



## Women's Sexual and Reproductive Health and Rights in Ethiopia: The Role of the National Government and U.S. Foreign Assistance

### *Report of a Study Tour to Ethiopia*

*On July 5-9, 2010, three U.S. state legislators traveled to Ethiopia to better understand the role of U.S. foreign assistance aimed at improving the quality of reproductive health care. This report documents that trip and makes recommendations for improving effectiveness of U.S. foreign assistance to advance the sexual and reproductive health and rights of women and girls in Ethiopia.*

## Acknowledgments

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*Meeting with Holiness Abune Paulos, Patriarch of Ethiopia and Itchegue of the See of St. Tekle Haimanot Ethiopian Orthodox Church*



*Delegates meet with Ayalew Gobezie, President, Amhara Regional State*

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# EXECUTIVE SUMMARY

**E**thiopia is a country that faces many challenges, yet is full of promise and possibilities. Its health challenges result from inadequate infrastructure and weak health systems that lack the necessary workforce and commodities to meet the needs of its predominantly poor and rural population. Lack of access to contraception and voluntary family planning services is an ongoing challenge that women and families face in Ethiopia. These factors, exacerbated by gender inequality and harmful traditional practices, have led to high rates of maternal morbidity and mortality, including many deaths and injuries due to unsafe abortion. In response to these health challenges, the Ethiopian government has developed an integrated and comprehensive health approach through its health extension program. The program has the potential to reach the hardest to reach, yet gaps remain in fully addressing the country's health and economic challenges. Ethiopian law that restricts the promotion of human rights and U.S. policies that restrict the availability and flexibility of funding for essential health services continue to impede progress towards increased access to comprehensive health care that efficiently and effectively results in positive health outcomes.

## Delegation Findings and Recommendations

### Findings

1. Ethiopia's unmet health needs are fueled by poverty, lack of infrastructure, health workforce deficiency, and gender inequality. Ethiopia's health extension program is a country-led solution to address the unmet health needs and underlying causes.
2. High rates of maternal morbidity and mortality a result of unsafe abortion, lack of access to voluntary family planning services, gender inequality, and harmful traditional practices.
3. There is a need for consistent supplies and a variety of family planning methods for women to have access to contraceptive options.
4. The U.S. government is a major donor to Ethiopia, providing US\$900 million in U.S. foreign assistance in 2009. The health sector (HIV/AIDS, tuberculosis, family planning and reproductive health, and maternal health) and food assistance receive the largest portion of contributions. The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) approved US\$334 million for HIV/AIDS in FY2010,<sup>1</sup> compared to

US\$23 million for family planning and reproductive health,<sup>2</sup> and US\$20.8 million for maternal and child health.<sup>3</sup> Because of current U.S. policy and funding structures, U.S. Mission staff does not have flexibility to tailor country programs to address national priorities and efficiently integrate health services.

5. The repeal of the Global Gag Rule (GGR) in 2009 allows non-governmental organizations (NGOs) receiving U.S. assistance to counsel and refer patients for safe abortion services in cases permitted by Ethiopian law. However, many NGOs and their staff continue to be uncertain about U.S. policy, causing them to curtail their activities unnecessarily or to not apply for U.S. funding.
6. The U.S. funds abstinence- and fidelity-only HIV prevention programs through the Ethiopian Orthodox Church and supports “silence” on condoms, even for youth and married couples who may be at risk of HIV infection.
7. Many human rights and pro-democracy NGOs have had their funding restricted by recent Ethiopian legislation that prohibits NGOs—except those that work on health or development issues—from receiving any more than 10 percent of their funding from international donors. These NGOs must raise 90 percent of their funding locally.

## Recommendations

1. Ethiopia's health extension program should be strengthened and developed to serve as a model for other countries.
2. The U.S. Department of State and United States Agency for International Development (USAID) should issue interpretation of the Helms Amendment to allow U.S. funds to pay for safe abortions in the cases of rape, incest, and to save the life of the mother, in accordance with Ethiopian law.
3. The U.S. should increase its international family planning funding to Ethiopia to increase access to contraceptive supplies and other reproductive health services.
4. The U.S. Congress and the Obama administration should ensure that global health funding to Ethiopia for HIV/AIDS, family planning and reproductive health, maternal and child health, and malaria and tuberculosis is flexible. This would facilitate efficient integration of health services and to ensure that U.S. Mission staff are able to tailor country programs to address national priorities and the health needs of women.
5. The USAID Mission in Ethiopia should reach out to all NGOs working in the field of health—those who do and do not receive U.S. foreign assistance—to explain the impact of the repeal of the GGR and eligibility for U.S. funding. The U.S. Congress should take legislative measures to block reinstatement of the GGR by executive order.
6. The U.S. should end funding for abstinence- and fidelity-only programs and provide information about and access to male and female condoms in all HIV prevention programs.
7. The U.S. should continue to work with the Ethiopian government and NGOs to advance human rights.

## INTRODUCTION

The Center for Health and Gender Equity (CHANGE) hosted a study tour to Ethiopia in July 2010 for a delegation of three state legislators to learn firsthand the role and impact of U.S. foreign assistance and policies on integrated and comprehensive sexual and reproductive health programs in Ethiopia. The delegates learned about the U.S. approach to global health assistance that supports the Ethiopian government's response to health and development challenges. They also learned how U.S. policies and assistance can continue to address global health challenges.

After two days in Addis Ababa and three days in the town of Bahir Dar (Amhara province), including rural site visits, the delegates gained understanding and insight into how health and economic issues intersect in individual lives. They met with international and local non-governmental organizations (NGOs) working on the ground and representatives of both the U.S. and Ethiopian governments. They also conducted site visits to rural and urban community health programs and clinics, and observed how the Ethiopian government's health extension program is functioning.

