

Family Planning and Linkages with U.S. Health and Development Goals

A Trip Report of the CSIS Delegation to Ethiopia, February 2014



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Janet Fleischman and Alisha Kramer¹

Family planning is the smartest investment a government can make to reduce the financial burden on the family, to reduce complications of pregnancy and childbirth, to reduce maternal mortality. It has a huge impact on the overall development of the nation. Once a family decides on the number of children [it wants to have], then the children can go to school, have better nutrition, and women have more time, which brings economic returns.—Dr. Kesetebirhan Admasu, Minister of Health, Ethiopia (February 21, 2014)

Introduction

For decades, the United States has been the global leader in supporting voluntary family planning services around the world.² The benefits of family planning are numerous, not only for women’s health, but also for increasing child survival, nutrition, education, and economic development, as well as preventing mother-to-child transmission of HIV. For these reasons, family planning is a core component of sustainable development.

To examine the linkages between family planning and health and development outcomes, the CSIS Global Health Policy Center led a delegation to Ethiopia in February 2014. CSIS identified Ethiopia for the visit based on several factors: the Ethiopian government’s high-level commitment to family planning, the marked increase in Ethiopia’s contraceptive prevalence rate (CPR) in recent years, and the importance of U.S. health investments in the country. Much of Ethiopia’s progress in expanding family planning services stems from its innovative Health Extension

¹ Janet Fleischman is a senior associate with the CSIS Global Health Policy Center. Alisha Kramer is a program manager and research assistant with the CSIS Global Health Policy Center. The authors would like to acknowledge the support provided by the U.S. Embassy in Addis Ababa and the U.S. government agencies, especially the U.S. Agency for International Development, the Centers for Disease Control and Prevention, and the President’s Emergency Plan for AIDS Relief. We also gratefully acknowledge the assistance of the government of Ethiopia, including the Office of the First Lady and the Ministry of Health. We also would like to thank the Pathfinder International country team for their assistance in Tigray. Finally, we would like to thank the Ethiopian health extension workers, health providers, and community members who provided us with important insights and perspective.

² The FY2014 request for U.S. Global Health Funding for Global Family Planning/Reproductive Health is \$534 million. See Henry J. Kaiser Family Foundation, “U.S. Global Health Funding: Family Planning/Reproductive Health (FP/RH), FY2001–FY2014,” <http://kff.org/global-health-policy/slide/u-s-global-health-funding-global-family-planningreproductive-health-fprh/>.

Program, which led to the deployment of 38,000 health extension workers (HEWs)—largely young women—throughout the country to provide basic health services, including family planning. The Ethiopian experience of training and paying community health workers and implementing task shifting for family planning services holds important lessons for other countries.

While Ethiopia’s achievements in the health sector have been considerable, there are also stark social, economic, and political challenges. As the second-most populous country in Africa, with a population of 90 million projected to double by 2050³ and with maternal mortality remaining unacceptably high,⁴ the imperative to increase access to women’s health services and to address the unmet need for family planning is urgent.⁵ Reaching adolescents and young women remains a major challenge, especially given the continued high prevalence of child marriage.⁶ These challenges are compounded by the government’s marked suspicion of civil society and the private sector; the government is especially restrictive in areas related to democracy and human rights. These factors complicate efforts to build sustainable family planning programs. Accordingly, the delegation made it a priority to explore key questions surrounding the sustainability of these programs and plans for gradual transition from U.S. and other donor support to greater financial ownership by the Ethiopian government.

The CSIS delegation was composed of bipartisan staff from three congressional offices, representatives of the Bill & Melinda Gates Foundation and Hope Through Healing Hands (founded by former Senate Majority Leader Bill Frist), and staff from the CSIS Global Health Policy Center.⁷ This trip followed a series of other delegations that CSIS has led both to examine women’s health and U.S. global health policy in Africa. It builds upon a substantial body of work that CSIS has undertaken in the area of women’s global health over the past decade.

While support for international family planning has been a key feature of U.S. global health policy, family planning has often been seen as contentious by some

³ Population Reference Bureau, “2010 World Population Data Sheet,” <http://www.prb.org/Publications/Datasheets/2010/2010wpds>.

