

# GHI Implementation and Sexual and Reproductive Health in Ethiopia: A Progress Report

Center for Health and Gender Equity (CHANGE)



## INTRODUCTION

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Sexual and reproductive health are at the core of global health. If women and girls have access to the services and tools that support healthy pregnancies and protect against unintended pregnancy, HIV, and other sexually transmitted infections, the benefits in terms of healthy women, young people, children, and communities are staggering.

The Obama administration's Global Health Initiative (GHI) marked an important shift in U.S. global health assistance by emphasizing an integrated, country-driven approach. Three of GHI's seven principles are particularly critical for advancing sexual and reproductive health: the focus on women, girls, and gender equality; country ownership; and integration of health sectors.

**METHODOLOGY:** To assess the development of GHI's implementation and the extent to which it is advancing sexual and reproductive health and rights, CHANGE staff and consultants interviewed stakeholders, engaged local civil society organizations, and conducted site visits in Guatemala, Ethiopia, and Nigeria. CHANGE staff also met with policy makers in Washington, D.C., and reviewed policy documents and GHI country strategies.

This analysis should be considered a preliminary snapshot of a developing initiative. CHANGE staff appreciates and recognizes that GHI is a work in progress, with important possibilities for significantly improving the impact of U.S. global health programs given limited resources. Gauging GHI's success or failure is not the purpose of this analysis. Rather, the analysis seeks to provide constructive guidance to facilitate fulfillment of GHI's promise.

Since the Global Health Initiative (GHI) was launched in 2009, CHANGE has recognized GHI's promise for advancing women and girls' access to sexual and reproductive health services and human rights. The input of civil society and the perspectives of those most affected by U.S. programs provide essential feedback to those implementing GHI principles and programs. In Ethiopia, Nigeria, and Ethiopia, CHANGE is collaborating with civil society to monitor GHI implementation and advocate for policies and programs that promote the health and rights of women and girls.

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**COUNTRY PROFILE:** Ethiopia has a population of more than 79.8 million people, with 85% of its population residing in rural areas.

- Maternal mortality ratio (deaths per 100,000 live births): 670/100,000
- Childbirth attended by skilled birth attendants: 10%<sup>1</sup>
- Almost 6 in 10 abortions performed in Ethiopia are unsafe.
- Contraceptive prevalence rate: 29%<sup>2</sup>
- Of currently married women, 25.3% have an unmet need for family planning. Although the government provides contraception at no cost, these supplies are frequently not readily available.<sup>3</sup>
- HIV transmission is primarily through heterosexual contact (87%), contributing to a generalized epidemic at 2.3%.<sup>4</sup>

In FY2010, Ethiopia received \$400 million in U.S. health investments, making it one of the primary recipients of U.S. foreign assistance on health.<sup>5</sup> Ethiopia is also a GHI Plus country, meaning that it is supposed to receive additional technical and management resources to quickly implement GHI's approach.<sup>6</sup> The GHI Ethiopia country strategy was released in the first round of country strategies, with the primary goal of improving the health status of Ethiopians through increased use of quality health services to protect women, infants, and children from preventable and treatable health conditions. The strategy notes that achieving this goal depends on the success of three "highly interdependent results":

- Improved access to health care services,
- Increased demand for health services, and
- Improved health systems.<sup>7</sup>

# FINDINGS

Outlined below are the factors this analysis used to assess GHI implementation progress in Ethiopia within each of the three key GHI principles that CHANGE has identified as essential to advancing sexual and reproductive health and rights. Figure 1 shows current progress on each of these principles, based on CHANGE’s research and subjective analysis, compared to progress we anticipate by the end of year 5. For the purposes of the graph, full implementation would mean that these principles are central to every aspect of U.S. government and U.S. contractor activities on sexual and reproductive health in Ethiopia.

