

The Case for Comprehensive: Ethiopia

The Importance of Comprehensive, Rights-Based Approaches to Sexual and Reproductive Health

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SITUATION AT A GLANCE

Maternal Health

Maternal Mortality:	720 deaths per 100,000 live births ¹
Births attended by skilled health personnel:	6% ²
Obstetric fistula:	100,000 cases ³
Unsafe abortion as part of maternal mortality:	33% ⁴
Legal status of abortion:	Legal in cases of rape, incest, to save life or health of mother, for minors

Family Planning

Contraceptive prevalence:	14% ⁵
Unmet need for family planning, 15-24 year olds:	30%

HIV/AIDS

HIV prevalence:	2.1% (2.8 million infected) ⁶
HIV prevalence among 15-19 year olds:	Seven times higher among young women ⁷
Ranking of AIDS as cause of morbidity/mortality:	First (for all adults) ⁸

U.S. Funding

Ethiopia was a PEPFAR focus country from 2003-2008, and the U.S. has budgeted \$337 million in HIV/AIDS funding in FY 2009. Funding from PEPFAR has allowed Ethiopia to provide antiretroviral therapy at no cost to patients, serving over 96,000 people by December 2006. Compared to HIV/AIDS funding, the budgeted U.S. contribution for other sexual and reproductive health concerns is relatively small: not quite \$14 million for family planning funding and \$8 million for maternal and child health.

CHANGE Field Study Findings

The Bottom Line

Ethiopian women face an **abysmal health situation**. Although the government's recent reproductive health strategy advocates a comprehensive, youth-friendly 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. Nongovernmental organizations have helped overcome personnel shortages by training and deploying community-based reproductive health workers.

HIV prevalence is high, yet **U.S. policies** that give preference to abstinence and faithfulness prevention activities have **hindered efforts to reach youth, married women, and high-risk populations**.

Because unsafe abortion causes one-third of maternal mortality in Ethiopia, the Ethiopian government reformed its abortion laws in 2005, making the procedure legal in cases of rape and incest, to save the life or health of the mother, and for minors. **Safe abortion remains largely inaccessible**, however, particularly in rural areas.

FGAE and ADA: Promising Practices

Family Guidance Association of Ethiopia (FGAE) and Amhara Development Association (ADA) both use a **Community Based Reproductive Health Agent (CBRHA) program**, which trains lay people to work directly with their communities on sexual and reproductive health, and which now forms an integral part of Ethiopia's health system. Many of the CBRHAs are trained in **offering comprehensive services** – including HIV prevention, family planning counseling, contraceptive provision, and maternal and child health information and referral. Through close contact with the community, they are able to work with pregnant women throughout pregnancy and educate the family about symptoms of complications. Because they visit the home, users do not have to be concerned about being seen visiting a clinic. They can identify women who need post-abortion care or other emergency medical needs.

FGAE also operates 18 clinics, 26 youth centers, 740 community-based reproductive health outlets, and 242 outreach sites.⁹ They are dedicated to a comprehensive approach to sexual and reproductive health, providing antenatal care, cervical cancer screening, family planning, abortion, HIV prevention and testing, and STI treatment. They screen and counsel for gender based violence and PEP (Post-exposure Prophylaxis) provision. Their youth centers have libraries and recreation rooms, and get youth involved through drama and volunteer activities. They also train midwives to improve access to skilled labor care.

According to ADA, **unmet need for contraception in the Amhara region has decreased from 45% to 29%** as a result of their work. Despite their dedication to seamless provision of comprehensive services, referral is not a smooth process, as distances to clinics and hospitals are generally quite far and roads are poor. Also, at the time of CHANGE's field visit, they were not performing abortion or referring clients for safe abortion, because of fears about the Global Gag Rule.

For both the public and private sectors, **getting contraception to people who want it is challenging** due to shortages and other supply issues. Despite the high HIV prevalence rate and unmet need for contraception, the rate of condom use in Ethiopia is extremely low. A recent study found that just half of young men used a condom as last high-risk sex, and only 28% of young women had.¹⁰

The government has followed the lead of ADA and FGAE. Beginning in 2003, the Ministry of Health began a health extension program, training Health Extension Workers (HEWs) to implement a package of 16 activities in villages. These HEWs are all women with some secondary education who get a year of training, then travel in pairs to conduct health visits with families in their homes and provide services at health posts. They oversee the volunteer health workers at the community level, including CBHRAs and Trained Traditional Birth Attendants (TTBAs).

