CENTER
for
HEALTH
and
GENDER
EQUITY

Investing in Reproductive Justice for All:

Toward a U.S. Foreign Policy on Comprehensive Sexual and Reproductive Health and Rights

A field report on the advantages and challenges to comprehensive approaches to sexual and reproductive health and rights in the Dominican Republic, Ethiopia and Botswana

About this Report

In 2008, the Center for Health and Gender Equity (CHANGE) conducted a field inquiry in Dominican Republic, Ethiopia and Botswana to examine examples of programs with comprehensive approaches to sexual and reproductive health, as well as explore the problems that arise when programs are artificially segregated and/or not based on human rights. The countries were chosen based on their particular situations of sexual and reproductive health and human rights, their diverse histories with U.S. assistance, and their different internal policies. The research consisted of extensive interviews with health practitioners, government officials, aid workers, and nongovernmental leaders (see Annex 1 for a list of institutions by country). In addition, researchers consulted recent data to complement or challenge interview findings.

All interviews were conducted in confidentiality, and the names of the interviewees are withheld by mutual consent.

This report is a sampling of findings and recommendations based on the field visits. CHANGE did not set out to collect empirical evidence about why each country has its specific HIV infection rates, maternal mortality rates, and other health indicators. Instead, this report examines concrete examples of the benefits of and challenges to providing comprehensive, rights-based sexual and reproductive health care.

Acknowledgments

The Center for Health and Gender Equity (CHANGE) would like to express gratitude to the many people in the Dominican Republic, Ethiopia and Botswana who kindly gave their time to meet and share openly with CHANGE staff and consultants. CHANGE also appreciates those in the United States who took time from their busy schedules to help this project with background information. The development and production of this report would not have been possible without the contributions of many people. In particular, CHANGE would like to thank Mary Beth Hastings for her contribution to and preparation of this report, and the invaluable assistance from our field consultants Selamawit Mussie, Grace Sedio and Wendy Alba. Jill Gay and Serra Sippel conducted field site visits and interviews in the Dominican Republic, Ethiopia, Botswana and the United States. CHANGE staff who were critical to the production of this report include Piotr Pawlak and Lauren Sisson.

International colleagues that generously gave their time to review and discuss a concept memo in preparation for the report include Mabel Bianco, Alessandra Nilo, Neelanjana Mukhia, Cynthia Rothschild, Alejandra Scampini, and Meena Seshu.

The Center for Health and Gender Equity would like to thank the Richard and Rhoda Goldman Fund for the generous grant that made this report possible.

Cover photo: Serra Sippel. Children at rural health post, outside Bahir Dar (Ethiopia).

Contents

Executive Summary 3

Introduction 9

1. International Consensus 11
   The U.S. as Outlier on Comprehensive Sexual and Reproductive Health and Rights 11

2. Context and Findings 21
   a. The Dominican Republic 21
   b. Ethiopia 25
   c. Botswana 29
   d. Marginalized Populations 32

3. U.S. Policy and Comprehensive Sexual and Reproductive Health and Rights 35
   a. Funding Issues 35
   b. Funding Silos 36
   c. Global Gag Rule 37
   d. Abstinence-Until-Marriage/ABC 38
   e. Anti-Prostitution Loyalty Oath 39
   f. Conclusion 39

4. Recommendations for U.S. Policy 41

Notes 43

References 48

Annexes
   1. List of Institutions Visited 53
   2. Statistics 55
   3. BONEPWA Contract 57
   4. Conecta Map 59

Executive Summary

From the 1974 World Population Conference in Bucharest to the 1994 Cairo International Conference on Population and Development (ICPD) and subsequent global fora, international consensus around population and development has undergone a monumental paradigm shift away from demographic-centered policies toward an emphasis on women's empowerment, gender equality, and sexual and reproductive health and rights as critical to the achievement of sustainable development.

Despite this, the U.S. currently does not have a cohesive, overarching strategy for tackling urgent global sexual and reproductive health issues, as illustrated by the configuration of U.S. foreign assistance agencies and the disjointed policies that govern aid distribution. Instead, the United States' foreign assistance structure and politically-motivated funding restrictions combine to create unnecessary barriers to effective, comprehensive, and integrated health care that includes HIV prevention, maternal health, and family planning.

Using the definition that emerged from the 1994 International Conference on Population and Development in Cairo as a point of departure, CHANGE sought to construct a conceptual definition of comprehensive sexual and reproductive health care based on evidence from the field. Our field inquiries and literature review point to three essential components of comprehensive sexual and reproductive health care: family planning; sexual health; and maternal health.

It is not just the combination of services, however, but also the approach of health care providers that distinguishes comprehensive care from other models. First, health systems must meet the continuum of sexual and reproductive health needs of the population by integrating services at the user level. Also, successful approaches employ this user-based integration perspective with a sensitivity to and understanding of contextual issues, particularly regarding gender-based violence against women. Successful programs are based on human rights, respecting the dignity, autonomy and agency of a diverse client base.

Comprehensive sexual and reproductive health programs must address health across the life cycle, providing services and programming appropriate to each stage of life. This includes comprehensive sex education for young people, youth-friendly sexual and reproductive heath services, family planning and maternal health care for those in their reproductive years, and care for post-menopausal women.

In field visits to the Dominican Republic, Ethiopia and Botswana, CHANGE found the following:

- *Profamilia* and *Colectiva Mujer y Salud* in the Dominican Republic provide high quality care in a full range of services to address the needs of women and youth, including those who are living with HIV. However, U.S. assistance for family planning and reproductive health has recently ended, leaving *Profamilia* relying more on user fees for sustainability and the Dominican government, under heavy influence of the Catholic Church, to prove its own commitment to ensuring access to sexual and reproductive health services.
- In Ethiopia, the 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 and services, fistula prevention and management, post abortion care, and maternal and child health information and referral.
- In general, sexual and reproductive health services in Botswana are fragmented and not comprehensive, and women's human rights are often undermined. For example, Tebelopele, the major U.S.-funded VCT (Voluntary Counseling and Testing) NGO in the country, does not offer family planning, STI treatment or other sexual and reproductive health service that sexually active clients may need. Another U.S.-funded organization requires that peer mothers living with HIV not become pregnant in order to receive their stipend and keep their position as a counselor, undermining their fundamental right to make reproductive decisions free from coercion.
- Women living on the margins of society are often neglected when it comes to sexual and reproductive health services. CHANGE's field visits found infrequent and inadequate attention to the needs of these women, specifically women in prison and sex workers.

U.S. Policy and Law Clash with Comprehensive Sexual and Reproductive Health and Rights

U.S. policies and funding structures often pose significant obstacles to comprehensive models of care. CHANGE's field visits exposed instances where U.S. policies create barriers to comprehensive sexual and reproductive health and rights programming:

- **Funding Issues** - While the large infusion of PEPFAR funding is critical to fighting the HIV/AIDS pandemic, and has brought many benefits to AIDS treatment, as has been reported elsewhere and was echoed by CHANGE's findings, health infrastructure outside of HIV and AIDS has suffered. The issue is not that there is too much funding for PEPFAR, as an increase in U.S. funding for HIV/AIDS is needed to address the burden of disease. At issue is the effectiveness of PEP-

FAR assistance and inadequate funding for all sexual and reproductive health programs. In Ethiopia, PEPFAR-funded programs pay two times government health salaries, causing a drain of doctors and other health care providers in other sectors. In Botswana, the large and heavily restricted PEPFAR budget and lack of any USAID funding for reproductive health has created booming—but vertical—programming just on HIV. Also, in several countries including the Dominican Republic, the U.S. has ended family planning funding. Advocates are concerned that the Dominican Republic will end up with a two-tier system: a rights-based, comprehensive system for those who can afford it and a low quality, non-integrated system for those without resources.

- **Funding Silos** - The U.S. government's funding silos make holistic, integrated approaches difficult. An implementing organization in Ethiopia compared U.S. funding to the Dutch government's efforts, saying that most comprehensive approaches are funded not by the U.S., but by the Dutch or the European Union. The Dutch have funded a large project that not only works to provide comprehensive reproductive health care, but also creates the institutional linkages to support this programming into the future. Whereas Dutch funding is flexible, allowing a complete shift in activities to address community priorities, U.S. funding is laden with earmarks and restrictions from Washington that eliminate discretion for making funding decisions based on local realities and restrict alignment with European counterparts.

- **Global Gag Rule** - The Mexico City Policy, or Global Gag Rule, has been a significant barrier to client-based, comprehensive care. Several of the best and most experienced organizations that implement sexual and reproductive health and rights programs had refused to sign the gag rule because of a principled support of their clients' rights and adherence to public health standards. This includes the Family Guidance Association of Ethiopia, which conducts well regarded sex education with adolescents, trains midwives to attend births, and provides comprehensive reproductive health care including HIV testing. All of these services are critical in a country where maternal mortality, HIV prevalence, and adolescent pregnancy are extremely high.

- **Abstinence-Until-Marriage/ABC** - U.S. funding preferences for abstinence-until-marriage programs have also undermined comprehensive approaches. The current U.S. guidance on PEPFAR programs limits condom programming to youth 15 and over. In the Dominican Republic, the U.S. guidance sharply contrasts with the government's recent action to revise the age of reproduction from 15 to 10 due to the high number of pregnancies and STIs occurring in this age group. A doctor in one youth clinic talked about girls in his community who were already sexually active at age 12. However, because of U.S. funding restrictions, he reported that they only provide condoms to these girls if they admit being sexually active; otherwise they only teach abstinence.

- **Anti-Prostitution Loyalty Oath** - The requirement that PEPFAR grantees have a policy against the practice and legalization of prostitution has had varied effects in the field. Some organizations sign the pledge and continue with their programs as before. Others interpret the policy as a prohibition against supporting sex workers, and either refuse to sign and turn down the money, or sign and stop outreach to sex workers. CHANGE found two key HIV/AIDS organizations in Botswana who do not include sex workers in their HIV prevention and education efforts, despite the high risk of HIV transmission for this population. Although reduction in the extent of prostitution is the stated goal of the APLO, none of the advocates and service providers interviewed noted a reduction in sex work as a result of the U.S. policy.

Recommendations for U.S. Foreign Policy and Law

The current structures and restrictions governing U.S. sexual and reproductive health programming clearly do not facilitate the comprehensive, rights-based approaches that are most successful in promoting global health and development. Unless the United States alters these policies, it will fall short of achieving its own development goals and those it has committed to in the form of the Millennium Development Goals. More importantly, it will continue to lose opportunities to protect the life, health, and rights of women and girls worldwide.

Based on findings from field visits to The Dominican Republic, Ethiopia and Botswana, CHANGE recommends the U.S. government do the following:

- **Affirm and recognize sexual and reproductive health rights of all people,** with special attention to women and youth, and ensure that U.S. ambassadors and missions support and promote comprehensive approaches to sexual and reproductive health and rights on the ground.

- **Rewrite the Foreign Assistance Act of 1961** to modernize our foreign assistance objectives to include gender equality and women's empowerment and human rights as principal goals; and to include a comprehensive sexual and reproductive health and rights framework within U.S. foreign assistance and programs.

- **Develop and issue joint guidance from the State Department, USAID and OGAC** for U.S. missions, ensuring family planning, maternal health and sexual health programs are integrated, reflect a comprehensive approach, and are informed by local realities. Issue guidance that allows U.S. funding to be used to save women's lives through safe abortion where legal.

- **Invest at least $1 billion in voluntary international family planning programs and services for FY 2011;** ensure that funding streams for family planning, maternal health and sexual health (including HIV/AIDS) receive robust funding with flexibility and guidance to allow integration of services on the ground.

- **Adopt a collaborative role for the U.S. in global affairs:** align U.S. foreign assistance with the ICPD Programme of Action and the Millennium Development Goals; pool resources with other donor governments where practicable; sign, ratify and incorporate into U.S. law key international treaties that recognize and promote sexual and reproductive health and rights, such as Convention for the Elimination of All Forms of Discrimination Against Women (CEDAW) and the Convention on the Rights of the Child (CRC).
- **Amend PEPFAR legislation to eliminate restrictions** such as the Anti-Prostitution Loyalty Oath, and end reporting requirements for abstinence, abstinence-until-marriage, and fidelity programs.
- **Introduce legislative measures** to ensure that policy restrictions such as the Global Gag Rule cannot be reintroduced to U.S. policy by future presidential administrations. Eliminate the Helms Amendment that bans U.S. funding for abortion services where legal.
- **Adopt a rights-based strategy for foreign assistance** to ensure that U.S. funded programs meet the sexual and reproductive health needs of women sex workers, women injecting drug users, women prisoners and those recently released back into communities.
- **Adopt modalities to ensure that U.S. funding goes directly to local, innovative, smaller grassroots organizations** that promote comprehensive sexual and reproductive health and rights and ensure that U.S. money gets in the hands of women's groups.
- **Strengthen health systems in developing countries to ensure integration** of sexual and reproductive health programs, promote rights-based approaches, and guarantee access to services and information, particularly for underserved users such as women in prisons, sex workers, and youth.

Reproductive Justice for All

Reproductive Justice is a concept that was framed and coined by women of color in 1994 following the International Conference on Population and Development in Cairo. This concept offers an analysis for addressing issues around sexual and reproductive health and rights from a comprehensive and rights-based approach, with a focus on ends that we strive for as advocates: better lives for women, healthier families and sustainable communities.[1] This comprehensive approach is informed by and responds to the oppressions that exist throughout all societies around race, class, and gender.

Comprehensive approaches to sexual and reproductive health and rights are fundamental to achieving reproductive justice, which cannot be achieved without critical changes to U.S. foreign policy and assistance in the area of global health and sexual and reproductive health. The U.S. was a leader at Cairo, but failed to take the achievements at Cairo back home. With a new U.S. administration committed to the sexual and reproductive health and human rights of women and girls worldwide, as recently articulated at the 42nd Session of the Commission on Population and Development, this report is timely in urging the U.S. forward in modernizing its approach to foreign assistance for sexual and reproductive health programs and services.

Reproductive justice cannot be achieved without critical changes to U.S. foreign policy and assistance.

Part I of this report gives an overview of the evolving global consensus around sexual and reproductive health, human rights and global development. It presents a historic overview of U.S. support for sexual and reproductive health through international family planning assistance, and explains what comprehensive sexual and reproductive health is and why it's important for the U.S. to support.

Part II of the report highlights key findings from field visits and interviews in three countries: Dominican Republic, Ethiopia and Botswana, providing examples of promising practices for comprehensive approaches to sexual and reproductive health and rights, and limited practices that impede comprehensive approaches.

Part III analyzes findings from the field visits of U.S. foreign policies and structures that impede programs' abilities to provide comprehensive approaches to sexual and reproductive health and rights, and Part IV offers recommendations to the U.S. government for changes that can move the U.S. government closer to ensuring reproductive justice for all.

Rather than approach the question of integrated services from the top down, or from a cost-benefit analysis (i.e. what services should we integrate in which locations?), CHANGE approaches the question from a user standpoint: What combination of services, programs, and referral systems and what set of rights protections do people need to achieve sexual and reproductive health? The report does not seek to provide a "how to"

of sexual and reproductive health service delivery or the systems needed to back up these services. For an excellent and thorough exploration of these issues, see *Integration Revisited,*[2] a background paper to the UN Millennium Project's report *Public Choices, Private Decisions: Sexual and Reproductive Health and the Millennium Development Goals.*

Part 1

International Consensus

The U.S. as Outlier on Comprehensive Sexual and Reproductive Health and Rights

From the 1974 World Population Conference in Bucharest to the 1994 Cairo International Conference on Population and Development (ICPD), international consensus around population and development has undergone a monumental paradigm shift away from demographic-centered policies toward an emphasis on women's empowerment, gender equality, and sexual and reproductive health and rights as critical to the achievement of sustainable development.