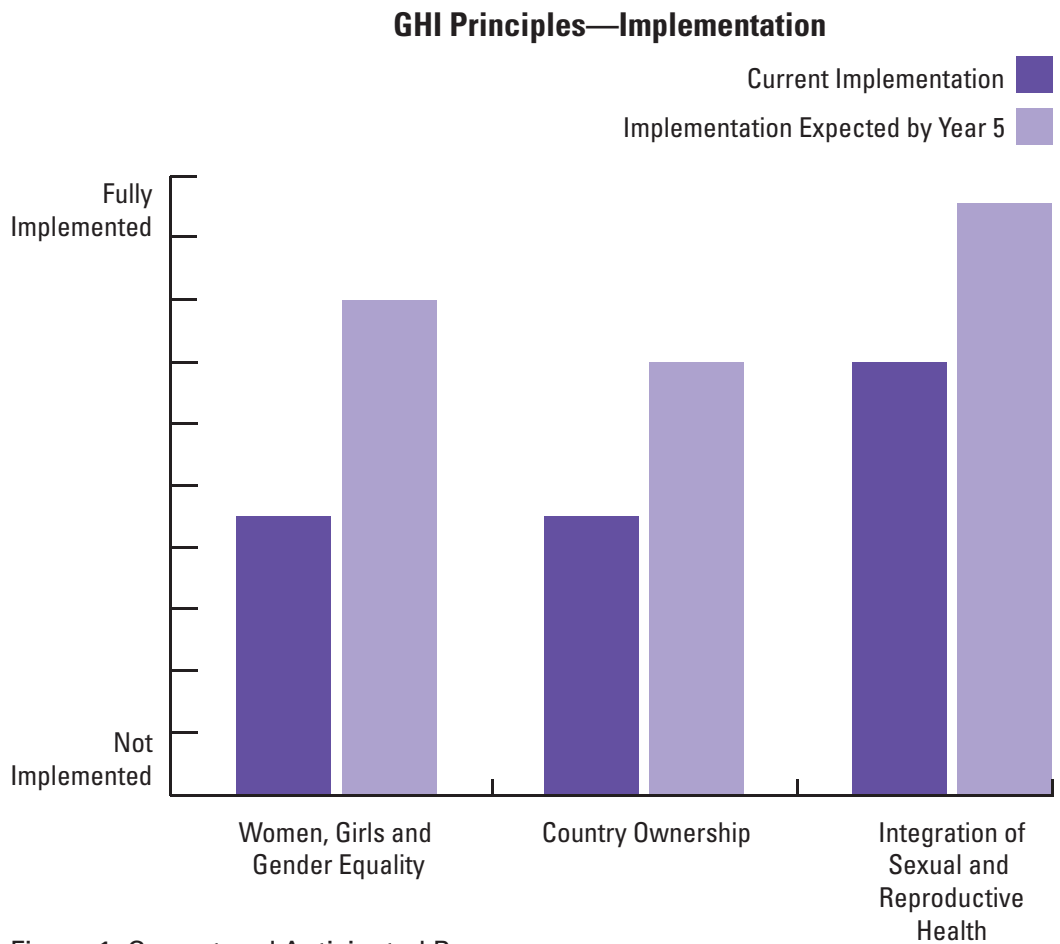


Figure 1: Current and Anticipated Progress

## FOCUS ON WOMEN, GIRLS AND GENDER EQUALITY

Promoting access to health care among women and girls is central to the GHI's expressed goals. In fact, of all the GHI principles, only this principle thus far has been defined through a U.S. government guidance.

As outlined in the GHI Supplemental Guidance on Women, Girls, and Gender Equality, U.S. global health programs should focus efforts on women and include them in program design, implementation, monitoring, and evaluation. This implies country health programs should:

- Work with stakeholders to facilitate access to a full range of health services, recognizing and addressing cultural, social, and legal barriers commonly faced by women and girls;
- Be based on a sound gender analysis, and include consultation with human rights and women's organizations;
- Proactively address issues that have substantial impact on the health of women and girls, yet are considered politically controversial, such as access to safe abortion, emergency contraception, and school-based comprehensive sex education;
- Address HIV risk among women, and provide access to tools women can initiate to prevent unwanted pregnancy and HIV, such as female condoms; and
- Seek to address harmful attitudes and behaviors among men, including gender-based violence and opposition to family planning.

