Oromia and Tigray]	The materials are locally available and also households can use other materials like plastic containers. Convenient for washing hands after using a latrine and before going back home. Families can easily maintain it. “The reason why it is suitable is that someone can clean (wash) his/her hand after using a latrine and get back home.” [43, Female, KII HDA, Adaba, Oromia]	It does not cost too much to install since every household has the materials.
Jerrycan with opening at the top hanged on a pole [Amhara and SNNP]	The material is available and it prevents contamination since there is no need to withdraw water. It is easy to use. Children cannot damage it easily. “For me, this one is suitable for this village because if it is available (used), there would not be any contamination.” [29, Female, KII HEW, Saint, Amhara]	It is possible since it does not need labor or money (expense) to construct at home. Jerrycan is locally available and easy to prepare.
Handwashing facility with tap (piped) [Amhara]	It is easy to use.	It could be costly, but possible for those who have the financial capacity. It could be easy if the material (container with a tap) can be modified locally.
Water with a jar for assisted handwashing with waste collection container [Amhara and Tigray]	It has a container to contain the wastewater. “The fourth one has a container to keep the dirty water. So, it does not make the place muddy.” [29, Female, KII HDA, Simada, Amhara]	It is possible if people are educated about the importance.

Figure 4: Different types of handwashing stations



SUMMARY OF FINDINGS

Early Antenatal Care (<12 weeks)

- Women reported no specific time for the first ANC checkup.
- The first ANC checkup usually occurs when the woman feels unwell; it could take place anytime between three to six months.
- There is no social norm for seeking early ANC care (<12 weeks).
- Long distance and lack of transportation are barriers to getting an early ANC checkup.

Family Health Guide

- More than half of study participants reported having the Family Health Guide.
- The content in the Family Health Guide is understood by community members.
- The use of Family Health Guide as an SBCC tool by HEWs is inconsistent.
- A key barrier related to the Family Health Guide is its availability and distribution.

Handwashing station

- Few households have functional handwashing stations.
- The upkeep and maintenance of handwashing stations, particularly having regular access to soap and water, is a problem.

CHAPTER 5. SOCIAL, CULTURAL, AND COMMUNITY DIMENSIONS OF BEHAVIOR CHANGE

Findings related to individual perceptions of health, behavior, and services are discussed in Chapter 3, while three gateway behaviors are the focus of Chapter 4. Chapter 5 shifts the focus to examine the social, cultural, and community dimensions of health behaviors. The social dimension explores the social norms related to the main health behaviors: social capital within Ethiopian communities; the role of formal and traditional social structures, such as HDA; and social networks. The social dimension includes identifying social norms related to early ANC checkups (discussed in Chapter 4 with the gateway behavior “early ANC visit”), the number of ANC checkups, delivery, and contraceptive use and number of children. Cultural beliefs related to pregnancy, newborn care, and health are also explored, as are community strengths and challenges. Community challenges include food scarcity, lack of safe drinking water, and having coping mechanisms.

Social Norms

Social norms are important drivers of health behaviors.¹⁰ Behavior change approaches need to be informed about the social norms that govern a specific behavior. Often prevalent social norms do not support the health behaviors promoted in SBCC programs. For this study, we used the principle of bounded normative influence, which explains “the tendency of social norms to influence behavior within relatively bounded, local subgroups of a social system rather than the system as a whole.”¹⁵

Social norms are informal rules that guide a most people to adopt a specific behavior. Often, we find that existing norms do not support the health behaviors necessary to reduce morbidity, mortality, or fertility. Shifting social norms toward healthy behaviors is a challenge that requires an in-depth understanding of the existing norms and what drives people toward unhealthy behaviors. The goal of this study was to understand the issues related to social norms in our study areas and uncover the unconscious pressures or constructs that govern mainstream behavior. We explored social norms related to six behaviors. These included three maternal health behaviors—early ANC checkup (<12 weeks), four ANC checkups, and place of delivery—as well as related to number of children, contraceptive use, and son preference (refer to the section on gender).

¹⁵ Kincaid, D. L. (2004). From innovation to social norm: Bounded normative influence. *Journal of Health Communication*, 9, 37-57.

Social Norms Related To Four Antenatal Care Checkups

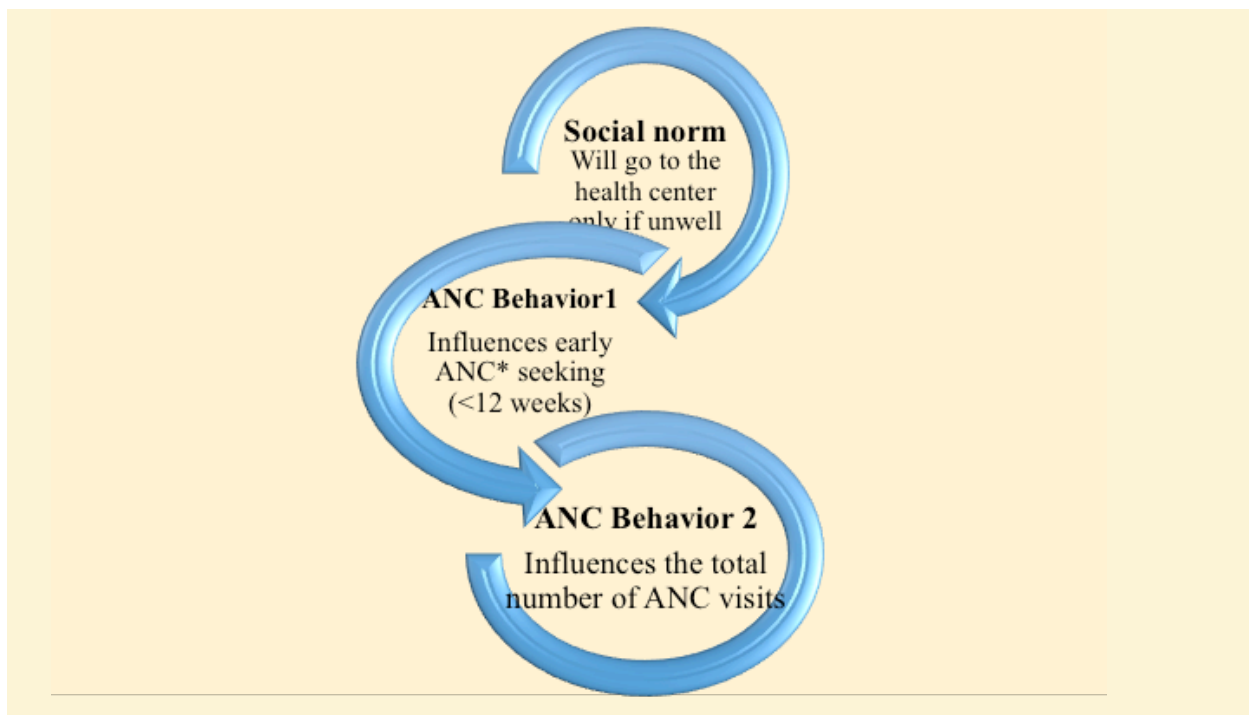
The social norms related to the number of ANC checkups women should or do attend varied according to the remoteness of location and availability of transportation. For example, data demonstrated that women who resided closer to the health center were likely to get four or more ANC checkups. However, women who lived far from a health center found it difficult to get more than two ANC checkups during their pregnancy. Some women also believed in going for their first ANC checkup after the fifth month, when they feel their baby moving. *“For example, I brought my wife only once because transportation is very difficult in our area.”* [55, Male, FGD, Adaba, Oromia]

“Village A, it is up and down and we have mountains and hills. It is not suitable to move from place to place. Some women come and attend antenatal visit but women who live near the mountain do not attend here.” [35, Female, KII HEW, Damote Sore, SNNP]

“But most of them start antenatal follow-up after they finish their five month, and so they might follow up three times” [25, Female, FGD, Damot Sore, SNNP]

However, the core issue driving the norm of women attending two or less ANC visits was that women only went to the health center when they felt unwell. *“However, there are also women who go in the seventh or eighth month of their pregnancy. They stay at their home until then and they go to health center in the seventh or eighth month when they feel sick.”* [32, Female, FGD, Tahtay Koraro, Tigray]

Figure 5: The social norm of visiting the health center only when unwell influences two important antenatal care behaviors



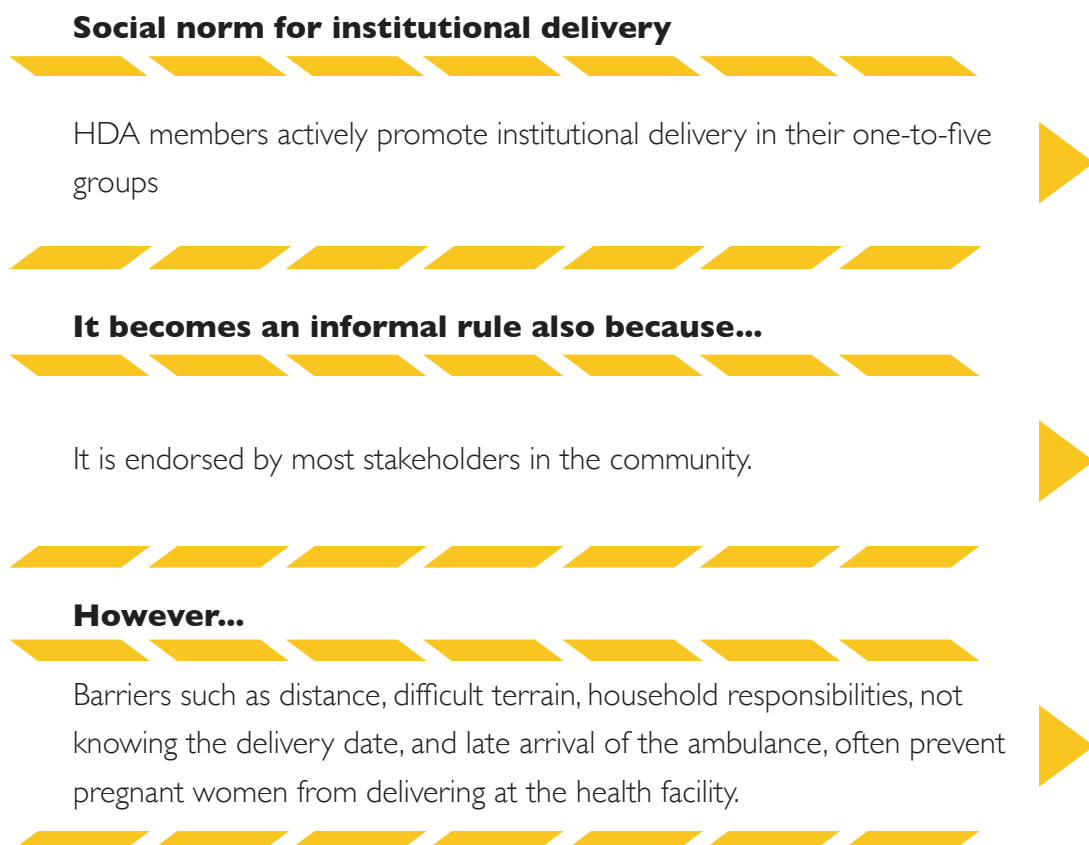
Social Norms On Delivery

The social norm related to a health facility delivery is much stronger than the social norms related to early ANC or four ANC checkups. HDAs, HEWs, and community members endorsed the importance of an institutional delivery. The norm of a delivery at the health facility is likened to following a rule. *“Those group leaders or members who let the women to deliver at home is considered as individual who is against the rule. They are going to be blamed by community.”* [40, Male, FGD, Sayint, Amhara]

Another example of community pressure on a pregnant woman to deliver at a health facility is described by a man from Tigray. He says, “about a month ago, a woman gave birth at home without informing the HDA, despite being told by them several times to deliver at the health center. The next day, the woman’s husband, went to other members and asked them to go to the health center and get some painkillers for the wife. The HDA members insisted that the woman should be taken to the health center to receive the painkillers. But the husband did not return or take his wife to the health center as he felt ashamed that she delivered at home.”

The practice of most women delivering at the health facility was listed as community strength by the kebele administrator in Tigray. However, study participants also pointed to several structural barriers related to delivering at a health facility, despite a strong social norm around facility delivery (for details, refer to Chapter 3).

Figure 6: How a social norm for institutional delivery was created



This study aimed to deconstruct the process of creating social norms by using the narratives provided by the study participants. The data indicate that the social norm for a health facility delivery is stronger than the norms related to early ANC and attending four ANC checkups. Figure 6 describes how the norm was created, as described by the study participants. Firstly, HDA members prioritized institutional deliveries to reduce maternal mortality, as described in both HDA and HEW KIs. This practice then became an 'informal rule,' a key characteristic of normative status. However, infrastructure and geographical factors make it difficult for women in remote communities to travel to health facilities for their deliveries. Other factors, such as knowledge of delivery date and organizing household support while the pregnant woman is at the health center, also facilitate health center deliveries.

Social Norms And Number Of Children

The overall social norm for number of children is skewed toward having many children. This norm is prevalent across all four regions, with minor variations. When asked how many children constitute a family with 'few children,' women in an FGD in Oromia replied three to four children. Data indicate that despite the introduction of family planning, the social norm remains skewed toward having more children. For example, a woman in a FGD in Tahtay Koraro, Tigray said, "most people have seven and eight children" even though some couples use family planning and have three to four children. We noticed that while community members provided higher figures for average number of children, seven to eight or nine to ten, the HEW from Tigray said that families usually had five to six children.

Asked if there are villages where many people have only two children, an HDA replied, "Am I going to tell you about a single household?" [56, Female, KI HDA, Adwa Rural, Tigray]

Similarly, a HEW from SNNP said there was only one woman in the village who has two children. "One woman who lives here has only two children. She uses family planning Depo-Provera and she is not interested to give birth to more children." [35, Female, KI HEW, Damot Sore, SNNP]

Reasons for preference for more children

Respect from the community: *"I come from Warza village. However difficult to raise more children, he will get respect from the community for he produced many offspring."* [32, Male, FGD, Damot Sore, SNNP]

"The family who has many children will work together in the farm, and their house always full and hunger will not be a problem in their house. The father gets rest due to having many children." [36, Male, FGD, Damot Sore, SNNP]

Social pressure to have more children: *"Most people have four or five children and I have only two children, I am considered as selfish who like my comfort. People also advise the husband to go to other wife who could have more children. They consult him to divorce me and have another wife who could give birth more children because I could not have more children."* [49, Female, FGD, Tahtay Koraro, Tigray]

The community will speak badly about families with two children: *“The community will backbite about them because they limited the number of their children to two. They respect women who have six or more children.”* [30, Female, FGD, Dale, SNNP]

Social Norms And Contraceptive Use

Social norms related to contraceptive use include the following three dimensions: an overall support for the use of modern contraceptive methods, the number of children after which family planning use acceptable, and the acceptability of contraceptive use immediately after marriage.

Data indicate normative support for contraceptive use, specifically injectables and implants. Women seem to prefer one of these two methods and often switch between them.

Female and male community members stated that the existing norm is for people to start using contraceptives after having four to five children. Data from FGDs in the four regions indicate a preference for contraceptive use after the birth of four to six children.