Beginning in the 1960s, the United States was at the forefront of the fight against global population growth, procuring the first contraceptive supplies for global distribution in 1968. By the mid 1970s, the United States Agency for International Development (USAID) had established a well-financed structure to address the issue.[4] While reproductive rights—the right of couples to decide the number and spacing of their children–were internationally recognized in 1968 at the First International Conference on Human Rights in Tehran, USAID's family planning assistance and U.S. foreign policy goals at this time were primarily focused on reducing population growth, rather than promoting the well-being and reproductive rights of couples and individuals.

Human rights are essential to health and development outcomes.

Just as the U.S. government institutionalized its approach to population growth, international support for this approach began to erode. The global women's movement—groups from the global North and South—joined reproductive rights with economic and social development issues in their efforts to influence national and global debates around population growth to ensure that population and reproductive health policies were based on human rights and social and economic justice. Development experts also had learned that strict and coercive demographic policies were often counterproductive. Cases of compulsory birth control, either as official or unofficial policy, often led to health workers prioritizing numerical targets and specific contraceptive methods over the needs or desires of patients. Health care professionals resorted to tactics such as reserving certain health care services to those who had been sterilized or denying maternity benefits to women having more than two children, thereby creating widespread suspicion of family planning service providers and advocates.[5]

An important lesson that emerged from this experience was that human rights are *essential* to health and development outcomes. They should not be considered bonus perks for those who have reached a certain standard of living. Not only do governments have the obligation to provide access to health care (as established by the Alma-Ata Conference on Primary Health Care in 1978), but health care programs—whether implemented by governments, nonprofits, or the private sector—must respect human rights in the provision of these services.

The International Conference on Population and Development (ICPD) in Cairo in 1994 broke new ground in contextualizing family planning within both a human rights and reproductive health framework, while arguing for sexual and reproductive health to be integrated into primary health care. Women's groups succeeded in gaining international recognition of the fundamental rights of reproductive self determination and reproductive health care. ICPD's Programme of Action—signed by 179 countries—and other UN conferences during that decade heralded a departure from coercive fertility reduction strategies, affirming government obligations to respond to demographic trends while protecting women's rights to be free from violence and coercion, to plan one's family, to have access to comprehensive reproductive health care (including family planning, prenatal care, safe motherhood, HIV and STI prevention, and infertility treatments) and to make reproductive decisions free from coercion, discrimination and violence. [6]

Chart 1.

Human Rights Instruments and their Application to Sexual and Reproductive Health
Convention on the Elimination of All Forms of Discrimination Against Women: Enshrines women's right to health; protects women's right to decide on the number and spacing of their children and to have access to the information and means to do so; requires equal access for women to educational materials and family planning advice.
Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment: Holds that torture is any intentional act, inflicted based on discrimination, which causes severe physical or mental suffering, and is committed with the consent of a public official. Has been interpreted by Committee to include denial of family planning services to women, which leads to illegal and unsafe abortions.
Civil and Political Rights Covenant: Protects every person's right to life; ensures the right to be free from arbitrary or unlawful interference in one's privacy, family, home and correspondence; enshrines the equality of rights and responsibilities of spouses.
International Convention on the Elimination of All Forms of Racial Discrimination: Protects the right to health of persons regardless of race.
Convention on the Rights of the Child: Protects children's rights to the highest standard of health and makes states responsible for guaranteeing proper health care, including family planning education and services, for mothers, children and families.
Economic, Social and Cultural Rights Covenant: Ensures the equal economic, social and cultural rights of women and men; protects the right to the highest attainable standard of physical and mental health; requires state action to reduce stillbirth and infant mortality.

The human rights treaties and conventions that include protections, explicitly or implicitly, for sexual and reproductive rights are listed in Chart 1.[7] It should be noted, however, that an international consensus has not yet emerged around the full extent of rights related to sexual and reproductive health, particularly in terms of abortion. The Cairo Programme of Action committed governments to provide safe abortion where it was legal, provide safe post-abortion care, and reduce the number of abortions by expanding family planning programs.[8] The Conference on Women in Beijing in 1995 went a step further, asking governments to review laws that punish women for illegal abortions.[9] But at the five-year review of the Cairo conference, similar language was eliminated due to a compromise with conservative delegations. However, the conference's Key Actions Document did include an important paragraph that requires nations allowing legal abortion to "train and equip health-service providers and...take other measures to ensure that such abortion is safe and accessible." [10]

As human rights bodies begin to address the human rights implications of lack of access to abortion services, consensus around the importance of sexual and reproductive rights to global health and development has continued to build. Regional agreements in Latin America, Asia, and Africa, such as the 2005 Framework for the Promotion of Sexual and Reproductive Health and Rights in Africa, have reaffirmed the value of sexual and reproductive health and rights in their own right and in the pursuit of development objectives. [11] These regional commitments reflect an awareness that reproductive health and development are interdependent, and that initiatives to address maternal mortality, HIV and AIDS, and adolescent sexual and reproductive health—which overlap with, but are not synonymous with family planning programs—are critical to development objectives.

A summit in September 2000 brought world leaders together to set specific targets for global poverty reduction and development. Strikingly, the Millennium Development Goals (MDGs)—eight goals which aim to cut poverty by half in 2015—explicitly and implicitly acknowledge the critical nature of sexual and reproductive health and rights to their attainment.[12] In 2007, at the World Summit that reviewed progress on the MDGs, global leaders committed themselves to the goal originally set in Cairo: to achieve universal access to reproductive health by 2015. A summary of the MDGs and the critical nature of sexual and reproductive health is included in Chart 2 (page 14).

In spite of endorsing international agreements, the U.S. government has not translated the principles and priorities of comprehensive sexual and reproductive health into action.

The U.S. Response to International Consensus on Sexual and Reproductive Health and Rights

As the world affirms and seeks to implement comprehensive, rights-based approaches to sexual and reproductive health, the United States is finding itself in small company, as in recent years it has not lived up to its promises in this area. In spite of endorsing international agreements such as the ICPD PoA and the MDGs, the U.S. government has not translated the principles and priorities of comprehensive sexual and reproductive health and rights into action through its international policies and foreign assistance.

In other words, the U.S. does not have a cohesive, overarching strategy for tackling urgent global sexual and reproductive health issues, as illustrated by the configuration of U.S. foreign assistance agencies and the disjointed policies that govern aid distribution.

The fragmented structure of U.S. foreign assistance is grounded in the U.S. government's historical approach to family planning. USAID's Office of Population was established in 1969, separate from other health offices. USAID added "reproductive health" to

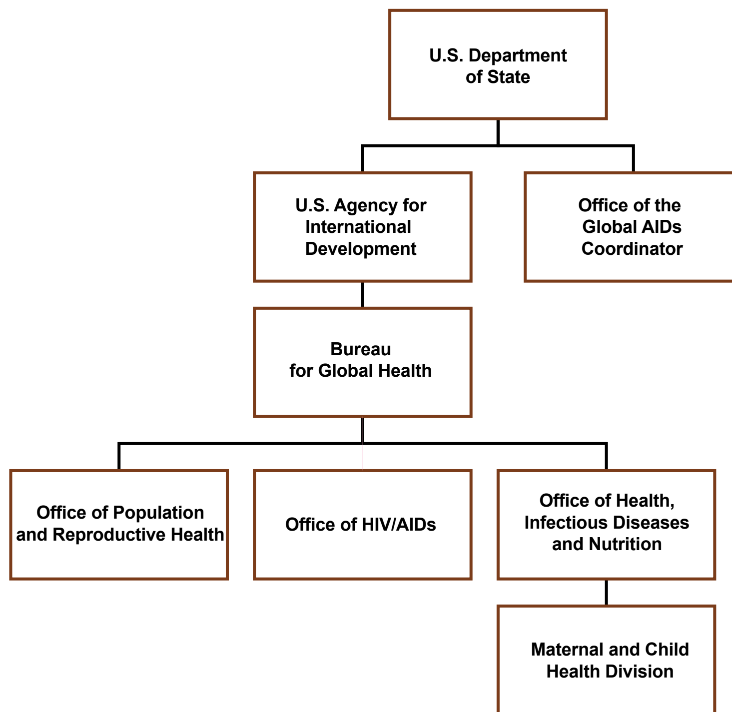
the office's title only in this decade, and placed the office under the newly formed Bureau of Global Health. Yet, the office is still functionally separated from maternal health, which is combined with child health in a division under the Office of Infectious Diseases and Nutrition (see Chart 3 for an illustration of the divisions among sexual and reproductive health areas). While the separate staff may occasionally collaborate and exchange information, their priorities, indicators, strategies and most granting mechanisms are developed separately.

Chart 2.

Millennium Development Goals and Sexual and Reproductive Health

MDG 1: Eradicate Extreme Poverty and Hunger	**MDG 2: Achieve Universal Primary Education**	**MDG 3: Promote Gender Equality and Empower Women**	**MDG 4: Reduce Child Mortality**
By allowing couples to choose the number and spacing of their children, reproductive health care gives families greater control over their economic resources.	When couples choose the number and spacing of their children, families are better able to afford and support schooling for each child. Also, avoiding adolescent pregnancies means girls are more likely to stay in school.	Comprehensive reproductive health programs empower women to make informed choices and better control their lives.	Healthy mothers are better equipped to care for their children, and child spacing allows for better nutrition and health.
MDG 5: Improve Maternal Health	**MDG 6: Combat HIV/AIDS, malaria and other diseases**	**MDG 7: Ensure Environmental Sustainability**	**MDG 8: Develop a Global Partnership for Development**
Access to rights-based services including family planning, prenatal care, skilled birth assistance, and HIV testing is fundamental to maternal health.	HIV prevention and treatment that is integrated with other reproductive health care services can lower stigma and increase access.	Families that can choose when and whether to have children are better able to manage scarce natural resources, including drinking water and land.	Cooperation with the private sector is essential to the accessibility of contraceptives and treatment medications.

Chart 3.



The U.S. response to the growing HIV and AIDS pandemic has exacerbated the segmentation of sexual and reproductive health issues within U.S. foreign assistance structures. In 2003, the U.S. Congress approved the President's Emergency Plan for AIDS Relief (PEPFAR), which has directed billions of U.S. funding to HIV/AIDS prevention, treatment, and care. While USAID has an Office of HIV/AIDS in its Global Health Bureau, the legislation created a new oversight body—the Office of the Global AIDS Coordinator (OGAC)—that operates alongside USAID within the State Department to direct the U.S. response to the pandemic.

While 80% of HIV infections are sexually transmitted, and despite the overlap of HIV/AIDS issues with reproductive rights and maternal health concerns, PEPFAR programming has largely operated independently of family planning and other reproductive health programs. In the last few years, some—including some officials at USAID and OGAC — have attempted to ameliorate the negative impact of these funding silos by promoting integration of HIV/AIDS and reproductive health programs, and there have been some notable successes. However, overall integration efforts have operated from a default position of non-integration: i.e. "where does it make sense to integrate efforts?" instead of "where does it make sense to separate efforts?" USAID's "Call to Action" on linking HIV and AIDS programming with reproductive health specifically focuses only on family planning. In a document published in conjunction with WHO, they acknowledge that reproductive health and HIV/AIDS integration is ideal, yet deal only with family planning as a practical first step.[13]

While other bilateral and multilateral donors have similar structural divisions between their HIV/AIDS response and other reproductive health programming, in the field these divisions are more permeable. This allows implementing organizations to easily pool funding for comprehensive approaches and to base their health programming on the needs of the community instead of on the donor's priorities.[14]

In contrast, the United States' outdated and centralized foreign assistance structure creates unnecessary barriers to effective, comprehensive, and integrated health care that includes HIV prevention, maternal health, and family planning.

A comprehensive and collaborative approach to sexual and reproductive health by the U.S. government has been further complicated in recent years by politically-motivated funding restrictions that run counter to the promotion of health and human rights. Some of these restrictions are being eliminated or eased under the Obama administration and a reproductive health-friendly Congress. The Mexico City Policy has denied family planning funding to reproductive health providers that counsel women about where to obtain an abortion, that advocate for liberalized abortion laws, or that provide legal abortion with their own funds. Introduced under the Reagan administration, this executive order was repealed by Bill Clinton, reinstated under George W. Bush, and repealed again by President Obama.[15]

President Obama has also reinstated funding to the UN Population Fund (UNFPA), which was cut off early in the Bush administration following allegations that it supported China's coercive population control efforts. Numerous experts disputed this allegation—including the Bush administration's own fact-finding delegation. Restoring U.S. funding to UNFPA will allow it to regain its strength around the world, financing projects on family planning, the prevention and treatment of obstetric fistula, and maternal mortality reduction.

Rights-violating restrictions written into the law will be more difficult to remove. Abstinence-only-until-marriage programs favored under PEPFAR legislation ignore basic human rights concerns—the right to information, the right to informed choice, the right to make choices about sex and reproduction and the right to non-discrimination, among others. The Anti-Prostitution Loyalty Oath (APLO) compels organizations receiving U.S. HIV funding to adopt a policy explicitly opposing prostitution. This policy has been found to compromise effective HIV-prevention programs that engage and protect sex workers.[16] The Helms Amendment, which states that U.S. foreign assistance funds cannot "pay for the performance of abortion as a method of family planning…" limits women's ability to access safe abortion in countries where it is legal.

This is not to say that the totality of U.S. foreign assistance in this area is flawed or that U.S. funding has not achieved important gains. Undoubtedly, the U.S. government has funded many laudable programs that have saved the lives of countless people. For example, a recently released study in *The Annals of Internal Medicine* found that PEPFAR had reduced the death rate from AIDS by ten percent.[17] Moreover, many health officials in many U.S. missions around the world have done their best to fund comprehensive programming in spite of the barriers. And despite the government-imposed restrictions that would hinder progress on comprehensive sexual and reproductive health care, there are many U.S. grantees that combine funding from other sources to implement rights-based, high quality and comprehensive programming. To a certain extent, then, the question is

not "how bad has the U.S. approach been for reproductive health in recent years?" but rather, "given its significant resources, how much better could the U.S. be doing to promote the sexual and reproductive health of the world's people, thereby contributing substantially to global development?"

The latter question becomes even more relevant as donor and recipient resource streams are threatened by the global financial crisis. U.S. foreign assistance is particularly vulnerable when economic crises hit, as policy makers see it as more politically expendable than domestic or military spending. And within the foreign assistance budget, reproductive health funding is not on solid ground, as many legislators don't see the connection between reproductive health and development, and may prioritize purely economic development programs over global health. In this context, it is extremely important that scarce dollars are spent wisely. Comprehensive sexual and reproductive health programming, aligned with Millennium Development Goals as embraced by other donors and recipients, can help ensure that U.S. foreign assistance attains maximum impact.

What Does Comprehensive Mean and Why is it Important?

> Comprehensive sexual and reproductive health care: The constellation of methods, techniques and services that promote the complete physical, mental and social wellbeing of individuals in all matters relating to the reproductive system and its functions and processes. – ***1994 ICPD Programme of Action, Cairo***

This discussion of comprehensive sexual and reproductive health care is not simply a matter of comparing and contrasting programs in the field to assess advantages and disadvantages, although that has value. More importantly, it is to set a standard for monitoring the ICPD and MDG target of universal access to reproductive health by 2015. World leaders did not set this goal to merely achieve universal access to contraceptives, or universal access to skilled attendants at birth. By setting the target at the broadest category—reproductive health—the world recognized that *all* the components of reproductive health were essential. Therefore, before we can measure any kind of progress, it is critical to know what that category includes.