⁴ According to the UN Population Fund (UNFPA), maternal mortality in Ethiopia is estimated to be 350 per 100,000 live births, with estimates ranging from 210 to 630 per 100,000. See WHO, UNICEF, UNFPA, and The World Bank, *Trends in Maternal Mortality: 1990 to 2010* (Geneva: WHO, 2012), http://www.unfpa.org/webdav/site/global/shared/documents/publications/2012/Trends_in_maternal_mortality_A4-1.pdf.

⁵ The Ethiopian government has identified runaway population growth as a strategic threat that could undermine its goal of becoming a middle-income country by 2025.

⁶ In our interview with Minister of Health Kesenbirhan Admasu on February 21, 2014, he noted that the average age of marriage is 16.5. According to UNICEF, between 2002 and 2012, 16.3 percent of girls in Ethiopia were married by the age of 15, and 47 percent were married by the age of 18. See UNICEF, “Ethiopia: Statistics,” http://www.unicef.org/infobycountry/ethiopia_statistics.html. In the Amhara region, the Population Council has found that 59.9 percent of girls are married by the age of 18. See Tigest Tamrat and Annabel Erulkar, “Married Adolescents and Family Planning: A Decade of Research and Programs for Adolescent Girls in Ethiopia,” May 2013, http://www.wilsoncenter.org/sites/default/files/Mengistu_Meeting_Sexual_and_Reproductive_Health_Needs.pdf.

⁷ The members of the delegation were Ms. Gretchan Blum, Office of Senator Mark Kirk (R-IL); Ms. Kristin Dini Hernandez, Office of Representative Charles W. Dent (R-PA); Ms. Sara Nitz, Office of Representative Karen Bass (D-CA); Mr. Tom Walsh, senior program officer, Bill & Melinda Gates Foundation; Dr. Jennifer Dyer, executive director, Hope Through Healing Hands; Ms. Janet Fleischman, senior associate, CSIS Global Health Policy Center; and Ms. Alisha Kramer, program manager and research assistant, CSIS Global Health Policy Center.

policymakers and other influential actors, particularly those who oppose abortion and question whether the term “family planning” includes abortion. U.S. laws on foreign assistance clearly prohibit funding for abortion overseas.⁸ Increasingly, ever-wider audiences, including many parts of the faith community and many who oppose abortion, have recognized the important goals of voluntary family planning, including healthy timing and spacing of pregnancies.⁹ Nonetheless, there continues to be tension and debate about the merits of U.S. support to international family planning. One of the aims of the trip was to clarify and illuminate the value of family planning through an on-the-ground study of a dynamic national program.

U.S. Health and Development Investments in Ethiopia

The United States has a complex bilateral relationship with Ethiopia, which includes important investments in the country’s health and development programs, a significant peace and security relationship, and a complicated dialogue on democracy and human rights. On the health front, Ethiopia is a focus country for key U.S. government health initiatives, including the President’s Emergency Plan for AIDS Relief (PEPFAR) and the President’s Malaria Initiative (PMI).¹⁰ Ethiopia is also a major beneficiary of the Global Fund to Fight AIDS, Tuberculosis, and Malaria, to which the United States is the largest single donor. Given the Ethiopian government’s focus on family planning and maternal health in its own health strategy, the United States is also a strong partner in those areas. U.S. government assistance to health programs in Ethiopia is provided through multiple, separate funding streams and implementing partners.¹¹

⁸ The family planning and abortion restrictions included in the annual appropriations bills include: The *Helms Amendment*: No foreign assistance funds may be used to pay for the performance of abortion as a method of family planning or to motivate or coerce any person to practice abortions. The *Tiahrt Amendment*: Service providers or referral agents may not implement or be subject to numerical targets or quotas of total number of births, number of family planning acceptors, or acceptors of a particular family planning method; there may be no incentives, bribes, gratuities, or financial reward for family planning program personnel for achieving targets or quotas, or for individuals in exchange for becoming a family planning acceptor.

⁹ The U.S. Agency for International Development (USAID) requires that family planning programs comply with the principles of voluntarism and informed choice to ensure that women are free to choose whether to use family planning and if so, what method is most appropriate for her; if a woman chooses sterilization, she must provide written voluntary consent. See USAID, “Voluntarism and Informed Choice,” <http://www.usaid.gov/what-we-do/global-health/family-planning/voluntarism-and-informed-choice>.