In Ethiopia, U.S. attention to gender issues is generally good, and the Ethiopian government has committed to expanding access to family planning and quality maternal health care. However, Ethiopia's recent law restricting funding for local groups that work on human rights, advocacy, and democracy has put a chill on efforts to generate accountability around commitments to gender equality and human rights-based services. The law has severely restricted actions of women's rights groups, and made other groups hesitant to use words like "advocacy."<sup>8</sup>

This assessment of the focus on women, girls, and gender equality by U.S. agencies in Ethiopia is informed by U.S. attention to: human rights/gender, adolescents, and abortion.

### HUMAN RIGHTS AND GENDER: PROGRESS

#### **RECOGNITION OF GENDER ISSUES IN PEPFAR AND USAID PLANS AND STRATEGIES.**

Ethiopia's FY2011 Country Operational Plan (COP) notes that "early marriage and sexual coercion ... cannot be ignored." The GHI strategy highlights a "more comprehensive life cycle approach to addressing the health of women and girls," and understands integration of sexual and reproductive health as a gender issue.

**IMPLICIT FOCUS ON HUMAN RIGHTS IN STRATEGY AND FUNDING INSTRUMENTS.** The GHI Country Strategy also reflects a recognition that services must be high quality and user-friendly.<sup>9</sup> While the strategy does not specifically discuss

human rights, USG officials clearly understand fundamental rights to quality health care and how this affects health outcomes. One subgrantee noted that funding instruments reflect attention to human rights through concern for equal access to care for women, girls, and marginalized groups, such as women with disabilities and sex workers.<sup>10</sup>

**GENDER MAPPING PART OF U.S. APPROACH.** In response to the GHI Supplemental Guidance on Women, Girls, and Gender Equality, the CDC and USAID in Ethiopia have undertaken a mapping of attention to gender within their programs, including those on HIV.<sup>11</sup>

**INCREASED ATTENTION TO SEXUAL AND REPRODUCTIVE HEALTH REPORTED BY IMPLEMENTING PARTNERS.** One NGO informant noted that “most local NGOs” are changing their strategy to work on reproductive health, including maternal health and family planning, as a direct result of USAID’s shift in priorities since GHI began.<sup>12</sup>

**PROVIDING HIGH-QUALITY SERVICE FOR STIGMATIZED GROUPS.** The FY2011 COP mentions expanding innovative strategies, such as confidential clinics for sex workers.<sup>13</sup> U.S. grantee Family Guidance Association of Ethiopia (FGAE) provides HIV testing, family planning, and other reproductive health services in six confidential clinics around the country,<sup>14</sup> and Marie Stopes International, with USAID funding, ensures equal access to reproductive health services for sex workers.<sup>15</sup>

## HUMAN RIGHTS AND GENDER: AREAS FOR IMPROVEMENT

**INCREASE EXPLICIT COMMITMENT TO HUMAN RIGHTS.** Explicit donor support for human rights as an essential characteristic of quality health programs is critically important, particularly considering Ethiopia’s law restricting funding for human rights groups. Because the Ethiopian government has been forward thinking on health issues, yet regressive on matters of human rights, building understanding around the link between the two is essential.

**INCREASE CONSULTATION.** Human rights and women’s groups were not consulted in development of the GHI country strategy. Consultation with these groups is essential to ensuring that programs protect and advance women’s rights, and is one of the specific recommendations of the GHI Supplemental Guidance on Women, Girls, and Gender Equality. Moreover, the Guidance specifies that “Women and girls need to participate in the design, management, monitoring and evaluation of health programs to effectively address their health needs.” U.S. agencies should assess whether grantees are implementing this recommendation.