The study tour was timely in light of the need for increased U.S. foreign assistance for reproductive health, including family planning and maternal health, and Congress' effort to rewrite the Foreign Assistance Act of 1961. In addition, the Obama administration recently rolled-out its U.S. Global Health Initiative (GHI), a plan that outlines a new way to approach global health with an emphasis on gender equality, the health needs of women and girls, and the integration and coordination of maternal health, family planning, HIV/AIDS, tuberculosis, malaria, and neglected tropical diseases.





## BACKGROUND: WHY A STUDY TOUR OF ETHIOPIA?

Ethiopia is one of the oldest independent countries in sub-Saharan Africa. It is also one of the poorest. The United States government is a major donor to Ethiopia and is currently helping to expand the country's community-based health extension program and strengthen basic reproductive health services, including voluntary family planning and maternal health services, to address the dire health needs of women and girls.

In Ethiopia, women and girls face an abysmal health situation. Although the government's reproductive health strategy advocates for a comprehensive approach to addressing reproductive health issues, progress has been stymied by traditional practices, gender discrimination, and a profound lack of infrastructure and other resources, generating appalling indicators. Maternal mortality is estimated at 720 deaths for every 100,000 births.<sup>4</sup> Only 6 percent of women have a skilled attendant at delivery<sup>5</sup> and rural women in particular have little or no access to modern health care. Children born in urban areas are 20 times more likely to be delivered in a health facility than those born in rural areas.<sup>6</sup> The few Ethiopian hospitals that provide emergency obstetric care are mostly in urban areas, making access extremely difficult for rural women who often live days away from the nearest hospital. Due to the lack of emergency obstetric care, an estimated 100,000 Ethiopian women suffer from obstetric fistula, which is caused by prolonged obstructed labor.<sup>7</sup>

According to the Ministry of Health, unsafe abortion claims the life of one of every three women who dies as a result of pregnancy or childbirth.<sup>8</sup> In 2005, abortion was legalized in the cases of rape, incest, to save the life or health of the mother, or for minors not able to raise a child. However, abortion services are not widely available, as many doctors are reluctant to perform abortion and the government has yet to issue guidance for facilities on abortion provision.

Child marriage is a harmful traditional practice that puts girls at high risk of obstetric fistula, maternal mortality, and HIV infection. While the legal age of marriage is 18, the median age of first marriage among 25 to 49 year old women in 2005 was 16.1 years.<sup>9</sup> Childbearing also begins early, with 45 percent of total births in the country occurring among adolescent girls and young women.<sup>10</sup>

AIDS is the leading cause of morbidity and mortality among adults in Ethiopia, with 980,000 people living with HIV in what is a generalized epidemic at 2 percent.<sup>11</sup> Young women aged 15 to 19 are seven times more likely to be infected than their male peers<sup>12</sup> and 87 percent of transmission is estimated to occur through heterosexual sex.<sup>13</sup> While the Ethiopian government's HIV policy is supportive of integrating HIV and reproductive

health services, these services remain predominantly vertical in terms of program administration, funding, and service delivery.

Although the government provides contraception at no cost, these supplies are frequently not readily accessible. Only 14 percent of married Ethiopian women are using a modern contraceptive method and their unmet need is estimated at 34 percent.<sup>14</sup>

Ethiopia was a U.S. President's Emergency Plan for AIDS Relief (PEPFAR) focus country from 2003 to 2008, and the U.S. approved US\$334 million in HIV/AIDS funding in FY2010.<sup>15</sup> Funding from PEPFAR has allowed Ethiopia to provide antiretroviral therapy at no cost to patients, serving 163,100 people through FY2009.<sup>16</sup> Compared to HIV/AIDS funding, the approved U.S. contribution for other sexual and reproductive health concerns is relatively small: US\$23 million for family planning and reproductive health<sup>17</sup> and US\$20.8 million for maternal and child health.<sup>18</sup>

As part of the roll-out of the Obama administration's Global Health Initiative, Ethiopia was named one of eight GHI+ countries in 2010. Ethiopia will be given special attention by the administration and provide lessons for the implementation and evaluation of GHI-based programs and plans in other countries.

# SUMMARY OF STUDY TOUR

## Ethiopia’s Health Challenges

Through meetings with local civil society organizations and leaders, in addition to international and U.S.-based NGOs, the delegates learned firsthand from those on the front-lines addressing health and human rights issues in Ethiopia. Meetings with Pathfinder International—Ethiopia, Family Guidance Association of Ethiopia (FGAE), and Marie Stopes International—Ethiopia (MSIE) provided an overview of critical sexual and reproductive health challenges and the needs of women and young people in the country. Whereas Pathfinder receives U.S. foreign assistance, MSIE and FGAE do not.

Ethiopia’s health challenges are fueled by high rates of poverty and the need for improved infrastructure and an increase in the number of health workers; a predominantly rural population that lacks access to family planning; alarming rates of unsafe abortion; and gender inequities rooted in harmful traditional practices and violence, including sexual violence against women.