“Most of the community use contraceptives after they give birth to four or five children.” [25, women, FGD, Sayint, Amhara]

“People start using contraceptive after having five to six children. Some may start after having two children.” [52, Male, FGD, Simada, Amhara]

“They use family planning after they have four or five children.” [24, Female, FGD, Jaldu, Oromia]

“After they have got four children they use family planning.” [22, Female, FGD, Dale, SNNP]

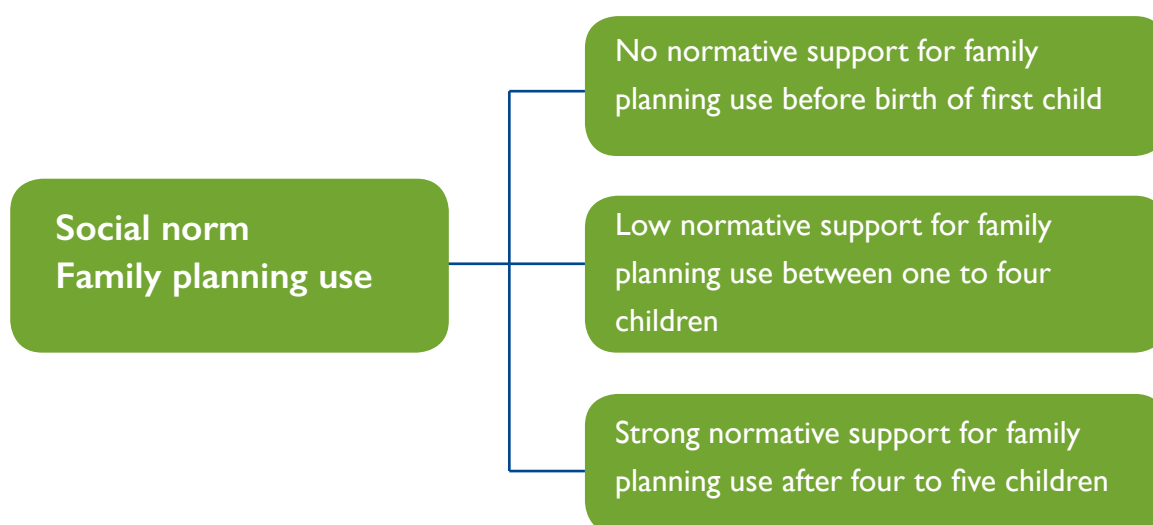
“They can start using it after having four to five children.” [30, Male, FGD, Tahtay Koraro, Tigray]

The current social norm is to start contraceptive use after a couple has four to five children (Figure 7). We found the norm for contraceptive use before first birth was weak. Two women from SNNP explain their views. *“When the woman married, she doesn't use family planning before she gets her first child because they think that it delays pregnancy even they have frustration that the method may inhibit giving birth.”* [28 and 45, Females, FGD, Dale, SNNP]

Similarly, men indicated that a woman has to prove her fertility before she can start using contraceptives. One of the men gave insight into the decision-making power of men on contraceptive use by saying, *“her husband cannot permit.”*

Some couples are hesitant to use contraceptives until they complete their need of family size (Figure 7). *“Most people start using contraceptives after finishing having all children they need to have in their life.”* [30, Female, FGD, Adwa Rural, Tigray]

The norm for using contraceptives after the birth of the first or second child is low in all four regions. A woman from Amhara said that women prefer to start using contraceptives after four children. *“This is because we don't want to have only one, two, or three children. We don't know what will happen to them so we need to add more.”* [40, Female, FGD, Sayint, Amhara]

Figure 7: Social norms for family planning use

Several beliefs state that using contraceptives will make women infertile, that that risk is exceptionally high for a newly married woman, and that the number of children a couple has reveals when they started using contraceptives. The data related to social norms for contraceptive use indicate a strong overall norm to use family planning after the birth of four to five children (Figure 7).

Social Capital

“A forest never stands without a root. Thus, the [one-to-five] network is a root.” [43, Male, FGD, Tahtay Koraro, Tigray]

A key objective of the study was to identify community strengths that can be leveraged for collective health behavior change. The study explored the modalities and structures of existing social organizations at the community level. Specifically, we studied the HDA, iddirs, equbs, and women's, men's, and youth organizations.

A range of social structures in rural settings can serve as channels to promote health behaviors. The data demonstrate that social support structures are an intrinsic part of Ethiopian culture. We define social capital as the support social structures and social relationships provide to communities for the improvement of their health. The study examines how key community structures operate and assesses their characteristics. The purpose of this section is to describe HDA and traditional community structures by describing the roles, functions, and outcomes of each type of organization. The community network closest to the household level is the one-to-five network. Study participants across all four regions reported the existence of the one-to-five network in their communities (gots/villages). These networks are the immediate support group available at the community level. A few study participants reported that they were not members and that the network was not active in their area.

The level above the one-to-five network is the HDA, which are development teams comprising 30 individuals. The HDA provides leadership to the one-to-five networks and is the bridge between health services and the community. HDAs are active in all four regions, according to the study participants.

Traditional social support groups, such as iddirs, also exist in all regions except Tigray, while equbs were less prevalent. This may be due to their chief purposes: equbs are organized more for the purpose of savings and finance, and iddirs—which are at both the village level and across several villages—were traditionally formed to help the community during the death of a family member. Iddirs now perform a more varied role (details in later section). Kebele-level organizations for women, youth, and men were found mostly in Tigray.

Health Development Army (One-To-Five Networks And Development Teams)

Structure

Groups of five to six households living in the same neighborhood make up a one-to-five network. HDAs are clusters of 20 to 30 households, clustered in one-to-five networks, living in the same neighborhood. Almost all study participants knew about the HDA and their role. Most of the study participants were members of the one-to-five networks. Only a few focus group members in all four regions were not members of the one-to-five networks.

According to one HEW's description, the health development team comprises "a minimum of 25 to 30 people. This divided into a group of one-to-five groups, which means in one development team, there may be five to six one-to-five networks. Generally, the number of development team is dependent on the size of the got (village) and that in most cases, in one got [village] there will be a maximum of five to six one-to-five networks." The network structure is the same in all four regions. According to a HDA leader from Socham kebele, Amhara, women's one-to-five groups usually have more members than men's groups because both married and single women participate. One-to-five networks and development teams follow a similar systematic process of selecting leaders and members. The women's FGD in Rahya Kebele, Adwa Rural Woreda, Tigray, describes the identification of leaders and members in detail:

"Firstly, the tabia (kebele) chairpersons recruit the development team leaders. They recruit five team leaders in a single 30 [group of 30 people]. Then those who are recruited select a group of six people and arranged as one-to-five. They [leaders] discuss with each other on how to handle their respective members. We say to each other 'you handle those five people and I will handle these ones'. The five people, we mobilize for immunization and other services.... and we know people under each of us and we instruct [command] and mobilize them." [30, Female, FGD, Adwa Rural, Tigray]

The one-to-five network meets twice a month and the leaders of the network meet monthly with the HEW. A majority of female FGD participants from the Sariti Kebele reported the lack of

one-to-five groups in their area. They said the development team does exist and, initially, one-to-five networks were also organized. However, their HEW had to leave for further education and this led to the dysfunction of the one-to-five networks. *“There are one-to-five structures, but it is just for name. There is no activity in it.”* [24, Female, FGD, Jaldu, Oromia]

While male FGD participants in Sariti reported similar views as the women, the men spoke in detail about the effectiveness the one-to-five networks when they were active.

Health-related roles and responsibilities of one-to-five networks

Study participants across the four regions described specific health responsibilities for the one-to-five networks, including promoting delivery at a health facility, mobilization for immunization, motivation for latrine construction, and promotion of environmental cleanliness. Other areas, such as the promotion of ANC visits, were not universally mentioned across the four regions.

The core role of the one-to-five network is to facilitate discussion among the members. For example, the issue of delivery at a health facility can be discussed within the real-life context, enabling problem solving and proactive action by members. Women in these networks discuss their problems, and provide guidance and direction to each other.

Male participants from Ashenga, Amhara, said that once a woman is pregnant, the entire group has the collective responsibility of following up with her and encouraging her to go for ANC checkups. The group leader is held accountable if the woman misses her checkup. *“It’s not just about health but also about doing activities together,”* they said. Women in the FGD from Socham echoed the same sentiment. *“We, one-to-five members, work together whether it is with weeding or latrine [construction]. We go around the village together and if we identified someone pregnant in the village, we come and report to the HEW. HEW will register and will refer her to the health center for further checkup. We also demonstrate them how to construct latrine and prepare mirt medja [best stove].”* [38, Female, FGD, Simada, Amhara]

Participants talked about the importance of discussion within the one-to-five network and the need to review each individual’s progress. For example, *“[t]here is a discussion among the members of our one-to-five network on different topics such as productivity, health and so forth. Each member of the network discusses those topics and finds a solution if there is problem. In the beginning, [HEWs] taught us about health. After that, we started discussing these issues.”* [35, Male, FGD, Jaldu, Oromia]

The one-to-five networks are often referred to as “chains” indicating an interlinkage among members and the ability to refer problems to the next level if they cannot be addressed within the one-to-five chain. *“As my friends said, the role of group is searching for solutions for the members in the group. If there is problem, they solve it at their level. If not, they report to the next level.”* [35, Male, FGD, Jaldu, Oromia]

Power of the collective

We present findings from all four regions that mentioned the power of the collective within the HDA and the one-to-five networks. Women in a focus group in Oromia alluded to the potential of the group and how a one-to-five network can help individual women. *“One of our members might either construct a house or she might have a social event such as baptism. During that time, five of us will go and support her, the support reduces much of the burden on her.”* [34, Female, FGD, Simada, Amhara]

One-to-five group as channel of communication: *One-to-five groups are used as bridge between the community and the government. They share the community’s information to the government and, similarly, they also share information from the government to the community. One-to-five group plays a great role for the community. Related to health, they teach how to prepare latrine and other sanitation; related with agriculture, they teach about weeding, and other treatment of crops.”* [40, Male, FGD, Simada, Amhara]

Problem solving through discussion – one-to-five members support one another financially by borrowing money: *“We help each other by working together. The one who didn’t have an ox borrowed from another one, we can solve our problem together. The benefit we get by being a member of one-to-five groups is that we are learning each other and we can get awareness on different issues. We started solving any problems through discussion.”* [36 and 35, Males FGD, Damot Sore, SNNP]

Focus areas of the one-to-five network

The activities undertaken by the one-to-five networks were varied across different regions and were dependent on kebele needs and context and problems of the one-to-five networks. One-to-five networks often include women’s groups, men’s groups, and even school children’s groups. Each network group has their own focus areas. For instance, the women’s groups focus more on the health issues, such as health facility delivery and sanitation, as well as saving money and empowering women.

The study participants were asked what community-related tasks the HDA should perform. The study participants suggested the main community focus areas for one-to-five networks should be:

Health

- Promoting ANC checkups
- Organizing delivery at a health facility
- Contraceptive use promotion
- Motivating households to build latrines
- Environmental cleanliness promotion

Agriculture and nutrition

- Providing information about effective agricultural practices
- Encouraging vegetable and fruits in the backyard
- Providing different seeds
- Collective labor for weeding

Household level

- **Resolving** marital discord and conflict
- Helping out with household chores, such as providing food for a woman who has recently delivered

PROMOTING FAMILY PLANNING

The three primary health areas that the one-to-five networks focus on are maternal health, specifically skilled delivery, family planning, and hygiene and sanitation. Several one-to-five network members reported family planning being discussed in their bimonthly meetings.

However, study participants who have participated in group family planning discussions said that they primarily talk about spacing children. Several men who participated in the FGD from Socham, Amhara, said that they use examples of role models who give birth after three years. The men from one-to-five networks were willing to talk to other men who are reluctant to use contraceptive methods. Men who participated in the Oromia FGD, echoed a similar approach. In contrast, a woman from SNNP said that she is not a member of a one-to-five network and has never participated in discussions about family planning.

“Yes. When there is discussion between one-to-five groups, they discuss to avoid child birth year after year. Instead, they take example of females in their groups who give birth after three years or more as a model. This is just by using contraceptives. They also say that if you fear your husband, we can tell him.” [39, Male, FGD, Simada, Amhara]

Female participants from an FGD in Shoye, SNNP, stated that they discuss different contraceptive methods in their one-to-five networks. Since the members of the network share their experiences, women are then able to decide which contraceptive method best suits their situation.

“Yes, we discussed in one-to-five network about types of family planning for instance injection type, its use and disadvantage; and advantage and disadvantage of other methods.” [30, Female, FGD, Dale, SNNP]

Impact of the Health Development Army (as perceived by study participants)

One of the major impacts of the one-to-five networks is in the area of health. Men in the Dembezame and Shoye, SNNP FDGs described similar experiences. Specifically, they described a change in delivery practices, from home to the health facility. The second area of change was in sanitation practices. The pressure from the one-to-five network enabled everyone to construct a latrine. *“A big change is achieved in health. Previously women gave birth at home and they faced so many problems during delivery. But now, we are telling women not to give birth at home. Many of them practiced health facility delivery. Another change is previously either adults or children defecated everywhere in open field but now this all changed. We are using toilet, there is no fly or rubbish even you walk and look around the field. If there is a person who is not willing to construct a toilet, we condemn him.”* [35, Female, FGD, Damot Sore, SNNP]

Impact of HDAs was illustrated through their involvement of various stakeholders in the community. For example, women in a focus group from Sariti described the role of the kebele manager who facilitated construction of toilets in the kebele by taking a video of the unclean villages due to open defecation. People felt ashamed when they saw their unclean village in the video and were motivated to build their own toilets.

Other areas of impact that were discussed by the study participants included resolving marital conflicts, supporting orphans, and protecting the environment. A woman from Gardilo kebele said that if marital conflict is not resolved at the one-to-five network level, community level members could approach leaders at the next level. A woman from Socham kebele, Amhara, spoke about identifying orphans in their got (village) and providing them with support. Her one-to-five network also planted trees to help protect the environment.

We described the collective experiences of study participations from eight kebeles in four regions. Their experiences speak to the vast potential of the HDA to bolstering community-level support for both normative and health behavior change. Study participants were asked how the HDA can be further strengthened. The following are some suggestions:

Experience sharing among one-to-five network and Health Development

Army leaders: Two female participants from Sariti kebele, Oromia region, spoke about the need for community members to become more active in order to increase the HDA's level of impact. Both women spoke to the issue of sharing experience and influencing other community members through their positive experiences.

Active participation in one-to-five networks: Women who were part of Gardilo kebele's FGD (Oromia region) strongly felt that to improve the one-to-five networks members needed to be actively engaged. Another FGD participant from Tigray also emphasized the involvement of one-to-five network in various developmental activities: "A forest never stands without a root. Thus, the network is a root. Nothing is done without the one-to-five network group involvement. It is the root of the government and the people." [43, Male, FGD, Tahtay Koraro, Tigray].

Traditional social structures – Iddirs and Equbs: Iddirs (indigenous voluntary organizations)¹⁶ and equbs (informal financial institutions) exist in three of the four regions of the study. Iddirs have been social structures that have existed in Ethiopian communities for a long time. Their primary role has been to help families in adversity, especially during the death of a family member. Most importantly, the iddir provides support during important life events such as marriage and death. Equbs, on the other hand, are savings groups for women and men that provide loans to members from the collective savings. As women from Gardilo kebele discussed, the social interaction and financial rotation of the equb and the financial and community support during key events, is crucial. "Iddir is most important, since it helps us during death. Equb (money rotation) is also

16 Pankhurst, A., Mariam, D. H. (2000). The Iddir in Ethiopia: Historical development, social function, and potential role in HIV/AIDS prevention and control. *Northeast African Studies*, 7(2), 35-57.

important for example if 10 individuals contribute 20 Birr per month the person who get his turn to have the collected money may do business with that money. Equb member regularly meet and discuss while collecting the money, which benefits us much because of that social interaction is very important. In addition iddir and equb members support one another when a person's son or daughter get married or in any other social event." [28, 37, and 35, Females, FGD, Adaba, Oromia]

Iddirs are for both women and men, and membership ranges from 35 to 150. Study participants described the specific community support offered by iddirs at the time of a funeral. "Members collect food items such as enjera, wot, tela, bread, and coffee, and stay with victim family for several days may be about seven days. This is what iddir is about. There is also iddir which contain the whole community members. For example, when there is loss of animals or damage of crops, then the chairman of the iddir and members will support." [29, Female, KII HDA, Sayint, Amhara]

Study participants from Oromia spoke about the crucial role of iddirs, which involves addressing serious social concerns the communities face, including the issue of older men luring young underage girls into matrimony and then deserting them, the prevention of violence against women, and even the prevention of violence against children.