Using ICPD's definition as a point of departure, CHANGE sought to construct a conceptual definition of comprehensive sexual and reproductive health care based on evidence from the field. CHANGE also consulted public health literature and guidance from the World Health Organization and UN implementing bodies. Our research and the literature point to three essential components of comprehensive sexual and reproductive health care: family planning; sexual health; and maternal health (leading into infant and child survival; see Chart 5, page 20).

This combination implies that health practitioners should understand the particular needs of individuals on a continuum of sexual and reproductive health. They must also understand—and accept without judgment—that the same individual who seeks family planning at one moment in life often seeks maternal health care at another moment, and that all sexually active individuals have particular health needs. This continuum of care implies not just that services are linked at the national government or clinic level, but *most importantly* at the level of the individual.

The UN Millennium Project's *Integration Revisited* suggests that integration efforts have too often started from the top, instead of from the bottom: "The attention given to sector wide or system level issues creates the risk of an over-emphasis on the integration of *systems* rather than remembering that the point of reference should be the integrated services sought by individuals."[18]

The most successful comprehensive approaches CHANGE examined employ this user-based integration perspective with a sensitivity to and understanding of contextual issues, particularly regarding gender-based violence against women. Successful programs are based on human rights, respecting the dignity, autonomy and agency of a diverse client base.

While co-location of services facilitates users' seamless transition among them, this does not imply that every health facility must provide every reproductive health service. As *Integration Revisited* clarifies, "in a 'linked response' or a 'continuum of care' model, different levels of integrated services are provided at different levels (e.g., FP, ANC, STI/HIV education, counseling and maybe testing at primary health clinic; surgical contraception, STI diagnosis, HIV treatment, abortion etc. at a hospital), *but the staff are able to assess an individual's needs and refer the same individual across different levels of the systems as needed* [emphasis added]."[19]

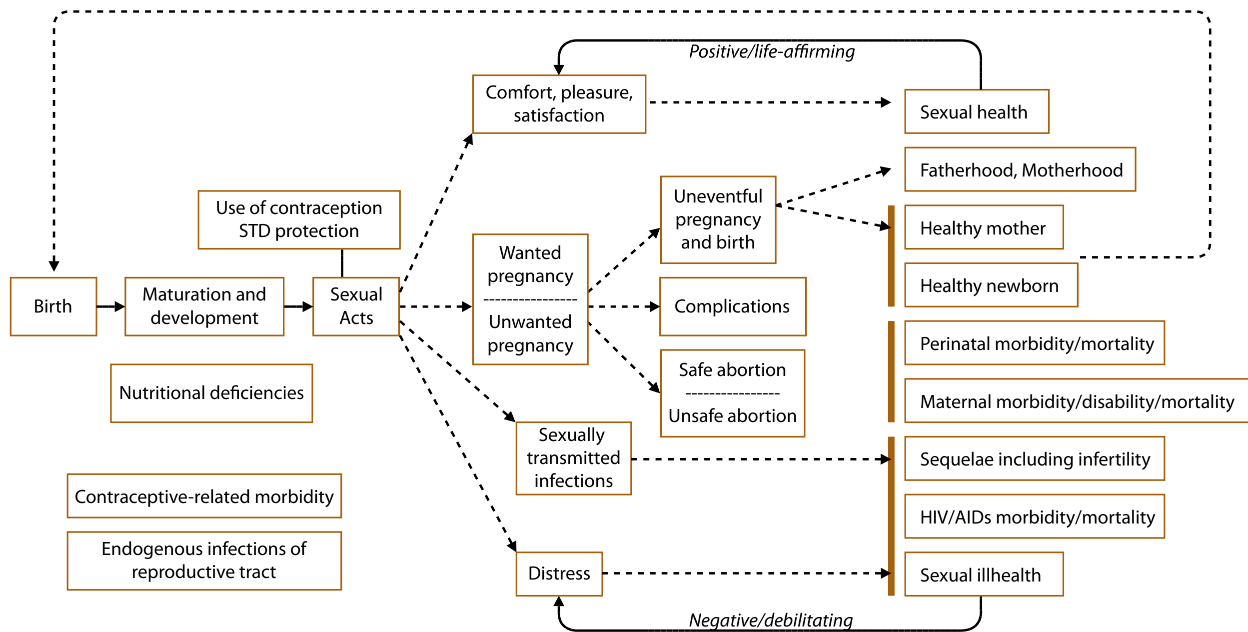
The services provided at each level of health facility will depend greatly on the country's infrastructure, health priorities, and cultural considerations.

For example, a rural woman seeking to space her children could have her first point of entry with a community-based health worker, who describes family planning choices with her, provides a family planning method, or refers her to a clinic for a long-term method or HIV testing. A pregnant woman who goes for HIV testing at the district hospital could be referred for antenatal care to her local clinic, where counselors could discuss her nutrition, ask her about partner violence, or give her information about postpartum family planning methods. The goal is for each person—according to his or her needs and without unreasonable barriers—to have access to the ICPD-defined "constellation of methods, techniques and services."

Unfortunately, there is no clear data yet establishing the cost effectiveness of the provision of comprehensive sexual and reproductive health services. In the recent Cochrane review of SRH and HIV integration, only two studies examined cost effectiveness, and both of these "suggested net savings from HIV/STI prevention integrated into maternal and child health services."[20] While this kind of evidence strongly implies that comprehensive SRH services may bring cost effectiveness, these studies have looked only at the quality and cost impact of piecemeal integration, not a comprehensive package.

More clearly needs to be done to research the cost impact of comprehensive SRH programming. However, in the absence of data, we can make some hypotheses based on what makes "people sense," and what is actually happening on the ground. Sexual and reproductive health programs that provide seamless referral to other services and facilities reduce or eliminate gaps in coverage that can result in health problems not being addressed. These gaps are costly both in terms of lives and financial resources. For example, a woman who can get HIV testing, postpartum care, and family planning in one provider visit does not have to spend more resources and time away from work traveling to differ-

Chart 4.



From Jane Cottingham and Cynthia Myntti; "Reproductive Health: Conceptual Mapping and Evidence" in *Engendering International Health: The Challenge of Equity,* by Gita Sen, Asha George, Piroska Östlin. The MIT Press, 2002. Reprinted with permission from The MIT Press.

ent providers. Moreover, it makes "people sense" that she would be less likely to actually obtain all three services if they were not offered seamlessly, thus risking a more costly unintended pregnancy or an undetected illness. If programs are rights-based, respecting the dignity and confidentiality of each client, individuals will be more likely to seek health care to facilitate a healthy pregnancy, to prevent illness or unintended pregnancy, or get treatment at the early stages of illness.

Both ICPD and the Beijing Conference affirmed a life cycle approach to women's health. Beijing's Platform for Action recognizes, "Women's right to the enjoyment of the highest standard of health must be secured throughout the whole life cycle in equality of men."[21] Comprehensive sexual and reproductive health programs must address health across the life cycle, providing services and programming appropriate to each stage of life (see Chart 4, above). This includes comprehensive sex education for young people, youth-friendly sexual and reproductive heath services, family planning and maternal health care for those in their reproductive years, and care for post-menopausal women.

CHANGE also found that the most successful sexual and reproductive health programs were those that both interacted with the communities they served and addressed the contextual issues that affect SRH. In Dominican Republic and Ethiopia, the use of community-based health workers effectively engages community members in their own health care and gives practitioners a clearer sense of the critical health needs in each community. By proactively addressing gender-based violence, genital cutting, early marriage, and other issues that have a strong bearing on the SRH of women and girls, innovative programs can address causes of illness and not just the illnesses themselves.

Chart 5. Comprehensive Sexual and Reproductive Health and Rights

Necessary Components	Family Planning	Sexual Health	Maternal Health
Program Goals and Values	Reduce the number of unplanned pregnancies and allow for optimal spacing of children	Prevent the spread of HIV and STIs, promote the healthy expression of sexual intimacy free from violence and coercion	Reduce maternal mortality and morbidity, reduce obstetric fistula, reduce unsafe abortion
User centered and participatory	No external incentives to promote particular method, involvement of beneficiaries in program design, service selection based on user needs	Programs present scientifically correct information on all prevention methods to users without judgment; involvement of beneficiaries in program design	Woman-centered antenatal care—including for HIV-positive women—space for questions, involvement of beneficiaries in program design, service selection based on user needs
Respect	Provision of services free from judgment and stigma	Interventions administered free of judgment and stigma	Choice of health provider; respect for childbearing decisions—including those of HIV-positive women
Informed Choice	Education about all available methods and potential side effects or consequences, education about rights	Education about all available prevention methods and treatment options, education about rights, no disclosure of status to others without consent	Education about all available options—including the option of abortion, education about rights
Freedom from Coercion	No pressure to use particular method, to prevent, continue or end pregnancy, or to conceive	No coercion to undergo testing, to reveal the results of positive tests, to undertake specific treatment	No pressure to prevent, continue or end pregnancy, or to conceive
Equal Access (race, class, age, gender, sexuality, HIV status, profession)	Reasonable cost of all available methods, range of providers, materials in appropriate languages, make services youth-friendly, use appropriate outreach to marginalized communities	Reasonable cost of all approved prevention methods, range of providers, materials in appropriate languages, ability to incorporate emerging technologies as they are approved, make services youth-friendly, use appropriate outreach to marginalized communities	Reasonable cost, range of providers, materials in appropriate languages, use appropriate outreach to marginalized communities
Quality of Care	Services provided by trained personnel, quality monitoring and evaluation performed regularly	Services provided by trained personnel, quality monitoring and evaluation performed regularly	Services provided by trained personnel, quality monitoring and evaluation performed regularly
Integration of Care	Family planning, sexual health, and maternal health services offered in one location or through seamless referral process, linked as well to services for survivors of gender-based violence. Providers fully trained in all technical aspects, as well as in providing rights-based, judgment-free services with awareness of gender-based violence.		

PART II

Context and Findings

A. Dominican Republic

Sexual and reproductive health issues have an enormous impact on the larger health picture in the Dominican Republic. The Dominican Republic has a strong health infrastructure with relatively wide access. However, this has not guaranteed positive health outcomes due to low levels of quality care, consumer information, and patient education.

Despite the fact that 96% of births are attended by skilled health personnel[22] and prenatal care is common, maternal mortality is very high for the region, at 180 deaths per 100,000 live births.[23] Half of these deaths occur during childbirth and the postpartum recovery period, strongly suggesting that these women are not receiving quality care with adequate patient monitoring.[24]

The Catholic Church has had enormous influence on the shaping of public policies related to reproduction and sex education. Abortion is illegal in all circumstances yet a study done in 1990 estimated the rate to be more than twice as high as in the United States,[25] with unsafe abortion contributing significantly to maternal mortality. One study estimated that 20% of maternal mortality in Santo Domingo was due to unsafe abortion.[26]

Contraceptive prevalence is relatively high at 68.9% in 2002.[27] Within this number, there is a heavy reliance on sterilization, in part because long-term, reversible methods are not consistently available in public sector health settings.[28] The median age of sterilization for women is 28, and 46% of all Dominican women were sterilized by 2007.[29] The high sterilization rate makes it more difficult for service providers to get people to use condoms to prevent HIV and other STIs.[30]

Family planning services appear to serve adolescents particularly poorly, as 29% of young people expressed an unmet need for family planning in 2002. In 2002, 19% of all 15- to 19-year-olds had had a child, and 23% had had a pregnancy that year or were pregnant at the time of the survey.[31] In fact, the government has lowered the age for onset of contraceptive need from 15 to 10, responding to the incidence of young teen pregnancies and HIV or other sexually transmitted infections.[32]

While at .8% the reported HIV rate is not extremely high in comparison to the other two countries studied,[33] HIV/AIDS is the leading cause of death for women of reproductive age.[34] Moreover, a significant number of people in the Dominican Republic don't have access to the health system, leading to a likely critical underreporting of HIV.[35] According to UNFPA, "epidemiological data from the Ministry of Health indicate that the prevalence rate is closer to 2 percent." Moreover, young women are increasingly affected by HIV, as

HIV prevalence among young people is now divided almost equally while it was almost exclusively a male disease twenty years ago.[36]

The Dominican Republic has received considerable assistance from the United States to address sexual and reproductive health issues. Because of the country's relatively high contraceptive prevalence rate, in 2008, the country "graduated" from U.S. funding for family planning programs. Between 2002 and 2008, the U.S. provided $35 million to the CONECTA Project to improve the health sector through attention to HIV/AIDS, reproductive health, child survival and health sector reform. While not a PEPFAR focus country, the Dominican Republic receives a significant amount of PEPFAR funding to address and prevent HIV/AIDS, totaling $ 5.75 million in 2009.

Profamilia – Promising Practice

International Planned Parenthood Federation member association Profamilia is seen as a leading sexual and reproductive health care provider in the country and a leader in defending women.[37] In one hospital, seven clinics, one mobile clinic, and 26 community distribution outlets, Profamilia provides the full range of reproductive health care—family planning, maternal health, and HIV/AIDS and other STI services. Profamilia's services include urology, sonogram, gynecology, mammograms, x-rays, antenatal care, postpartum care, echocardiograms, infertility, emergency contraception, colonoscopy, cardiology, gastrointestinal health, family planning, gender violence, counseling and others.[38] They also incorporate youth-friendly outreach and programming.

Because these healthcare providers may be the only health professionals to see these women regularly, the importance of their proactive attention to gender-based violence is clear.

Their family planning services include a wide range of methods.[39] A visit to a Profamilia Clinic in Santo Domingo and interviews with staff found that they had birth control pills, Depo Provera, emergency contraception, IUDs, condoms and spermicides in stock, in addition to offering vasectomy and female sterilization. Except for counseling, there is a fee associated with all services. Profamilia had experienced political backlash when the Catholic Church denounced Profamilia for distributing emergency contraception; however, some felt the controversy actually helped people know where they could get EC.[40]

In the city of Santiago, Profamilia opened a model maternity hospital in 2003 that is open twenty-four hours a day and serves 1,000 birthing women per year. This is the only nongovernmental organization providing birth services in the country. [41] Researchers visiting the hospital found it clean and professional, with patients thanking providers for the good care they received. [42] The hospital and attached clinic offer surgery (including C-section), CD4 counts, counseling, community outreach and education.

Unlike other health providers, Profamilia incorporates attention to gender-based violence in all their levels of service. They offer professional counseling on gender-based violence (GBV) from a rights-based approach, focusing on educating the woman about violence and her legal rights, while empowering her to take action to change her life. Because these health care providers may be the only health professionals to see these women regularly, the importance of their proactive attention to gender-based violence is clear. One Profamilia provider reported, "I asked a woman whom I had been treating for a long time about whether she was experiencing violence. She said, 'Caramba, I have wanted to talk with you about this for a long time, but I thought that you wouldn't be interested.'" [43]

Posters in Profamilia clinics with photos of staff physicians let women know that they can raise issues of GBV there. Their reputation for dealing with gender violence reaches into other clinics and even the private sector. They have trained doctors to screen for GBV and worked with public hospitals to establish GBV protocols based on the successful Profamilia model. [44] In the free trade zones, manufacturers have contracted with Profamilia to train employees about GBV. [45]

This attention to gender-based violence is in no way peripheral to reproductive health. Profamilia staff tells of a low-income woman with preeclampsia who had gathered money to get the medically necessary caesarean section at the local public hospital. Her partner beat her up and stole the $2000 RD pesos. Upon learning of her case, Profamilia intervened with the public hospital to pressure them to do the c-section. After the life-saving procedure, they supported the woman as she filed charges against her partner.