**Findings from meeting with Marie Stopes International—Ethiopia, Family Guidance Association of Ethiopia, and Pathfinder International—Ethiopia:**

- High rates of maternal morbidity and mortality in Ethiopia are due to unsafe abortion, lack of access to family planning services, gender inequality, and harmful traditional practices
- 6.7 million women in Ethiopia who want access to family planning do not have it
- 22,000 women in Ethiopia die from pregnancy-related causes every year
- 85 percent of Ethiopians live in rural areas
- Increased resources that support reproductive health interventions are necessary
- A variety of family planning methods are necessary for women to have choices, however, sufficient contraceptive supplies are not available to service providers
- Capacity building for health workers at the local level is needed

**Unsafe abortion.** In May 2005, Ethiopia's abortion law was amended to expand the exceptions within which a woman could legally seek an abortion. In a meeting with members of the Consortium of Reproductive Health Associations (CORHA), including Ethiopian Society of Obstetricians and Gynecologists, Ethiopian Public Health Association, EngenderHealth, and Ipas, members explained how the high incidence of deaths as a result of unsafe abortion in the country led the government to make the change. The law now allows abortion in cases of rape or incest, when the woman's life or health is in danger, fetal abnormalities, for women with physical or mental disabilities, and for minors who are physically or psychologically not prepared for motherhood. The criminal penalties for abortion may be mitigated by poverty or other social factors. Because U.S. foreign assistance is subject to abortion-related statutory restrictions, such as the Helms Amendment, no funds provided by the U.S. government to organizations in Ethiopia can be used for abortion as a method of family planning.

**Abduction and other harmful traditional practices.** Abduction is a result of a loophole in Ethiopian law that exempts a man who rapes a woman from being prosecuted for the crime if he marries her. Because of this loophole, the practice of abduction is common: a man abducts a woman and rapes her, then asks her parents for her hand in marriage. The man knows that the parents will likely agree since it is difficult to find a husband for a girl who has been "spoiled." The delegation met with the Ethiopian Women Lawyers Association (EWLA), a national human rights organization that has recently received attention because of its invaluable work representing women who are fighting against the traditional practice of abduction. EWLA represents women whose rights have been violated, especially in regards to harmful traditional practices and not having access to safe, legal abortion despite the change in law. Pathfinder International—Ethiopia also addresses the impact of harmful traditional practices on reproductive health and rights through its gender equality and empowerment program.

**Weak infrastructure and health system.** The delegates visited the Bahir Dar Hamlin Fistula Center, an extension of the well-known and highly-respected Addis Ababa Fistula Hospital, and heard inspiring stories of women whose lives had been changed in an instant by receiving the simple surgery necessary to repair their fistula. Obstetric fistula is a preventable condition that results from a lack of access to proper care during labor and delivery. After visiting the pristine yet simple clinic, the delegates stepped across the street and walked through the government hospital—the destination for those who are referred there by local health clinics and are fortunate enough to be able to travel far and reach it. The stark differences between the fistula clinic and the government hospital were jarring—the hospital was filled with patients lying on cots just a few feet away from each other and relatives sitting at their sides. There did not appear to be any doctors, charts, medical equipment, or other semblance of what is considered essential in a hospital in the West; the lack of sanitation resulted in a strong odor and the lack of resources was apparent from the condition of the hospital.

## Ethiopia's Integrated and Country-led Solution: The Health Extension Program

USAID has identified Ethiopia as having a country-led response to health concerns. As the core of the country's comprehensive and integrated strategy to improve health out-

comes, the Ethiopian government's health extension program provides a successful example of how health services can be integrated with limited resources. The program, which is supported by international NGOs—some of which are funded in part by U.S. foreign assistance—trains young women to serve their communities by providing basic health care services and referrals. The director general in the Ministry of Health gave delegation members an overview of how the health extension program was developed, the core principles and practices, the long term goals of the program, and the state of its implementation thus far.

The program's core curriculum consists of 16 packages that focus on the following: disease prevention and control, including HIV/TB/malaria education, prevention, and counseling; family health, including maternal and child health, family planning, immunization, and nutrition; and hygiene and environmental health, including personal hygiene, proper latrine construction, building of smoke-free stoves, and rodent and insect control. Of the 16 million homes reached, the program has converted six million homes into "model homes" that successfully implement all of the packages.

Delegates visited a rural health extension post outside of Bahir Dar in the Fogera Woreda District of the South Gonder zone. The health post was managed by two young female health extension workers who explained to the delegates the extensive range of services they provide, including HIV testing and counseling, antenatal care, and family planning. Delegates got a close look at the daily life of those living in "model" homes, who welcomed the delegation and showed them how they have implemented the health extension program packages. Walking through the thatched roof mud huts and navigating among smiling, curious children, the delegates witnessed the stark contrasts between urban life in Addis Ababa and how the majority rural population live and work to combat the challenges they face in achieving a basic level of health.

In a meeting with the President of the Amhara region, which includes Bahir Dar, delegates heard about the success of the government's health extension program and how the program has affected the Amhara region, which has 2,900 health extension posts. He also emphasized the need for additional health infrastructure. The region has a vision to construct 800 additional health centers to supplement the existing 190 centers that support the health extension posts.

In Bahir Dar, delegation members also had the opportunity to visit an urban health extension program that is in development with technical assistance from John Snow, Inc., a U.S.-based organization and recipient of U.S. foreign assistance. Through PEP-FAR, the U.S. is funding a three-year, US\$7.1 million project aimed at strengthening the ability of the Ethiopian government's urban health extension program to identify vulnerable populations most-at-risk of contracting HIV and provide HIV prevention, care, and support services to improve overall health outcomes. The project seeks to bridge the gaps between most-at-risk populations and the urban health extension program workers, including by engaging civil society and community-based organizations.

