Gender Disparities in Primary Health Care

Introduction

Gender disparities in primary healthcare, particularly in utilization of reproductive, maternal, neonatal, child, adolescent and youth health and nutrition (RMNCAYH-N) services, are a concern in both in agrarian and pastoral settings in Ethiopia. The Ethiopian government, along with development partners, is actively working to address these disparities at various levels. Challenges persist due to cultural values, traditions, stereotypes, and gender norms, particularly in rural areas. The five-year Improve Primary Health Care Service Delivery (IPHCSD) project is commissioned by the Bill & Melinda Gates Foundation, being implemented by Amref Health Africa and JSI Research & Training Institute, Inc. (JSI). The project aims to improve access to equitable quality health services in the primary healthcare setting. The project has been implementing its pressure tests in 14 selected woredas and is being scaled up to include an additional 30 woredas in nine regional states of Ethiopia.

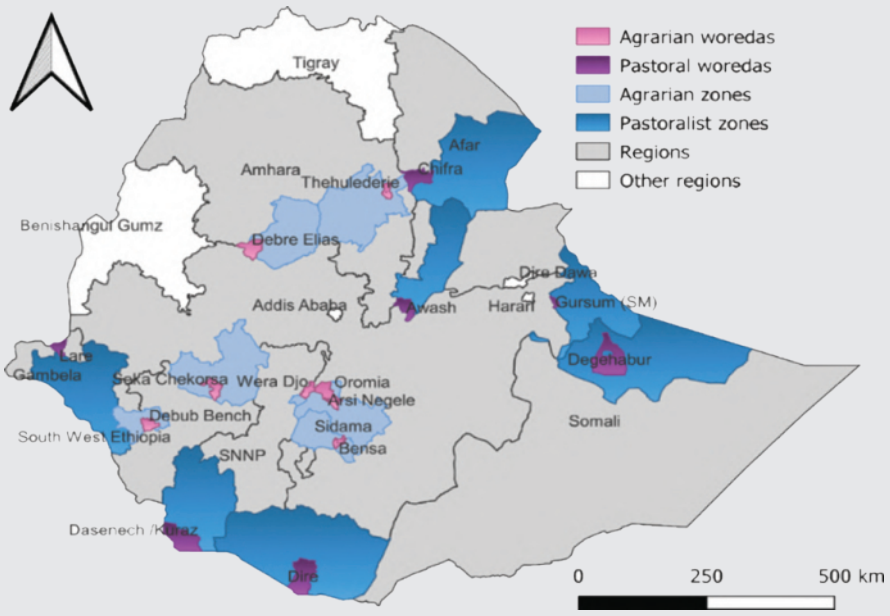

Figure 1: IPHCSD pressure test implementation sites

This gender analysis was conducted to uncover key gaps and barriers affecting women, men, girls, and boys in accessing and utilizing RMNCAYH-N services in nine woredas, i.e., Chifra in Afar, Benchi in Southwest Ethiopia, Dire-Borena in Oromia, Seka Checkora-Jimma in Oromia, Were Dijo-Halaba in Central Ethiopia, Dasenech-South Omo in South Ethiopia, Degahbur in Somali, Bensa in Sidama and Lare in Gambella regions of Ethiopia. The data were collected from August 15 to September 15, 2023.

Barriers to ensuring equitable access to and utilization of essential health services

Cultural norms and beliefs

Various gender-related cultural norms, beliefs, and practices favor males over females in communities. Though women generally have the freedom to visit health facilities, except for family planning and facility-based childbirth, women in rural areas are hindered by rigid gender-norms to access RMNCAYH-N services, particularly for unmarried adolescents and pregnant women, and women within polygamous marriage. In these areas, girls and women often require permission from their fathers or husbands to visit health centers, and unmarried adolescents face negative judgmental attitudes from care providers. Additionally, religion and cultural norms influence utilization of family planning services differently in various communities.

Division of labor

Women's primary responsibilities in all targeted woredas were managing household chores and providing care for children and elders, hindering their access to healthcare services. Therefore, domestic duties often consume their time and limit opportunities to seek RMNCAYH-N services.

Control over resources

In all pastoralist communities, assets and resources are owned and controlled by men. Access to vital information on RMNCAYH-N services is dependent on the commitments of health experts, NGO programs, religious institutions, and social media. However, these information sources may not be adequate to each woman in lower-income households.

Patterns of power and decision-making

Women in pastoralist settings are dependent on their husbands' permission to seek medical care for all household members; they themselves can only access RMNCAYH-N services after getting their husbands' approval. This limited self-autonomy hinders women's ability to make independent decisions about their health. Existing norms and values also restrict women's public engagement, further constraining their reproductive health choices. Addressing these challenges is vital for promoting gender equality and improving RMNCAYH-N service access in pastoral communities.