"The problem we encounter is that men especially youngsters ask under age girls for marriage. Even if it is not abducting, they take girls by deceiving them and prohibit them from going to school." [38, Female, FGD, Jaldu, Oromia]

"In iddirs, we discuss violence prevention in our community, women and every segment of the society. We even condemn child labor abuse like when they are forced to carry big water jars. We discuss these matters so that every family member prevents any form of violence happening to children." [55, Female, KII HDA Jaldu, Oromia]

A religious leader from Oromia stated that the iddirs and equbs have their own rules and regulations. He felt that these rules should accommodate health issues, too. "This social way of helping each other [iddir and equb] has its own rules and regulations. They can improve their rules and regulations by including how to improve the health of mothers." [23, Male, KII Religious leader, Jaldu, Oromia]

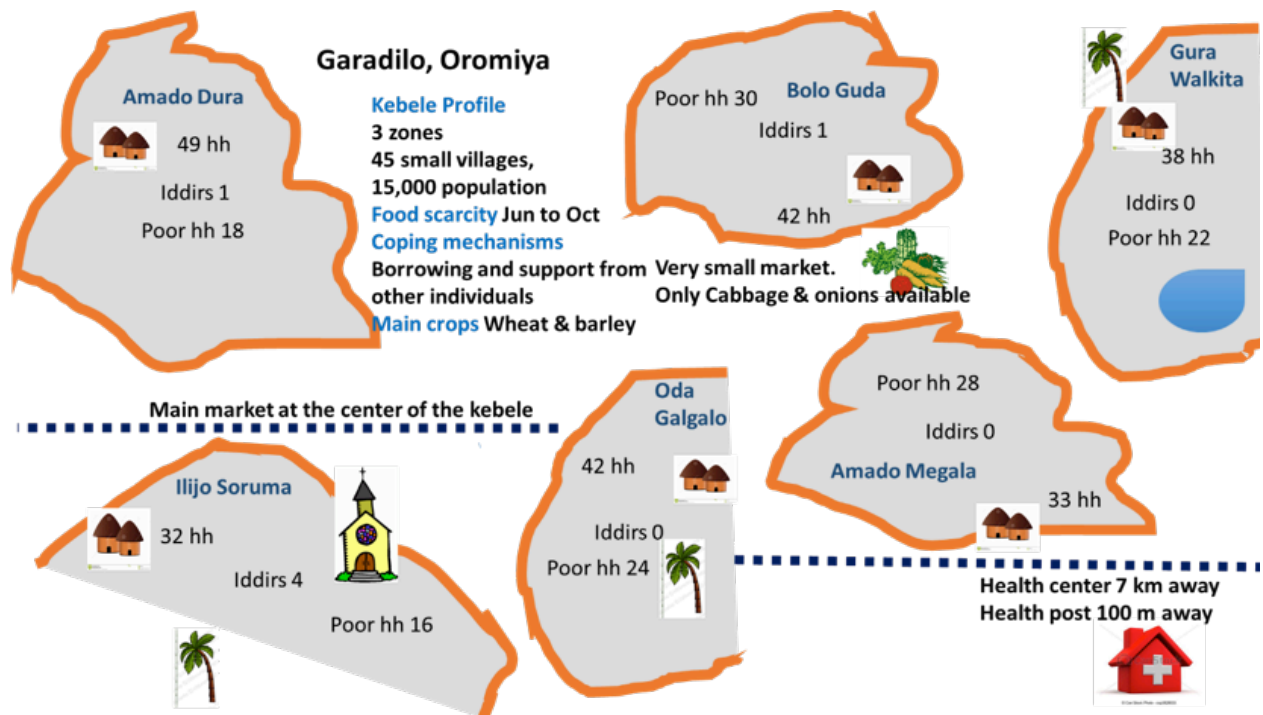
Another religious leader from Tigray also felt that although the iddirs do not support the health of women and children, they can easily do so.

Community challenges

The eight study kebeles varied widely in terms of number of villages, ranging from four to 45 villages per kebele. A commonly mentioned challenge facing people in the kebeles was seasonal food insecurity. Seasonal food scarcity is common and occurs from July to October in the Amhara, Oromia, and Tigray regions, and from April to July in SNNP region. Gardillo kebele in Oromia reported 50 to 70 percent of households face food insecurity during the food scarcity season compared to two percent of households in Shoye kebele, SNNP. Three of the eight kebeles—Ashenga (Amhara region), Rahya (Tigray), and Gardilo (Oromia)—reported a considerably high level of food insecurity during the scarcity season.

We present a profile of Gardilo kebele where food insecurity is acute. Gardilo provides us with detailed information about the challenges people face during times of food insecurity.

Figure 8: Profile of Gardilo Kebele, Oromia



The kebele administrator from Gardilo described the situation in his kebele during the food scarcity situation. Gardilo kebele (Adaba district, Oromia) has 45 villages and is divided into three zones with a total population of 15,000. The villages are small with an average of 25 to 30 households. The kebele administrator provided detailed information on six villages (Figure 8). Of these, only three villages had iddirs and the villages had no equbs. The main crops of the area are wheat and barley. A small market exists at the center of the kebele, but has very few vegetables. “We have a petty market in our kebele and a big market in Haku. But people do not go to market because they do not have money to buy things. For our kebele petty market the market day is Saturday and Monday. About four villages are seven to 20 km from the small market.”

When asked about the food scarcity situation in Gardilo, the kebele administrator responded, “The season where food insecurity occurs is from June to October. All villages faced food security problem during this season. For instance, in this month there is a problem of food insecurity. People come to my home and complained about the problem and they told me to report the problem to higher level. People are suffering a lot due to food insecurity.”

“According to science, one person should eat four times a day. But in our village, due to bad weather, all families are poor which means they are unable to eat two times or three times. In our kebele, those families who are able to eat two or three times a day do not exceed five percent. Majority of families are poor. They eat in the morning and majority of them do not eat twice a day... Even if they are able to eat twice a day, the food they eat is not a balanced diet or nutritious. They just eat to sustain life.”

The purpose of presenting the Gardilo example is to provide some direction to the nutrition

SBCC program to inform the development of realistic, feasible communication options based on the contextual analysis of a community. For example, it may not be the best strategy to promote “food diversity” during the food scarcity season as it is not a realistic option.

Cultural Practices

The study explored cultural practices in each of the eight study sites. Descriptions of pregnancy and delivery-related practices were primarily provided by IDI participants. Several HEWs and HDAs stated that the health centers have de-emphasized traditional cultural practices and that they no longer exist. The study data, however, indicate a coexistence of cultural beliefs and “modern” health care.

Female FGD participants identified cultural practices related to pregnancy such as, smearing butter on the heads of pregnant women and massaging their abdomens with butter. “Smokes” is the practice of steaming a “pregnant women’s vagina with a smoke by burning different plants” to induce labor pains. In some areas of the Amhara region, a gun is fired to make a pregnant woman smell smoke during prolonged labor. These are cultural practices that can harm a women’s health.

Pregnant women are often forced to drink liquids made from honey, linseed, flax seed, red teff, and holy water. A doro (hen) must be slaughtered because of its evil spirit and pregnant women must then eat the hen, according to several study participants from Amhara. Many people believe that pregnant women must reduce their food intake during pregnancy because eating more food creates a big fetus, resulting in prolonged labor. Eating less, especially in the last trimester, is supposed to facilitate an easy delivery. Reducing consumption of food and special foods during pregnancy was reported by participants from all four regions. The cultural practice of eating less during pregnancy, however, can have an adverse effect on the health of both the pregnant woman and her child.

A traditional belief of Zar is common in areas of Amhara. A few religious leaders identified it as a barrier for the uptake of health services. *“My neighbor has this problem. So, she doesn’t go for a checkup because she is afraid that something will happen if she goes to health center and... such people fear that this traditional belief can do something to their life and taking medication is disrespecting the Zar.”* [42, Male, KII Religious leaders, Simada, Amhara]

From the eighth month of pregnancy until two months after delivery, women are not allowed to go out of their homes. *“A woman is not allowed to come out and speak publicly during her time of confinement room. No one has to see her child and he/she would not be exposed to light/air.”* [43, Female, KII HDA, Adaba, Oromia]

Cultural practices related to the care of newborns include providing butter to the newborn and giving them herbal drugs made from certain leaf to prevent evil eye (Yebudamedhanit). *“When children are crying and restless, and people said it is because they are affected by evil eye. Often they provide an evil eye medicine [‘ye buda medehanit].”* [20, Female, IDI, Dale, SNNP]

In some communities in Tigray, putting butter on newborn's navel is common. They believe that butter can heal the baby's wound in short time. *"We follow her after delivery and there are development groups nearby and they advise her not to wash the baby before it is 24 hours, to feed breast milk to the newborn and not to do anything to the baby's navel. But they put butter on it in order to dry fast."* [27, Female, KII HEW, Adwa Rural, Tigray]

How widespread these cultural practices are vary from region to region and village to village. The findings suggest that it is important to identify the kebeles with a high prevalence of cultural practices that are barriers to adopting healthy maternal and newborn health behaviors.

Community support for pregnant women

The study findings indicate that support to pregnant women from their husbands and others varies by type and consistency, and may include one of the following: reducing workload, advising women to attend ANC, accompanying them to the health facility, serving them appropriate food, and allowing them to not fast during the fasting period. Support to pregnant women can be from their husbands, other family members, neighbors, religious leaders, elders, and other community members. Several study participants agreed that support to pregnant women needs to increase, especially since support by husbands is often limited to activities commonly undertaken by men. For instance, husbands do not support their wife by cooking food at home.

Husbands' support to the pregnant woman: Some husbands support their pregnant wife by chopping firewood, fetching water, buying items from market, carrying heavy things, and weeding on her behalf; helping her to go to health facility; and preparing bedding and clothes for the mother and newborn. Very few husbands do household chores, which are culturally expected to be done by women. For instance, women bake injera and cook wot.

"I am just telling you about him [neighbor], he is so brave and when his wife become pregnant, he is doing all the household chores. He looks after the baby, when she makes injera... he is assisting his wife a lot. Now everybody in the village is trying to be the same like him. My husband is also helping me by looking after babies when I am busy with household chores." [25, Female, IDI, Simada, Amhara]

Elder women's support to pregnant women: Older women provide support to pregnant women by giving them advice and share their experiences. *"Elders advice to the pregnant women not to pick up heavy weight while being pregnant; previously we used to use pots to fetch water but now we use plastic cans; so this elders advise them not to pick the heavy plastic cans by themselves. They also advise them to eat food like red teff (another type of teff) and entatie, an oil seed. They advise them not to take dry foods but instead to take softer or liquid foods which makes delivery easier. They also advise them to walk until she is in her seventh month. After seventh month gestation she doesn't have to go away from home and they tell her to sleep in the right position. They give her lots of information from their experience."* [55, Male, FGD, Adwa Rural, Tigray]

Other community support to pregnant women: Depending on the needs of pregnant women, especially those who do not have relatives to help them, neighbors and the nearby community may assist in various ways. They help with household chores, collecting firewood,

fetching water, buying items from market, financial support, and arrange transportation to take them to the health facilities. *“In our village, all people sympathize with the pregnant woman. For example if they see her carrying water, whether male or female and child or adult, they all help her and they bring the water to her.”* [20, Male, FGD, Damot Sore, SNNP]

“As other people said we help her by doing house chores and other things. If the time is the time of harvest, we help her with the harvest.” [39, Female, FGD, Jaldu, Oromia]

Some female FGD participants in Dale woreda reported that support for pregnant women was not good. *“Pregnant woman does not take rest that means they work from gestation to birth. She cleans the house, mowed the grass and carries it for the cattle. Nobody thinks that she carries a fetus in her uterus and she may be tired. She gives birth without any rest. Even her labor may start while working and she may give birth spontaneously. In our area nobody supports and gives care for pregnant women.”* [30, Female, FGD, Dale, SNNP]

Religious leaders’ support to pregnant women: Religious leaders are highly respected in the study regions, and their communities value their advice. Some religious leaders said they visit pregnant women at their home and advice them to attend health services, to not fast, and to reduce their workload. *“We teach them about use of vaccination, to give birth in the health facility. So we teach them and also pray for them.”* [KII, 43, Male, Dale, Religious Leader, SNNP]

Identifying Local Narratives and Proverbs

The study explored common proverbs and folktales that depict either the value of women or their low social status. The primary reason why folktales were explored in this study is that direct messaging on gender inequity is difficult to incorporate in SBCC programs. We felt proverbs and folktales could be a mechanism for sharing positive and relatable gender images with program audiences. Table 8 provides a regional distribution of different proverbs associated with women, men, and son preference, as reported by the study participants. Amhara, Oromia, and Tigray participants reported several gender “positive” proverbs about women. Participants from Amhara offered a few proverbs related to why a mother should not die, which may be useful to maternal health programs. Most of the gender negative proverbs came primarily from two regions, Oromia and SNNP. In fact, not a single gender-positive proverb was reported from SNNP. These included references to a “nagging wife,” likening her to an unclean dress, and stating that a woman is not equal to the child she produces and is not capable of providing good advice. The proverbs highlight the need for couple communication and to support women’s strength and wisdom (Table 8). The proverbs can be used to promote a positive image of women and to add respect and value to her worth in the household and the community.

Table 8: Gender “positive” and “negative” proverbs from four regions of the study

Local proverbs	Amhara	Oromia	SNNP	Tigray
Gender “positive” proverbs	<p>“A mother should not die, she should live since she will take out louse in the dark.”</p> <p>“I will not be sad as long as my mother is alive.”</p> <p>“Let you have the wisdom of female.”</p>	<p>“He who discussed with his wife sold an ox, not a cow.”</p> <p>“Men also are pregnant with women.”</p>	None	<p>“A woman is the light of a household. It is impossible for a man to live without women in a household.”</p> <p>“Females are good in reasoning.”</p> <p>“Mother is strong as a stone.”</p>
Gender “negative” proverbs	<p>“A person who has a nagging wife always faces a problem just like a bad soap which does not clean a dress.”</p>	<p>“Woman does not know both/two [things], but she is not ignorant of one/ single.”</p> <p>“Woman gives birth to a child, but she is not equal with a child.”</p> <p>“Woman do not speak twice, and they hold on one thing”</p> <p>“Laboring is the custom of women, so look after my cattle.”</p>	<p>“If a male child is not born, the farm land will remain unused.”</p> <p>“When females give advice, the grass will not grow.”</p>	None

A total of 11 folktales were shared by participants across four regions. Of these, we present three folktales that could be useful in the SBCC campaign related to promoting gender-equity norms. The first folktale is from Oromia and is about three men who were asked how they will win their wives.

Folktale 1. Using couple communication to prevent physical violence, Oromia

“There were three men. Each of them are asked if they will win their wives. All three said they would win, but their reasons were different. When the first man was asked how to his wife, he said that he will beat his wife when she refuses to do something that he wants done. But according to the audience’s opinion he has failed to win his wife. The second person was asked the same question and he said, ‘if my wife stood in her position on a certain issue, I will tell her to bring her family, divide our assets and divorce her.’ The audience said that the second man also fails to win. When the third man is asked he said that ‘I will tell her to come to me and have a sit. Then, I will tell her faults and let her tell me my faults. I will accept mine [if acceptable] or let her know why I did so. By doing so, we will discuss the issue in detail and convince her to accept my idea. ‘Discussion is better than beating.’ He is told by the audience that he has won his wife.”

FGD, Male, Dale, Oromia

The second folktale is from SNNP and is about a famous queen from Sidama. She was strongly against gender discrimination that relegated women to a lower social position than men. Queen Fura was killed because of her strong stand for the rights of women. Women still consider her as their “female guardian.”

Folktale 2. Queen Fura, SNNP

“Queen Fura was a famous queen in Sidama who taught women how to behave, and they still follow her advice to this day. Fura strongly opposed females’ oppression and mistreatment by males. She was killed by a male because of her advocacy for women. Women expressed their opposition to Fura’s murder through the following poem. The women sang the poem pretending they are trying to make their child stop crying while holding it on their back.”

“He who killed Fura, the female’s guardian; let his life be inferior to other persons.”

FGD, Females, Shoye, SNNP

The third folktale is from Oromia. It asks who is the king of men, trees, earth, and animals. And, after some serious thinking, the people found that even the king of men comes from women, as they give birth. This folktale can be used to illustrate the strength and power of women.

Folktale 3. King of trees, king of men, king of earth, and king of animals

“Once it was asked to find who the king of trees, the king of men, the king of earth and the king of animals are. Finally, it was found that the king of men come from women.”

FGD, Male, Gardilo, Oromia

Couple Communication

This study explored interpersonal discussions at household level, including patterns of couple communication and the frequency and duration of discussions about different household concerns. We explored couple communication on health issues, specifically related to women’s health, child health, family planning, and HIV.