Meetings with Ambassador Donald E. Booth and USAID Mission representatives provided an analysis of Ethiopia's health landscape. USAID representatives shared with study tour delegates the challenges they experience in trying to successfully implement programs on the ground and the gaps that still need to be addressed. There is a great need for additional health workers to assist the current overburdened health work force

and meet the geographic need for services in a largely rural population. With the success of the health extension program, USAID representatives expressed the need to resist the temptation to try to solve all other health-related issues by putting them in the health extension program “basket.” To reduce maternal mortality, they also emphasized the need to focus on building and strengthening health systems that include more health workers, health clinics in remote locations, and the establishment of logic and information systems.

CORHA members explained to delegates the importance of the government health extension program in getting sexual and reproductive health information and prevention interventions to rural areas. The program has faced challenges that have slowed its progress, including gaps in the practical skills of health extension workers. While they serve their communities well in difficult conditions, health extension workers do not have advanced health education and lack the skills that a midwife or an obstetric nurse may have. However, they are often put in a position where they are providing primary labor support or assisting traditional birth attendants with deliveries. There is also insufficient support, supervision, evaluation, and monitoring of the programs due to a lack of personnel and resources. While the health extension program is delivering desperately needed basic services in an integrated way, efficacy is limited as they are overburdened with work and responsibility.

## Other Examples of Integrated Health Programs

**Community-based programs.** The visit to FGAE in Bahir Dar provided the delegates an opportunity to see a bustling community program that provides integrated and comprehensive services. The program includes a fully-staffed sexual and reproductive health clinic, HIV and STI testing and counseling, an on-site pharmacy, and community-building youth services. The executive director and staff made it clear that increased funding is essential to continuing to meet the health needs of the people that visit FGAE, especially when it comes to contraceptive supplies. In addition, FGAE had examples of clear gaps to achieving a fully integrated and comprehensive system. While the Bahir Dar clinic provides HIV testing and counseling and provides referrals for HIV treatment, HIV treatment programs are not providing referrals for family planning services. Additionally, the clinic staff has identified a gap in their ability to provide labor and delivery services in the health clinic.

**Rural development programs.** The Amhara Women's Association (AWA) is an example of an integrated program that is taking a multi-sectoral approach to addressing the underlying causes of gender inequality and barriers to women's health. The delegates visited an AWA program in the rural town of Yigage in the Libokemken Woreda District. AWA is working with Pathfinder International—Ethiopia and the Amhara Development Association (ADA) to support girls who try to avoid early marriage. This year alone they are responsible for cancelling 135 early marriages in one district. In addition, the program helps support girls in continuing their education, helps young women start income-generating activities, administers family planning and immunization awareness programs, and works with health extension workers and traditional birth attendants to ensure women have the safest labor and deliveries possible. AWA is also working extensively with communities on gender mainstreaming, including counseling couples on how to reduce women's work load.

**Amhara Development Association.** The ADA is a model example of an integrated health program at work. It is a grassroots non-profit organization that links sexual and reproductive health issues with the larger development context through their Community-Based Reproductive Health Program. It also works on larger related issues like road construction, skills-based training, and natural resource preservation. The ADA works to address all the health needs of a population including promoting and providing family planning services, reducing maternal and infant morbidity and mortality, reducing the incidence of HIV/AIDS and other STIs, and eradicating harmful traditional practices. To accomplish this, ADA works with other stakeholders like government entities and NGOs to provide support and engage the local communities through conducting training, with a particular emphasis on targeting hard to reach populations.

**Marie Stopes International—Ethiopia.** Delegates visited a Marie Stopes clinic in Addis Ababa and learned about the comprehensive sexual and reproductive health services they provide to poor women, either for a small fee or for free. Services include voluntary family planning counseling, a range of contraception choices, HIV testing and counseling, prenatal care, pap smear testing, and health screenings. Marie Stopes also provides safe abortion under the provisions of Ethiopian law. Ninety-five percent of the women that receive abortion services leave the clinic with some type of contraception of their choice. MSIE also has an obstetrics center in the capital, where it provides comprehensive obstetric care and skilled deliveries. In addition to its 29 clinics throughout Ethiopia, Marie Stopes has mobile health teams which provide access to free voluntary family planning services to the underserved in the rural areas of Ethiopia, where family planning services are not otherwise available.

### **Human Rights: The Ethiopian government still has work to do**

Ethiopian Women Lawyers Association (EWLA) has worked to represent women resisting abduction, female genital mutilation, and other harmful traditional practices that are a violation of human rights and critically affect the health and lives of women. In a meeting with the executive director, the delegates were discouraged to learn about a recently passed Ethiopian law that severely restricts the amount of international funding that can be accepted by local human rights organizations. Exempting only health and development organizations, the law restricts foreign funding for all organizations to only 10 percent, meaning that the other 90 percent must come from the limited local sources available in Ethiopia. This new law has had a dramatic impact on human rights organizations, including EWLA, which has had to cut services and activities as a result. Officials at the USAID Mission are aware of the new law and are concerned about the possible impact it will have on groups working to advance human rights in Ethiopia.

## The Role of U.S. Foreign Assistance in Ethiopia

**The U.S. Global Health Initiative in Ethiopia.** The USAID Mission in Ethiopia has made significant progress in improving health outcomes there, including launching a campaign on maternal mortality in January 2010 and implementing wrap-around programs that build linkages with health and nutrition. In addition to this progress, the government's health extension program has the potential to serve as a model for other countries. As a GHI+ country, Ethiopia will benefit from an intensified effort by the U.S. government through additional technical, management, and financial support on program interventions involving maternal and child health, family planning, infectious disease, and health systems strengthening. The USAID Mission's concept paper on Ethiopia as a GHI+ country, due to be completed by the end of 2010, should provide clarity on the details and next steps in GHI implementation.