¹⁰ For fiscal year 2013, 40 percent of USAID’s budget in Ethiopia was focused on health: \$37.1 million for maternal and child health (MCH), \$30 million for family planning/reproductive health (FP/RH), \$13 million for tuberculosis, \$7.2 million for nutrition, and \$43 million for malaria, totaling \$130.3 million. New PEPFAR funding under Country Operational Plan (COP) 2013 will total approximately \$271 million, including unexpended funds from previous fiscal years. This brings the U.S. health budget to \$401.3 million. Data from interviews with officials at the U.S. Embassy in Addis Ababa, Ethiopia.

¹¹ This ensures, for example, that U.S. HIV/AIDS funds are not used to purchase family planning commodities (other than condoms, which also protect against HIV transmission), in accordance with PEPFAR policy. According to PEPFAR’s COP Guidance for 2014: “As part of comprehensive care for HIV and AIDS, field teams are expected to prioritize opportunities to use PEPFAR funds to support voluntary family planning and reproductive health (FP/RH) services. These services must meet an HIV prevention, treatment, or care purpose and/or link PEPFAR-funded activities with FP/RH activities funded from separate U.S. government accounts or other non-U.S. government sources of funds. As in years past, PEPFAR funds may not be used to purchase family planning commodities; however, male and female condoms can be purchased using PEPFAR funds.” See President’s Emergency Plan for AIDS Relief

USAID in Ethiopia has focused on increasing utilization of family planning services through a number of approaches: building capacity of the health extension workers (HEWs) to integrate family planning into community health and HIV/AIDS services; supporting scale-up of long-acting family planning methods, like implants and intrauterine devices (IUDs),¹² through the HEWs; strengthening private clinics to provide family planning/reproductive health services; providing contraceptive commodities and strengthening the logistics system; and supporting the Ministry of Health to improve monitoring and evaluation of the demand, uptake, and quality of family planning services.¹³

USAID's flagship family planning program is the Integrated Family Health Program (IFHP), implemented by Pathfinder International and John Snow, Inc. IFHP is embedded in the public health system and provides technical assistance to the Ministry of Health and regional health bureaus in six of the country's eight regions. In particular, IFHP provides training to HEWs, midwives, and health care providers at health posts and health centers.¹⁴

The Centers for Disease Control and Prevention (CDC) in Ethiopia focuses on HIV, laboratory systems, and strategic information. To carry out its work on the Prevention of Mother-to-Child Transmission (PMTCT) of HIV, CDC uses its PEPFAR funding to strengthen health systems and health infrastructure. This includes offering family planning to HIV-infected women at the six-week postpartum visit, as part of "prong 2" of PMTCT, established by the World Health Organization.¹⁵

The Health Extension Program

In 2003, the government of Ethiopia launched its Health Extension Program (HEP), with the aim of making health services available and accessible to Ethiopia's rural populations. Ethiopia is a vast country, approximately twice the size of Texas, with mountainous terrain and remote villages that are sometimes inaccessible by roads or motorized vehicles. It is estimated that almost 84 percent of the country's population resides in these rural areas.¹⁶ In order to deliver preventive and basic curative services and to provide health education to these populations, the government of

(PEPFAR), "FY2014 Country Operational Plan (COP) Guidance," November 8, 2013, <http://www.pepfar.gov/documents/organization/217765.pdf>.

¹² In fiscal year 2013, the U.S. government procured over \$9.7 million in contraceptive commodities for Ethiopia, including male condoms, Depo Provera, Microgynon, Jadelle, Implanon, and Combined Oral Contraceptives.

¹³ USAID Ethiopia presentation on MNCH and RH/FP Program to CSIS delegation, February 17, 2014.

¹⁴ Other USAID programs that support family planning include: Maternal and Child Health Integrated Program (MCHIP), focusing on postpartum family planning and IUDs; Support for International Family Planning Organizations (SIFPO), which conducts social franchising of family planning services in private health facilities; and the Program Research for Strengthening Services (PROGRESS), which works with the government to increase capacity for monitoring and evaluation on family planning initiatives. See USAID, "Family Planning and Reproductive Health," October 2013, <http://www.usaid.gov/sites/default/files/documents/1860/Family%20Planning%20Reproductive%20Health%20Fact%20Sheet.pdf>.

¹⁵ Comprehensive PMTCT programs include a four-prong approach: prong 1, prevention of HIV among women of childbearing age; prong 2, prevention of unintended pregnancy among HIV-infected women; prong 3, prevention of transmission of HIV from women living with HIV to their infants; prong 4, treatment, care, and support for women living with HIV, their children, and their families.