Open Discussion Among Couples

Most community members and female IDI participants across all regions reported open discussion among couples on various issues. Most claimed that open discussion among couples was becoming a positive trend. However, HDAs and HEWs believed the extent of open discussion in their communities was not high, and that some couples do not openly discuss issues due to various factors. *“No, it is not common practice for women here to freely discuss with their husbands.”* [35, Female, KII HEW, Jeldu, Oromia]

Women are often the instigators of discussions, and a husband’s acceptance of his wife’s opinion varies among households. Although some participants reported a progressive trend, with husbands paying more and more attention to wives’ counsel, husbands still have the upper hand when

it comes to making final decisions for the couple. Participants across regions reported male dominance in decision making, stating that it is the husband's ideas and decisions that prevail during discussions.

Program Focus: Couple communication reflects a gender imbalance in decision making

"What men say will be done immediately, while what women say will be done after a year." [38, Female, FGD, Simada, Amhara]

"In the past, I used to tell her [my wife] not to interfere with my work or, I did not discuss with her, but now I discuss with her." [60, Male, FGD, Dale, SNNP]

"Men's opinion always prevails. Most women here are illiterate thus men lead their household." [60, Male, FGD, Tahtay Koraro, Tigray]

Although some women initiate discussions with their spouses, couple communication is dominated primarily by men's overall decision-making power. Men seem to have the final say in a discussion. If not, the matter becomes a conflict situation and has to be mediated. The normative nature of predominant male decision making was evident by reports by both female and male participants. Couple communication needs to be highlighted within the context of decision making **where men's decisions are easily accepted and women's decisions are deferred or rejected**. Programs will have to include respect for women and their decision-making abilities, while promoting couple communication. While superficially it may seem that couples are "communicating," an in-depth analysis indicates that the basic gender inequity dominates these interactions.

Naturally, some discussions are likely to end in disagreements; this appears to be when the wife does not accept the husband's idea. Such disagreements are usually resolved by women, either by accepting their husbands' command, requesting neighbors/relatives advise him, or by insisting on their own choice. According to reports from a majority of the community members interviewed, the latter two options can result in quarrels and wife beating. The culture of wife-beating in these four rural regions seems to be pervasive.

"If she resists accepting her husband's idea, he may beat her." [60, Male, FGD, Sayint, Amhara]

"Disagreements might happen during discussion... then, the husband may beat and forcefully hold her neck...till neighbors get there and reconcile... this often happens if she does not earn her own money and depends on her husband's income." [25, Female, FGD, Damot Sore, SNNP]

"If a woman refuses to accept her husband's decision and goes against his command, he will thrash her with a stick." [38, Female, FGD, Adwa Rural, Tigray]

"If disagreement happens in a certain family, neighbors should go and reconcile that family." [42, Male, FGD, Jeldu, Oromia]

To summarize, although couple communication does occur, it is strongly dominated by men's decision-making powers, primarily because open discussions among couples are rare.

Frequency And Duration Of Couple Communication

Study participants found it hard to specify the frequency of discussion with their husbands, since most discussions among couples are usually unplanned. Some study participants did report that their usual time for couple discussion was during a small break after daily chores, usually in the evening.

"Daily; yesterday and today we were talking together." [37, Female, IDI, Sayint, Amhara]

"[Discussions always happen on] evenings or night time,... they [discussions] are not as such planned." [24, Female, IDI, Adaba, Oromia]

"We discuss always." [31, Female, IDI, Adwa Rural, Tigray]

Among female IDI participants, the reported duration of discussions with their husbands ranged from 10 minutes to two hours.

"We discuss starting from 7:00 pm to 9:00 or 10:00 pm, we discuss till we sleep." [22, Female, IDI, Jeldu, Oromia]

"We discussed for about 15 minutes." [23, Female, IDI, Jeldu, Oromia]

"My husband initiated the discussion, and it took 10 to 20 minutes." [25, Female, IDI, Dale, SNNP]

"We discussed for half to one hour." [32, Female, IDI, Tahtay Koraro, Tigray]

There were regional differences among the communities in the four regions regarding the practice of couple communication. HDAs and HEWs in Oromia and HEWs from Tigray expressed their reservations about free discussion among couples. According to them, open discussion among a husband and wife is rare, and that some women prefer to talk to other people than their husband if they have issues.

"No, they do not. Still, they are not comfortable to express their ideas freely to their husbands. They tell us other than their husbands." [20, Female, KII HEW, Tahtay Koraro, Tigray]

There were no regional differences regarding the frequency and duration of discussion, acceptance of wives' counsel by husbands, and decision-making power during discussions.

Topics

Couples across the four regions reported discussing different life issues. Among the most common topics discussed during the most recent couple conversations were agriculture-related issues; child care, mostly related to their clothing and schooling; and household financial issues such as expenses (particularly holiday expenses), refilling household groceries, how to improve their livelihood by generating income, saving money, or getting credit. Although health-related topics did not often occur spontaneously, study participants were asked about couple communication specifically on issues related to maternal health, family planning, child health (focusing on nutrition), and HIV testing.

Maternal health

Communication among couples on woman's health, especially healthy pregnancy and delivery, was reported as being practiced across all regions. A majority of the female participants confirmed that, currently, couples discuss various health issues during pregnancy. Usually, couples discuss maternal health when the woman is pregnant, and the place of delivery is the most common topic of discussion. Some women also reported that they discussed ANC follow-up, started sharing household chores with their husband, and followed recommendations on maternal nutrition after informing their husband about their pregnancy.

"We have been discussing about ANC... he helped me with household chores... and we agreed to deliver at the [health center]." [24, Female, IDI, Adaba, Oromia]

"We have not discussed about it. Since the doctor told me to deliver the baby at the [health center] and I knew what benefited me, I did not want to discuss with him." [19, Female, IDI, Damot Sore, SNNP]

"We have discussed everything... he advised me to take a variety of food... tells me the right time to check at the [health center]... I gave birth at the [health center]." [25, Female, IDI, Simada, Amhara]

However, across regions, most HEWs reported that women share pregnancy-related news with other women before talking with husbands. Commonly, women prefer to discuss pregnancy with their friends, followed by their mothers and mothers-in-law. This shows the role of fellow women, both in the community and inside the family, in sharing a woman's concern and influencing her decisions regarding maternal health. One participant even said people referred discussion on pregnancy-related issues with a husband to be somewhat 'indecent.'

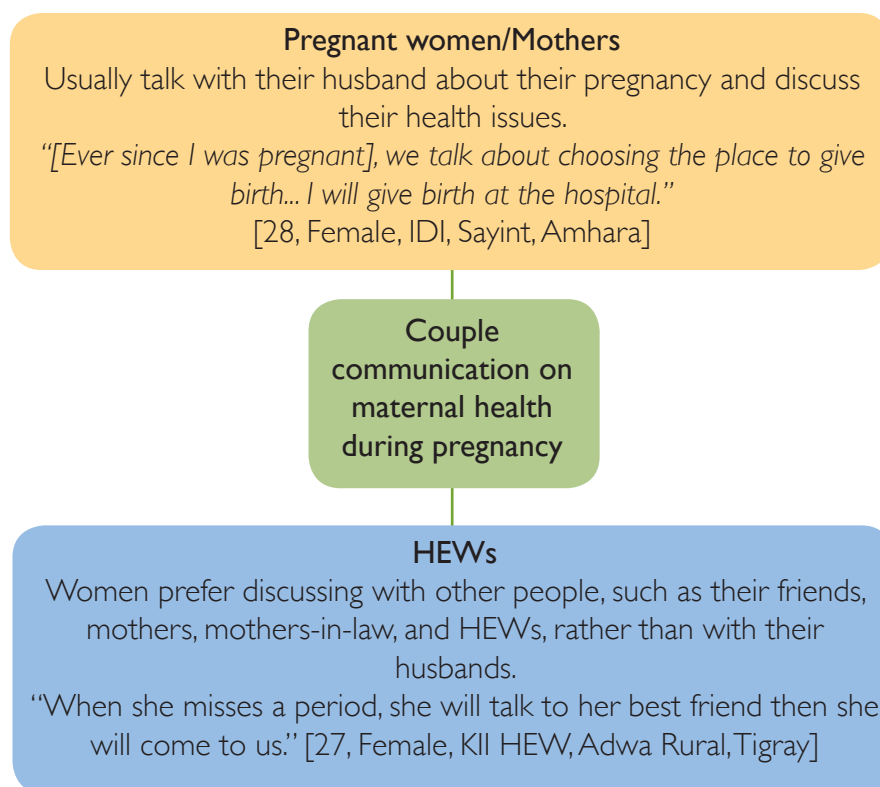
"When they miss a period, some discuss with husbands, but, most of them discuss with their women friends... Unless the husbands know by himself, most women keep silent, they did not discuss such issues." [29, Female, KII HEW, Simada, Amhara]

"They share their problems [including pregnancy] with their mothers rather than with their husbands." [20, Female, KII HEW, Tahtay Koraro, Tigray]

"Discussion on problems of pregnancy with husband, never, it is indecent." [28, Female, KII HEW, Dale, SNNP]

Responses to couple communication on maternal health during pregnancy varied among mothers and HEWs. Respondents at individual/household level (mothers) claimed that discussions about women's health during pregnancy were common in their community. However, most HEWs did not believe it, and described a different picture regarding couple communication on maternal health. The figure below depicts the different responses related to couple communication on maternal health at individual/household, community, and health-system levels. Since the HEWs work with women, they may have a more realistic overall assessment of how the women in their communities interact with their spouses.

Figure 9: Different perspectives related to couple communication on maternal health using the SEM model



Family planning

The majority of female IDI participants reported that they usually discuss family planning with their husbands. Discussions are usually about the decision to use contraceptives, not about the type of contraceptives to use. HEWs and HDAs also noted the presence of such discussions in most cases. However, some women did report that there are instances where women secretly use contraceptives without discussing with or telling their husband. Men's desire to have more children and religious beliefs were the primary factors for secretly using contraceptives.

“For example, on 2007 E.C. [three years back] after we gave birth to our previous child, we discussed whether we should give birth soon after or give some space.” [28, Female, IDI, Sayint, Amhara]

“Yes, we discussed. It is not difficult [to discuss about family planning] for me. The reason is that he is my husband. We are one body, and discussion about our life is not difficult.” [23, Female, IDI, Jeldu, Oromia]

“Yes, they discuss how many children they need to have.” [30, Female, KII HDA, Dale, SNNP]

“Never, the husband wants to get a child as soon as he gets married. Because of this, the wife takes family planning secretly. Even when the newborn is female, the husband needs male child immediately, because of these women take family planning secretly.” [28, Female, KII HEW, Dale, SNNP]

Compared to other woredas, family planning discussions among couples was limited in the Adaba woreda of Oromia region and Damot Sore woreda of SNNP, as reported by IDI participants. In

Adaba woreda, religious beliefs consider the use of family planning to be a sin, while in SNNP, the community relates contraceptive use with selfishness.

"No, we have not...As I told you before, I was taking family planning method without letting my husband know. He wants to have more children, and he believes that using family planning is a sin." [24, Female, IDI, Adaba, Oromia]

"No, I do not discuss about family planning." [29, Female, IDI, Damot Sore, SNNP]

Except for a few women, female IDI participants claimed they discuss family planning issues with their husbands. Although HDAs acknowledged that couples in their community discuss family planning, they noted that it is more common among educated couples. According to HEWs, family planning discussions among couples has improved over time, as husbands have become more supportive of using contraceptives.

"Yes, it is based on our agreement and discussion that I started taking the injection method." [25, Female, IDI, Dale, SNNP]

"There are those who discuss. Those who discuss are educated ones. However, I do not think other families discuss." [55, Female, KII HDA, Jeldu, Oromia]

"When a woman visits our health post to use birth control, we, the health-care professionals ask her whether she discussed the issue with her husband or not... a majority of the husbands allow their wife to use family planning or contraceptive... currently it (the situation) has improved." [29, Female, KII HEW, Simada, Amhara]

Child health

The majority of IDI participants said that they discuss their children with their spouses, but usually only after the child reaches the age of about six months. Couples appear to mostly discuss their child's well-being and nutrition, particularly complementary feeding and how to improve child feeding practices. A few women reported that their husbands supported them in child feeding after their discussions. *"Yes, we did. He brings vegetables and asks me to make it in a special way for the children."* [30, Female, IDI, Tahtay Koraro, Tigray]

"Yes, we have talked about the food of our child... after six months, Even the appetite of the child is different when I feed him and when his father feeds him. The baby is not easy for me to feed compared to his father." [25, Female, IDI, Simada, Amhara]

Discussions among couples about child health, however, seem limited in Amhara and Oromia regions, specifically, Adaba woreda.

"My husband didn't visit and asked me about the child after divorce. Not only this... he has not been giving me any support for the child. I do everything with my family." [30, Female, IDI, Simada, Amhara]

Overall, couples didn't report frequent discussions on child health. When they did, nutrition, specifically complementary feeding, was what they discussed. Discussions about health-seeking behaviors or immunization were not mentioned by the study participants.

HIV/AIDS

In general, HIV/AIDS appears to be the least discussed topic between husband and wife. The majority of women said they don't discuss HIV with their husbands. While couples sometimes discuss HIV after the wife is tested during an ANC checkup, only a few women told their husbands about being tested for HIV during ANC visits and mentioned being tested together after that. There was no notable difference in discussing HIV among couples across regions.

"No, I did not. We have never talked about getting tested for HIV." [28, Female, IDI, Sayint, Amhara]

"Yes, we discussed about HIV... about being faithful to each other, not sharing sharp objects with others." [23, Female, IDI, Jeldu, Oromia]

"Yes, we discussed when a health professional told me to get HIV test during my pregnancy... We agreed and went together." [19, Female, IDI, Damot Sore, SNNP]

"Yes, that is the main issue that we talked... Then, we took HIV test together." [38, Female, IDI, Adwa Rural, Tigray]

Of the different health topics, it seems that family planning was most frequently discussed followed by maternal health. Complementary feeding was primarily discussed by couples, while other areas of child health—such as diarrhea, acute respiratory infection, and immunization—were not discussed. HIV/AIDS was the least discussed health area.

Barriers To Couple Communication

While most women across communities reported they could discuss various issues easily with their husband, some factors hindered couple communication. Our analysis identified the following barriers to couple communication: lack of time, religious beliefs, educational status, husbands' attitude toward wives' counsel, and gender inequity. Although the barriers were mostly similar across regions, barriers related to religion were more commonly reported in Adaba community of Oromia region. Some of the overall barriers mentioned included:

Lack of time: Women bear a heavy burden of the household chores in the study communities. As a result, they have limited time to sit and talk with their husbands. *"No time for women to sit down. Busy with markets and home chores throughout years [to discuss with their husbands]."* [43, Female, KII HDA, Adaba, Oromia]

Men's negative attitude toward wives' counsel: Traditionally, men tend not to accept advice from their wives. Men are considered the sole decision makers on household issues and, to that end, tend to not discuss concerns with their wives. *"Some men say since we are men how can we be guided by women, how she can advise us. Others discuss and agree."* [32, Female, FGD, Adaba, Oromia]

Religious beliefs: Entrenched community beliefs of reportedly/supposedly religious origin are also potential barriers to couple communication, especially discussions related to family planning. *"As a religious leader, what I say is that according to our religion, it is impossible to quit having children because it is what God gives. The law of God forbids to use family planning, our Sharia Law. It is God who*

gives children to people according to his wish.” [46, Male, KII Religious leader, Adaba, Oromia]

Gender inequity: Gender inequity affects open discussion among a wife and her husband. Some women are afraid of discussing issues with their husbands because they fear their husbands' reactions. Wife beating is a common threat and occurrence. *“She is afraid to talk to him, she prefers talking with her fellow women. Most of the women discuss pregnancy issues with their fellow women instead of discussing with their husbands... Unless the husband knows by himself, most women keep silent, they did not discuss such issues.” [27, Female, KII HEW, Adaba, Oromia]*

Educational status: There are also reports that couple communication is more common among educated couples than uneducated ones. *“It [open discussion] differs from person to person. The educated will discuss their issues freely than those who are not educated.” [27, Female, KII HEW, Adwa Rural, Tigray]*

Responses to barriers to open discussion varied among participants. However, there were issues, such as family planning, that women did not feel comfortable discussing with their partners. Barriers identified by FGD participants mostly related to men's attitudes toward women's counsel and gender inequity (specifically, wife beating). HDAs reported lack of time as the primary barrier, while HEWs noted that women are afraid to talk with their husbands, and, instead, choose to discuss concerns with their friends.