## Overcoming Policy Barriers and Funding Restrictions

**Flexibility in funding.** Study tour delegates found that current U.S. funding structures result in limitations on flexibility for USAID Missions. USAID Mission funding is separately allocated for different program elements such as HIV/AIDS, tuberculosis, malaria, maternal and child health, and family planning and reproductive health. The Missions are, therefore, required to create separate parallel Operational Plans (the Country Operational Plan (COP), the Malaria Operational Plan (MOP), and the Operational Plan (OP)) that outline how the money for each program element will be spent, which increases the reporting burden as each of these plans have different reporting requirements. The separation of program elements makes it difficult to tailor country programs so that they address national priorities and integrate all health programming in the most efficient manner; nevertheless, under the GHI, the Missions will be called on to overcome these obstacles and to coordinate across programs and across U.S. government agencies working in health. To address these challenges, Washington should actively consult Missions and allocate money for programs in a manner that would allow for more flexibility of programming, streamline the planning and reporting requirements and processes, and ensure a woman-centered and integrated approach to health programs.

**Increased funding.** There continue to be gaps in services in even the most promising examples of comprehensive and integrated programs in Ethiopia, such as the lack of labor and delivery services in the FGAE's sexual and reproductive health clinic. Rural health extension workers indicated that they face an ongoing problem of unreliable and inadequate supplies of contraceptives for the populations they serve. Urban health extension workers stated that there was a lack of basic office supplies needed for them to carry out their functions, including a shortage of questionnaires for the workers to collect baseline data from families. Ethiopia urgently needs more money to support family planning programs—US\$32 million is needed to meet contraceptive needs, yet they receive just US\$18 million. The U.S. must continue to prioritize unmet contraceptive needs when developing their global health budgets.

**Global Gag Rule and the Helms Amendment.** Despite the fact that the GGR is no longer in effect, CORHA members noted that it continues to complicate efforts to address



unsafe abortion in Ethiopia. When President George W. Bush reinstated the GGR, the U.S. Mission called a meeting of NGOs and announced the GGR was being implemented in Ethiopia. Since President Obama rescinded the GGR, the U.S. Mission has been silent, leading to some confusion on the ground about who is eligible for U.S. funding and how the U.S. Mission is now operating differently.

The Helms Amendment prohibits U.S. foreign assistance from paying for abortions “as a method of family planning.” The lack of proper legal interpretation of the Helms Amendment has prevented U.S. funds from paying for safe abortions in the cases of rape, incest, or to save the life of the mother, as permitted under Ethiopian law. The U.S. government’s continued funding restrictions on abortion conflict with Ethiopian law and undercut progress in promoting GHI principles, including emphasizing a country-led approach toward addressing health challenges.

**Accountability in funding.** The U.S. continues to fund abstinence- and fidelity-only HIV prevention programs, including through the Ethiopian Orthodox Church, despite evidence showing its ineffectiveness in preventing HIV infections. The Church is silent on condoms and any other form of family planning, even for youth and married couples who may be at risk of HIV infection and unintended pregnancy. By supporting the Church, PEPFAR continues to fund programs that are not evidence-based.

**Donor coordination.** Coordinating efforts among donors and government ministries is essential to efficiently and effectively meet the sexual and reproductive health needs of women and girls. The delegates met with the United Nations Population Fund (UNFPA) and United Nations Children’s Fund (UNICEF) and learned about their work on HIV prevention, girls’ empowerment and education, delaying marriage, and combating gender-based violence. It became clear that the landscape in Ethiopia still includes obstacles, many of which can only be addressed with additional and less restrictive funding from the U.S. that would allow for improved coordination among other international donors in the country.

### **The Ethiopian Orthodox Church**

The Ethiopian Orthodox Church has a strong and widespread presence among communities. They have a wide reach and well-established vehicles through which to do extensive community outreach. The Church operates development programs and projects with field workers on staff. They do important work on issues such as violence against women, harmful traditional practices, child marriage, voluntary counseling and testing of HIV, and immunization and vaccine programs. However, the Church entirely omits family planning education and services from their outreach. Moreover, when a community member brings up family planning, they do not refer the person to other appropriate resources to get information, but rather teach abstinence and being faithful. Given the number of maternal deaths that result from unwanted pregnancies and the lack of access to family planning, the delegates expressed concern about the U.S. funding health programs that neglect women’s sexual and reproductive health needs.



## CONCLUSION: FINDINGS AND RECOMMENDATIONS

**E**thiopia is a country that faces many challenges, yet is full of promise and possibilities. Through the study tour meetings and site visits, U.S. state legislators developed an understanding of health challenges that need to be addressed in Ethiopia, despite the government's promising comprehensive and integrated approach to improving health outcomes. Increased U.S. support in Ethiopia that promotes human rights, combats underlying barriers to health, and addresses significant causes of maternal morbidity and mortality, like unsafe abortion, can dramatically impact the health and well-being of Ethiopian women and girls. By designating Ethiopia a GHI+ country, the U.S. has created an opportunity to meaningfully implement GHI principles by strengthening and developing programs that work, supporting the potential of a country-led solution, and using Ethiopia's successes as a model for scale-up in other countries.