¹⁶ The Central Statistics Agency, "Summary Report 2007 Census: Ethiopia," <http://www.ethiopianvision.com/2007Census.pdf>.

Ethiopia developed the HEP. The program was built on the widely used community health worker model—where members of the community work as volunteers and are provided some training to deliver basic health information and services—but with one key difference: health extension workers would be formally trained and paid as full-time government workers.

The HEP was an ambitious plan that called for a rapid scale-up of infrastructure in the form of health posts, human resources created through the training of HEWs, and education and awareness in order to increase demand for services within the communities. The impetus for the HEP came from high levels of the Ethiopian government—especially then-health minister (now foreign minister) Tedros Adhanom Ghebreyesus and including then-prime minister Meles Zenawi. The current government has continued the commitment to this program. There were many skeptics at the outset, but the government was able to deliver 16,000 health posts—a massive increase from the 76 health posts that existed in 1996—and over 38,000 health extension workers (35,000 rural and 3,000 urban) that were trained for one year and then assigned to health posts in their home communities.¹⁷

Each health post serves a population of about 5,000 and has two HEWs, who alternate between providing health services, hosting educational sessions at the health post, and going out into the communities for house-to-house visits. The HEWs, mostly young women with a 10th-grade education, deliver a package of health services that includes hygiene and environmental sanitation, disease prevention and control, family health services, and health education. Family planning services are provided along with other family health services, such as maternal and child health, adolescent reproductive health, and immunization, as well as for HIV and TB.¹⁸

The HEP has created a critical platform for advancing health and development in rural communities. Within the span of a decade, CPR doubled and the government of Ethiopia achieved UN Millennium Development Goal 4 to reduce under-five child mortality by two-thirds by 2015.¹⁹ The HEP has played an important role in achieving these successes, but long-term sustainability of the program is not guaranteed. Retention of health care providers, continued training and career advancement, and increasing costs related to rising demand for commodities and equipment are serious challenges.

Family Planning at the Health Post

HEWs provide a method mix of short- and long-acting family planning methods. Women can obtain birth control pills and condoms, but the majority of women (estimated at 75 percent) currently opt for injectable contraceptives and long-acting

¹⁷ David J. Olson and Andrew Piller, “Ethiopia: An Emerging Family Planning Success Story,” *Studies in Family Planning* 2013 44, no 4. (December 2013): 445–59.

¹⁸ Nejmuudin Kedir Bilal et al., “Health Extension Workers in Ethiopia: Improved Access and Coverage for the Rural Poor,” in *Yes Africa Can: Success Stories from a Dynamic Continent*, ed. Punam Chuhan-Pole and Manka Angwafo (Washington, DC: World Bank, 2011), 433–43, http://siteresources.worldbank.org/AFRICAEXT/Resources/258643-1271798012256/YAC_Consolidated_Web.pdf.

¹⁹ Sarah Crowe, “In Ethiopia, a far-reaching health worker program has helped reduce child mortality across the country,” UNICEF, September 16, 2013, http://www.unicef.org/infobycountry/ethiopia_70372.html.

methods such as contraceptive implants (estimated at 15–20 percent).²⁰ It is only recently that women were able to access these long-acting contraceptive services at the health post level. As part of the initial program, the HEWs were trained to administer injectable contraceptives, and in 2009, the government started training HEWs in the insertion of Implanon implants.²¹ This example of task shifting is one of the most important contributions of the HEP. Women still must travel to higher-level health centers for IUD insertion and implant removal, and to hospitals for tubal ligation, but the opportunity to get injectables, combined oral contraceptives, condoms, and implants at the health post level has had a significant impact. Largely as a result of the HEP, contraceptive prevalence increased from 15 percent in 2005 to 29 percent in 2011.²² An evaluation in 2013 by IFHP found that the modern contraceptive prevalence rate had risen to 39.1 percent in 2013.²³

At a rural health post in Gemad Kebele in the Tigray region, the delegation saw firsthand the changes brought about by the health extension program, as well as the ongoing challenges. Mihret, a HEW at Gemad Health Post, described the progress she has seen in women accessing family planning methods. More women are seeking family planning services. Of these, the majority choose injectables though demand for implants is on the rise for those who want to space their children three years or more apart.