Profamilia began adding HIV/AIDS services in 2004, integrating testing, antiretroviral treatment, and support groups into one clinic, Clinica Evangelina Rodriguez. In fact, Profamilia was among the first health care providers to give access to ARVs. Profamilia staff provides ongoing support and treatment literacy to encourage adherence with ARV regimens. Moreover, all patients can access the staff psychologist for counseling if necessary.[46] Profamilia staff helps HIV-positive clients sero-disclose to partners and/or children.

To combat stigma, their clinics do not physically separate HIV services from other sexual and reproductive health services. All users use the same entrance, lobby and lab services, regardless of the reason for seeking care. (Note: This type of integration is not always successful, and could inadvertently result in increased stigma and discrimination particularly in small and rural communities.) Discrimination by providers against people living with HIV is not accepted; providers who will not provide good quality care to people living with HIV are fired.[47]

In 2007, the Profamilia clinic in Santo Domingo also began offering post-exposure prophylaxis. Between April 2007 and February 2008, staff reported providing six rape victims with PEP. Hospitals have been referring patients to them for PEP. Profamilia staff educate patients about PEP and its availability through waiting room lectures.[48]

Health advocates in Dominican Republic report that adolescents as young as 9 or 10 are having sex, which is consistent with the data mentioned above. However, there is no national sexuality education curriculum, and teachers are limited to discussions of anatomy with no graphic representations of genitalia allowed. In 1993, the government asked Profamilia to produce a sexuality education curriculum and teach the classes. Profamilia designed a curriculum that provided comprehensive sexuality education that would meet the standards for effective programming,[49] but the effort was suppressed in 1998 due to opposition from the Catholic Church.[50] Now, they do sex education directly in communities, including peer youth outreach.

Colectiva Mujer y Salud – Promising Practice

Profamilia is not alone in providing high quality, rights based and comprehensive care. The feminist NGO Colectiva Mujer y Salud (Women's Health Collective) has a strong community presence from years of outreach and education, and opened the Monte Plata health center in March 2008. This center offers family planning, antenatal care, voluntary

counseling and testing, antiretrovirals, sexual education for ages 10 and up, and community outreach that includes gender violence screening and focuses on women's rights and gender equity. They base service selection on women's needs as identified by women in the community.[51]

Although the Ministry of Health provides no female condoms, Colectiva is working to train Ministry of Health personnel on their use and is working in communities to raise awareness about female condoms. However, low supplies of female condoms have been a consistent challenge to fully execute the program.

Moreover, Colectiva Mujer is the only women's NGO that openly advocates for safe and legal abortion. They've also worked to raise awareness about emergency contraception. They produced a model community education program to teach women condom negotiation skills, and are strong advocates for the rights of people living with HIV and AIDS. They have trained municipal authorities about the links between gender-based violence and HIV.[52]

Limited Promises in the Public Health System

The contrast between the quality and breadth of care offered by Profamilia and Colectiva as compared with the Dominican Republic's public health care system is striking. The Ministry of Health's family planning distribution has been plagued by major supply problems, including poor or nonexistent registration of contraceptive supplies. The only forms of contraception offered by public health outlets are birth control pills, IUDs, condoms, Depo Provera, and sterilization.

The public sector also suffers from a lack of integration between services. In a study exploring provision of family planning to postpartum women, the authors note that while 97 percent of women entering the hospital for labor had indicated interest in using family planning postpartum, only 12 percent received a method before leaving the hospital. For post-abortion care clients, the situation was even worse: only 12 percent even received counseling on family planning, and just 9 percent received a method before leaving. One main reason was the hospitals' lack of user-based programming. "In most establishments, family planning services are offered in the outpatient area and for a limited period of time (usually Monday through Friday during the morning shift), whereas most postpartum and post-abortion women are discharged after noon."[53]

These kinds of issues in maternity wards are unfortunately not surprising in the Dominican Republic. In general, maternity care offered by public hospitals has been rife with overcrowding, poor cleanliness, a lack of professionalism, and poor quality care. The postpartum family planning study also commented on the general state of maternity wards: "The large hospitals were so crowded that many beds in the rooms were occupied by two women and their babies at the same time…Because clean blankets were seldom available, women were commonly lying naked or covered with a piece of cloth on a bare, dirty mattress while others watched."[54] A USAID assessment team looking at public hospital maternity wards in 2002 found that high maternal mortality was due to "lack of quality of care and lack of adherence to protocols in maternity hospitals…In addition, the physical space was found to be dirty and crowded and the personnel rude. Complicated cases were not given the attention they deserved and normal cases were overmedicalized."[55]

In contrast to Profamilia's approach, the public health system provides care to those living with HIV and AIDS through separate clinics—sometimes attached to hospitals although with separate entrances—called "Integrated Attention Units" (UAIs). However, despite their name, UAIs and hospitals have no referral system between them. Moreover, UAIs have no gynecologists on staff and provide no services for contraception or GBV.[56] Neither are testing or treatment services for other STIs provided by UAIs. They do not have youth-friendly counselors or other staff and they have little outreach to communities. Many Dominicans do not want to access their services because of the stigma attached to entering one of their clinics. In 2006, UAIs served only 21% of people living with HIV.[57]

Hospitals that provide antiretrovirals to women during pregnancy to prevent transmission to the child do not continue women's treatment postpartum. As late as 2004, women living with HIV were not allowed to give birth in public health hospitals and therefore resorted to either hiding their sero-status or giving birth at home.[58] The divisions within the Ministry of Health between those working on HIV and those working on maternal health has meant little crossover training on maternal health of HIV-positive women.[59]

B. Ethiopia

Ethiopian women face an abysmal health situation. Although the government's recent reproductive health strategy advocates 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.[60] Only 6% of women had a skilled attendant at delivery[61] and rural women in particular have little or no access to modern health care. Children born in urban areas are twenty times more likely to be delivered in a health facility than those born in rural areas.[62] The few Ethiopian hospitals that do 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 obstetric fistula, which is caused by prolonged obstructed labor.[63]

Unsafe abortion claims the life of one of every three women who dies as a result of pregnancy or childbirth.

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.[64] 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.[65] There are reports that doctors refuse to provide abortion in hospitals, then perform it clandestinely for higher fees outside of their formal employment.[66] The Ethiopian Society of Obstetricians and Gynecologists estimates that 45% of those who seek abortions are younger than 18.[67]

Child marriage is another significant contributor to maternal mortality and obstetric fistula. While the legal age of marriage is 18, the median age at first marriage among 25-29 year old rural women in 2005 was 15.9. Childbearing also begins early, with 45% of total births in the country occurring among adolescent girls and young women.[68]

AIDS is the leading cause of morbidity and mortality among adults in Ethiopia, with 2.8 million people living with HIV in what is a generalized epidemic at 2.1%.[69] Young women aged 15 to 19 are seven times more likely to be infected than their male peers.[70] Eighty-seven percent of transmission is estimated to occur through heterosexual sex.[71] 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% of married Ethiopian women are using a modern contraceptive method and their unmet need is estimated at 34%.[72] In 2005, 30% of young women ages 15 to 24 reported an unmet need for family planning.

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.

FGAE and ADA: Promising Practices

Ethiopia's government has a laudable strategy to address reproductive health issues in a comprehensive way. The Ministry of Health advocates opportunities to integrate and link reproductive health services with other health and non-health interventions, contextualizing reproductive health in a broader picture. The government expresses an understanding of the links between reproductive health and gender-based violence, female genital cutting and early marriage. They also have embraced a commitment to a rights-based framework, including for youth: "Reproductive health services are the basic human rights for all people and the youth have inherent sexual and reproductive rights, including the right to a full range of reproductive health information."[73]

The Ministry of Health advocates opportunities to integrate reproductive health services with other interventions, contextualizing reproductive health in a broader picture.

However, severe lack of infrastructure and shortage of health practitioners makes following through on this policy extremely difficult. With an estimated one physician per 33,000 (WHO's standard is one for 12,000), Ethiopia has a severe doctor shortage.[74] The country has under 200 obstetricians and gynecologists.[75]

Nongovernmental organizations have attempted to fill this gap through the training of lay health workers. In 1996, the Family Guidance Association of Ethiopia (FGAE) began the first community-based distribution network in the country to advance contraceptive delivery. This idea grew into the 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. A study of CBRHAs found that nearly half offered integrated services, depending on their training and experience.[77] 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.

An International Planned Parenthood Federation member association, FGAE also operates 18 clinics, 26 youth centers, 740 community-based reproductive health outlets, and 242 outreach sites.[78] 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 provision. They provide free female condoms, which are in high demand.[79] 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.

FGAE lost 35% of its budget and donated contraceptive supplies in 2001, when they refused to sign the reinstituted Gag Rule.[80] Even with this decline in funding, they have a strong reputation for providing a broad range of contraceptive supplies. Other health implementers report that when clients cannot find a particular method through public clinics, they recommend going to FGAE.[81]

FGAE integrates family planning services and HIV testing at the user level, with positive results. A study which reviewed 43,000 VCT records from FGAE clinics found that those with room- and counselor-level FP-HIV integration are both more likely to initiate HIV testing than those attending facilities where HIV and family planning services are simply co-located, with the odds of self-initiated testing more than four times for men and more than seven times for women.[82]

The Amhara Development Association (ADA) comes to sexual and reproductive health through a different path. Started in 1992, they focus on poverty alleviation, peace, education and promotion of democracy in the Amhara region. They added reproductive health in 2000. Between 2000 and 2007, ADA reached and educated over 9 million people on family planning, 12 million on maternal health, 8 million on female genital cutting, and 10 million on HIV/AIDS. In 2007 alone, they served 44,000 people with VCT. They have over 200 reproductive health "clubs" that reach over 4 million people with peer education on family planning, maternal health and post-abortion care.

They have also trained and deployed almost 3,000 high school graduates as CBHRAs. Like the FGAE lay workers, these health workers travel house to house to provide a range of counseling, education, and services. They counsel women on maternal health issues, conduct family planning education, provide contraceptive methods, identify fistula patients, and create safe spaces for adolescents to discuss sexual and reproductive health. When services are warranted that these workers are not trained to provide, they refer patients to emergency obstetric care providers, fistula surgeons, antiretroviral providers, or perinatal HIV prevention providers. However, at the time of CHANGE's research, they were not performing abortion or referring clients for safe abortion, even in cases of rape, because "we signed Mexico City."[83]

ADA's approach has been extremely successful in many ways, most obviously in increasing the contraceptive prevalence rate. According to ADA, unmet need for contraception in the Amhara region has decreased from 45% to 29% as a result of their work. However, they face significant challenges. ADA's director reported, "We have access to

only two or three contraceptive methods and even for those there are problems with availability and shortages."[84] Moreover, referral is not a smooth process, as distances to clinics and hospitals are generally quite far and roads are poor. ADA advocates for continuous education on condoms as there is resistance to condom use.[85]

ADA operates youth clubs which include information on reproductive health. Because it is a community-based organization, they have generated the confidence of the community, so "families of girls have no problems with girls coming to our youth clubs." Reproductive health issues are addressed starting at age nine, with information on the menstrual cycle and condoms. ADA also provides educational support to girls in secondary schools.[87]

These two nongovernmental organizations stand out in the provision of comprehensive sexual and reproductive health care, and the government relies on them to provide services it cannot. The government has followed their lead, however. 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 are trained in both preventive and curative care, and focus on disease prevention, family health, hygiene, and health education. They are also trained to refer cases that require more expertise. By February 2008, the government had trained and deployed over 24,000 HEWs.[88]

Shortages of contraceptive supplies are common, as well as a lack of adequate educational materials about family planning options.

HEWs also oversee the volunteer health workers at the community level, including CBHRAs and Trained Traditional Birth Attendants (TTBAs). However, this can cause difficulties because the HEWs receive a government salary and the volunteers do not. Some observers reported that HEWs are overwhelmed by the many health demands of the community, and lack the confidence and credibility to attend births.[89]

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.[90] 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. The country has just one shelter for victims of gender violence.

For both the public and private sectors, getting contraception to people who want it is challenging. Community based distribution of contraceptive methods is limited to hormonal contraceptives and condoms. Providers such as Marie Stopes International fill the demand for longer-term methods only in clinics.[91] Shortages of contraceptive supplies are common, as well as a lack of adequate educational materials about family planning options.[92]

Despite the high HIV prevalence rate and unmet need for contraception, the rate of condom use in Ethiopia is extremely low. Condoms are perceived as used only by sex workers.[93] For young people, a recent study found that just half of young men used a condom at last high-risk sex, and only 28% of young women had.[94] Another study found that both married and never married young men had engaged in risky sexual behaviors, but

condom use in marriage was rare for both men and women.[95] Female condoms are mostly not available, despite great interest.[96]

Neither FGAE nor ADA operates a hospital in Ethiopia, and though the vast majority of women do not deliver in a hospital, those that do often encounter poor quality care. A number of health advocates cited reports of lack of infection control at the largest maternity hospital in Addis Ababa. One study found a high level of distrust and frustration with the public health system. One respondent reported, "When my wife was in labor we went to a public facility and she was left unattended for three days…"[97] Only the major hospitals and a few of the district hospitals provide emergency surgical or obstetric services because of the lack of essential inputs.[98]

Every year, 9,000 women develop obstetric fistula in Ethiopia. Most 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 a gynecologist, midwife, nurse and health officer. In 2004, seeing a rise in fistula cases, the Bahir Dar Clinic began collaborating with the government to build community awareness on fistula. They organized workshops with women's groups about fistula prevention and worked to educate community members about curing fistula. They have 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 at the clinic, and start on ARVs and counseling if they test positive. They also screen for TB, diabetes and hypertension.[99]

C. Botswana

With relatively good roads, solid communications network, and 24-hour hospitals fairly well distributed throughout the country, Botswana does not have the extreme infrastructure problems of Ethiopia. The government requires that sexual and reproductive health services, including family planning, prenatal care, delivery, post-abortion care, and STI services are provided at no cost by maternity care providers, hospitals and government clinics. Where there is no access to clinics, the government mandates that health workers must provide these services through outreach teams.

Despite these structural advantages, women's sexual and reproductive health and rights in Botswana are not well protected. WHO reports a maternal mortality rate of 380 women per 100,000 births.[100] While this figure is low compared to other African countries, it appears incompatible with the high percentage of births attended by skilled personnel—95% according to the Botswana Multiple Indicator Survey in 2000. This discrepancy reflects inconsistent access to emergency obstetric care, and shortages of emergency equipment and medications.[101] Moreover, maternal mortality figures vary widely because Botswana has not developed a reliable system for complete reporting on the causes of maternal deaths. A system developed in 1998 still suffers from widespread negligent data gathering by health providers.[102]

In 2004, contraceptive prevalence was just 48% among women aged 15 to 49.[103] While young people know about male condoms, they believe they have high failure rates.[104] And although sexual and reproductive health services are available, they are not accessible,

particularly for young people. Despite the fact that 90% of people in Botswana live within 15 kilometers of a health center, use of these centers for SRH services is very low, especially among young people. Young people say they are kept away by inconvenient hours, poor information about services, and unwelcoming attitudes toward youth among service providers.[105]

Abortion in Botswana is legal up to 16 weeks only in the cases of rape, incest, fetal impairment or when pregnancy poses a risk to the health of the mother. To obtain a legal abortion, a woman must get two physicians to certify one of the reasons above. Because of these restrictions, legal abortion is extremely rare—if it occurs at all. Women either resort to unsafe abortion, or if they have enough resources, they travel to South Africa for an abortion.