### Findings

1. Ethiopia's unmet health needs are fueled by poverty, lack of infrastructure, health workforce deficiency, and gender inequality. Ethiopia's health extension program is a country-led solution to address the unmet health needs and underlying causes.
2. High rates of maternal morbidity and mortality are due to unsafe abortion, lack of access to voluntary family planning services, gender inequality, and harmful traditional practices.
3. There is a need for consistent supplies and a variety of family planning methods for women to have access to contraceptive options.
4. The U.S. government is a major donor to Ethiopia, providing US\$900 million in U.S. foreign assistance in 2009. The health sector (HIV/AIDS, tuberculosis, family planning and reproductive health, and maternal health) and food assistance receive the largest portion of contributions. The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) approved US\$334 million for HIV/AIDS in FY2010,<sup>19</sup> compared to US\$23 million for family planning and reproductive health,<sup>20</sup> and US\$20.8 million for maternal and child health.<sup>21</sup> Because of current U.S. policy and funding structures, U.S. Mission staff does not have flexibility to tailor country programs to address national priorities and efficiently integrate health services.

5. The repeal of the Global Gag Rule (GGR) in 2009 allows non-governmental organizations (NGOs) receiving U.S. assistance to counsel and refer patients for safe abortion services in cases permitted by Ethiopian law. However, many NGOs and their staff continue to be uncertain about U.S. policy, causing them to curtail their activities unnecessarily or to not apply for U.S. funding.
6. The U.S. funds abstinence- and fidelity-only HIV prevention programs through the Ethiopian Orthodox Church and supports “silence” on condoms, even for youth and married couples who may be at risk of HIV infection.
7. Many human rights and pro-democracy NGOs have had their funding restricted by recent legislation that prohibits NGOs—except those that work on health or development issues—from receiving any more than 10 percent of their funding from international donors. These NGOs must raise 90 percent of their funding locally.

### **Recommendations**

1. Ethiopia's health extension program should be strengthened and developed to serve as a model for other countries.
2. The U.S.-funded health intervention programs in Ethiopia should be woman-centered and explicitly address unsafe abortion, lack of access to family planning services, gender inequality, and harmful traditional practices. The U.S. Department of State and United States Agency for International Development (USAID) should issue interpretation of the Helms Amendment to allow U.S. funds to pay for safe abortions in the cases of rape, incest, and to save the life of the mother.
3. The U.S. should increase its international family planning funding to Ethiopia to increase access to contraceptive supplies and other reproductive health services.
4. The U.S. Congress and the Obama administration should ensure that global health funding to Ethiopia for HIV/AIDS, family planning and reproductive health, maternal and child health, and malaria, and tuberculosis is flexible, to facilitate efficient integration of health services and to ensure that U.S. Mission staff are able to tailor country programs to address national priorities.
5. The USAID Mission in Ethiopia should reach out to all NGOs working in the field of health—those who do and do not receive U.S. foreign assistance—to explain the impact of the repeal of the GGR and eligibility for U.S. funding. The U.S. Congress should take legislative measures to block reinstatement of the GGR by executive order.
6. The U.S. should end funding for abstinence- and fidelity-only programs and provide information about and access to male and female condoms in all HIV prevention programs.
7. The U.S. should continue to work with the Ethiopian government and NGOs to advance human rights.

## NOTES

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## ANNEX 1: ETHIOPIA 2010 SUMMER STUDY TOUR ITINERARY

	DATE	TIME	ACTIVITY
<b>1.</b>	Sunday, July 4, 2010	7:00 pm	Arrive Addis Ababa
		9:00 pm	Dinner with delegates to review itinerary and meetings
<b>2.</b>	Monday, July 5, 2010	9:00 am–10:00 am	Country briefing and issue overview: Dr. Fisseha Mekonnen, Executive Director, Family Guidance Association of Ethiopia Grethe Petersen, Country Director, Marie Stopes International Ethiopia Konjit Worku, Gender and HTP Project Officer, Pathfinder International–Ethiopia
		10:00 am–11:00 am	Zenaye Tadesse, Executive Director, Ethiopian Women Lawyers Association
		1:00 pm	Meeting with Consortium of Reproductive Health Associations (CORHA) members: Ipas, Engender Health, Ethiopian Public Health Association, Ethiopian Society of Obstetricians and Gynecologists and CORHA
		3:00 pm	Meeting with Dr. Kesete Birhane Admasu, Director General, Health Promotion and Disease Prevention General Directorate, Ministry of Health
		4:30 pm	Meeting with Ethiopian Orthodox Church
<b>3.</b>	Tuesday, July 6, 2010	9:30 am–10:30 am	Meeting with USAID Misson Ethiopia: Jeanne Rideout, Team Leader for Health Meri Sinnitt, Office Chief, Health AIDS Population Nutrition office Premila Barlett, Senior Reproductive Health and Family Planning Advisor Dr. Carmela Green-Abate, Coordinator, PEPFAR Ethiopia Coordination Office Eshete Yilma, Deputy Team Leader Health
		11:30am	Meeting with US Embassy: Ambassador Donald E. Booth Dawn Broussard, Deputy Director, Centers for Disease Control and Prevention Thomas H. Staal, Mission Director, USAID
		3:30pm	Flight to Bahir Dar

	DATE	TIME	ACTIVITY
4.	Wednesday, July 7, 2010	9:00 am–10:30 am	Visit Bahir Dar Hamlin Fistula Center Dr. Andrew Browning
		2:00 pm–3:30 pm	Site visit to Family Guidance Association of Ethiopia Dr. Fisseha Mekonnen, Executive Director
		3:45 pm–4:30 pm	Urban Health Extension Worker Program at Bahir Dar Health Clinic
		5:00 pm	Meeting with Ayalew Gobezie, President, Amhara Regional State
5.	Thursday, July 8, 2010	9:00 am–11:30 am	Rural site visit to Amhara Women's Association program, Yifage, Libokemkem Woreda District, South Gonder Zone
		12:45 pm–3:00 pm	Rural site visit to Health Extension Worker Post and model homes implementing packages of the Health Extension Program, Fogera Woreda District, South Gonder Zone
6.	Friday, July 9, 2010	10:30 am	Flight to Addis Ababa
		1:00 pm–2:30 pm	Lunch meeting with United Nations Population Fund and UNICEF Benoit Kalasa, UNFPA Representative to Ethiopia Roger Pearson, Social Policy Specialist, UNICEF
		3:00 pm–4:30 pm	Visit to Marie Stopes International clinic in Addis Ababa Grethe Petersen, Country Director Sister Alemu Shewaye, Nurse and Area Manager
		5:00 pm	Meeting with Holiness Abune Paulos, Patriarch of Ethiopia and Itchegue of the See of St. Tekle Haimanot Ethiopian Orthodox Church Development and Inter Church Aid Commission