Health care cost

Despite women's membership in Community-Based Health Insurance (CBHI) programs, transportation and medication costs remain a hidden barrier to seek medical care. Consequently, women may struggle to effectively access the necessary healthcare services, despite having insurance.

Barriers to equitable quality of essential health services

Gender awareness

Gender awareness among healthcare workers in agrarian and pastoral regions is low due to either insufficiency or lack of gender training programs. This knowledge gap contributes to disparities in accessing and delivering quality healthcare services. Without adequate gender training, healthcare workers may struggle to address the unique needs and challenges faced by women and other marginalized groups.

Healthcare workforce leadership positions

Gender disparities persist in healthcare leadership roles, with underrepresentation of women and persons with disabilities (PWDs) in top positions. This lack of representation hampers progress towards gender equality and limits diverse perspectives in decision-making.

Promoting gender diversity and inclusivity in leadership is essential to address these disparities. By empowering women and PWDs to assume leadership roles, the healthcare sector can benefit from their valuable contributions, fostering an equitable and inclusive environment for all.

Lack of supply

Availability of essential drugs and equipment/tools varies across regions, with rural areas experiencing greater shortages. Insufficient resources hinder the delivery of comprehensive RMNCAYH-N care, leading to suboptimal health outcomes for women and children in these areas.

Lack of context sensitive healthcare service

Disparities persist in accessing services sensitive to the needs of women, adolescents, and PWDs. These marginalized groups encounter barriers in accessing tailored healthcare services. The lack of gender-responsive and inclusive services exacerbates existing healthcare inequalities.

Barriers to accountability in the primary healthcare

Poor enforcement of existing policy

Health policies often overlook local realities and context, posing implementation challenges. When policies disregard specific needs, resources, and cultural nuances of a region or community, they fail to address healthcare challenges effectively. This hampers policy implementation and limits their intended impact. To ensure successful implementation, it is crucial to consider local realities, engage with community stakeholders, and tailor policies accordingly. By addressing unique local realities, policies can align better with community needs and resources, resulting in more effective healthcare interventions.

Community feedback mechanisms and women's voice

The underutilization of formal feedback mechanisms at hospitals hampers communication and accountability. Without structured channels, patients and their families face difficulties in sharing their experiences and concerns about healthcare services. This limits hospitals' ability to identify areas for improvement and address service shortcomings. Informal feedback mechanisms, if present, often lack standardized record-keeping processes. As a result, valuable feedback received informally may not be documented or acted upon consistently, resulting in missed opportunities for quality improvement.

Conclusions and Recommendations

In conclusion, gender inequality and intersecting factors significantly impact the utilization of RMNCAYH-N services in Ethiopia.
Gender-based power dynamics contribute to poor RMNCAYH-N outcomes. Context-based disparities, supply and demand barriers, and feedback/accountability issues further compound these challenges. Addressing gender disparities in healthcare requires transformative changes in well-being, power dynamics, and structural aspects. This includes changing norms, gender-awareness training for healthcare workers, increasing women's leadership representation, improving resource availability, and strengthening accountability mechanisms. The gender analysis findings guide targeted interventions to address disparities in primary healthcare. By prioritizing gender-responsive approaches, Ethiopia can make significant progress in ensuring equitable access to essential health services for all individuals.

Conclusion and recommendation

Ensure equitable access to and utilization of essential health services

- Organize awareness campaigns and community conversations to transform harmful cultural practices and promote gender equality.
- Engage religious leaders and community influencers to provide accurate information about family planning and equal sharing of domestic responsibilities.

- Support young people and students advocating for gender equality.
- Recognize male role models as gender champions to promote shared responsibility in domestic work.
- Increase gender- equitable access to resources and knowledge.

Improve the quality of essential health services

- Provide training on gender mainstreaming in primary healthcare for service providers.
- Promote women's empowerment and gender balance in primary healthcare positions.
- Support women in leadership positions and create an enabling environment for female healthcare workers.
- Engage communities including women in quality improvement activities.
- Support PHC facilities to conduct gender analysis and implement tailored interventions.
- Involve women and girls using participatory learning and action approach.
- Integrate comprehensive psychosocial and medical care for Sexual and Gender Basic Violence (SGBV) victims within primary health care system.

Strengthen technical oversight and accountability for PHC

- Provide training to health facility managers on data utilization for monitoring and evaluation.
- Collect gender-disaggregated data during routine monitoring, and evaluations of RMNCAYH-N service provision.
- Strengthen community scorecard approach and ensure women's / girls voice in the feedback mechanism to health facility.
- Empower women to handle their reproductive choices.
- Foster partnerships and networks committed to gender equity in primary healthcare.
- Invest in research and monitoring programs for evidence-informed primary healthcare service.

By prioritizing gender-responsive approaches, Ethiopia can make significant progress in ensuring equitable access to essential health services for all individuals.