Summary Of Findings

Social norms

- The social norm for four ANC checkup is weak. It is tied to the belief that an ANC checkup is required only when a pregnant woman experiences physical distress.
- The social norm related to facility delivery is strong; most people interviewed endorsed hospital delivery. Mostly structural barriers prevent delivery in health facilities.
- The social norm related to contraceptive use is strong, but is tied to the number of children a woman 'should' have. Data indicate that contraceptive use is normative after a couple has four to five children.

Social capital

- New and traditional social structures—one-to-five networks and iddirs—reach almost every household, indicating that rural communities have social capital.
- In the field of health, one-to-five networks primarily emphasize hospital deliveries and latrines.
- Specific health behaviors related to maternal health, nutrition, and hygiene are not promoted by the one-to-five networks.

- The HDA and one-to-five network structures are functioning in all the eight kebeles studies.

Community challenges

- The main community challenge is food scarcity.
- The role of the community is crucial for enabling access to food via loans, charity, or labor.
- Vegetable gardens are actively encouraged by one-to-five networks in some kebeles.
- The 'false banana' helps during the lean food season.

Local narratives

- Local folk tales exist in all four study regions. They can be adapted to illustrate gender-equitable norms.
- Local narratives provide an alternate channel for promoting gender-equitable norms.

Couple communication

- Although couples discuss issues, it is the husband's decision that usually prevails.
- Due to the prevailing gender inequity, women do not feel comfortable speaking freely with their husbands.
- Women reported that they talk to their husbands, but HEWs stated that women do not discuss their problems with their husbands.

CHAPTER 6. GENDER NORMS AND INEQUITY

Gender-equity norms—in addition to social norms, social capital, community strengths, and local narratives—were the major crosscutting themes of the study. Gender-equity norms emerged as the main predictor of 10 health behaviors in the baseline survey for the Communication for Health project. As a result, a contextual qualitative study of gender dynamics was undertaken as a part of the larger sociocultural study. Multiple gender dimensions were identified for further in-depth inquiry. The study explored themes related to gender-inequity norms, including son preference; household-level decision making between spouses; husbands' support for their wives' health, especially during pregnancy, and involvement in household chores; and gender-based violence in households and among the community.

Gender dynamics and female disadvantage operates at the couple, household, and community levels. This chapter provides an assessment of the complex gender dynamics within rural Ethiopian communities and explores how these dynamics influence health-seeking and health behaviors.

Son Preference

"A father mostly needs to have son when a baby is in the womb of mother. He prefers the male child in his heart not publicly, because he thinks the son will accomplish the dream of his father. There is an Oromo proverb called 'Jibicha korma bahu haadaratti beekan!' [Which means a good bull is known at early age.] A father dreams about the son in the early age of the baby. He dreams that if good boy is born for me, he is not only the son of mine, but also the son of nation." [40, Male, FGD, Adaba, Oromia]

FGDs with female and male community members explored societal norms regarding sex preference for children. KIs with HEWs and HDAs further explored the implications of sex preference norms and health. Across all regions, a majority of FGD participants acknowledged a preference for male children in their communities. Some participants expressed that preferences for male or female children existed in the past, but now the norms have shifted.

A few participants denied sex preference altogether, stating that such disparities do not exist. However, existing cultural practices, behaviors related to pregnancy, and proverbs indicate that gender inequity does indeed exist. Most of the themes discussed cut across all regions, demonstrating the gender-inequity spectrum where sex preference ranges from celebrations for giving birth to male child and proverbs that value males over females within the community to preferential land ownership and marriage laws and policies.

Physical strength and mobility: Discussions with female and male participants revealed sex preferences are rooted in gender-related norms regarding physical strength and ability to help with labor-intensive activities, such as farming or goldmining. Relating to physical strength for work and daily labor, male children were considered to have greater mobility to migrate to other places in order to find work and earn an income to support their families. Female children, on the other hand, were seen as 'vulnerable' in terms of physical strength, and perceived as susceptible to being raped or getting pregnant, which community members stated was an extra burden to families. A

male community member described in detail the reason for preferring male children. *“When she gets mature, she may be pregnant and give birth before marriage, which affects her future life because in our culture it is completely forbidden to have sex and get pregnant before marriage. It is against our norm... Considering all these issues, a husband is ashamed of having more female children in a family. Naturally, they are vulnerable, for example, concerning sex, the negative consequence of having sexual relationship with someone before marriage more affects females than male. The males are free and can work wherever they go without any limitation but the females may be pregnant, may be raped or get another challenge, which affects the successfulness of their job.”* [54, Male, FGD, Sayint, Amhara]

Family support and land inheritance: A majority of female and male participants noted that once women are married, they leave their immediate family—with some participants mentioning a dowry that is paid when she is married—and move in with their in-laws. This was compared to men who remain with their immediate families, even after marriage, and are able to inherit land. On a broader policy level, several female community members, including HEW and HDAs, mentioned land inheritance as an underlying factor to gender preference for males. *“They may love girls more but she does not stay with them long, since she marries. I did not stay long with my parents that is why they do not prefer females. I may say if I give birth to a girl, she will help me the household work, but she does not stay with me. Boys stay with us and inherits our resources. The reason that girls not chosen is because they leave their family because of marriage.”* [28, Female, FGD, Adaba, Oromia]

Health consequences of sex preferences: Despite a few male and female community members stating that sex preference does not exist in their communities, HEWs and HDAs across all regions shared negative experiences in which sex preferences were detrimental to the health of mothers and their babies. HEWs and HDAs noted instances in which husbands reacted negatively toward their wives when the women did not give birth to sons. Experiences included husbands not sharing food, money, or other resources when their wives gave birth to a girl. Different cultural practices are celebrated for boys compared to girls, such as the type of food offered—sheep is slaughtered and honey, sugar, barley, and other food items are arranged. HEWs also noted that women will continue to give birth to children until they get a male child, or their husbands will marry another woman in order to get a male child. An HEW in Tigray shared a story in which a husband reacted angrily at a health center and how she intervened. *“To tell you from my experience, there was a pregnant mother, who has six female children. I was responsible caring for the mother and when the delivery date reached, I took her to health center in order to give birth. This mother faced many complications during delivery and at last, she gave birth to a baby girl. At that time, the husband asked for the sex of the baby and when he found out that the baby is a girl he said, ‘this baby should be thrown to a lake.’ At this time, I got very emotional and talked to him using unnecessary words.”* [20, Female, KII HEW, Tahtay Koraro, Tigray]

Decision Making in the Household

"I don't care what he thinks, as it endangers my life. I will be able to decide for myself to save my life. But in my case, we both agree on the place of delivery." [30, Female, IDI, Tahtay Koraro, Tigray]

Decision making in the household focused on household purchases and woman's health care—particularly, decision making for institutional delivery. Across all participant types, including male and female community members, HEW and HDAs, and religious leaders, clear distinctions arose between the type of decision-making power a husband had in comparison to his wife.

Women understand the needs of the household: Wives oversee decisions related to nutrition: what types of foods to purchase and cook for the household. Women were considered the most knowledgeable about the needs of the home according to female and male community members and religious leaders. *"This is decided by the women. The husband may suggest things to be done for the child but it is the women who decide finally because she knows what the child really needs. For example, if you ask me about my child, I may not know what type of food he should take. But, my wife knows more about it. I do not say no when she asks me to buy food for the child. The husband only decides on pocket money."* [36, Male, FGD, Sayint, Amhara]

Although the above quote shows a man saying that women make the decisions about food purchases, women are generally bound by monetary restrictions. Regionally, in SNNP during the food insecurity season, a woman discusses what she wants with her husband and decides what is needed. In Tigray, mothers-in-law were mentioned as supporting young mothers in making decisions related to daily food purchases, cooking, and child-care guidance.

Men control resources and major household items: Husbands are generally considered the head of household and most participants felt that husbands ultimately have control over money and resources. Female FGD participants said that there were instances in which husbands would not make a decision without first consulting their wives, especially when it related to a major household purchase, such as oxen or farming tools. *"When a neighbor asks me to borrow the ox for agriculture purpose and if I give him without consulting my husband, he will kill me, so that I have to tell the person like this: 'My husband is not here now so I will ask him and you will take it tomorrow.' Then, when my husband comes to home from work, I tell him about the issue and if says 'Ok' it is ok if he says 'No' it is no."* [34, Female, FGD, Simada, Amhara]

Health consequences of decision making: IDIs with women of reproductive age revealed that either they made the decision to deliver in a facility by themselves or were supported by their husbands. However, women noted that if their husbands did not want them to deliver in a health facility, conflict would arise and they would have to find support elsewhere, such as their neighbors. While no woman mentioned that her husband forced her to deliver at home, a few mentioned that their husband's decisions should be respected if that was requested. If their husband did not want them to deliver in the health facility, however, women discussed how they might seek assistance from their neighbors or relatives to mediate making the final decision. *"This discussion is started when she is in labor then they discuss about the place of delivery. She wants to go health center but the husband may not want. During labor other persons from neighbor or relatives will*

come to their home and discuss with them. The husband is the head of the household so she may not get power to decide. The discussion is not only between the husband and the wife but also others share their idea. Anyhow the decision maker is the husband.” [28, Female, FGD, Dale, SNNP]

Male Involvement in Health and Other Household Spheres

“In Sidama culture, pregnant women do not have respect. When women are pregnant, the husbands’ mothers do not come to the house to support the pregnant women. This is true. No husbands support their pregnant wives so the pregnant women work day and night then give birth without rest and support. I remember one woman who scrap false banana during the day and gave birth at night. Even the labor has started and has abdominal pain but she prepares food, moved grass for cattle, cleaned her house.” [45, Female, FGD, Dale, SNNP]

Although some women mentioned receiving support from their husbands, as they are the head of household, there were defined activities and roles which are socially acceptable among men. When women are not pregnant, men’s involvement with household chores is limited. During a woman’s pregnancy, many women noted that their husbands or other husbands provided general support, ranging from purchasing food to reminding the women to attend their ANC checkups.

More physically taxing chores that husbands were reported to assume during their wife’s pregnancy, included starting fires, lifting heavy objects, and cutting grass. However, several HEWs and HDAs felt that husbands’ involvement in household chores and support during pregnancy was not as dominant. The religious leaders interviewed felt it was important for husbands to support their wives by helping with more laborious chores and visits to the clinic.

Loss of masculinity: Interviews with women, HEWs, and HDAs revealed that within their culture, shame or embarrassment is associated with men doing what is considered ‘women’s work.’ When men were involved with chores, it usually involved collecting wood, grinding grains, and heavy lifting; rarely did it involve cooking, specifically, making injera or boiling/preparing coffee. While there were a few role-model husbands, it appears that a majority of men in their communities do not help or assist much outside of their traditional roles. If a husband is seen doing an activity that is considered to be a ‘duty’ of a woman, such as milking a cow or cooking, he feels shame and embarrassment. “He does not cook her food. She cooks the food herself. He may help her to collect firewood, or go to the grinder. But, it is considered shameful to cook food when she is pregnant or after she delivers. He does not help her. You may find one male out of ten who protects his wife and assist her in fetching water, cooking food. Very few males support their wife.” [27, Female, KII HEW, Adaba, Oromia]

Another common factor across all regions was related to men’s support and ability to provide is having sufficient funds to purchase food, clothing, and other needs while a woman is pregnant. Suggestions by women in Tigray to decrease spending, included reducing alcohol consumption and using family planning. “They have to minimize drinking alcohol. For instance, if they work daily labor and

get 50 or 40 birr per day, rather than spending all, they have to spend small amount of it on alcohol. In addition, they have to plan where and how to spend their incomes for their households' expenditure." [31, Female, IDI, Adwa rural, Tigray]

Program focus: Educating husbands to support their wives

"There is a model husband... in Simenga got (village). He takes good care of his wife... He also slaughtered goat and lamb for his wife when she delivered and he took necessary care of his wife. The couple are in fact well to do and can provide what is needed for the rural standard. There are people with similar personality... but this individual has brought about change after listening to Biiftuu Jireenyaa radio programme. He was listening regularly to the radio programme. He takes very good care for his wife." [35, Female, KII HEW, Jeldu, Oromia]

Education was often mention as an important factor that encouraged men to support their wives; suggestions included peer-to-peer meetings or experience sharing, role models, or meetings facilitated by health workers. Moving beyond awareness, the meeting can also work on support specific behaviors such as asking men to accompany their wives to the clinic, helping their wives with reminders, and providing opportunities, such as caring for their children, so that their wives can attend health clinics. Health workers and religious leaders are important stakeholders to engage men and encourage more supportive behaviors from husbands before, during, and after a woman's pregnancy and delivery.

"To keep the health of the women both the males and females should implement what the health workers advise them. For example, when the health workers advised them to use family planning, they should implement and use family planning to limit the number of families." [35, Male, FGD, Dale, SNNP]

Health consequences to male involvement: Male involvement to reduce the workload for pregnant women was a prominent theme, due to fear of miscarriages or harm to the fetus. A HEW also discussed shaming husbands that did not help, especially during pregnancy. *"The kind of support that husbands are providing to their pregnant women is protecting them from going to market, men are going to market, protecting them not to do heavy work like going to milling machine as it is also believed in the community that if pregnant women touches flour she would miscarry the baby. They also collect wood."* [29, Female, KII HEW, Sayint, Amhara]

Women also discussed the importance of men providing nutrition during pregnancy by purchasing the right foods such as milk, eggs, and meat. Consequently, when men are not involved, it may result in increasing adverse health consequences for the pregnant woman, and, in one case mentioned in Oromia by a HDA, death. *"'Waan ulfaa ulfoodha' [meaning, pregnancy issue is respectful]. The husband collects firewood up to the day his wife gives birth. He does not let her work hard. He tells her to have meals four times a day as per the education of [HEWs]. There are husbands like this who support their wives. But there are also husbands who do not care whether she gives birth or not. They do not care. There is a recent story in which two women gave birth at home and died due to lack of necessary*

support. They were kept at home for three days during labor. Finally, when they were about to be taken to health facility, they were lost [died]. This was the problem.” [43, Female, KII HDA, Adaba, Oromia]

Perceptions and Behaviors Related to Gender-Based Violence

“It is not allowed to hit the teeth, eyes so, they use [alenga] skin band made for beating. There is no respect for females.... They are also kicked. Women always live under pressure... women are beaten for something wrong they do... For example, when my husband leaves home in the morning and comes back in the evening [if] I am still sitting not preparing meal for him, it is obvious that he will beat me. I know and I am expecting the punishment. The other reason to punish me is that if he see me while I am talking with someone. I may not escape from being beaten. When I also severely beat the children, my husband may punish me. [Women] are beaten for these reasons.... It is because he loves her... a husband who loves his wife beats her.” [43, Female, KII HDA, Adaba, Oromia]

Most participants in all interview types acknowledged that some form of gender-based violence exists. However, several participants revealed that they encountered no instances of recent violence. A few participants stated that gender-based violence is an issue that should be dealt with in the household. IDIs with women and KIIs with HDAs and HEWs revealed numerous instances of gender-based violence, with a few reporting their own experiences. A majority of women had either heard of it or seen it happen to a neighbor or someone they knew.