## ANNEX 2: BIOGRAPHIES OF STUDY TOUR PARTICIPANTS

### DELEGATES

#### **State Senator Arthenia Joyner (FL)**

Arthenia L. Joyner was elected to the Florida Legislature in 2000. She served six years in the Florida House of Representatives and is currently serving in the Florida Senate. She is a shareholder in the law firm of Stiles, Taylor & Grace, P.A. specializing in probate, guardianship and public finance law. Sen. Joyner has been a groundbreaking leader in her profession. She was the first black female attorney in Polk and Hillsborough Counties. She has been in private practice for 41 years—longer than any other black woman in the history of Florida. She received her B.S. and J.D. from Florida A & M University (FAMU).

Sen. Joyner is an ardent advocate for civil rights and has always stood for what she believes to be fair and just. Facing segregation and discrimination, she participated in the first civil rights demonstrations in her hometown of Tampa; was arrested twice while attending FAMU when participating in efforts to desegregate movie theaters; and 1985, while serving as president of the National Bar Association, she was again arrested in a protest against apartheid outside the South African Embassy.

Senator Joyner has received numerous awards. Among her most prestigious awards are appointments by President Clinton to the U.S. Delegation to the Population Conference in Cairo, Egypt (1994) and the U.S. Delegation to the United Nations 4th World Conference on Women in Beijing, China (1995). Other recent awards include the Warrior for Women Award from the Florida Council Against Sexual Violence (2009 & 2010); Florida State Massage Therapy Association Legislator of the Year (2010) and Planned Parenthood's 37th Anniversary Roe v. Wade Choice Award (2010). She continues to be recognized by numerous groups for her leadership on womens' and human rights issues and her relentless passion for justice, truth, and equal rights.

#### **State Representative Kay Khan (MA)**

Kay Khan, State Representative for the 11th Middlesex District in Newton, Massachusetts is currently serving her eighth (2-year) term in office, and is also a psychiatric nurse clinical specialist. Most recently, for the 2009-2010 legislative session, Rep. Khan is the House Chair of the Joint Committee on Children, Families and Persons with Disabilities.

Throughout her career in the legislature, she has been a leading voice for affordable and compassionate health and mental health care, public education, housing and human services. Rep. Khan strongly promotes better transportation and a healthier environment. She has been the legislature's leading advocate for progressive policies for incarcerated individuals, including women and their children.

Rep. Khan was the co-chair of the Caucus of Women Legislators in 1998 and remains an active member of the Caucus and is the co-chair of its task force on Women in the Criminal Justice System. Through this task force, she established a working group of legislators, advocates, academics, and community leaders who share an interest in helping the women who enter the criminal justice system understand the affect of incarceration on the children of these women and promote better gender specific programs outcomes for the future for the women.

In 1998 Rep. Khan founded the Legislative Mental Health Caucus, the first of its kind nationwide, which she continues to co-chair. This caucus has spurred greater understanding, attention, and advocacy for improved mental health services and laid the groundwork for the creation of a Joint Legislative Committee (House and Senate) on Mental Health and Substance Abuse in Massachusetts. Kay has a passion for democracy, equal rights and social justice. Rep. Khan has lived in the city of Newton for 40 years with her husband Nasir Khan, M.D. They have three married children and seven grandchildren.

### **State Senator Sandra L. Pappas (MN)**

Sen. Sandy Pappas was first elected to the Minnesota House of Representatives in 1984, where she served three terms. In 1990 she was elected to the Minnesota State Senate and is now serving her sixth term. Her district includes downtown St. Paul, inner city neighborhoods to the west, north and south of downtown, and the area surrounding the state capitol. Currently, Sen. Pappas chairs the Senate Higher Education Budget and Policy Committee. She also serves on the Finance Committee, the State and Local Government Oversight Committee and its Budget Division, the Capital Investment Committee, and the Legislative Commission on Pensions and Retirement.

Beyond her accomplishments in the area of higher education, Sen. Pappas is known as a human rights and women's advocate, a consumer protection watchdog, and a protector of the environment. She has passed legislation to prohibit the trafficking of persons; to curtail investment of state pension funds in companies complicit in genocide in the Darfur region of Sudan; to provide emergency contraception for sexual assault victims; to eliminate predatory lending practices, regulate debt settlement companies, and to require that state-funded construction and renovation of buildings do not produce an increase in greenhouse gas emissions. As a member of the Capital Investment Committee, she has, over the years, secured funding for a number of projects in St. Paul including the Children's Museum, Wabasha Bridge, Harriet Island Regional Park, Union Depot, Raspberry Island, Central Corridor Light Rail, and the Great River Park along the Mississippi.

Born in Hibbing, Minnesota, Sen. Pappas attended the University of Minnesota, is a graduate of Metropolitan State University, and has an MPA degree from the Kennedy School of Government at Harvard University. She is married to Neal Gosman, and they have three married daughters—Mina Ruth, Leah Davida, and Sarah Chava. Besides traveling to Israel to visit her 12 grandchildren, Sen. Pappas enjoys biking, reading novels and spending time with friends.