Mihret’s own story illustrates both the barriers that girls face in Ethiopia as well as the changes that have occurred in recent years. When she was almost 11 years old in grade 3, her family arranged for her to be married to a man more than twice her age. Although she was allowed to stay in school until grade 8, she became pregnant and had her first child when she was 17 years old. Mihret managed to go back to school until grade 10, after which she underwent training to become a HEW. She told the delegation that she enjoyed helping the community, noting: “My work involves the health of women and children, and I’ve seen changes.” Mihret’s reflections on the important changes that Ethiopia has undergone in recent years track with what the delegation learned about the improved health outcomes from family planning. In particular, family planning has contributed to the decline in total fertility rates in Ethiopia, from 5.5 in 2000 to 4.8 in 2011, with fertility rates in urban areas falling to 2.6 in 2011.²⁴

²⁰ Health providers interviewed by the delegation indicated that most Ethiopian women prefer family planning methods like injectable contraceptives (depo provera), because one shot lasts for three months, and some find it important that the injectable is discreet, meaning that husbands, partners, or mothers-in-law do not need to know. Increasingly, women are choosing contraceptive implants (Implanon or Jadelle), which last three to five years. These long-acting methods reduce the time that women have to spend traveling to a health facility and the frequency of their visits.

²¹ Olson and Piller, “Ethiopia: An Emerging Family Planning Success Story.”

²² Pathfinder International, “Contraceptive Use in Ethiopia Doubles Twice in Ten Years,” December 1, 2011, <http://www.pathfind.org/news/Contraceptive-Use-in-Ethiopia-Doubles-Twice-in-Ten-Years.html>.

²³ Pathfinder International and John Snow Inc., “Integrated Family Health Program (IFHP): Household Survey Report on Baseline-Endline Comparison of Key Outcome Indicators in Program Areas,” USAID Addis Ababa, January 2014.

²⁴ Central Statistical Agency (Ethiopia) and ICF International, *Ethiopia Demographic and Health Survey 2011* (Addis Ababa: Central Statistical Agency, March 2012), <http://dhsprogram.com/pubs/pdf/FR255/FR255.pdf>.

Challenges

Reaching Young Women and Adolescent Girls

The highest unmet need for family planning is among married and unmarried adolescents ages 15 to 19, which according to the 2011 Ethiopia Demographic and Health Survey (DHS) was estimated to be 33 percent of the population. The government of Ethiopia has made it a priority to reach adolescent girls with a range of services, but significant social, cultural, and religious barriers remain. Despite a law that prohibits child marriage before the age of 18, many rural families arrange for their daughters to be married at young ages to much older men, and both the husbands and their families expect the girls to give birth soon after marriage. This often leads to poor health and development outcomes for the girl and her children; marriage makes it difficult for the girl to stay in school and continue her education, and early pregnancy can lead to severe health complications such as obstetric fistula. Youth-friendly health services, available in some health centers, are important where they exist, but are not sufficient to address these needs.

To reach this population of young women will require not only expanding information, access to services, and a mix of contraceptive commodity choices, but also supporting programs focused on behavior change and reaching “gatekeepers” in the communities. This means engaging men and boys, religious and community leaders, and others who exert control over the lives of young women, such as mothers-in-laws.

Integration of Family Planning with Other Health and Development Programs

Many opportunities exist to integrate family planning into other program activities, ranging from maternal and child health services, to HIV/AIDS and PMTCT programs, to economic empowerment and agricultural outreach programs, to education at the primary, secondary, and tertiary levels. Integration can help ensure that all opportunities are taken to address a woman’s health more comprehensively, such as addressing the family planning needs of a woman living with HIV as part of her HIV care. The goal of integration is to ensure that all of the health needs of the individual are addressed when she accesses health services. Ethiopia provides important examples of the impact of promoting integration in the health sector, especially through IFHP’s work with the health extension workers and other health providers.

Ultimately, integration often means a more efficient and effective use of U.S. government assistance; however, given the separate funding streams that come from the United States, the Global Fund, and other donors, integration requires understanding where the funding comes from and whether that funding includes any restrictions on its use. The complexity of U.S.—and international—funding mechanisms and their real or perceived restrictions can be a major barrier to successful program integration.

Private-sector Engagement

Government restrictions on the private sector and nongovernmental organizations (NGOs) have resulted in a very limited space where such entities can operate. This is evident in the family planning arena, where opportunities are limited for the private sector and NGOs to provide family planning services. To meet Ethiopia's family planning goals and make the program sustainable, it will be important to shift wealthier women away from the free, public-sector services to private providers.²⁵ This strategy of market segmentation and cost recovery from clients who would be able to pay modest sums for family planning commodities can offset costs for public-sector commodity procurement and help build more sustainable cost-sharing schemes for family planning services.