**ENSURE ACCESS TO COMPREHENSIVE PREVENTION FOR ALL.** The PEPFAR FY2011 COP specifically references access to male and female condoms for those groups at high risk for HIV. However, it also notes that for prevention in the general population, the Ethiopian government and religious groups favor programs promoting abstinence and faithfulness only. Access to comprehensive prevention information and female and male condoms should not be restricted to certain groups. This is particularly important

for women and girls. When condoms are stigmatized by their association with marginalized groups only, women and girls have increased difficulty in negotiating their protection.

**ENSURE ACCESS TO FEMALE CONDOMS.** Despite mentioning female condoms explicitly in the FY2011 COP, U.S. officials in Ethiopia did not seem knowledgeable about or encouraging of female condom procurement, mentioning their cost and the prioritization of long-term family planning methods as a barrier. Female condoms can be a powerful tool for empowering women to protect themselves from both HIV transmission and unintended pregnancy, and should be promoted as such by U.S. agencies.

**PILOT, SCALE UP EFFECTIVE MALE INVOLVEMENT PROGRAMS.** Work on male involvement seems to be a limited portion of the USG portfolio. One group identified (EngenderHealth) is working on engaging men and boys on gender issues to decrease HIV transmission and increase involvement on reproductive health issues. Yet a CHANGE NGO partner commented, “It is safe to conclude that in the entire health system and other SRH programs in Ethiopia, the critical factor of engaging men and boys as an intervention to reduce gender-based violence is missing.”<sup>16</sup>

**CONTINUE TO PRESS ETHIOPIAN GOVERNMENT ON REMOVAL OF ANTI-ADVOCACY LAW.** This law, which forces human rights, democracy, and advocacy groups to receive only 10% of their funding from sources external to Ethiopia, has critically undermined attempts to increase accountability and promote human rights. U.S. officials have taken a strong stand on the law from the moment of its introduction, and have tried to mitigate the damage through diplomatic channels. U.S. officials should continue to strenuously object to it, emphasizing the law’s negative impact on the development indicators Ethiopia strives to advance.

**ADDRESS HUMAN RIGHTS AND GENDER IN PROVIDER TRAINING.** While some implementing organizations train health care providers on gender, U.S.-backed training tends to focus on and track progress on technical issues. U.S. agencies should require grantees to perform human rights and gender training for health providers, and track increases in ability to provide rights-based care to women and girls.

## ADOLESCENT GIRLS: PROGRESS

**ATTENTION TO GIRLS’ EMPOWERMENT:** USAID reports that they are increasing their attention to gender through scaling up of girl empowerment programs across Ethiopia. YWCA, a USAID subgrantee, is implementing a project to increase HIV prevention knowledge and practices among youth and young adults, and offered testing to participating youth. They also partner with Population Council to economically empower migrant girls to keep them from risk of HIV infection that results from poverty and isolation.

## ADOLESCENT GIRLS: AREAS FOR IMPROVEMENT

**OUTLINE STRATEGY TO COMBAT EARLY MARRIAGE.** Although PEPFAR Ethiopia’s FY2011 COP cites early marriage as something that “cannot be ignored,” there is no clear strategy in the COP or GHI strategy to combat it. Because GHI is an approach that integrates social and educational interventions with health targets, it provides an excellent opportunity to develop a clear multi-sector strategy to dissuade early marriage, thus averting the maternal deaths and health complications that result.

**ENSURE GIRLS’ ACCESS TO MALE AND FEMALE CONDOMS AND INFORMATION.** While U.S. strategy documents discuss improving access to youth-friendly family planning services, HIV-prevention efforts for young people tend to focus on abstinence programming. U.S. officials should work to ensure that adolescent girls have access to comprehensive HIV prevention information and protection methods.

## ABORTION AND EMERGENCY CONTRACEPTION: PROGRESS

**THE REMOVAL OF THE MEXICO CITY POLICY (GLOBAL GAG RULE).** Since President Obama rescinded the Global Gag Rule in January 2009, the U.S. government is no longer restricted in providing family planning support to organizations that use their own funds to advocate for, perform, or provide referral to legal abortion services.