Most participants focused on physical violence or ‘beatings’ when discussing violence against women, although sexual violence (abduction, rape), forced marriages, and female mutilation was also mentioned. Overall, the female FGDs listed higher instances of gender-based violence occurring, ranging from two to 10 out of 10 women experiencing some form of violence or conflict, while male FGDs listed lower rates, such as none or one to two out of 10 women. However, a number of men did acknowledge that while there have been steps toward equality in households, women are still held to unequal standards and have limited decision-making power: *“We thought that some activities are exclusively given for the female and most husbands were ostracized by other if they do activities assigned for the female. This has changed, for example, I personally cook wot when my wife bake injera and eat together. These are things changed through time but still we have no equal decision-making power. Males are more respected than females.” [36, Male, FGD, Sayint, Amhara]*

Decision making and altercations among couples: (Also see above men control resources and major household items in Theme 2: Decision making in the household.) Decision making in the household regarding money and household purchases—such as cattle and mobile phones—and the selling of goods and values was a point of conflict in households where men were considered the decision maker. Such decisions have the potential to result in violence between husbands and wives, especially when women try to intervene and question their husbands. *“This year I have gotten rest from being beaten, thank God. However, previously, do not ask me how he used to beat me whenever he got drunk. For instance, there is a man who is our neighbor. He*

lost his mobile phone outside home. When he returned back, his wife asked him where he lost his mobile. But, he got angry and told her that it is she who lost his mobile phone. Then, she told him that he lost his mobile where he spent his day. However, he beat her terribly. Oh! He beaten her too much and even one of her eyes was damaged. I think he has beaten her by stick. It was last May. All men are not similar but such kinds of situation are happened sometimes in some women in our area because they need to stay in their marriage.” [31, Female, IDI, Adwa rural, Tigray]

Overwhelmingly among women participants in all regions, drinking alcohol or alcoholism was frequently mentioned as an element that would facilitate conflict or physical violence by husbands toward their wives. Men using household resources—money earned from farming or selling at the market—on alcohol was mentioned as a reason why gender-based violence occurred in their communities. Women also shared experiences where husbands lied to their wives about how the money they earned from the market was spent and, when confronted, women often faced the consequence of violence from their husbands. *“We have a neighbor here, it was last year in August, he sold it [sheep] and came [home] after spending the night drinking. They had a fight and he beat her. She slept and they had a fight in the morning as well. ‘The sheep that you sold’ she said that clothes should have been bought for the children. When she kept on saying that, he just kept quiet. He just kept quiet, then he said, ‘It is none of your business’ and they had a fight again. He will at least drink when he goes to the market [every week].” [30, Female, IDI, Sayint, Amhara]*

Across all regions, issues of food insecurity and having enough money for food was a point of conflict that sometimes lead to instances of gender-based violence. In Oromia, a participant mentioned that a husband with two wives would withhold food and resources from one wife over the other. In SNNP, a major cause of conflict in the household was the shortage of food. In Tigray, a woman had the responsibility for not only being economical when she prepared food for the family but also being able to satisfy her family’s hunger. She shared her experience and the stress and conflict food shortages caused during her pregnancy. *“For instance, when I was pregnant, we finished our food. Then, I told him that we have finished our food. Then, he said, ‘I do not know, it is your business! Why did you not eat economically?’ then, I have been under too much stress at that time. Then, I thought why I am with him if he does not fulfill my food? My husband is not good all the time. If you do not have enough economically, you will disagree [have conflict] with everyone. If you have a full economic situation, you are always free of worry.” [30, Female, IDI, Adwa rural, Tigray]*

Expectations of wives and their role in the household: Across all regions, interviews with female and male community members and HEWs and HDAs revealed the demands and expectations women face in their household roles. While this did not occur in all households, discussions suggested that some women were held to specific standards of behavior where they were expected to ‘behave’ and not ‘make mistakes,’ or they may face beatings or other forms of violence. Such behaviors included not talking back to their husbands and preparing desired meals at the appropriate time, which meant whenever their husbands demanded their meals. In addition to household chores and serving their husbands, female participants in Oromia mentioned that they also must fulfill the sexual needs of their husbands, even after a long day working in the field

or completing household chores. *"If the husband is a drunkard, when he drinks and comes home, he finds the reason to beat his wife. He starts by [yelling] at the children or beating them. If the wife asks him why he beats their children, he also beats her because he has a good reason to beat her. Instead of his guilt, he beats his family to cover up his problem. He also harasses her if she is tired and cannot have sexual intercourse with him. If she prepares food, he may say that the wot has no salt or it is not good."* [38, Female, FGD, Jeldu, Oromia]

Program focus: Mediators of conflict

"I remember what once happened to a woman. A woman whose husband was a drunkard came to me for consultation. She told me that he usually came home after drinking. She needed advice on how to accuse and divorce him. She said her husband also spend the children's budget on alcohol. And she wanted me to help her. Following her request, I contacted her husband including his brothers. I told him and his brothers her complaint. This was what I experienced. At the end of the day the couple agreed to live together peacefully." [35, Female, KII HEW, Jeldu, Oromia]

Study findings reveal several mediators of conflict related to altercations within households, including physical or verbal violence. Mediators of conflict included but were not limited to iddirs, associations, HEWs and HDAs, family members, neighbors, and elders. Legal actions were rarely taken for conflicts, although prison was mentioned once by an HDA in Amhara. On the other hand, it was discussed that some couples keep conflicts within their families and do not seek help. A potential area for programmatic impact is to reach out and include mediators in activities, with the knowledge that they may hold greater authority within their communities and can potentially be vehicles for health action and behavior change.

Women's Contributions and Respect for Women

Women work extensively in the field and household and at the market, with some men even acknowledging that women do 'equal' work in the field. However, signs of disrespect toward women were mentioned often. In SNNP, an example was that women are not respected during their pregnancy; in Amhara, women were not allowed to be present at community meetings. Some discussions revolved around women earning respect by behaving 'good' or having a 'good tongue' by societal standards or by giving birth, particularly to a male child.

Program focus: Stories of respect for women

Stories of respect for women exist in the culture and are about 'Queen Fura.' Such stories can be used as archetypes for radio programming, poster messaging, or other types of communication media. Using a character that people are familiar with may resonate more (refer the stories in the folktales).

Going ‘outside the home’: An overarching theme of “having respect for women” among the men and women interviewed was increasing women’s voices and increasing their access to avenues in which they can be heard—in the household and in public spheres, such as community groups. Going ‘outside the home,’ both literally and figuratively, is often mentioned as a means toward achieving women’s empowerment. FGDs with female community members focused on women’s empowerment strategies, including, but not limited to, attending community meetings. Social status may affect whether women feel comfortable working outside and whether they feel undermined by the community. *“If women attend different meetings and share what they learn in the meeting with her neighbor and encourage neighbor to go to meeting, that will result in improved respect. Then husband also start to become reserved since she goes to places and learn from experiences. They do not abuse women that attend meetings and spend time out of home. He may be afraid to abuse her; since she goes to places she may inform others about it. Women need to learn about their rights and obligations. Help us to get out of home, there are women that spend all their time at home, they should meet others and attend meeting.”* [28, Female, FGD, Adaba, Oromia]

Supporting women to attend meetings: Similarly, men acknowledged that they can support women to attend community meetings by helping with chores since women are often not able to attend the meetings because of their household responsibilities. FGD males in each region stated several strategies for increasing respect for women. In Amhara, they recognized that while there are growing opportunities for women to participate in meetings, the reality is that women are not often present. In Oromia, respect for women is related to discussions in one-to-five meetings and access to health centers. In SNNP, respect for women is increased through dialogue and discussion. In Tigray, the men mentioned reducing use of alcohol and discussing and communicating with their wives was important. *“To keep females respected, they have to actively participate in the government’s strategies. Meetings are held but participants are only male. We do not send them to participate rather they are assigned to domestic activities. Females are not free, you can see administrators most of them are males, we do not give women a chance and nominate females. Therefore, to improve this situation and promote their right and respect them we should play role, we have to let them participate in meetings and other social and economic scenarios at home or outside. It includes children and wife.”* [50, Female, FGD, Sayint, Amhara]

Characteristics of a Good Wife and Good Husband

FGD female and male participants were asked to describe characteristics of a ‘good’ wife and a ‘good’ husband (see Table 9). Each profile was similar across all regions, however small variations existed, even within one kebele. Regional variations are described below.

Table 9: Summary of characteristics of a good wife or good husband from study participants

	Woman's View	Men's View
Characteristics of a good wife	<ul style="list-style-type: none"> • Good behavior toward husband, family and neighbors • Prepares food • Hospitality • Completes chores 	<ul style="list-style-type: none"> • Maintains peace and harmony in household • Good behavior • Respect toward relatives • Keeps secrets • Completes chores
Characteristics of a good husband	<ul style="list-style-type: none"> • Assist wife with childcare and household chores • Cares for their wife • Does not disturb/disrupt household/neighbors (e.g., because of conflict or alcohol use) 	<ul style="list-style-type: none"> • Provides financially for the family • Respects wife • Physically heavy tasks

For men, the good qualities of a wife were more centrally focused on the family/relatives and maintaining a household. Maintaining peace and harmony in a household was mentioned several times in different forms, such as advising the husband (and his behavior), having a good approach to communicating with relatives and community, and not bringing conflict. Interestingly, in Oromia, the quality of a good wife was to keep secrets. In SNNP, the men focused more on daily tasks a woman should accomplish, including making food and coffee, going to the market, cleaning, caring for child/children, in addition to being generally polite and peaceful. Hunger was mentioned in SNNP, specifically, that a good wife does not starve her family. There were also frequent mentions of respecting the guest(s) of the husband that come into the house and maintaining the home without the husband present. "Since you brought this issue, let me tell you one saying. Once the husband went out for an issue and a guest came to his home. When the guest arrived, the wife welcomed the guest and prepared a place also for his horse. She gave the guest all the necessary honor and feed him with well-prepared food. Then, the guest went to his home. On the road to his home, the guest found the husband and said to him, "Wayita mana jirullee mana jiruu, wayita mana hin jirrellee mana jiruul;" which means [you have a good wife who knows what to do when a guest comes]. On the other hand, a good wife tries many times to calm the issue before leaving home if the husband enforced her to leave the house for him. She first should inform the elders and settle the issue in peaceful manner. That is, what I think the quality of a good wife." [40, Male, FGD, Adaba, Oromia]

For men, good qualities of a husband were focused on a husband's role to provide and care for their family and support their wives. This included financial and physical support to their wives, helping around the house, supporting tasks during pregnancy, and purchasing clothes. Husbands' good qualities, were, in many respects, linked to how they treat their wives, including loyalty to wife in Tigray, not stressing their wives in SNNP, maintaining a good relationship with their wife in Oromia, and listening to their wives in Amhara. Noteworthy qualities to mention in SNNP were: a husband that does not let a family starve (makes sure family is fed) and discusses money matters with his wife. In Tigray, not hurting their wife and not drinking was mentioned. Determining the number of children and helping their wives attend a health center were also mentioned.

For women, the good qualities of a wife were focused on their behavior and their relationship

with the community and their family. For example, not saying anything bad in Amhara, having good behavior with their husband and relationship with neighbors in Oromia, respecting husband and receiving guests in SNNP, and being a hospitable wife in Tigray. A good wife was also expected to prepare food properly (coffee and breakfast), clean their homes, and manage household chores, such as what her husband brings her. Most interestingly, women were expected to manage the household purchases that come in and were in charge of saving money and rationing food (handles food economically), a strong example was in SNNP and Tigray. Giving food or preparing food at the right time for their family were also mentioned. *“The one who trade and brought food to her family in order not her family get hungry. The one who makes up her home full fill, brought what her husband harvest to market and sale and care her family, then she is called a good wife.”* [22, Female, FGD, Damot sore, SNNP]

For women, the good qualities of a husband were less focused on their behavior and more on their willingness to help their wives with child care and household chores, such as holding the baby while she cooks. Women also mention taking care of the cattle, not losing money, being faithful, and not drinking. In Oromia, women mentioned that a good husband does not disturb the household or is peaceful and does not disturb neighbors. A good husband is one who cares, even during bad times (in Tigray). In all regions, “helps with children” was frequently mentioned, particularly “holding a baby.” *“A good quality of husband is that when he holds a child for her when she is involving at works without considering holding a child is meant for a woman role, that [holding a baby] is also men’s role. He does not have to underestimate household chores. If she is busy of works, even he makes stew to support her. This is considered in our community as good husband and the woman is lucky to have such husband.”* [35, Female, FGD, Tahtay Koraro, Tigray]

Summary Of Findings

- Gender inequity norms are prevalent in women and men across socioecological settings.
- Son preference exists. Experiences of retribution for giving birth to a female included husbands not sharing food, money, and other resources with their wives.
- Men hold the primary decision-making power, as “head of household,” related to major expenses and access to resources.
- Women are often not accorded respect at crucial times, such as pregnancy, delivery, and child rearing.
- Women carry a triple burden of working on the farm, child rearing, and household chores. In the context of the social norm of having four to five children, their burden is further exacerbated.

CHAPTER 7. CONCLUSIONS AND RECOMMENDATIONS

This sociocultural study explores gender-inequity norms, couple communication, and social norms, identified in the baseline analysis as core areas for further study. These determinants of health behaviors provide insights on how to effectively design a multifaceted communication program by addressing audience needs and promoting specific behaviors. Other study domains include identification of gateway behaviors, behavioral barriers and facilitators, and community strengths. The SEM model guided the analysis by examining each level of influence to create a holistic picture of the microenvironment and the larger community environment in four regions of Ethiopia. The findings indicate that perceptions of study participants vary at different ecological levels.

The study examined three gateway health behaviors that can help accelerate the adoption of multiple behaviors along the maternal, newborn, and child health continuum. To hasten the adoption of early ANC registration (<12 weeks) and attendance at four ANC checkups, the program needs to address current social norms that hinder uptake of these behaviors. In terms of maternal health, the key finding was that the low prevalence of early ANC checkup (<12 weeks) is due to the predominant social norm that pregnant women will go to a health facility only if they are unwell. This social norm, in addition to no special care provided to pregnant women, also results in pregnant women attending less than four ANC visits. While the social norm related to institutional delivery is strong, it is limited by structural barriers of remote location and lack of adequate transportation.

A latent demand for family planning exists, which can be fulfilled by shifting the social norm of using contraceptives from after four to five children to after two to three children, and increasing contraceptive use among nulliparous couples. In the existing social structures, both modern (HDAs) and traditional (iddirs and equbs) structures can be leveraged to address specific behavioral needs of the community.

The sociocultural study supports the findings of the baseline survey that gender-inequity norms, which exist in several spheres, adversely affect health behaviors. Gender inequity influences couple communication, as the main decision maker is a male; even after a discussion, the wife usually adheres to her husband's decision. Lack of respect for women during pregnancy, childbirth, and the postnatal period results in an enormous burden on women, often forcing them make poor health choices, such as not going for an ANC visit or opting out of an institutional delivery. Additionally, son preference exists, and women bear the brunt of having multiple births.

In contrast, the existence of strong and well-entrenched social structures at the community level provide an opportunity to reach a large number of rural households. The HDA are connected with the health system and their vast outreach can be used to channel strategic behavior change approaches. In addition, traditional social structures, such as iddirs and equbs, are also present at the community level. These social groups and networks can amplify the reach of the Communication for Health program.

Perceptions of Health Problems

Malnutrition, delivery-related complications, diarrhea, malaria, and cough/TB were reported as common health problems in the community in four study regions. Shortage of food items at the household, workload on mothers, unemployment, and poor hygiene and sanitation practices were mentioned as causes for malnutrition. Similarly, prevalence of home delivery in remote areas, low health seeking behavior of rural women, and poor quality of health services in health facilities were indicated as contributing factors for delivery complications. Low health-seeking behavior of pregnant women was attributed to the norm that a pregnant woman only needs to go to the health facility if she feels physically unwell.

Malaria was reported as a common health problem in all study regions. Most study participants either did not know the cause of malaria or believed that it is caused by cold weather. Poor environmental protection activities and incomplete distribution of insecticide-treated nets, especially in remote areas, were identified as causes for malaria. Persistent cough/TB was also mentioned as a common health problem in the study regions, however, most study participants did not know what causes TB.

Recommendations

- Male involvement in household chores and gender-equity norms about men's work in the household need to be promoted.
- The study identified misconceptions about the causes of malaria and TB in the four regions. These misconceptions adversely affect the health-seeking behaviors and decision-making capacity of rural communities. The SBCC program should promote accurate information about the causes of these health problems.