## **CHANGE STAFF**

### **Serra Sippel**

Serra Sippel is the president of the Center for Health and Gender Equity (CHANGE), where she leads the organization's advocacy agenda to ensure that U.S. foreign policies and programs promote sexual and reproductive health and rights of women and girls globally. CHANGE advocates for human-rights- and evidence-based approaches to prevention and treatment of critical reproductive and sexual health concerns and increased funding for critical programs. Serra has more than 17 years of experience advocating for women's rights and related issues. Prior to joining CHANGE, Serra was the international program

director at Catholics for a Free Choice (CFFC), where she worked for more than eight years to advance the sexual, reproductive, and other human rights of women around the world. In addition to her years at CFFC, Serra has been involved in the fight for women's rights through her work at a homeless shelter for women with children in Texas, and on behalf of women prisoners in the state of Indiana. Serra also has collaborated with women's rights activists around the world to secure and promote sexual and reproductive health and rights. Among Serra's many achievements as an advocate is her leadership at the United Nations to safeguard the critical agreements regarding women's sexual and reproductive rights made at the U.N. world conferences in Cairo and Beijing. Serra holds a master's degree in religion, with an emphasis on peace and justice. She is the author of numerous articles and other publications on sexual and reproductive health and rights, has spoken at international conferences, and is sought after for commentary and analysis on U.S. foreign policy and sexual and reproductive health rights.

### **Deepika Allana**

Deepika Allana is senior public policy associate at the Center for Health and Gender Equity (CHANGE). At CHANGE, Deepika is responsible for analyzing U.S. legislation, policies, programs, and funding streams related to U.S. foreign policy and assistance; creating policy advocacy strategy; and building relationships with critical government agencies and offices to advance CHANGE's agenda in key issue areas. Prior to joining CHANGE, Deepika was the senior public policy attorney at the Tahirih Justice Center, where she conducted legislative advocacy and educational outreach related to their Campaign to Prevent Abuse and Exploitation through the International Marriage Broker Industry (so-called "mail-order bride" agencies). Deepika also has experience working on issues related to anti-human trafficking, including serving as a senior legal fellow for Polaris Project and as a legal consultant to Amnesty International. Deepika has practiced intellectual property law at several law firms, during which time she maintained an active portfolio of pro bono work, focusing on women's human rights issues. She received her J.D. from Boston University and her B.A. in Psychology and a Certificate in Community Health from Tufts University.

## **CONSULTANTS**

### **Helina Demeke**

Helina Demeke organized and coordinated logistics for the CHANGE study tour to Ethiopia. Helina has more than eight years of experience in planning and managing national-level events and has considerable experience in office management with international NGOs. Helina is a temporary travel and event organizer with the London School of Hygiene and Tropical Medicine. Previously, she worked with Population Council's office in Addis Ababa and Project Concern International Ethiopia. Helina holds a post-MBA degree from Indira Gandhi National Open University, a B.A. from Addis Ababa University, and a Diploma in Secretarial Science and Office Management from Addis Ababa Commercial College.

**Jessie Auritt**

Jessie Auritt, a videographer, editor, and producer, served as videojournalist for the study tour to Ethiopia. Jessie first became interested in social issue media when she produced the documentary film, “The Price of Education,” while a student at Tufts University. Since graduating and moving to New York, Jessie has worked in production on numerous shows for the Discovery Networks; and as a videographer, editor, and producer for the career information company Vault.com, the Independent Film Channel, *The New York Daily News*; and most recently, “Beyond Bullets,” an anti-gun violence media campaign.

## Acronyms

ADA—Amhara Development Association  
AIDS—Acquired Immunodeficiency Syndrome  
AWA—Amhara Women's Association  
CHANGE—Center for Health and Gender Equity  
COP—Country Operational Plan  
CORHA—Consortium of Reproductive Health Associations  
EWLA—Ethiopian Women Lawyers Association  
FGAE—Family Guidance Association of Ethiopia  
FY—Fiscal Year  
GHI—U.S. Global Health Initiative  
GGR—Global Gag Rule  
HIV—Human Immunodeficiency Virus  
MOP—Malaria Operational Plan  
MSIE—Marie Stopes International—Ethiopia  
NGO—Non-Governmental Organization  
OP—Operational Plan  
PEPFAR—U.S. President's Emergency Plan for AIDS Relief  
STIs—Sexually Transmitted Infections  
TB—Tuberculosis  
UNFPA—United Nations Population Fund  
UNICEF—United Nations Children's Fund  
USAID—United States Agency for International Development



*Senator Pappas with health extension worker and resident in front of latrine outside model home in Fogera Woreda District, South Gonder Zone*



*State legislators with students at rural site visit to Amhara Women's Association program, Yifage, Libokemkem Woreda District, South Gonder Zone*



*Delegates participate in a traditional coffee ceremony at the Bahir Dar Fistula Clinic*



*Delegates visit model homes implementing packages of the Health Extension Program, Fogera Woreda District, South Gonder Zone*

## About the Center For Health and Gender Equity

The Center for Health and Gender Equity (CHANGE) is a U.S.-based nongovernmental organization whose mission is to ensure that U.S. international policies and programs promote sexual and reproductive health within a human rights framework for women and girls worldwide. CHANGE advocates for effective, evidence-based policies and increased funding for critical programs. CHANGE believes that every individual has the right to basic information, technologies, and services needed to enjoy a healthy and safe sexual and reproductive life free from coercion and preventable illness.

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