**U.S. ENGAGEMENT OF ORGANIZATIONS WORKING ON ABORTION.** Elimination of the Global Gag Rule has made a substantial difference in Ethiopia, as the U.S. is now engaged with (funding or consulting with) highly effective organizations including Family Guidance Association of Ethiopia (FGAE), Ipas, and Marie Stopes International. While in other countries there is still distance between the U.S. Mission and groups that work on abortion, USG officials in Ethiopia seems to have taken advantage of the removal of the GGR to improve attention to women’s health.

## ABORTION AND EMERGENCY CONTRACEPTION: AREAS FOR IMPROVEMENT

**PROVIDE FUNDING FOR PROGRAMS THAT PERFORM ABORTIONS IN CASES OF RAPE, INCEST, LIFE OF WOMAN.** One-third of Ethiopia’s high maternal mortality rate results from unsafe abortion.<sup>17</sup> Despite Ethiopia’s decriminalization of abortion in many circumstances, access to safe abortion is still very limited. The U.S. is legally able to fund abortion in cases where it is not used for family planning, such as rape, incest, and to save the life of the woman. Increasing access to safe abortion in these cases would dramatically improve maternal health and save lives in Ethiopia.

**INCREASE ACCESS TO POST-ABORTION CARE.** A USAID official indicated that Ethiopia’s change in abortion law has actually caused USAID to keep more distance from post-abortion care, presumably because of potential accusations that they are funding actual abortions. While the official also said they are ensuring access to vacuum extraction where emergency obstetric care is available, USAID should prioritize post-abortion care.

## COUNTRY OWNERSHIP

GHI documents stress the importance of country ownership, defining this to mean that not only will the U.S. seek to align GHI activities with the priorities of the national government, but that they will also seek out civil society input and ownership.

- Developing meaningful country ownership is tremendously complex given the many diverse opinions and priorities within any society. As elaborated in GHI documents, country ownership should:
- Generate consultation with diverse sectors of recipient countries so that they are invested in the outcomes of global health programs;
- Not be merely a government-to-government relationship; to ensure sustainability, local civil society must be given the power to debate, shape, and monitor implementation;
- Include consultation, not just information sharing; and
- Proceed rapidly and strategically, with careful deliberation and an eye to long-term sustainability.

The GHI strategy in Ethiopia is well aligned with the Ethiopian government's health plan, and U.S. officials in Ethiopia consistently refer to this alignment as a strength of country ownership. In 2011, USAID invited key partners to the Mission to consult them about the five-year strategy for Ethiopia.<sup>18</sup> However, civil society organizations aside from direct USG contractors report that they have heard little or nothing from U.S. officials about the Global Health Initiative.

This assessment of the implementation of country ownership focuses on meaningful consultation with civil society organizations, and the extent to which marginalized populations are involved in problem definition, program design, implementation, and evaluation.

### COUNTRY OWNERSHIP: PROGRESS

#### **ALIGNMENT WITH ETHIOPIAN HEALTH PLAN CREATES SYNERGIES WITH CIVIL SOCIETY.**

The Ethiopian Ministry of Health plan is strong, facilitating U.S. cohesion with its plan. The GHI Country Strategy refers to Ethiopian government targets in each section, describing how the U.S. government will contribute to achieving these targets. Such alignment provides a common point of reference for Ethiopian health officials, U.S. officials and SRHR NGOs.

**SUBSTANTIAL UNDERSTANDING OF GHI AMONG DIRECT GRANTEEES.** Prime grantees seemed to have a firm understanding of GHI and its principles, reflecting a positive relationship with U.S. officials.

**INCREASED FOCUS ON LOCAL PARTNERS.** U.S. officials are making a deliberate effort to advance sustainability by transitioning programs to local partners in the medium and long term. One Ethiopian NGO leader noted that funding instruments over the past year have begun to encourage local organizations to apply.<sup>19</sup>



## COUNTRY OWNERSHIP: AREAS FOR IMPROVEMENT

**DEVELOP A MECHANISM TO INFORM AND UPDATE CIVIL SOCIETY ABOUT GHI.** Many civil society representatives mentioned that they had not received information about GHI from the U.S. government, and one former grantee responded that they were not aware of GHI at all. One representative noted that even in a recent Reproductive Health Roundtable, a regular meeting between USG officials and health CSOs, there was no mention of GHI.<sup>20</sup> U.S. officials explained that messaging around GHI is difficult due to increased expectations for additional funding.<sup>21</sup> However, GHI is a positive framework for U.S. health programming, and CSO leaders surveyed—especially subgrantees—are eager to be better informed about its principles.