The human rights situation in Botswana, particularly for women, girls, and persons living with HIV, is poor. While civil law has been reformed to reflect progress in women's rights, customary law recognizes few rights for women, and continues to be applied in many parts of the country.[106] Marital rape is not recognized by the civil legal system in Botswana, and a study found that 39% of men believed that women do not have the right to refuse sex with their husbands or boyfriends.[107] Because women must present a police report certifying a rape to access post-exposure prophylaxis or emergency contraception, married women who are raped by an HIV-positive husband do not have access to these medications.[108]

Botswana illustrates how programming that is not integrated or rights-based affects the most vulnerable groups in society, particularly women and youth.

Botswana has the second highest HIV and AIDS rate in the world. According to recent UNAIDS estimates, 24.1 percent of adults aged 15 to 49 are HIV positive.[109] The feminization of the epidemic has been particularly rapid among young people. A 2004 survey found that nearly 10% of women ages 15 to 19 were HIV positive, as compared to 4% of young men.[110] While prevalence has dropped slightly for all age groups in recent years, the decline is least among young people.[111]

PEPFAR has poured millions of dollars into Botswana to fight and treat HIV and AIDS —over $47 million between 2004 and 2008. Despite high numbers of HIV discordant couples, PEPFAR's prevention focus has been very heavily weighted toward abstinence and faithfulness. In 2008, over $200,000 was spent on abstinence and faithfulness activities, while only $38,000 was spent on all other activities, including promotion of HIV testing, education on risk avoidance, and social marketing of condoms.[112]

The U.S. gives no funding to Botswana for family planning, reproductive health, or maternal health.

Limited Promises

Botswana presents a complicated picture because of its many contradictions. It is economically advantaged over many neighboring countries, yet income inequality has kept a quarter of the population under the poverty line. The country implemented a National Policy of Women and Development in 1996, yet progress has not reached most women.[113] And while heralded as a success story in the battle against HIV because of its universal access to ARVs, the reality on the ground is much more nuanced. What emerges is a strong illustration of how programming that is not integrated or rights-based affects the most vulnerable groups in society, particularly women and youth.

In general, sexual and reproductive health services in Botswana are fragmented and not comprehensive. Piecemeal projects focus mainly on HIV prevention and treatment, and while many of these are quality projects, there is little coordination between their efforts and the public health sector that provides family planning and maternal health. For example, Tebelopele, the major U.S.-funded VCT NGO in the country, does not offer any family planning, STI treatment or other sexual and reproductive health service.[114]

The IPPF member association BOFWA (the Botswana Family Welfare Association) comes the closest to providing comprehensive care in Botswana. They provide antenatal care, breast exams, pap smears, STI management, VCT and pregnancy tests. They distribute male and female condoms. Like Profamilia in the Dominican Republic, they combine clinic space for their HIV, family planning and maternal health services to reduce stigma. They have a youth-friendly clinic that serves ages 10 to 29. However, they do not have a lab, so clients must go to the hospital for all lab tests. Moreover, they do not provide ARVs or PMTCT, but refer clients to government services instead. While they screen for gender-based violence, they do not provide more than counseling, referring survivors to Gaborone's shelter for other services.[115]

Researchers heard of widespread discrimination against those living with HIV and AIDS. Botswana law prohibits youth access to VCT under the age of 21 without parental consent, violating confidentiality rights. The government does not currently have a mechanism to monitor HIV-related human rights abuses. One lawyer told CHANGE that most employers in Botswana are not aware of the law that prohibits discrimination against people living with HIV and AIDS, and that there is no training program to educate them. While in office, the former Minister of Health said in the media that women are the ones spreading HIV.[116]

This environment has a clear impact on how sexual and reproductive health programs are implemented. One project targeting women who are HIV positive and pregnant has the stated intent of giving counseling, health information and other support to such women, such as what and how to feed their babies. The counselors, all mothers living with HIV, must sign a contract in order to receive their stipend. The contract asks that they pledge not to become pregnant while in the program. If they become pregnant, they lose their position and their stipend—violating their fundamental right to make reproductive decisions free from coercion (see Annex 3). One woman reported that she heard on the radio that HIV-positive women should not get pregnant. Moreover, women who are HIV positive and become pregnant tend not to seek out PMTCT services because of associated stigma, as well as abuse and discrimination by service providers.[117] Health workers and clients report that the stigma is so significant that they breastfeed children because formula use is associated with HIV.[118]

If they become pregnant, they lose their position and their stipend—violating their fundamental right to make reproductive decisions free from coercion.

One attempt to reach youth with comprehensive programming was successful yet short-lived. African Youth Alliance Botswana (AYA), a collaborative effort of UNFPA, PATH and Pathfinder funded by the Bill and Melinda Gates Foundation, conducted a five-year project to empower young people with information and skills on sexual and reproductive health. AYA trained peer education officers on teen pregnancy, abortion, peer pressure, and other themes and equipped them to train fellow students. They distributed condoms, worked to promote life skills planning, and engaged tens of thousands of

youth through outreach visits.[119] The project ended in 2004, but has had a lasting impact in building the capacity of organizations in Botswana to implement youth-friendly programs.[120]

Heavily reliant on PEPFAR funding that emphasizes abstinence and faithfulness, HIV prevention programs in Botswana have nevertheless succeeded in raising awareness about condoms but not significantly increasing their use. In a study on HIV knowledge, attitudes and behaviors, Physicians for Human Rights found widespread awareness that condoms could prevent the transmission of HIV. However, this knowledge did not translate into behavior, as 46 percent of sexually active respondents reported unprotected sex over the past year. Over half of the women who had not used a condom in the past year reported that at least one instance of unprotected sex was due to partner refusal to use a condom. One pregnant woman who was HIV-positive explained that she had not increased condom use because, "if he refuses, I have no say."[121]

Women's economic dependency plays a large role in their inability to negotiate condom use. One respondent in the PHR survey reported, "I was given things in exchange for sex. I had trouble saying no to sex because he was supporting me…After he gave me money, I felt I had to have sex.[122] Health advocates report that this transactional sex is common, with girls visiting the diamond mines for their "sex allowance."[123]

Gender violence is also a factor. A woman told the PHR researchers, "My husband had other partners. He refused to use a condom. I could not say no. We fought because I said no to sex without a condom. He abused me physically because of this, and afterwards I was afraid to say no." In spite of the prevalence of gender-based violence and its impact on HIV prevention, VCT provider Tebelopele will refer clients to the women's shelter in Gabarone only if women raise the issue themselves.[124] UNAIDS guidelines for gender- and rights-based programming suggest that HIV programs without such programming risk perpetuating the social conditions that contribute to the spread of HIV.[125] Moreover, U.S. investment in VCT that ignores gender violence does not make financial sense. For women who are abused by their partners and cannot refuse sex, knowing their HIV status does not alter their inability to prevent sexual transmission.

D. Marginalized Populations

Women living on the margins of society are often neglected when it comes to sexual and reproductive health services. In our interviews and outreach we asked specifically about sex workers and women in prison. Although we did not seek out information about women injecting drug users, we found that most women in prison in the Dominican Republic were incarcerated for drug-related crimes.

Women in Prison

In preparation for travel to the three countries, researchers requested meetings and interviews at prisons where women were incarcerated. The Dominican Republic was the only country where we were able to do this, due to a progressive and innovative program in a women's prison outside of Santo Domingo.

Unfortunately, we were not able to secure visits to prisons in Botswana and Ethiopia. We did however inquire with reproductive health and HIV service providers if they served women prisoners who are re-entering communities. The responses were similar: they had not thought of including incarcerated or recently released women prisoners into their programs. This response illustrates well the invisibility of women who are incarcerated.

The Dominican Republic has developed a model reproductive health program for women imprisoned in Anajayo, outside of Santo Domingo. Physicians who staff the jail health center are trained in HIV, VCT, STIs and psychological counseling. There is no mandatory HIV testing, and the women meet with a psychologist after post-test counseling. ARVs are available for those women who need them. Women also have access to a dentist, neurologist and gynecologist.[126]

Under the leadership of Dr. Rosalia Flores, an HIV/AIDS physician who initiated these programs, women prisoners have a number of programs within the prison system to give them options to earn a living upon release. These include literacy, computer, agriculture, sewing, hairdressing and other classes.[127]

Women have a legal right to conjugal visits; however, they must take an HIV test in order to do so.[128] In Anajayo, there are six conjugal visit rooms, and prison authorities are conducting education on condom and other contraceptive use.[129]

Women prisoners also get prenatal care and can give birth at a local hospital, then keep their baby with them in prison until the baby turns one. There is also a child care center with toys where children can visit their mothers.[130]

This model prison system is currently being replicated in nine of the country's 37 penitentiaries. The Dominican government gave the prison an award for quality of health service care.

Sex Workers

In Botswana, it is illegal to live from the proceeds of sex work, and brothels are also illegal. The Nlkailela Youth Project in Gabarone has a sex worker project, and has signed the prostitution loyalty oath to receive PEPFAR funding. They provide income generating activities, such as horticulture and cooking as alternatives to sex work and educate them about HIV. They also provide male and female condoms and accompany sex workers to VCT. However, this group is not equipped as a health care provider; although they do help sex workers negotiate the health care system. Clinics in Botswana are not generally responsive to sex workers' needs because their hours are not convenient for sex workers.[131]

The Dominican Republic has a high number of people in the sex trade per capita, with 50,000 female sex workers in Santo Domingo alone. HIV prevalence among sex workers in Santo Domingo was 3% compared to 1.7% in the general population.[132]

Commercial sex or the act of exchanging sex for money is not illegal in the Dominican Republic, as long as the sex worker is not under the age of 18. Since there is no law explicitly prohibiting commercial sex, neither sex workers nor their clients are prosecuted by law enforcement officials. There are two types of sex establishments in the Dominican Republic: direct (brothel) and indirect (bars, discos and nude dancing clubs).[133] In Santo Domingo, 90% of sex establishments are indirect.[134]

The HIV law in the Dominican Republic that prohibits discrimination based on sero-status has had a profound impact on sex workers. Sex workers can no longer be fired simply for testing sero-positive. HIV test results are now confidential and not given to brothel owners.[135] Before the HIV law, advocates report that physicians who tested sex workers for STIs were abusive, forcing sex workers to simply drop their underwear while standing in order to check for STIs, and yelling things like: "You are garbage" at the sex worker.[136] But protests in front of the Ministry of Health and organizing by MODEMU, Movimiento de Mujeres Unidas, a Dominican sex worker union run by sex workers for sex workers, resulted in provision of quality care by a physician who only provided test results to the woman herself.[137]

In Ethiopia, a government survey in 1998 found HIV prevalence among sex workers to be almost 70%.[138] The Sister Self-Help organization reaches out with peer educators and community based counselors, serves as a social support network for sex workers and trains sex workers for occupations in sewing and hairdressing. But they say the reality is that sex workers cannot survive and feed their children on what they make in alternative employment. Still, the organization's project officer says that they have helped over 150 women to stop sex work.[139] They train partners and clients of sex workers, but they have found that sex workers will use condoms with clients, but not with their partners. The organization is the first association of sex workers for Ethiopia, but Sister Self Help does not espouse sex worker empowerment. Even though Sister Self-Help Organization does not advocate for sex worker rights, the organization does not currently receive U.S. funds.[140]

Part III

U.S. Policy and Comprehensive Sexual and Reproductive Health and Rights

CHANGE found a natural tendency on the ground to create comprehensive models of sexual and reproductive health care—many health practitioners and NGOs see these issues as inextricably connected and attempt to meet as many sexual and reproductive health needs as possible given resource constraints. Barriers to this model come from above in the form of national and donor laws, policies, bureaucratic divisions and low resources that interfere with comprehensive, rights-based approaches. Barriers also come from below, in the form of grassroots resistance to equal rights and popular misconceptions about sexuality and disease.

As mentioned above, U.S. policy has been out of step with many other donors when it comes to a comprehensive, rights-based approach to SRHR issues. In fact, U.S. policies and funding structures often pose significant obstacles to comprehensive models of care. While in the Dominican Republic and Ethiopia, the U.S. had provided funding to some of the most promising examples of comprehensive care, these models emerged because of each implementing organization's commitment to sexual and reproductive health and rights, and U.S. funding arose in recognition of their success and quality of approach. These models were not successful because of U.S. policy restrictions, but rather in spite of them.

CHANGE's research found several examples of policies that create barriers to comprehensive sexual and reproductive health and rights programming:

A. Funding Issues

> "Unless we do SRH, we will lose the battle of HIV"
>
> —***Argentina Matavel,***
> *UNFPA Representative,*
> *Gabarone, Botswana*

The size of the U.S. budget for PEPFAR dwarfs that of any other U.S. global health programming. While the large infusion of PEPFAR funding is critical to fighting the HIV/AIDS pandemic, and has brought many benefits to AIDS treatment, as has been reported elsewhere and was echoed by CHANGE's findings, overall health infrastructure has suffered. In Ethiopia, PEPFAR-funded programs pay two times government health salaries, causing a drain of doctors and other health care providers in other sectors.[141] As mentioned above, Ethiopia can ill afford loss of doctors in any one area, as it has a severe shortage of physicians. Although maternal mortality in Ethiopia is extremely high, the budget

for addressing these deaths does not approach the significance of the problem. One health advocate described a VCT and family planning program where providers received 45 days of training on VCT and five days on family planning.[142]

In Botswana, the large PEPFAR budget and lack of any USAID funding for reproductive health has created booming—but vertical—programming just on HIV. As a result, while there is a growing civil society movement on HIV and AIDS, there is little to no advocacy around reproductive rights.

Also, in several countries including the Dominican Republic, the U.S. has ended family planning funding. Because these countries have relatively high contraceptive prevalence and relatively low fertility rates, the U.S. has announced that these countries have "graduated." This has provoked concern, particularly in the Dominican Republic. Even though the country has a high contraceptive prevalence rate, much of this is sterilization due to limited method options in public health centers. Profamilia provides an alternative to public clinics and hospitals, and is particularly strong in providing youth services. They have received U.S. assistance for family planning, youth outreach, and HIV prevention, in addition to donated contraceptives. Anticipating graduation in 2008, Profamilia adapted by becoming more sustainable, yet this means charging for services, thus making them less accessible to poor people and youth. Leaders of other health NGOs and even some USAID officials expressed concern about the cut off in funding, worried about what this will mean for the organization and for low-income access to comprehensive sexual and reproductive health services.

The concern is higher because the Dominican government has shown little willingness to embrace comprehensive sexual and reproductive health and rights in its policies and budgeting. With the enormous influence of very conservative Catholic leaders on these issues, there is concern that the political will to keep Profamilia's model accessible to all women, regardless of income, will not exist. In an example of the government's conservative position on reproductive health, the Dominican Republic recently passed legislation that protects life beginning at conception within the constitution. It remains to be seen how this measure may be used to threaten distribution of some types of contraception. The danger is that the Dominican Republic will end up with a two-tier system: a rights-based, comprehensive system for those who can afford it and a low quality, non-integrated system for those without resources. This situation warrants close monitoring.

B. Funding Silos

> "The project has not achieved integration"
>
> — ***Dr. Jorge Blanco,*** *assistant director of Conecta, a USAID-funded project on family planning, maternal and child health, HIV and tuberculosis*

The U.S. government's funding silos are heavily laden with restrictions and inflexible funding mechanisms, making holistic, integrated approaches difficult. In fact, one respondent reported that these silos affect even condom distribution, as the U.S. separately tracks condoms for HIV prevention and condoms for family planning.