Unfortunately, these HEWs do not receive training on gender based violence, despite its widespread nature. WHO found that **59% of Ethiopian women had experienced sexual abuse and sexual violence from partners**, and 17% reported that their first sexual intercourse was forced. Gender based violence is common and generally goes unchallenged. The WHO survey found that two-thirds of women agreed that not completing housework is acceptable justification for wife-beating.¹¹ The country has just one shelter for victims of gender violence.

Every year, 9,000 women develop obstetric fistula in Ethiopia, which is caused by prolonged obstructed labor and a lack of emergency obstetric care. Most women go untreated and are rejected by their husbands and ostracized from their communities as a result. A model **fistula clinic in Bahir Dar**



provides comprehensive sexual and reproductive health services, as well as providing fistula surgery. The clinic has trained HEWs to conduct home visits and refer women with fistulas to the clinic. All fistula patients receive family planning counseling, and for those who want a contraceptive method, they begin the method while they recuperate after surgery. They can get VCT (Voluntary Testing and Counseling) at the clinic, and start on ARVs (Antiretrovirals) and counseling if they test positive. They also screen for TB, diabetes and hypertension.

Impact of U.S. Policy on SRHR in Ethiopia

PEPFAR's limits on condom promotion among youth distort HIV prevention programming in Ethiopia, as elsewhere. One program director explained that their **youth clubs have to be divided based on donors** – in some groups they can promote condom use, but in the U.S.-funded groups they cannot. The director discussed the issues that this raises, as they are challenged by the youth in the PEPFAR-funded groups, who say “why don't you teach us about condoms? It is our right.”¹²

The Global Gag Rule has also had an impact. **FGAE lost 35% of its budget** and donated contraceptive supplies in 2001, when they refused to sign the reinstated Gag Rule.¹³ ADA required all its CBRHAs to sign the Gag Rule. Moreover, like many organizations around the world, they **over interpreted the reach of the rule**, and wouldn't even refer for abortion in cases of rape and threats to the life of the mother, even though this was technically allowable under the Mexico City Policy.

¹ UNICEF. 2005. “State of the World's Children 2005: Childhood Under Threat.” New York, NY: UNICEF. Accessed at: <http://www.unicef.org/sowc05/english/index.html>.

² UNICEF. 2000-2006. “State of the World's Children.” New York, NY: UNICEF. Accessed at: <http://www.unicef.org/sowc/>.

³ NOVA. “A Walk to Beautiful.” March 2008 Accessed at: <http://www.pbs.org/wgbh/nova/beautiful/program.html>.

⁴ Ministry of Health, Ethiopia NRHS 2006

⁵ Rahman M, T Giday, M Asknake and J Wilder. 2007. “Enhanced access to reproductive health and family planning: Pathfinder International in Ethiopia 2002-2007.” Watertown, MA: Pathfinder International.

⁶ World Health Organization. 2007. “World Health Statistics 2007.” Accessed at: http://www.who.int/whosis/database/core/core_select_process.cfm.

⁷ Ministry of Health, Federal Democratic Republic of Ethiopia. 2007. “National Adolescent and Youth Reproductive Health Strategy, 2007-2015.”

⁸ World Health Organization. 2007. “World Health Statistics 2007.” Accessed at: http://www.who.int/whosis/database/core/core_select_process.cfm.

⁹ Family Guidance Association of Ethiopia (FGAE). FGAE @ 40. 2007.

¹⁰ UNICEF. 2008. “State of the World's Children 2005: Women and Children - Child Survival.” New York, NY: UNICEF. Accessed at: <http://www.unicef.org/sowc08/index.php>.

¹¹ World Health Organization. 2005. “WHO Multi-country Study on Women's Health and Domestic Violence against Women. Initial Results on Prevalence, Health Outcomes and Women's Responses” Summary Report. Geneva, Switzerland.

¹² Interview with program director. April 2008.

¹³ Population Action International. 2005. Access Denied Project. Ethiopia: Overview. Accessed at <http://www.populationaction.org/globalgagrule/Ethiopia.shtml>.