**INCREASE CONSULTATION WITH CIVIL SOCIETY.** Informing civil society is a fundamental precursor to involving them in consultation. U.S. officials have already invited some key groups to consult on U.S. health strategies, yet those who are not current U.S. grantees have not been consulted. The GHI Supplemental Guidance on Women, Girls, and Gender Equality recommends involving women's and human rights groups in program design, implementation, and monitoring. Such consultation can ensure that U.S.-funded programs meet the needs of marginalized groups and advance human rights.

**DEVELOP CAPACITY OF CIVIL SOCIETY.** While it is a positive trend that local partners are being sought out by U.S. government agencies, sustainability of this effort requires significant investment in capacity building. International NGOs have a strong presence in Ethiopia, and have contributed greatly to health successes, yet country ownership over the long term must include increasing local capacity by investing in infrastructure of local NGOs to address health and related issues.

## INTEGRATION OF SEXUAL AND REPRODUCTIVE HEALTH<sup>22</sup>

Women and girls experience sexual and reproductive health issues—including HIV/AIDS, maternal health, and family planning—in overlapping ways. To meet the needs of women and girls, these issues should be addressed holistically, ideally in one service location or through a robust referral system.

U.S. foreign assistance has historically maintained conceptual and geographical distance among sexual and reproductive health issues. Integration of maternal health, family planning, and sexual health (including HIV/AIDS) should:

- Promote a woman’s access to all the services she needs for sexual and reproductive health;
- Build communication within and among U.S. aid agencies;
- Provide client access to a wide range of information and services at one location, or through seamless referral systems; and
- Integrate basic sexual and reproductive health care in rural clinics and health promoter programs, as meaningful referral is particularly challenging for rural women and girls.

Widely acknowledged to be on the forefront of integration of sexual and reproductive health, Ethiopia’s government and U.S. agencies in Ethiopia have long demonstrated a solid commitment to ensuring same-site access to family planning, HIV services, and maternal health care. The Ethiopia GHI Country Strategy and PEPFAR FY2011 COP show a sophisticated understanding of the impact of integration on health outcomes.

This assessment of integration focuses on inter- and intra-agency coordination, same-site integration, health workforce issues, and the human rights of sexual and reproductive health integration.

### INTEGRATION OF SEXUAL AND REPRODUCTIVE HEALTH: PROGRESS

**BUILDING ON A STRONG FOUNDATION.** Integration of family planning, maternal health, and HIV in Ethiopia predates GHI, and is embraced by the Ethiopian government as well as donors. For example, the health extension worker program has enabled young women to reach 16 million Ethiopian homes with information, referral, and basic health services. Even so, grantees reported an increased U.S. emphasis on integration after GHI began. One noted that USAID, CDC, and PEPFAR all are strongly encouraging the integration of HIV, family planning, and maternal health. From the perspective of this NGO representative, proposed projects must include a direct or indirect focus on each of the three components in order to receive U.S. funding.<sup>23</sup>

#### **FUNDING INTEGRATED PROJECTS REDUCES IMPLEMENTING ORGANIZATIONS’**

**SILOS.** Organizations that have excelled at providing family planning are now integrating attention to HIV/AIDS because of the U.S. emphasis on integration. For example, Marie Stopes International in Ethiopia reports that their expertise on family planning and other reproductive health issues made

them an attractive subcontractor, and that the prime grantee now assesses their integration of HIV services.<sup>24</sup>