Maternal Health Behaviors

Early Antenatal Care

Knowledge of pregnancy status should determine early ANC attendance. However, many pregnant women across the regions wait to visit the health facility for the first time until they experience illness. Although this implies that the first ANC visit is usually delayed, it does facilitate subsequent ANC follow up, as it creates an opportunity for counseling services and getting the next appointment. In contrast, women in Tigray reported that they visited health facility for the first time explicitly for ANC checkup.

The prevalent social norm for the first ANC checkup across all four regions is at 16 weeks (four months). This norm needs to shift to the recommended "early ANC (<12 weeks) checkup." Baseline data indicate that women who go for early ANC checkup are more likely to have four ANC checkups, opt for an institutional delivery, and adopt healthy newborn care practices. The number (frequency) of ANC checkups reported by women may have included visits to both health center and health post.

A few women said that support from husbands for ANC attendance has improved over time. Despite this, some women reported that they often do not tell their husbands before visiting a health facility the first time, which suggests that husbands' influence on early ANC attendance is not overly strong. Support and encouragement by a husband to visit health facility is, in most cases, for medical care when the woman is sick. Although, this support is not specifically for an ANC checkup, still it facilitates ANC attendance, as the women will have the chance of receiving that service. Overall, husbands and other family members, especially mothers-in-law, were perceived to have a negative influence on ANC attendance. Distance and a lack of transportation were also significant barriers to ANC attendance.

Recommendations

- SBCC activities should emphasize informing women about early signs of pregnancy and going for first ANC visit within the first 12 weeks of pregnancy.
- SBCC on the first ANC visit needs to be prioritized, as it is a gateway way behavior.
- We recommend coordination between HDAs and public transportation service providers, especially in Adaba woreda of Oromia region, to encourage them to provide transportation service and priority to pregnant women.
- Interventions should be designed to address identified barriers to ANC with tailored messages, and messages should be designed in a way to address unique barriers specific to particular communities.

Social Norms And Maternal Health

The study explored social norms related to maternal health, number of children, and contraceptive-use behaviors. We were able to assess where each norm was situated along the continuum from nonexistent to strong norms, and were also able to identify the areas in need of a specific program focus. While the norm of early ANC seeking (<12 weeks) is nonexistent and the norm of four ANC checkups is weak, the norm for institutional delivery is strong.

However, home delivery remains dominant in certain regions, such as Oromia. The study identified the facilitators for and barriers to health facility delivery. Access to ambulance service, proximity to health facility, birth preparedness, positive attitude on quality of the health services at the health facility, high-risk perception on delivery complications, exposure to counseling by HEWs, and use of ANC services were among the facilitators that enable a women to deliver at health facility.

Recommendations

- A new social norm on early ANC visit should be created.
- The core practice of only visiting a health center when the pregnant woman is unwell must be replaced with the practice of attending four ANC visits, even when a pregnant woman's is healthy.

Barriers And Facilitators Of Institutional Delivery

Women's barriers to delivery at health facility include low risk perception, fear, and low decision power; infrastructure-related issues, such as a lack of transportation, poor mobile network connection, and absence of water at the health facility; the poor quality of health services, including an unfriendly care provider and a lack of comprehensive health services at health facilities; lack of support, such as being unable to find a person to go to health facility with; and experience of short labor time were reported among the main barriers for health facility delivery.

Perceptions as to why women do not deliver at health facility were varied across different levels of participants. Women who delivered at home said their short labor time and lack of support were the main reasons for not delivering at health facilities. HDAs and HEWs believed women's resistance to change was a major barrier to not delivering at a health facility, but suggested the reason for that was that some women have no one to manage their household and children when they go for delivery. Focus group participants emphasized that the long distance to health facilities and poor quality of health services were the main barriers to health facility delivery.

Access to an ambulance service, proximity to a health facility, birth preparedness, a positive attitude about the quality of the health services at the health facility, high-risk perception on delivery complications, exposure to counseling by HEWs, and previous use of ANC services were among the facilitators that enable women to deliver at health facility.

Recommendations

- The SBCC program should emphasize the overall concept of birth preparedness, where both money and transportation are planned in advance in case of an emergency and/or labor.
- The SBCC program should advocate and work with other partner organizations to minimize infrastructure-related issues that discourage women to deliver at health facility, such as lack of transportation, poor mobile network, and absence of water at the health center.
- The SBCC program should promote male involvement and community support for pregnant women to improve health service uptake.

Postnatal Care

Mothers do not commonly visit a health facility within seven days of delivery in the study kebeles. Among the reasons for lack of PNC are beliefs that a mother should not go outside the home for a month after delivery and low knowledge among rural women about attending PNC services within seven days of delivery. The current social norm is to only visit the health facility when the mother or newborn has a health problem. HDAs' low levels of knowledge about PNC services were also reported as barriers to PNC uptake.

Recommendations

- SBCC on PNC should be provided during a pregnant woman's ANC visits.
- Use role model mothers who fully attended maternal health services, including PNC, to address the beliefs that prevent women from leaving their homes for one month after delivery.

Contraceptive Use

Perceptions about side effects were reported as the main reason for a woman's choice of contraceptive method. Some HEWs contributed to misconceptions about contraceptives among their community.

Responses about decision making varied among the female participants and HEWs. Most female IDI participants claimed that they decided together with their husbands to use contraceptives, although they said some couples in their communities do not discuss family planning use and some men do not allow their wives to use contraceptives. In contrast, HEWs reported that husbands were mostly the ones who decided if their wives would use family planning. Hence, the claim by women about deciding with their husbands to use contraception may not reflect general decision-making practice within the community. The data on gender inequity indicates a strong male bias when it comes to decision making. Several women reported using contraceptives secretly.

Beliefs and misconceptions associated with contraceptive side effects, including fear of pregnancy, were significant factors reported to affect contraceptive use across all study communities. However, the types of misconceptions varied among communities. For example, one belief associates contraceptive use (mainly implants) with the amount and variety of food and physical activity a woman needs.

The key normative shift related to family planning is that more couples should use contraceptives earlier, in order to space their first four children. Currently, the norm is that couples start using contraceptives after the birth of four or five children. The SBCC program needs to shift this norm to initiate the use of contraceptives earlier in a woman's childbearing experience.

Recommendations

- Depict postpartum family planning as an important component of the family planning program.
- In radio and digital media, show women using contraceptives after the birth of their first child.
- Show nulliparous women using contraceptives in radio and digital media.
- The social norm of using contraceptives after the birth of four to five children needs to be shifted.
- SBCC programs aimed at improving family planning use should focus on addressing the misconceptions associated with implants and injectables.

- Family planning-related SBCC programs need to emphasize the importance of a women's choice of using contraceptives and should promote joint decision making.
- With a focused family planning campaign that involves mass media, HEWs and HDA can build upon the existing latent demand for family planning.

Child Nutrition

Malnutrition was perceived by study participants as the biggest health problem facing their communities. In some areas, suboptimal breastfeeding behaviors, such as delayed initiation of breastfeeding, discarding of colostrum, and failure to practice exclusive breastfeeding were reported to be related to case-specific, rather than societal/cultural factors, were reported. This may require categorization of some child feeding behaviors for social behavior change and others for individual behavior change communication for more focused action. The existing culture of continuing breastfeeding to children aged one year and under is a good practice shared among all assessed communities.

A commendable level of knowledge on the timely initiation of complementary food was noted, as almost all participants reported that an infant should start taking additional food at six months of age. While most of them also agreed on the need for preparing porridge, some caregivers specifically cited watery preparations such as 'thin porridge' and gruels as the most beneficial.

During the interviews, more challenges surfaced related to key complementary feeding practices, such as dietary diversity, frequency, and quantity of food. Although caregivers across regions appeared to understand that complementary foods need to be diverse, very real constraints, such as availability and affordability of foods like meats and vegetables, were evident.

Beyond food, a lack of clean water was also mentioned as a factor that affects complementary feeding behavior. We have discussed the issue of food insecurity during the food scarcity season in this report. Study participants stated that adults often deprive themselves to ensure that children get enough (or something) to eat. Household access to diverse food and economic status were frequently cited as factors that affect optimal complementary feeding practice. The gender section notes how male decision making in SNNP, for example, can hinder a woman's ability to cope during the food insecurity period.

The study participants identified local food models based on the pile sort exercise. These local food models need to be studied in detail to develop a locally relevant and culturally acceptable nutrition promotion strategy.

Recommendations

- The program needs to provide context specific options for promoting food diversity.
- Given that the recommended duration of exclusive breastfeeding is widely known in the study communities, ensuring that the knowledge is translated into practice should be the next step to changing behavior through supporting caregivers.

- A specific nutritional SBCC strategy for the food scarcity season needs to be developed to enable parents to protect their child's nutritional health (for more details refer recommendations on challenges).
- The nutrition education strategy should be built on local foods and their seasonal availability instead of promoting the “six food groups,” a categorization not understood by study participants. The final local food model presented in the report should be the foundation of the nutrition promotion strategy.

Women's Nutrition

Responses to women's nutrition during pregnancy showed that the practice of special nutrition-related care for mothers during pregnancy is low. Rather, feeding during pregnancy is shown to be negatively affected by cultural beliefs. Fears of a 'big fetus/baby' and the practice of fasting during pregnancy are culture-related factors that must be addressed.

The need for special nutrition care for women immediately after giving birth is another widely accepted practice in all assessed communities: the woman gets break from daily chores, porridge prepared from cereals is served, and higher fluid intake is encouraged in the first few days.

Depending on household status, families also give animal foods to newly delivered women.

However, such special care is limited to the ceremony that follows childbirth. Care for a lactating mother is for a short duration.

Gender inequity was evident in the nutrition offered to a pregnant versus a lactating mother, indicating that a newly delivered mother is prioritized over a pregnant women.

Overall, women's nutrition during pregnancy and lactation appears to become a household issue only after childbirth, while women are left without appropriate nutritional support to during pregnancy and the long duration of lactation that follows first weeks of childbirth. The neglect of the woman during pregnancy needs to be appropriately addressed.

Recommendations

- Health service contact points, such as ANC in health facilities and birth preparedness in maternal waiting homes, can be used to promote special and reasonable nutritional support to pregnant and lactating mothers.
- The SBCC program should prioritize pregnant women for additional nutritional intake. Pregnant women require more attention and care by their families.
- Limited feeding during pregnancy appears to be widely affected by food beliefs. The widely reported 'fear of big fetus,' in particular, needs to be a focus of both social and individual behavior change communications. Supporting religious leaders to provide consistent messages on the exemption of pregnant and lactating mothers from fasting where the problem occurs is also essential.

- Building on the good tradition of providing nutritional care to mothers immediately after childbirth, communities need to be supported to devise ways on how to lengthen maternal nutrition support throughout the long lactation period, particularly during the period of exclusive breastfeeding.
- Regional variation in the content and preparation of special foods, both for mothers and children, are often related to locally available food types and the local food culture. Thus, existing local recipes should be the basis for promoting more nutritive and region-specific enriched recipes.
- Given the general societal preference for male children, adequate nutrition to ensure the health of baby girls needs to be emphasized.

Coordination With Woreda-Level Authorities To Facilitate Behavior Change

The study participants reported that “directions” can reach every member of a one-to-five network through a well-set communication chain. If Communication for Health can provide a list of specific behaviors, such as early ANC care (<12 weeks), four ANC checkups, and starting contraceptive use after the birth of the first or second child to the woreda authorities with a Family Health Guide for each one-to-five network leader, perhaps behavior change can occur more widely.

Similarly, the HDA provides a system through which planned SBCC inputs can create an environment for behavior change.

Recommendations

- Engage primary health care units in health promotion activities through a community outreach program.
- Providing training to HEWs and HDA leaders will enhance the effort of HEW and HDA activities.

Family Health Guide

Most households do not have a copy of the Family Health Guide. There seems to be a shortage of the guides and, therefore, they are primarily given to pregnant women. Many women reported that the guides do not last long due to improper use or storage. Although, one HEW in Tigray said that they are attempting to prevent damage to the guides by providing women with bags for holding the guide, as poor handling was reported to be the primary challenge for regular use of the guide by women.

HEWs felt that women could easily understand the messages in the Family Health Guide. Women reported that they would ask their older children to read the Family Health Guide to them. HDAs reported that they, too, used the guide and that the women in the community understood the visuals. However, many HDAs indicated that they did not have copies of the Family Health Guide.

Recommendations

- SBCC efforts should be made to improve the practice of handling and storing the Family Health Guide at home. Here, the lesson from HEWs in Tigray in preparing bags to hold the guide should be replicated in other areas.
- HEWs and HDAs need to encourage educated children to support their mothers to use the guide.
- There is a need to sensitize HEWs to regularly use the guide while providing health education and counseling during home visits.
- The Family Health Guide should be given to every one-to-five network leader; HEWs can instruct the HDAs which themes to focus on each quarter; in addition to addressing the maternal, child health, nutrition, malaria, and TB needs of the community.

Wash Practices

Availability of a handwashing station near a latrine positively influences handwashing with soap of women, as they can easily access water and soap/ash. However, not all households have handwashing station; most women take water in a jug to the latrine for handwashing purposes. The main insight from the handwashing data was that almost all participants spoke about 'handwashing' and not 'handwashing with soap.' Establishing handwashing stations in households can be a precursor to regular handwashing with soap.

Recommendations

- Interventions should focus on increasing access to latrine facilities with handwashing station at the household level, as it improves handwashing practice after latrine use.
- The use of soap or ash should be emphasized in handwashing promotion efforts.

HANDWASHING STATION

Overall, availability of handwashing station at the household level is limited, although responses about the availability varied among HEWs and HDAs and across regions. Handwashing stations also appeared to have a limited lifespan. Many participants reported frequent damage and lack of regular maintenance are the reasons for this.

Recommendations

- The handwashing station must have soap and water.
- Interventions should focus not only on installing handwashing stations but also ensuring sustainable functionality through regular maintenance.
- The promotion of handwashing stations should consider the preferred types of facilities in communities and across regions.

SOCIAL CAPITAL

The presence of new and traditional social structures in Ethiopia is widespread, and these structures work directly with and for community members. One-to-five networks and HDAs are present in all eight kebeles included in this sociocultural study. These social structures can be leveraged for the specific purpose of promoting health behavior change and creating a conducive social environment that supports behavior change at the community level.

The data from the study are illustrative of the overall potential of these social structures. While they do not indicate whether HDA networks are functioning in every got (village), they do provide us with an understanding of how the networks operate. For example, several one-to-five network leaders reported making home visits. The leadership network of the HDA functions in such a way that directions provided by the kebele leader to the HDA groups reach the leaders of the one-to-five networks.

Overall, the data on social capital in the eight study kebeles indicate that Ethiopian communities are rich in social networks and structures that can be mobilized to accomplish the goal of collective behavior change across the six key health areas.

Recommendations

One-to-five networks and the Health Development Army

- The Communication for Health project should work with woreda and regional administration to collaborate with the Federal Ministry of Health and HDAs to prepare guidelines to promote health behaviors using the Family Health Guide and digital SBCC resources.
- Narrowcasting relevant portions of the radio episodes to the mobile phones of one-to-five leaders will ensure coverage of a large number of households, as one-to-five network leaders make home visits and conduct regular meetings with their members.
- Although one-to-five networks actively engage on health issues, they could benefit from strategic guidance on health behavior change. For example, they can promote four ANC checkups and other specific behaviors. Guidelines on health behaviors need to be issued to the HDA through the woreda authorities.
- The Hulubatena app can be distributed by HDAs as they already identify and track pregnant women.
- The Family Health Guide must be given to at least every leader of a one-to-five network with a specific set of behavioral messages to be promoted.
- The HDAs provide an ideal platform creating new social norms—such as early ANC care and four ANC visits—that can lead to a conducive environment for health behavior change.

Iddirs

- Iddirs can be used to promote priority theme behaviors every quarter.
- Digital health resources such as the Hulubatena app and relevant radio content can be provided to the iddirs to be shared with their members to increase coverage to community members who are not already covered by the one-to-five networks.
- Iddirs can also be used to create new social norms.
- Iddirs are a good space to promote gender-equitable norms.

Community Challenges

The primary community challenge mentioned by study participants is food scarcity. We studied food scarcity to provide program guidance on how to formulate a nutrition education campaign for women and children during times when regular nutrition messages may not be relevant due to lack of food availability and diversity.