In the Dominican Republic, Family Health International developed and implemented the CONECTA project in a good faith effort to integrate approaches to HIV/AIDS, reproductive health, child survival and tuberculosis. Observers report that the project had a very good reputation in the country, funding some high quality interventions. However, because the funding for the project came from different parts of USAID, integration wasn't as successful as it could have been. In fact, the map of where each intervention was implemented shows that only in one province were all four interventions combined (see Annex 4). In six provinces, only one of the four interventions was implemented. Because USAID's priorities and bureaucratic processes are organized in these silos, integration of health interventions is problematic. Moreover, the next award that USAID is granting in these areas will again fully separate the interventions.

Fortunately, the USAID mission in Ethiopia champions integrated approaches to sexual and reproductive health. The mission has a bilateral MCH/FP program that integrates HIV using multiple funding streams. This has meant more work for USAID staff to overcome existing barriers, but they have fought for integration.[143]

An implementing organization in Ethiopia compared U.S. funding to the Dutch government's efforts, saying that most comprehensive approaches are funded not by the U.S., but by the Dutch or the European Union. The Dutch have funded a large project that not only works to provide comprehensive reproductive health care, but also creates the institutional linkages to support this programming into the future. Also, Dutch funding is more flexible, allowing a complete shift in activities to address community priorities.[144] In contrast, U.S. funding is laden with earmarks and restrictions from Washington that remove local discretion from funding decisions and limit alignment with European counterparts.

C. Global Gag Rule

> "The Mexico City Policy is not fair
> What you shouldn't do in the U.S., you shouldn't do here."
>
> — ***Ato Solomon Tadesse,*** *Director,*
> *Amhara Development Association, Ethiopia*

The Mexico City Policy, or Global Gag Rule, has been a significant barrier to client-based, comprehensive care. Several of the best and most experienced organizations that implement SRHR programs had refused to sign the gag rule because of a principled support of their clients' rights and adherence to public health standards. This includes the Family Guidance Association of Ethiopia, which conducts well regarded sex education with adolescents, trains midwives to attend births, and provides comprehensive reproductive health care including HIV testing. All of these services are critical in a country where maternal mortality, HIV prevalence, and adolescent pregnancy are extremely high.

Those who signed felt they could no longer provide important information to their clients, and even over-interpreted the rule to avoid problems. Technically, the GGR had exemptions for abortion in cases of rape, incest and the life of the mother—where abortion is legal under Ethiopian law. Therefore, NGOs should have been able to refer women—or even perform abortion with their own funds—in these cases. However, like NGOs around the world that signed the GGR, Ethiopian groups steered clear of any possible accusation of GGR violation. For example, the Amhara Development Association signed the GGR

to get U.S. funding, and a staff member commented that, "we are not referring those who need safe abortion—this is a big problem."[145] Given that over 30% of Ethiopia's high maternal mortality rate is due to unsafe abortion, this over-interpretation had a significant impact.

Some groups even interpreted the Gag Rule to prohibit work on post-abortion care, which was allowed under the policy.

Those who signed the Gag Rule had to remain silent even when government leaders sought information about abortion law reform. By silencing health advocates who work daily with women and know their health needs most intimately, the Gag Rule undermined democratic processes and deprived decision makers of essential information. In the Dominican Republic, Profamilia had signed the Gag Rule, and thus could say nothing about the impact of the country's complete prohibition on legal abortion on the high maternal mortality rate. Moreover, Colectiva Mujer, which did not receive U.S. funding due to the Gag Rule, was the only group that speaks out on the need for abortion law reform. The Gag Rule prevents their natural allies from collaborating with them, thus sapping the strength of a potentially significant civil society movement.

Fortunately for the women in these three countries and around the world, the GGR was overturned by President Obama in his first week in office. However, there is always a danger that a future U.S. president will reinstate it.

D. Abstinence-Until-Marriage/ABC

" 'Be faithful' is not enough."

— ***Irene Kwape,***
HIV counselor for BOCAIP,
Botswana

U.S. funding preferences for abstinence-until-marriage programs have also undermined comprehensive approaches. The current U.S. guidance on PEPFAR programs limits condom programming to youth 15 and over. In none of the three countries was this seen as a common sense restriction that addressed the needs of youth. Almost every youth program manager that CHANGE spoke to remarked that, while they tried to promote only abstinence, reality often dictated a less stringent approach to condom promotion.

In the Dominican Republic, the U.S. guidance sharply contrasts with the government's recent action to revise the age of reproduction from 15 to 10 due to the high number of pregnancies and STIs occurring in this age group. A doctor in one youth clinic talked about girls in his community who were already sexually active at age 12. However, because of U.S. funding, he reported that they only provide condoms to these girls if they admit being sexually active; otherwise they only teach abstinence.

Transactional and intergenerational sex was an important risk factor for HIV in all three countries, and the prevalence of child marriage in Ethiopia exacerbated this issue.

In Ethiopia, a 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."[146]

In Botswana, a U.S.-funded group was careful not to criticize restrictions on U.S. funding they received. But when asked how they would want things done differently in the future of PEPFAR, the youth responded unanimously that they would like the U.S. to fund all prevention methods equally—not just abstinence and fidelity. One youth leader who had recently begun receiving U.S. funding commented that the switch in funding made them "sacrifice our holistic program to meet our funder's demands."[147]

Young people, of course, are not the only ones affected by the ABC policy. An investigation by the Center for Public Integrity found that programs in Ethiopia targeting high-risk groups such as sex workers and truck drivers had limited funding because of the emphasis on "A" and "B". One program targeting a high-risk area of Ethiopia and neighboring Djibouti had to devote fully 80% of its prevention budget to abstinence and fidelity activities. According to this report, "In 2006, only $110,000 was allocated for condom programs for commercial sex workers and other high-risk groups such as truck drivers."[148]

E. Anti-Prostitution Loyalty Oath

> "We can't moralize sex work out of human nature; we need to make it safe."
>
> ***— Carol Squire,***
> *Former Acting Director, Marie Stopes International, Ethiopia*

The requirement that PEPFAR grantees have a policy against the practice and legalization of prostitution has had varied effects in the field. Some organizations sign the pledge and continue with their programs as before. Others interpret the policy as a prohibition against supporting sex workers, and either refuse to sign and turn down the money, or sign and stop outreach to sex workers. CHANGE found two organizations in Botswana who have ended their efforts with sex workers, despite the high risk of HIV transmission for this population. Although reduction in the extent of prostitution is the stated goal of the Anti-Prostitution Loyalty Oath (APLO), none of the advocates and service providers interviewed noted a reduction in sex work as a result of the U.S. policy.

F. Conclusion

Overall, responses to U.S. restrictions progressed from acceptance, to reluctant acceptance, to surreptitious disregard, to outright rejection. Many U.S.-funded groups are careful in what they report—particularly in terms of condom promotion for youth and programs with sex workers—for fear of losing funding. However, groups seemed to fear breaking the Global Gag Rule more than some of the other restrictions, since they tended to over-interpret the restriction (for example, by not providing abortion or abortion counseling for rape victims which was allowable under Mexico City Policy).

Part IV

Recommendations for U.S. Policy

During his inaugural address, President Obama made a bold pledge to remove policies and programs that don't work. The current structures and restrictions governing U.S. sexual and reproductive health programming clearly do not facilitate the comprehensive, rights-based approaches that are most successful in promoting global health and development. Unless the United States alters these policies, it will fall short of achieving its own development goals and those it has committed to in the form of the MDGs. More importantly, it will continue to lose opportunities to protect the life, health, and rights of women and girls worldwide.

Based on research and field inquiries, in order to align U.S. policy with health practitioners and government leaders in the rest of the world and generate full support for comprehensive, rights-based approaches to sexual and reproductive health care, CHANGE recommends the U.S. government do the following:

- **Affirm and recognize sexual and reproductive health rights of all people,** with special attention to women and youth, and ensure that U.S. ambassadors and missions support and promote comprehensive approaches to sexual and reproductive health and rights on the ground.

- **Rewrite the Foreign Assistance Act of 1961** to modernize our foreign assistance objectives to include gender equality and women's empowerment and human rights as principal goals; and to include a comprehensive sexual and reproductive health and rights framework within U.S. foreign assistance and programs.

- **Develop and issue joint guidance from the State Department, USAID and OGAC** for U.S. missions, ensuring family planning, maternal health and sexual health programs are integrated, reflect a comprehensive approach, and are informed by local realities. Issue guidance that allows U.S. funding to be used to save women's lives through safe abortion where legal.

- **Invest at least $1 billion in voluntary international family planning programs and services for FY 2011;** ensure that funding streams for family planning, maternal health and sexual health (including HIV/AIDS) receive robust funding with flexibility and guidance to allow integration of services on the ground.

- **Adopt a collaborative role for the U.S. in global affairs:** align U.S. foreign assistance with the ICPD Programme of Action and the Millennium Development Goals; pool resources with other donor governments where practicable; sign, ratify and incorporate into U.S. law key international treaties that recognize and promote sexual and reproductive health and rights, such as Convention for the Elimination of All Forms of Discrimination Against Women (CEDAW) and the Convention on the Rights of the Child (CRC).
- **Amend PEPFAR legislation to eliminate restrictions** such as the Anti-Prostitution Loyalty Oath, and end reporting requirements for abstinence, abstinence-until-marriage, and fidelity programs.
- **Introduce legislative measures** to ensure that policy restrictions such as the Global Gag Rule cannot be reintroduced to U.S. policy by future presidential administrations. Eliminate the Helms Amendment that bans U.S. funding for abortion services where legal.
- **Adopt a rights-based strategy for foreign assistance** to ensure that U.S. funded programs meet the sexual and reproductive health needs of women sex workers, women injecting drug users, women prisoners and those recently released back into communities.
- **Adopt modalities to ensure that U.S. funding goes directly to local, innovative, smaller grassroots organizations** that promote comprehensive sexual and reproductive health and rights and ensure that U.S. money gets in the hands of women's groups.
- **Strengthen health systems in developing countries to ensure integration** of sexual and reproductive health programs, promote rights-based approaches, and guarantee access to services and information, particularly for underserved users such as women in prisons, sex workers, and youth.

Notes

1. Loretta Ross, "Understanding Reproductive Justice," (SisterSong, 2006)–**www.sistersong.net/publications_and_articles/Understanding/RJ.pdf**

2. Marc Mitchell, Susannah Mayhew, and Irina Haivas. "Integration Revisited" (Millennium Project, 2004).

3. UN Millennium Project, *Public Choices, Private Decisions: Sexual and Reproductive Health and the Millennium Development Goals* (United Nations Development Program, 2006).

4. USAID Timeline–**www.usaid.gov/our_work/global_health/pop/timeline_b.pdf**

5. Amartya Sen, *Development as Freedom* (New York: Anchor Books, 1999).

6. Information on some of these meetings and agreements can be found here: ICPD in Cairo–**www.iisd.ca/Cairo.html**; Convention on the Rights of the Child–**www.unhchr.ch/html/menu3/b/k2crc.htm**; Fourth World Conference on Women, Beijing–**www.un.org/womenwatch/daw/beijing/**

7. Center for Reproductive Rights, *Bringing Rights to Bear: An Advocate's Guide to the Work of UN Treaty Monitoring Bodies on Reproductive and Sexual Rights* (CRR 2002).

8. ICPD Programme of Action, paragraph 8.25.

9. Fourth World Conference on Women Platform for Action, paragraph 106.

10. FWCW Platform for Action, paragraph 63(iii).

11. African Union Commission, "Continental Policy Framework for the Promotion of Sexual and Reproductive Health and Rights in Africa" (African Union, Gaborone, 2005).

12. Several documents have described the relationship between the Millennium Development Goals and sexual and reproductive health in detail. The most thorough examination is *Public Choices, Private Decisions: Sexual and Reproductive Health and the Millennium Development Goals* (UN Millennium Project 2006).

13. USAID and WHO, *Strategic Considerations for Strengthening the Linkages between Family Planning and HIV/AID Policies, Programs and Services: A Tool for Planning and Implementation* (USAID and WHO, forthcoming) 7.

14. Email correspondence between CHANGE staff and international donor staff and grant recipients, April 2009.

15. Center for Health and Gender Equity, *International Reproductive Health and Family Planning: U.S. Funding Priorities and Policy Implications* (Washington, DC: CHANGE, 2009).

16. CHANGE has documented the impact of U.S. policy restrictions on health and human rights elsewhere. Recent publications include *Making Foreign Assistance Work* (**www.genderhealth.org/pubs/foreignassistancereform.pdf**) and *Implications of U.S. Policy Restrictions for HIV Programs Aimed at Commercial Sex Workers* (**www.genderhealth.org/pubs/APLO.pdf**).

17. Eran Bendavid, MD and Jayanta Bhattacharya, "The President's Emergency Plan for AIDS Relief in Africa: An Evaluation of Outcomes," *Annals of Internal Medicine* Volume 50 Issue 10 (May 19, 2009).

18. Mitchell, Mayhew and Haivas, 7.

19. Ibid., 8.

20. WHO, UNFPA, IPPF, UNAIDS, and UCSF, "Sexual and Reproductive Health and HIV. Linkages: Evidence Review and Recommendations," 2008.

21. FWCW Platform for Action, paragraph 92.

22. World Health Organization, "World Health Statistics 2008" (Geneva, 2008) **www.who.int/whosis/database/core/cor_select.cfm**

23. United Nations Development Program, "2007/2008 Human Development Report; Data Sheet: Dominican Republic" (United Nations 2008).

24. UNDP and UNFPA, "Country programme for the Dominican Republic" (United Nations 2006).

25. As cited in Population Action International, "Access Denied: U.S. Restrictions on International Family Planning. Dominican Republic Case Study," **http://www.globalgagrule.org/country_dr3.htm**

26. S. Miller et al., Strategic Assessment of Reproductive Health in the Dominican Republic (New York: Population Council, 2002).

27. WHO 2008.

28. Miller et al. 2002: 49.

29. Centro de Estudios Sociales y Demograficos (CESDEM), United States Agency for International Development, COPRESIDA, World Bank, DERSS and Measure DHS, *Republica Dominicana: Encuesta Demografica y de Salud, 2007, Informe Preliminar* (Santo Domingo: Editorial Gente, 2007).

30. Interview of NGO staff by CHANGE, February 19, 2008.

31. Measure DHS 2002, *Dominican Republic: Standard DHS, 2002* **www.measuredhs.com/pubs/FR146/FR146.pdf**

32. Interview of NGO staff with CHANGE February 5, 2008.

33. Measure DHS 2007.

34. R. Goldberg, "Living Up to their Name: Profamilia Takes on Gender-based Violence," *Quality/Calidad/Qualite* (New York: Population Council, 2006).

35. PAHO and UNICEF, *Evaluación de la respuesta del sistema nacional de salud al VIH/SIDA en la REpublica Dominicana: Una herramienta política, gerencial y técnica para avanzar hacia el aceso universal* (Washington, DC: PAHO, May 2007) 29.

36. UNDP and UNFPA 2006.

37. Interview with U.S. official, February 4, 2008; interview with health center director, February 7, 2008.

38. Jill Gay, site visit and interviews with patients living with HIV, Clinica Evangelina Rodriguez (Profamilia) September 13 and 15, 2006.

39. Interview with Vivien Breche by Jill Gay. Clinica Evangelina Rodriguez (Profamilia) Santo Domingo, September 15, 2006.