**UNDERSTANDING LINKS BETWEEN QUALITY MATERNAL HEALTH CARE AND PREVENTION OF VERTICAL TRANSMISSION.**

The FY2011 PEPFAR COP demonstrates a clear understanding that women will not seek antenatal care if it is not high quality and if it does not respond to their needs. In turn, if women do not seek antenatal care, those living with HIV are at risk of giving birth to newborns with the virus. In response, PEPFAR is investing in antenatal care infrastructure and provider training. Not focused only on a healthy child, PEPFAR pledges to link HIV-positive postpartum women with care and treatment.<sup>25</sup> Such a critical understanding of how access and quality of maternal health and HIV/AIDS services intertwine is fundamental to meeting women's needs and advancing their rights.

## INTEGRATION OF SEXUAL AND REPRODUCTIVE HEALTH: AREAS FOR IMPROVEMENT

**DEFINE INTEGRATION OF SEXUAL AND REPRODUCTIVE HEALTH.** One informant noted that integration is defined differently by different groups of people implementing and overseeing health projects.<sup>26</sup> Such differences in definition can be problematic if an implementer's definition of integration includes family planning, HIV, and maternal health, yet keeps the services geographically separate or directed at different populations. The U.S. could reduce confusion and improve integration by clearly endorsing same-site integration of sexual and reproductive health services.

**INCREASE ACCESS TO FAMILY PLANNING.** One informant asserted that shortages in contraceptive supplies are a major obstacle to integration, pointing out that in order for Ethiopia to reach the government's goal of a 65% contraceptive prevalence rate, all health programs should be working toward this goal.<sup>27</sup> Another noted that the distribution of family planning exacerbates shortages, because commodities are sent to the government, which then distributes to implementing partners.<sup>28</sup>

**CONTINUE TO DEVELOP HEALTH WORKFORCE CAPACITY.** Health extension workers provide a foundation for much of the work happening in Ethiopia on SRH integration, yet they are heavily burdened and receive little pay. Attention to building a professional health workforce in Ethiopia is critical, yet a persistent challenge.

**PROVIDE HEALTH WORKFORCE TRAINING ON HUMAN RIGHTS.** U.S. agencies have invested heavily in health workforce training on technical issues. Such training should be supplemented by human rights education to ensure that providers provide integrated SRH services without stigma. Technical expertise alone is not sufficient to guarantee the rights of women and girls to accessing health services without judgment or discrimination.



# CONCLUSION AND TOP RECOMMENDATIONS

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Building on a strong foundation provided by a progressive Ethiopian health sector plan, U.S. agencies are contributing significantly to reaching Ethiopia's health goals. Ethiopia faces daunting health challenges, which cannot be confronted without combined and coordinated government, donor, and NGO efforts to reduce maternal mortality, increase contraceptive prevalence, and decrease HIV transmission. The Global Health Initiative has successfully solidified existing trends in U.S. health assistance to Ethiopia, while providing new opportunities to focus more closely on the needs and rights of women and girls.

Lack of resources and poor health care infrastructure are the major obstacles to Ethiopia's progress on health indicators. Moreover, the law restricting advocacy and human rights organizations stands in the way of meaningful country ownership. Civil society must have the ability to participate actively in debating and discussing health approaches and monitoring human rights protections. Health programs cannot be fully accountable to those they serve without robust civil society.

Despite these challenges, there are several areas where GHI principles can be effectively and rapidly advanced to achieve sexual and reproductive health goals. Of the areas of improvement listed above, the following should be considered most urgent or are most easily achievable:

- **Increase consultation with civil society and the participation of women and girls.** The GHI's woman-centered approach in Ethiopia does an excellent job of targeting women, yet its strategy documents do not spell out a role for Ethiopian women as consultants in the problem definition, design, implementation, and evaluation processes of health programs. Moreover, while consultation with grantees is important, U.S.-funded health programs would benefit from a broader consultation with subgrantees, women's rights, and advocacy groups.
- **Increase access to female condoms as part of a comprehensive approach to prevention.** Female condoms represent an important and empowering tool that gives women the possibility of initiating their own protection from HIV transmission and unintended pregnancy. Instead of being viewed by U.S. agencies as a poor substitute for long-acting contraceptives, female condoms should be seen as an important woman-centered prevention tool that complements existing family planning programs. Access to female and male condoms is critical for women who are at risk of contracting HIV from their partners, yet the only Ethiopian women who currently seem to be receiving targeted condom messaging are sex workers and others engaging in transactional sex.