The example from Gardilo kebele illustrates the need to understand the variation in seasonal food scarcity and how it impacts households. Our data indicate that while all kebeles face food scarcity, the level and magnitude varies. People have to dig deep into their resources to tide themselves over during periods of food insecurity. Kebele administrators stated that vulnerable households typically had one or two meals a day during this period. The role of the community is crucial for enabling access to food via loans, charity, or labor. In some places, vegetable gardens are actively encouraged in one-to-five networks to help during the scarcity season. In others, the availability of the “false banana,” which makes a person very full, can help during the lean season. Food diversity is not always possible during the scarcity season, and this has implications for the diet of young children, pregnant and lactating women, and women of reproductive age.

Recommendations

- The four regions need to plan a specific nutrition promotion strategy during the food scarcity season, which occurs in all four regions.
- The promotion of vegetable gardens and the availability of seeds can be coordinated with the one-to-five networks.
- The Communication for Health project can consult with a nutritionist to develop a dietary plan for children under five and for pregnant and lactating women.
- The “false banana” can be promoted during the food scarcity season.

Gender Norms And Inequity

This sociocultural study examined several dimensions of gender in detail. These included decision making, son preference, gender-based violence, male involvement, and gender-based roles. The study also explored local narratives and idioms that illustrated these gender-inequity norms. The data indicate that any gender strategy needs to emphasize a general respect for women as decision makers, as pregnant women, and as mothers. Women carry a disproportionately high burden of

the child bearing, child rearing, and farming responsibilities.

The data also indicate that Ethiopia has a rich tradition of communities working together and helping each other in times of need. Gender-inequity norms need to change by promoting compassion, male involvement, and positive role models.

Similar to findings in the baseline study (see Ethiopia Baseline Report), we found gender-inequity norms in Ethiopia to be broad, dynamic, and multi-faceted. Permeating several health areas and socioecological levels, gender issues can be found in all spheres of daily life for both women and men. The analysis aimed to explore individual-, household-, community-, and larger structural-level factors that influence gender-inequity norms and to identify potential programmatic areas in which gender inequity could be reduced and health outcomes improved.

We explored gender preferences for children, decision making in the household, husband's support and involvement in the household, perceptions and behaviors related to gender-based violence, women's contributions, respect for women, and, finally, qualities of a 'good' wife and 'good' husband. Each of these overarching themes revealed subthemes in which we can better understand the complexities and contexts in which gender inequities operate. Programs should incorporate these and similar themes and subthemes when creating health communication messages, trainings, and other programmatic activities. The following are insights and programmatic recommendations for each theme.

A strong system of community volunteers that works specifically on health issues is entrenched in all four regions. In addition, traditional social structures, such as iddirs and equbs, also exist in most Ethiopian communities. This system can be leveraged for health behavior change through strategic inputs from the Communication for Health Project by focusing on specific health behaviors, instead of general health areas, such as maternal health and malaria. The data identified only two specific behaviors that the HDAs currently promote through their networks: hospital deliveries and construction of latrines.

The social structure of HDAs and one-to-five networks can ensure that the 'nudge' for behavior change occurs at the got (village) level, as HDAs are in regular contact with its members at least once or twice a month. The follow up required at the community level for health behavior change can be provided through HDAs. Gender-equity norms will be an important crosscutting issue.

Recommendations

Male preference

- **Identify HDAs and HEWs with first-hand experiences of gender inequity.** At first mention, some participants said that there is no longer a preference for sons over daughters, and that such preferences were of a time of the past. One or two HDAs and HEWs were much more forthright in their response about gender preference, while others did not think this was a major issue anymore. HDAs and HEWs had strong stories of the influence of gender preference on health. It is important to identify the HDAs and HEWs who have had experiences with issues related to gender preference in the community and have them share their stories during community discussions.

- **Recognize the influence of gender preference on women's and children's health.** Male preference influences the sphere of the family and community and appears to have health consequences for both women and children. We see that the cultural preference for males influences the uptake of family planning. Negative attitudes toward the birth of female children can result in family shame and anger. The SBCC campaign must create value for the girl child by showing or creating messages or stories that break down male preference, such as a father providing good nutrition to his girl child.
- **Identify men who are supportive of girls'/women's education.** It may be important to identify men who are supportive of women—especially with regard to getting an education. The men may serve as advocates for women, helping to bridge the gender-inequity gap. Education for girls/women is an important idea that community members mention as an example of how they are moved beyond gender preferences.

Decision making in the household

- **Show examples of husbands and wives making decisions (both harmonious and non-harmonious).** Men are generally considered the head of household and, culturally, the decision maker; however, this responsibility appears to be more nuanced, depending on the decision being made. Women are generally seen as in charge of the decisions about food and nutrition (i.e., what to buy and what to cook), but the purchaser is the husband. Messages or stories can be created to show how a husband and wife that make appropriate decisions together can have harmony in the household, and that the opinions of both the husband and wife are respected. In contrast, a household where the decision making is focused on one person—such as the husband—can be shown as non-harmonious. In SNNP, a focus on decision making and food insecurity may be most relevant.
- **Incorporate examples of mediators (iddirs, relatives, neighbors, community members) who can help resolve health conflicts in a household.** The study explored decision making for delivering in a health facility. While men were considered generally supportive, the women mentioned that if their husbands did not allow them to deliver at a health facility they would find other means and support to ensure they were able to do so. Some participants believed that the husband's decision should be respected. Women whose decisions are rejected by their husbands often go to mediators to help them convince their husbands or find other ways to accomplish their goal.
- **Explore other health issues that may have more conflict.** Many women indicated that it is a source of strength that women are empowered to make decisions related to delivering in a health facility, so it may appear that decision making issues related to this topic may not be an issue, since most agreed that a health facility delivery is important. However, this cannot be said for the decision making process for other health issues, such as family planning.

Male involvement in health and other household spheres

- **Support during and beyond pregnancy can be modeled in programming.** Traditional understandings of the roles of men and women in the household—men labor outdoors while women labor in the household—still prevail even during pregnancy. Much gender work needs to be done in this area if half of men do not help their wives, especially after a baby is born. While men are seen as providers, they sometimes help by reducing pregnant women's more laborious tasks, such as walking to the market or fetching water; however, when it comes to cooking, boiling coffee, and taking care of children, those tasks remain the wife's, even during pregnancy.
- **Encourage specific actions in the household.** Overall, husband involvement in household chores were reported as limited and mostly focused on more field work, while chores in the home is seen as a model/ideal. Men support in hard labor; but women still need to support themselves and their families with cooking and other household tasks. Messages can focus on assisting their wives with household chores or child care while she visits the market or health center.
- **Men can help with visits to antenatal care services and reminders.** Some noteworthy items is the importance of communication between husband and wife during this time. Women appreciated husbands not only giving them reminders but also going to the ANC with them.
- **Educating husbands.** In each of the regions, participants mentioned 'model' husbands who can be used as examples to model good supportive behavior to other couples.
- Perceptions and behaviors related to gender-based violence
- **Incorporate major themes of gender-based violence into programs.** Issues related to food, resources, and money underlie most conflict in the household. These conflicts tie into other forms of gender-based violence, such as physical and sexual violence. Although not mentioned frequently, women talked about the need to satisfy their husbands by not only completing the multiple household chores they have throughout the day but also fulfilling their husband's sexual needs. Women were reported to be punished by 'making mistakes' in their household chores or not pleasing their husband.
- **Address alcoholism as a health issue.** Men engaged in excessive alcohol drinking often were in conflict with their wives. Issues related to alcoholism, food insecurity, gender roles in the household, and gender-based violence were often interlinked or intersected in the examples above.
- **Encouragement to find support in the community or to talk about gender-based violence issues is important due to limited support.** Gender-based violence was often not reported to authorities, although a few stories did mention that the perpetrator was jailed or in prison. More often than not, such conflicts are kept within the household, or simply not talked about. If it was discussed, couples or individuals sought help from their

relatives, neighbors, elders, associations (iddirs), religious leaders, or HDAs or HEWs to mediate the conflict and facilitate dialogue between the couple.

- **Identify men and women who recognize there is still inequity toward women.** A potential type of participant to recruit or identify as change agents are the men that recognize that women are not equal despite modern changes in land ownership and so on. They may play a crucial role in terms of changing norms or shifting normative behavior toward women because they are aware of the inequality. Lastly, some women are aware and frustrated by gender inequality in their lives, they also may be recruited or identified as change agents, as they are aware of the inequality and may want to do something or can help with shifting normative behavior toward women.

Women's contribution and respect for women

- Recognize women's significant contributions in and outside of the household. Despite women's significant contributions to activities inside and outside the home, there is little to no mention of their contributions outside of the home and in the field. This may be related to the dynamics of son preference and decision making in the household. It is important to mention their significant contributions both inside and outside the household and incorporate it into trainings. Programmatically, a woman's health day or appreciation day may be noteworthy.
- Engage men who feel they need to support their wives more. Identifying men who feel it is important for women to attend community meetings and support their wives to do so by taking on their chores may be a key facilitator in encouraging other men to take on similar roles of support. If we are able to identify these men and provide training, they can potentially be a main mode in which health communication messages move further.
- Increase efforts to engage women during community meetings. Issues related to low attendance, or barriers to attendance should be addressed. Even though not mentioned frequently, the one-to-five group can be a potential solution. Holding meetings at appropriate times or on market days while women are already moving and traveling may be key.
- Incorporate cultural stories of strong women. Stories of respect for women are deeply rooted in cultural stories related to 'Fura,' which may be an avenue to emphasize in specific regions.

Qualities of a 'good' wife or husband

- Identify community member qualities to emphasize in messages. Expectations are different for what constitutes a 'good' wife and a 'good' husband. Interestingly women repeatedly mentioned that a 'good' husband is one who holds their child, which may be used in campaigns to encourage husbands to help their wives by starting with this step.

Couple Communication

Although the study showed the presence of discussion among couples across the study communities, couple communication was rare in the Adaba woreda of Oromia on a wide spectrum of topics; religious beliefs were cited as a reason. Although the data on couple communication indicated that couples do discuss issues among themselves, it is not enough. Findings from the decision making data show that the man is the ultimate decision maker in most instances, even if the woman initiates discussion. The consequences of a woman not agreeing with a man's decision can lead to conflict and even physical violence. This angle adds another dimension to our understanding of couple communication within the Ethiopian rural context. In the context of health behavior change, women's decision making is crucial in ensuring their children's and their own health.

The study did identify patterns of couple communication, specifically on maternal and child health issues. However, this does not mean that maternal and child health were frequent topics of discussion among couples. Instead, other routine concerns of couples, such as agriculture, household income and expenses, and children education were the major issues of discussion.

Positive maternal health practice, particularly in the case of health facility delivery, is being accepted widely and is now a less contentious issue among couples. However, participants also reported that couples rarely discuss other maternal health issues, such as ANC and PNC. Most participants highlighted the role of fellow women—both in the community and in the family—in sharing a woman's concern and influencing her decisions regarding maternal health. Neighbors also play a decisive role in settling disagreements among couples and influencing husbands in promoting health decisions. From the specifically assessed health issues, HIV testing was the least discussed agenda among couples.

Couple communication on child health was reported as limited to complementary feeding. Discussions about child health rarely included hygiene, child immunization, sick child management, or health-seeking behavior.

Religious and cultural factors, as well as workload and lack of time among women, limits free discussion among couples. In general, while the perceived positive trend of couples listening to each other's advice can be acknowledged, male dominance in decision making was observed across regions. Although there was reported progress in resolving disagreements through educational and legal measures, physical threats and wife-beating are likely to continue to hinder open couple discussion.

Recommendations

- The SBCC program should identify couples where a woman has a strong decision-making role and model the interaction of such couples.
- Couple communication in the Ethiopian context needs to be promoted as an equitable decision-making process.

- Rather than focusing on promoting health as a standalone topic of couple communication, integrating it with everyday concerns of couples could make it a universal discussion agenda.
- The practice of communication among couples about hospital delivery should be promoted further to include discussions about early ANC registration (<12 weeks), four ANC checkups, and birth preparedness.
- Drawing couples' attention to jointly discuss and act on HIV, both before and during pregnancy, may need to be a priority action. An opportunity could be created for integrating the topic of HIV into pregnancy/maternal health-related discussions while couples discuss the place of delivery.
- SBCC inputs should include men as an audience, as it will be an opportunity to promote maternal and child health behaviors and create a supportive environment for behavior change.
- Use of community-based platforms working with peers, development networks, neighbors, and existing community-based organizations need to be emphasized to improve couple communication and settle disagreements. Where mothers-in-law or mothers of the couples live together, a 'family-based' approach, rather than individual dialogues and counseling, may need to be encouraged.
- Factors affecting open discussion among couples need to be addressed to promote effective household communication.
- The culture of wife-beating is still pervasive and its practice should be closely followed up and discouraged through the promotion of alternative solutions, such as participatory discussions with peers and health workers/HEWs, before opting to violent solutions.
- Engaging religious leaders in promoting open discussion among couples needs to be encouraged to address barriers related to religious beliefs.
- Couple communication promotion activities should be integrated with gender interventions.

In conclusion, this sociocultural study provides detailed insights into the core health behavioral issues of an integrated health program such as Communication for Health. The primary focus of the program should be on crosscutting areas of gender-equity norms, couple communication, and the role of social structures for promoting health behavior change. The strategic findings of the study includes:

- Gender inequity operates primarily through male decision making, which renders women voiceless and unable to adopt critical health behaviors.
- The existing social structures—both HDAs and traditional groups—need to be leveraged to increase program coverage. The core insight from the social structure findings is that strategic communication inputs are required as currently the health promotion efforts reported by HDAs are general, except for institutional delivery and building latrines.

- The main barrier to early ANC attendance and four ANC checkups is the social norm governing ANC visits. The social norm of going to a health facility only when a pregnant woman is unwell needs to be replaced with norm of visiting a health facility as a routine task during pregnancy.
- In promoting couple communication, family communication should be a core approach of the program. Here, the emphasis should be on respecting a woman, her value and her decision-making ability.
- A latent demand for family planning services exists. Here, the focus should be on couples with one or two children. If they start using contraceptives before the current norm of four or five children, the contraceptive prevalence will increase.
- The gateway behaviors need to be strategically prioritized. The Family Health Guide should be provided HDA members.

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APPENDIX A. STUDY AREAS

Region	Zone	Woreda	Kebele
Oromia	West Arsi	Adaba	Garadilo
	West Shewa	Jeldu	Saratti
Amhara	South Gondar	Simada	Socham
	South Wollo	Sayint	Ashinga
SNNP	Wollayita	Damot Sore	Dembezame
	Sidama	Dale	Shoye
Tigray	Central	Adwa Rural	Rahya
	Northern	Tahtay Koraro	Mytimket

APPENDIX B. PILE SORT FOOD LIST

Amhara Region	Tigray Region	Oromia Region	SNNPR Region
1. Barley	1. Barley	1. Beans	1. Kocho
2. Beans	2. Beans	2. Beef	2. INSET
3. Beef	3. Beef	3. Beets	3. Potato
4. Cabbage	4. Butter	4. Cabbage	4. Sweet potato
5. Chickpeas	5. Cabbage	5. Carrots	5. Kochecho
6. Chicken	6. Cactus	6. Chickpeas	6. Beef
7. Corn	7. Carrots	7. Corn	7. Green pepper
8. Egg	8. Chickpeas	8. Egg	8. Cabbage
9. Green pepper	9. Corn	9. Green paper	9. Pumpkin
10. Lentils	10. Egg	10. Lentils	10. Wheat
11. Milk	11. Flaxseed	11. Milk	11. Yam
12. Millet	12. Grass Pea	12. Oats	12. Sugar cane
13. Oil	13. Green paper	13. Onion	13. Chickpeas
14. Onion	14. Kale	14. Peas	14. Collard green
15. Peas	15. Lentils	15. Potato	15. Yoghurt
16. Potato	16. Milk	16. Sugar cane	16. Milk
17. Sorghum	17. Oil	17. Teff	17. Corn
18. Spinach	18. Onion	18. Tomato	18. Beans
19. Teff	19. Potato	19. Wheat	19. Teff
20. Tomato			20. Onion
21. Wheat			21. Banana