40. Interview with NGO director, February 7, 2008.

41. Interview with U.S. official, February 4, 2008.

42. CHANGE researcher observation, February 9, 2008.

43. As quoted in Goldberg 2006.

44. Interview with NGO staff, February 7, 2008.

45. Interview with NGO staff, February 9, 2008.

46. Interview with NGO staff and tour of Profamilia facility, February 7, 2008.

47. Interview with NGO staff, February 7, 2008.

48. Interview with NGO staff, February 7, 2008.

49. D. Kirby, B. Laris and L. Rolleri "Sex and HIV Education Programs: Their Impact on Sexual Behaviors of Young People Throughout the World," Journal of Adolescent Health (40: 2007).

50. Interviews with program directors, February 2, 2008; February 7, 2008.

51. Interview with NGO staff, February 8, 2008; email communication with program director, February 9, 2009.

52. Interview with NGO staff, February 8, 2008.

53. Gisela Quiterio, M. Molina, M. Miric, R. Vernon and M.E. Rivero-Fuentes, *Situation Analysis of the Integration of Family Planning Services in Postpartum, Post-abortion and Prevention of Mother to Child Transmission Programs in the Dominican Republic.* (FRONTIERS in Reproductive Health: 2008).

54. Ibid. p20.

55. Miller et al. 2002: 2.

56. Interview with program director, February 8, 2008.

57. PAHO and UNICEF 2007: 61.

58. Breche 2006; Human Rights Watch, *A Test of Inequity: Discrimination against Women Living with HIV in the Dominican Republic* (Washington, DC: HRW, 2004).

59. Interview with program director, February 2, 2008.

60. UNICEF, *State of the World's Children 2005: Childhood Under Threat* (New York: United Nations: 2005).

61. UNICEF, *State of the World's Children,* 2000-2006.

62. Macro International, Trends in Demographic and Reproductive Health Indicators in Ethiopia (Macro International, 2007).

63. Interview with Catherine Hamlin, MD in *A Walk to Beautiful* (PBS, May 13, 2008).

64. Ministry of Health, Federal Democratic Republic of Ethiopia, *National Reproductive Health Strategy, 2006-2015* (Addis Ababa, March 2006).

65. Interview with government official, April 1, 2008.

66. Interview with program director, April 1, 2008.

67. Ethiopian Society of Obstetricians and Gynecologists 2008 as cited by Ipas: **www.ipas.org/countries/ethiopia.aspx**

68. H. Alemu, D. Mariam, K. Belay and G. Davey, "Factors Disposing Out of School Youth to HIV/AIDS-related Risky Sexual Behavior in Northwest Ethiopia," *Journal of Health, Population and Nutrition* (3:2007) 344-350.

69. WHO 2007.

70. Ministry of Health, Federal Democratic Republic of Ethiopia, "National Adolescent and Youth Reproductive Health Strategy, 2007-2015" (Addis Ababa: 2007).

71. Marina Walker Guevara, *Ethiopia Country Profile* (Center for Public Integrity, 2007) **http://projects.publicintegrity.org/aids/country.aspx?cc=et**

72. M. Rahman, T. Giday, M. Asknake and J. Wilder, *Enhanced Access to Reproductive Health and Family Planning: Pathfinder International in Ethiopia 2002-2007* (Watertown, MA: Pathfinder International, 2007).

73. Ministry of Health, Federal Democratic Republic of Ethiopia, "Standards on Youth Friendly Reproductive Health Services" (Addis Ababa: 2006) 10.

74. K. Hartwig, J. Pashman, E. Cherlin, M. Dale, M. Callaway, C. Czaplinski, E. Wood, Y Abebe, T. Dentry and E.H. Bradley. "Hospital Management in the Context of

Health Sector Reform: A Planning Model in Ethiopia" *International Journal of Health Planning and Management* (22:2007).

75. Hamlin in *A Walk to Beautiful,* 2008.

76. A. Creanga, H. Bradley, A Kidanu, Y. Melkamu and A. Tsui, "Does the Delivery of Integrated Family Planning and HIV/AIDS Services Influence Community-Based Workers' Client Loads in Ethiopia?" *Health Policy and Planning* (22:2007) 404-414.

77. Rahman et al. 2007.

78. Family Guidance Association of Ethiopia (FGAE), "FGAE @ 40" (Addis Ababa, 2007).

79. Interview with NGO staff, April 1, 2008.

80. PAI, "Access Denied," 2005.

81. Interview with program director, April 16, 2008.

82. Bradley et al. 2008.

83. Interview with program director, April 3, 2008.

84. Ibid.

85. Interview with NGO staff, April 4, 2008.

86. Interview with NGO staff, April 4, 2008.

87. Interview with program director, April 3, 2008.

88. Jennifer Wilder, "Ethiopia's Health Extension Project: Pathfinder International's Support 2003-2007," (Watertown, MA: Pathfinder International, 2008).

89. Interview with international donor, April 16, 2008.

90. World Health Organization, "WHO Multi-Country Study on Women's Health and Domestic Violence against Women," (Geneva: WHO, 2005).

91. Interview with program director, April 2, 2008.

92. Interview with program director, April 1, 2008; Interview with program director, April 2, 2008; Interview with program director, April 3, 2008; Interview with program director, April 16, 2008.

93. Interview with NGO staff, April 4, 2008.

94. UNICEF, *State of the World's Children* (New York: UNICEF, 2008) **www.unicef.org/sowc08/index.php**

95. M. Molla, Y. Berhane and B. Lindtjorn, "Traditional Values of Virginity and Sexual Behavior in Rural Ethiopian Youth: Results from a Cross-Sectional Study," *BMC Public Health 8* (9) 2008.

96. Interview with health worker, April 15, 2008; Interview with NGO staff, April 4, 2008.

97. As quoted in M. Lindelow and P. Serneels, "The Performance of Health Workers in Ethiopia: Results from Qualitative Research," *Social Science and Medicine* (62:2006) 2225-2235.

98. Y. Kitaw, D Mariam, A Desmissie, D Wolday, T Messele, E Aberra, T Belay and A Kassa, "Ethiopia" *The HIV Pandemic: Local and Global Implications* (New York: Oxford University Press, 2006) 198-214.

99. Interview with health worker, April 3, 2008.

100. WHO, World Health Statistics 2005.

101. K. Mogobe, W. Tshiamo and M. Bowelo, "Monitoring Maternal Mortality in Botswana," Reproductive Health Matters 15:30 (November 2007) 163-171.

102. Ibid.

103. World Bank, "GenderStats Database of Gender Statistics: Summary Gender Profile, Botswana" 2008.

104. M. Sabone, E. Ntsayagae, M. Brown, N. Seboni, K Mogove and M. Sebego, "Perceptions of Undergraduate Students Not Participating in HIV/AIDS Prevention Activities in Botswana" *International Council of Nurses* 2007, 332-336.

105. UNFPA, "Case Study: Botswana; Reproductive Health for Youth at the Workplace" (New York, May 1, 2003).

106. Physicians for Human Rights, *Epidemic of Inequality: Women's Rights and HIV/AIDS in Botswana & Swaziland* (Cambridge, MA: PHR, 2007).

107. N. Andersson, A Ho-Foster, S. Mitchell, E. Scheepers and S. Goldstein, "Risk Factors for Domestic Violence: National Cross-Sectional Household Surveys in Eight Southern African Countries" BMC Women's Health 7(11) 2007.

108. Interview with NGO staff, April 7, 2008.

109. UNAIDS 2006.

110. PHR 2007.

111. UNAIDS, "Government of Botswana Country Report, " December 2007.

112. PEPFAR, "Accountability: Report on PEPFAR Partnerships for Prevention, Treatment and Care" in *Celebrating Life: The U.S. President's Emergency Plan for AIDS Relief* (Washington, DC: OGAC, 2008).

113. PHR 2007.

114. Interview with international agency staff, April 9, 2008.

115. Interview with NGO staff, April 10, 2008.

116. Interview with NGO staff, April 9, 2008.

117. Interview with health advocate, April 8, 2008.

118. Interview with NGO staff, April 10, 2008.

119. African Youth Alliance, "Improving Health, Improving Lives" 2007–**www.ayanline.org**

120. Interview with NGO staff, April 11, 2008.

121. As quoted in PHR 2007.

122. PHR 2007.

123. Interview with NGO staff, April 11, 2008.

124. Interview with program director, April 8, 2008.

125. UNAIDS 2005, 16.

126. Interview with prison staff, February 5, 2008.

127. Ibid.

128. Ibid.

129. Interview with former prison staff, February 6, 2008.

130. CHANGE researcher observation, February 5, 2008.

131. Interview with NGO staff, April 8, 2008.

132. Sandra Garcia, Eileen Yam and Michelle Firestone, "No Party Hat, No Party," *Reproductive Health Matters* 28:2008) 53-62.

133. C.Barring, B. Gomez, H. Jerez, D. Kerrigan, L. Moreno, E. Roca, S. Rosario, J. van Dam, E. Weiss, "Combining Community Approaches and Government Policy to Prevent HIV Infection in the Dominican Republic," (Population Council, 2004).

134. Kerrigan 2001 as cited in Barring et al. 2004.

135. Interview with NGO staff, Februrary 9, 2008.

136. Interview with NGO staff, February 9, 2008.

137. Ibid.
138. Walker Guevara, "Helping and Hampering."
139. Interview with NGO staff, April 15, 2008.
140. Ibid.
141. Interview with program director, April 2, 2008.
142. Interview with independent researcher, April 14, 2008.
143. Interview with international donor, April 16, 2008.
144. Interview with program director, April 16, 2008.
145. Interview with health worker, April 4, 2008.
146. Interview with program directors, April 3, 2008.
147. Interview with youth leader, April 11, 2008.
148. Walker Guevara, "Helping and Hampering."

References

African Union Commission. "Continental Policy Framework for the Promotion of Sexual and Reproductive Health and Rights in Africa. Meeting of Experts, 10-12 October, 2005, Gaborone, Botswana.

African Youth Alliance (AYA). "Improving health, improving lives." 2007.–**www.ayaoline.org**

Alemu, H., D. Mariam, K. Belay and G. Davey.. "Factors disposing out-of-school youth to HIV/AIDS-related risky sexual behavior in Northwest Ethiopia." *Journal of Health, Population, and Nutrition* 3: 2007. 344-350.

Andersson, N., A. Ho-foster, S. Mitchell, E. Scheepers and S. Goldstein. "Risk factors for domestic violence: National Cross-sectional household surveys in eight southern African countries." *BMC Women's Health* 7 (11). 2007.

Barring, C., B. Gomez, H. Jerez, D. Kerrigan, L. Moreno, E. Roca, S. Rosario, J. van Dam, E. Weiss. *"Combining Community Approaches and Government Policy to Prevent HIV Infection in the Dominican Republic."* Population Council. 2004.

Bendavid, Eran, MD, and Jayanta Bhattacharya, MD, PhD. "The President's Emergency Plan for AIDS Relief in Africa: An evaluation of outcomes." *Annals of Internal Medicine;* Vol. 150 (10). May 19, 2009. Available at: **www.annals.org/cgi/content/full/0000605-200905190-00117v1**

Bradley, H., A. Bededa, A. Tsui, H. Brahmbhatt, D. Gillespie, and A. Kidanu. "HIV and family planning service integration and voluntary HIV counseling and testing client composition in Ethiopia." *AIDS Care 20* (1): 2008. 61-71.

Center for Health and Gender Equity. *Making U.S. Foreign Assistance Work: Sexual and Reproductive Health and Human Rights as Key to Global Development.* Washington, DC: Center for Health and Gender Equity. 2008.

Center for Health and Gender Equity. *International Reproductive Health and Family Planning: U.S. Funding Priorities and Policy Implications.* Washington, DC: Center for Health and Gender Equity. 2009.

Center for Reproductive Rights (CRR). *Bringing Rights to Bear: An Advocate's Guide to the Work of UN Treaty Monitoring Bodies on Reproductive and Sexual Rights*. 2002. Available at: **reproductiverights.org/sites/crr.civicactions.net/files/documents/pub_bp_BRB.pdf**

CESDEM (Centro de Estudios Sociales y Demograficos), USAID, COPRESIDA, Banco Mundial, DERSS, and MEASURE DHS. "Republica Dominicana: Encuesta Demografica y de Salud, 2007, Informe Preliminar." Santo Domingo Este, Republica Dominicana: Editorial Gente. 2007.

Creanga, A, H Bradley, A Kidanu, Y Melkamu and A Tsui. "Does the delivery of integrated family planning and HIV/AIDS services influence community-based workers' client loads in Ethiopia?" *Health Policy and Planning* 22: 2007. 404-414.

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

Fourth World Conference on Women. 1995. Platform for Action. Beijing, China: United Nations Fourth World Conference on Women. Available at: **www.un.org/womenwatch/daw/beijing/platform/**

Garcia, Sandra G., Eileen A. Yam, and Michelle Firestone. 2006. "No Party hat, no party": successful condom use in sex work in Mexico and the Dominican Republic. *Reproductive Health Matters* 28: 53-62.

Goldberg, R. 2006. "Living Up to their Name: Profamilia Takes on Gender-based Violence." *Quality/Calidad/Qualite* New York, NY: Population Council.

Guevara, Marina Walker. "Helping, and Hampering: Funds to combat HIV welcome in Ethiopia, but not the strings attached." November 30, 2006. The Center for Public Integrity. Accessed at: **projects.publicintegrity.org/aids/report.aspx?aid=801**, January 14, 2008.

Guevara, Marina Walker. 2007. Country Profile: Dominican Republic. In: Divine Intervention: U.S. AIDS Policy Abroad. Washington, DC: Center for Public Integrity. Accessed at: **projects.publicintegrity.org/aids/country.aspx?cc=et**

Hartwig, K., Pashman, J., Cherlin, E., Dale, M., Callaway, M., Czaplinski, C., Wood, E., Abebe, Y., Dentry, T., and Bradley, E.H. 2007. Hospital Management in the Context of Health Sector Reform: A Planning Model in Ethiopia. *International Journal of Health Planning and Management* 22: 1-16, 2007.

Hamlin, Catherine. March 2008. Interview by Mary Olive Smith and Amy Bucher, codirectors. "A Walk to Beautiful." WGBH Educational Foundation and Engel Entertainment, PBS. Accessed at: **www.pbs.org/wgbh/nova/beautiful/hamlin.html**

Human Rights Watch. *A Test of Inequity: Discrimination against Women Living with HIV in the Dominican Republic.* Washington, DC: HRW. 2004.

International Conference on Population and Development. Programme of Action. Cairo, Egypt: United Nations Conference on Population and Development. 1994. Available at: **www.un.org/popin/icpd/conference/offeng/poa.html**

IPAS. "Ethiopia." **www.ipas.org/countries/ethiopia.aspx**

Kirby, D., B. Laris, & L. Rolleri.. "Sex and HIV Education Programs: Their Impact on Sexual Behaviors of Young People Throughout the World." *Journal of Adolescent Health,* 40, 2007. 206-217.

Kitaw, , Y, D Mariam, A Desmissie, D Wolday, T Messele, E Aberra, T Belay and A Kassa.. "Ethiopia." *The HIV Pandemic: Local and Global Implications,* edited by E Beck, N Mays, A Whiteside and J Zuniga. (New York: Oxford University Press, 2006) 198-214.

Lindelow, M. and P. Serneels. "The performance of health workers in Ethiopia: Results from qualitative research." *Social Science and Medicine* 62: 2006. 2225-2235.

Macro International, Inc.. *Trends in demographic and reproductive health indicators in Ethiopia.* USA: Macro International Inc. 2007.