- **Train providers on gender and human rights.** Technical training for providers should be supplemented with training on gender and human rights to ensure that women and girls have stigma-free access to all the health services they may need. This is particularly important for highly-stigmatized services such as abortion. Providers should be trained on Ethiopia’s abortion law reform so they can accurately and compassionately counsel women seeking abortion services.

## NOTES

- 1 UNICEF Ethiopia Statistics, [http://www.unicef.org/infobycountry/ethiopia\\_statistics.html#80](http://www.unicef.org/infobycountry/ethiopia_statistics.html#80)
- 2 Guttmacher Institute: Facts on Unintended Pregnancy and Abortion in Ethiopia, <http://www.guttmacher.org/pubs/FB-UP-Ethiopia.pdf> (accessed 1.19.12)
- 3 Measure DHS: Ethiopia Demographic and Health Survey 2011 Preliminary Report, <http://www.measuredhs.com/pubs/pdf/PR10/PR10.pdf> (accessed 3.29.12)
- 4 The United States Global Health Initiative: Ethiopia Global Health Initiative Strategy, The US Ethiopia GHI Team, March 2011.
- 5 Ethiopia FY2011 Country Operational Plan
- 6 USAID Press Release: U.S. Government Support for Global Health Efforts, <http://www.usaid.gov/press/releases/2010/pr100618.html> (accessed 1.19.12). In an email, a Mission official reports that additional assistance has not yet materialized.
- 7 U.S. Global Health Initiative. GHI in Country, Ethiopia: <http://www.ghi.gov/country/ethiopia/index.htm> (accessed 1.19.12)
- 8 Interview with CORHA, August 22, 2011
- 9 Ethiopia Global Health Initiative Country Strategy, page 11
- 10 Interview by NEWA with NGO informant cited in report to CHANGE, November 2011
- 11 Interview with U.S. Officials, U.S. Embassy Ethiopia, August 22, 2011
- 12 Interview with NGO official cited in NEWA report to CHANGE, November 2011
- 13 FY2011 COP
- 14 Interview with NGO informant during site visit, August 2011
- 15 Interview by NEWA with NGO official cited in report to CHANGE, November 2011
- 16 Report to CHANGE from CORHA, November 2011.
- 17 Ministry of Health, Federal Democratic Republic of Ethiopia, National Reproductive Health Strategy, 2006-2015 (Addis Ababa, March 2006).
- 18 Interview with NGO informant, August 22, 2011
- 19 Interview with NGO informant, August 22, 2011
- 20 Report to CHANGE from CORHA, November 2011
- 21 Interview with U.S. officials, August 22, 2011
- 22 While GHI promotes integration of health sectors more broadly, this analysis focuses on sexual and reproductive health, thus assessing only the integration of HIV/AIDS, family planning, and maternal health.
- 23 Interview by NEWA with U.S. grantee cited in report to CHANGE
- 24 Interview by NEWA with NGO informant cited in report to CHANGE
- 25 PEPFAR Ethiopia, Ethiopia FY 2011 Country Operational Plan
- 26 Interview with NGO Informant, August 22, 2011
- 27 Interview with NGO Informant, August 22, 2011
- 28 Interview with NGO informant, August 22, 2011

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This assessment report was written by Mary Beth Hastings, vice president of the Center for Health and Gender Equity (CHANGE) as part of CHANGE's GHI Accountability Project.

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## ABOUT CHANGE

The Center for Health and Gender Equity (CHANGE) is a U.S.-based nongovernmental organization that promotes the sexual and reproductive health and human rights of women and girls globally by shaping rights-based and just U.S. policies. 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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