Measure DHS. "Dominican Republic: Standard DHS, 2002." Accessed at: **www.measuredhs.com/pubs/pdf/FR146/FR146.pdf**

Miller, S., A. Tejada, P. Murueytio, J. Diaz, R. Dabash, S. Bjegovi, and G. Caraballo. *Strategic Assessment of Reproductive Health in the Dominican Republic.* Santo Domingo, Dominican Republic: USAID, Secretaria de Salud Publica y Asistencia Social (SESPAS) and Population Council. 2002.

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

Ministry of Health, Federal Democratic Republic of Ethiopia. "National Reproductive Health Strategy, 2006-2015." March 2006.

Ministry of Health, Federal Democratic Republic of Ethiopia. "Standards on Youth Friendly Reproductive Health Services, Service Delivery Guideline and Minimum Services Delivery Package on YFRH Services." 2006.

Mitchell, Marc, Susannah Mayhew, and Irina Haivas. *Integration Revisited.* New York: United Nations Development Programme. 2004. Available at: **www.unmillenniumproject.org/documents/Mitchell_Mayhew_and_Haivas-final.pdf**

Mogobe, K., W. Tshiamo and M. Bowelo. "Monitoring Maternal Mortality in Botswana." *Reproductive Health Matters* 15 (30): November 2007. 163-171.

Molla M., Y. Berhane and B. Lindtjorn. "Traditional values of virginity and sexual behavior in rural Ethiopian youth: Results from a cross-sectional study." *BMC Public Health* 8 (9) 2008.

PAHO and UNICEF. "Evaluacion de la respuesta del sistema nacional de salud al VIH/SIDA en la Republica Dominicana: Una herramienta politica, gerencial y tecnica para avanzar hacia el aceso universal." Washington, DC: PAHO. May 2007.

PEPFAR (The United States President's Emergency Plan for AIDS Relief). "Accountability: Report on PEPFAR Partnerships for Prevention, Treatment and Care" in *Celebrating Life: The U.S. President's Emergency Plan for AIDS Relief* (Washington, DC: OGAC, 2008).

Physicians for Human Rights. Epidemic of Inequality: Women's Rights and HIV/AIDS in Botswana & Swaziland. Cambridge, MA: PHR. 2007. Available at: **physiciansforhumanrights.org/library/documents/reports/botswana-swaziland-report.pdf**

Population Action International (PAI), Planned Parenthood Federation of America (PPFA), International Planned Parenthood Federation (IPPF), Ipas, EngenderHealth, and Pathfinder International. *Access Denied.* 2005. Accessed at **www.globalgagrule.org/**

Quiterio, G., M. Molina, M. Miric, R. Vernon, and M. E. Rivero-Fuentes. "Situation Analysis of the Integration of Family Planning Services in Postpartum, Post-abortion and Prevention of Mother to Child Transmission Programs in the Dominican Republic." Dominican Republic: USAID and Population Council. 2008. Accessed at: **pdf.usaid.gov/pdf_docs/PNADL819.pdf**

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

Ross, Loretta. "Understanding Reproductive Justice." SisterSong Women of Color Reproductive Health Collective. 2006. Available at: **www.sistersong.net/publications_and_articles/Understanding_RJ.pdf**

Sabone, M., E. Ntsayagae, M. Brown, N. Seboni, K. Mogove and M. Sebego. "Perceptions of Undergraduate students not participating in HIV/AIDS prevention activities in Botswana." *International Council of Nurses* 2007. 332-336.

UNDP and UNFPA. Country programme for the Dominican Republic. Executive Board of the United Nations Development Programme and of the United Nations Population Fund. 2006. **www.unfpa.org/exbrd/2007/firstsession/dpfpa_dom_4_eng.pdf**

UNDP. 2007/2008 Human Development Report. Data Sheet: Dominican Republic. 2008. Accessed at **hdrstats.undp.org/countries/data_sheets/cty_ds_DOM.html**

UNICEF. "State of the World's Children 2005: Childhood Under Threat." New York, NY: UNICEF. 2005.Accessed at: **www.unicef.org/sowc05/english/index.html**

UNICEF. "State of the World's Children." New York, NY: UNICEF. Accessed at: **www.unicef.org/sowc/**

UNICEF. "State of the World's Children: Women and Children - Child Survival." New York, NY: UNICEF. 2008. Accessed at: **www.unicef.org/sowc08/index.php**

UN Millennium Project. Public Choices, Private Decisions: Sexual and Reproductive Health and the Millennium Development Goals. United Nations Development Programme. 2006. Available at: **www.unmillenniumproject.org/documents/MP_Sexual_Health_screen-final.pdf**

UNFPA. Case Study: Botswana: Reproductive Health for Youth at the Workplace, May 1, 2003, New York" UNFPA. 2003.

UNAIDS. Government of Botswana Country Report, December 2007. Progress Report of the National Response to the UNGASS Declaration of Commitment on HIV/AIDS. United Nations General Assembly Special Session on HIV/AIDS. 2008.

UNAIDS. Intensifying HIV prevention: a UNAIDS policy position paper. Geneva, Switzerland: UNAIDS. Accessed at: **data.unaids.org/publications/irc-pub06/jc1165-intensif_hiv-newstyle_en.pdf**. 2005.

USAID. "USAID Family Planning Timeline." Washington, DC: USAID Family Planning and Reproductive Health Program. Accessed at: **www.usaid.gov/our_work/global_health/pop/timeline_b.pdf**

USAID and WHO. *Strategic Considerations for Strengthening the Linkages between Family Planning and HIV/AIDS Policies, Programs, and Services: A Tool for Planning and Implementation.* Forthcoming.

Warriner, Ina K. and Iqbal H. Shah, ed. *Preventing Unsafe Abortion and its Consequences: Priorities for Research and Action.* New York, NY: Guttmacher Institute. 2006. Accessed at: **www.guttmacher.org/pubs/2006/07/10/PreventingUnsafeAbortion.pdf**

Wilder, Jennifer. Ethiopia's Health Extension Project: Pathfinder International's Support 2003-2007. USAID, Pathfinder International Ethiopia. 2008. Available at: **www.pathfind.org/site/DocServer/CBRHAs__HEWs_REVISED_REPRINT__2_.pdf?docID=11303**

World Bank. GenderStats. Database of Gender Statistics. Summary Gender Profile, Botswana. 2008. As accessed at: **devdata.worldbank.org/genderstats/genderRpt.asp?rpt=profile&cty=BWA,Botswana&hm=home**

World Health Organization.. "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. 2005.

World Health Organization. "World Health Statistics." 2005. Accessed at: **www.who.int/entity/whosis/whostat/whostat2005en.pdf**

World Health Organization. "World Health Statistics 2007." Geneva: WHO. 2007. Available at: **www.who.int/whosis/database/core/core_select_process.cfm**

World Health Organization. "World Health Statistics." Geneva: WHO. 2008. Available at: **www.who.int/whosis/database/core/core_select.cfm**

WHO/HIV, UNFPA, IPPF-HIV, UNAIDS, and UCSF. 2008. Linkages: Evidence Review and Recommendations. Final report available at: **www.unfpa.org/webdav/site/global/shared/documents/publications/2009/linkages_evidence_2009.pdf**

Annex 1

List of Institutions Visited

CHANGE is deeply grateful for all the individuals from the following institutions that met with CHANGE. All interviews were conducted in confidentiality, and the names of the interviewees are withheld by mutual consent.

Dominican Republic

Anajayo Mujeres
Asociación Dominicana de Planificación Familiar Inc. (ADOPLAFAM)
Centro Materno-Infantil San Lorenzo de los Minas
Centro de Salud Integral Dra. Evangelina Rodriguez (Profamilia)
Centro de Salud para Jóvenes
Centro de Promoción y Solidaridad Humana (CEPROSH)
Centro de Orientación e Investigación Integral (COIN, Santiago)
Centro Materno-Infantil San Lorenzo de los Minas
Colectiva Mujer y Salud (Monte Plata)
Dirección General de Materno Infentil y Adolescencia (DIGEMIA)
John Snow International/Deliver
Profamilia
Proyecto Conecta (Family Health International)
Consejo Nacional de Población y Familia (CONAPOFA)
Maternidad Alta Gracia
Movimiento de Mujeres Unidas (MODEMU)
Nacional Programa de Planificación Familiar y Viriato Acosta
Programa de Asistencia y Tratamiento del Sistema Penitenciaria
Secretaria de Salud Pública y Asistencia Social (SESPAS)
USAID

Botswana

Bomme Isago Association
Botswana Christian AIDS Intervention Program (BOCAIP)
Botswana Family Welfare Association (BOFWA)
Botswana National Youth Council
Botswana Network on Ethics, Law and HIV/AIDS (BONELA)
Botswana Network of People Living with AIDS (BONEPWA)
Botswana Rehabilitation and Crisis Centre
Botswana-USA (BOTUSA)
Centre of Youth of Hope (CEYOHO)
Family Health International

Botswana (continued)

International Community of Women Living with HIV and AIDS
Khumaga Support Group
Makgabaneng Radio Serial Drama
Ministry of Lands and Housing
Nkaikela Youth Project
Peace Corps (Volunteer)
Sekgoma Memorial Hospital
Sunshine Support Group
Tebelopele
UNFPA
Youth Health Organization (YOHO)

Ethiopia

Adama Hospital
Amhara Development Association (ADA)
Amhara Women's Association (Bahir Dar)
Bahir Dar Fistula Clinic
Bahir Dar Health Clinic
Bishoftu Zonat Hospital
CARE
Consortium of Reproductive Health Associations (CORHA)
Engenderhealth
Family Guidance Association of Ethiopia (Head Office and Addis Ababa Branch Clinic)
Federal Ministry of Health
Felege Hiwot Hospital (Bahir Dar)
HIV/AIDS Care and Support Project (Management Sciences for Health)
IntraHealth
Ipas
Marie Stopes International
National Committee on Harmful Traditional Practices
Organization for Rehabilitation and Development in Amhara (ORDA)
Pathfinder International
Royal Netherlands Embassy
Sister Self Help Organization
UNFPA
USAID

Annex 2

Country Statistics

	Botswana	Ethiopia	Dominican Republic
Population[1]	1.8 million	77 million	9-10 million
Gross National Income per capita[2]	11,730	630	5,550
% Population living on less than $1/day[3]	Not Available	23	2.8
Life Expectancy at Birth[4]	52	56	70
Government Health Spending (% budget)[5]	17.8%	10.6%	9.5%
Contraceptive Prevalence[6]	44.4%	14.7%	69.8%
Adolescent Fertility Rate[7]	51	109	118
Total Fertility[8]	3	5.4	2.9
Maternal Mortality Rate per 100,000 births	380[9]	720[10]	180[11]
Infant Mortality (per 1000 live births)[12]	90	77	25
HIV Prevalence, ages 15-49[13]	23.9%	2%	1.1%
Deaths due to HIV/AIDS (per 100,000 people per year)[14]	1,020	Not Available	75

[1] CIA 2007
[2] WHOSIS 2006
[3] WHOSIS 2000;2004
[4] World Health Organization, WHO Statistical Information System, 2008.
[5] WHOSIS 2006
[6] United Nations, "World Contraceptive Use 2007," New York, 2008
[7] WHOSIS 2001;2003
[8] WHOSIS 2006
[9] WHOSIS 2005
[10] UNICEF 2005
[11] UNDP 2005
[12] WHOSIS 2006
[13] UNAIDS 2008
[14] WHOSIS 2005

Annex 3: BONEPWA Contract

Botswana Network of
People Living with HIV and AIDS

P O Box 1599 • Mogoditshane • Botswana
Tel: (267) 306224
Plot 5306• Maratadibe Road/Shashe North Road •The Village

01st April 2008

P/O. Box

Dear Ms

On behalf of BONEPWA, I am pleased to offer you the post of Peer Mother. The terms and conditions of this assignment are as follows:

Reporting Office:	BONEPWA National Office, Gaborone, Botswana
Term of Contract:	100% of your time will be devoted to the "Expansion of Psycho-social support to HIV Pregnant mothers, their partners and families" project. Extension or early termination of this contract will be dependent upon employee performance and necessary funding.
Office Hours:	0730hrs - 1630hrs (1 hr lunch break from 1245hrs - 1345hrs)
Date of Start:	01st April 2008
Monthly Salary:	P700-00 per month
Base Operation:	Tawana Clinic, Letlhakane
Annual Leave:	You are entitled to 24 days of vacation annually, 12 compulsory days will be taken in December when BONEPWA closes office.
Termination:	Either party may terminate this agreement at any time by giving the other party 1 months notice in writing of their intention to do so.
Other terms:	As a Peer Mother/Male Peer you are expected to be a role model in the society therefore, you are not expected to a. Fall pregnant whilst you are an employee under the project b. To use, or come to work under the influence of alcohol, drugs and other substances

c. To engage in any other unbecoming behavior that may compromise the standards ofBONEPWA and the project

Failure to abide by the above mentioned will result in immediate dismissal from the project.

You will be under probation for two (2) months after which time you will be evaluated by the Site Facilitator in collaboration with the Project Officer and Sister in Charge to determine if your contract will be continued.

Job description: The employee will be guided by the annexed job description/terms of reference. The employee will be supervised by the Site Facilitator.

If you are in agreement with the terms of this letter, kindly indicate your acceptance by signing below.

Yours sincerely,

Tiny Boitumelo Nyawe
Project Officer

Accepted: [redacted] Date: [redacted]

Annex 4: Proyecto Conecta Map

Acronyms

ABC - Abstain, Be Faithful, Use Condom
ADA – Amhara Development Association
AIDS – Acquired Immunodeficiency Syndrome
ARV – Antiretroviral
CBHRA – Community Based Reproductive Health Agent
CHANGE – Center for Health and Gender Equity
DHS – Demographic and Health Survey
FGAE – Family Guidance Association of Ethiopia
FP- Family Planning
GBV – Gender-Based Violence
HEW – Health Extension Worker
HIV – Human Immunodeficiency Virus
ICPD – International Conference on Population and Development
MDG – Millennium Development Goal
NGO – Non-Governmental Organization
PAHO – Pan-American Health Organization (Regional Office of the World Health Organization)
PEP – Post-exposure Prophylaxis
PEPFAR – President's Emergency Plan For AIDS Relief
SRH – Sexual and Reproductive Health
SRHR – Sexual and Reproductive Health and Rights
STI – Sexually Transmitted Infection
UNAIDS – Joint United Nations Programme on HIV/AIDS
UNDP – United Nations Development Programme
UNFPA – United Nations Population Fund
UNICEF – United Nations Children's Fund
USAID – United States Agency for International Development
VCT – Voluntary Counseling and Testing
WHO – World Health Organization

About the Center For Health and Gender Equity

The Center for Health and Gender Equity (CHANGE) is a U.S.-based nongovernmental organization that seeks to ensure that U.S. international funding, policies and programs promote sexual and reproductive health and rights and gender equality by advocating for effective, evidence-based policies and increased funding for critical programs; and by holding the U.S. government accountable when policies and funding fail to uphold human rights or promote public health.

CHANGE believes that every individual has the right to basic information, technologies, and services necessary to enjoy a healthy and safe sexual and reproductive life free from coercion and preventable illness.

Center for Health and Gender Equity (CHANGE)
1317 F Street NW, Suite 400
Washington, DC 20004 USA
tel +1 (202) 393-5930 fax +1 (202) 393-5937
Email: change@genderhealth.org
www.genderhealth.org

This report was developed and published by the Center for Health and Gender Equity (CHANGE).

Please cite as:
Center for Health and Gender Equity. *Investing in Reproductive Justice for All: Toward a U.S. Foreign Policy on Comprehensive Sexual and Reproductive Health and Rights*. Washington, DC: Center for Health and Gender Equity, 2009.

© 2009 by Center for Health and Gender Equity. All rights reserved.