Government restrictions are especially apparent in the effect of the Charities and Societies law. In 2009, the Ethiopian government passed the Charities and Societies Proclamation (draft law) to register and regulate civil society organizations (CSOs). The CSO law, overseen by the Charities and Societies Agency, restricts civil society's ability to work on areas related to human rights and advocacy. According to the law, organizations classified as Ethiopian charities can engage in some advocacy work; however, they cannot receive more than 10 percent of funding from foreign sources.²⁶ This law has had a direct impact on NGOs working in Ethiopia and thus been a limiting factor for access to health services.

The CSO law further requires that 70 percent of an organization's expenses go toward programmatic activities, while administrative costs are limited to 30 percent of total costs. The Ethiopian government justifies these restrictions by citing the need to reduce programs' overhead costs, such as salaries and office space, for organizations operating in the country. However, the definition for what are considered administrative versus operational costs has proven problematic for many organizations, including those working on women's health and family planning. In particular, activities related to technical assistance, training/capacity building, and monitoring and evaluation are all considered administrative costs under the act. Accordingly, organizations providing these services have been compelled to cut them back to keep administrative costs under 30 percent of total costs, again reducing availability of services to Ethiopians.

Gender Disparities

Ethiopia remains a male-dominated society. This manifests in gender-related disparities in social, cultural, economic, and political spheres. Harmful traditional practices, including child marriage and female genital mutilation/cutting (FGM/C), remain important challenges to women's and girls' health and rights. Although the

²⁵ Karlan Jankowski et al., *Ethiopia: Family Planning Market Analysis: Using Evidence on Demand and Use for Contraception to Plan for a Total Market Approach in Ethiopia* (Washington, DC: USAID, June 2013), xii, http://deliver.jsi.com/dlvr_content/resources/allpubs/countryreports/ET_FamiPlanMark.pdf.

²⁶ The CSO law defines three types of charity organizations: (1) Ethiopian charities, with at least 90 percent of funding generated locally; (2) Ethiopian residents charities, with less than 90 percent of funding generated locally; and (3) foreign charities based outside of Ethiopia. Only Ethiopian Charities Organizations are allowed to engage in some rights and advocacy-related works. See Christian Relief and Development Associations (CRDA) Ethiopia, "Charities and Societies Proclamation," [http://www.crdaethiopia.org/Documents/Charities%20and%20Societies%20Legislation%20\(3rd%20Version\).pdf](http://www.crdaethiopia.org/Documents/Charities%20and%20Societies%20Legislation%20(3rd%20Version).pdf).

age of marriage is legally 18, and FGM/C is illegal, government enforcement of these laws remains very weak.²⁷ Maternal mortality in Ethiopia remains high, due to the low percentage of women who deliver at health facilities. The 2011 DHS survey put the national rate for facility deliveries at 10 percent.²⁸ More recent data suggests that the national average has increased to 20 percent,²⁹ although estimates suggest facility rates as high as 39 percent in some of the U.S. government-supported areas.³⁰

Gender inequalities also are apparent in education. Although in recent years young girls' enrollment in primary schools has increased sharply, many drop out before or during secondary school, when the family deems that household chores, marriage, or pregnancy should take priority. Even if a girl is able to continue her schooling through secondary school, household chores, child care, and lack of support from the family often prevent her from studying. Many girls are therefore unprepared to pass the national exam after grade 10 that would allow them to continue to university education. Female participation in universities is increasing steadily but from an extremely low baseline. Even those that make it to university face a range of social pressures, including sexual assault and harassment and unintended pregnancy, that often result in adverse health outcomes and undermine their academic performance.

These and other factors result in barriers to women's access to economic empowerment and resources. Women often work in agriculture, but they are rarely able to access the agricultural inputs that could help improve their crop yields. In government, civil servants are overwhelmingly male, and at the national level, out of 22 ministry officials, only two are women.³¹

Sustainability and Transition

The Ethiopian government has demonstrated strong country ownership for its health program, increasing its allocation of domestic resources, as well as the budget line for family planning. However, the health budget is still heavily reliant on external donors, including the United States, with the government estimating that 50 percent of the health budget comes from external resources.³² Even though the government pays the salaries of the HEWs, for example, the long-term sustainability of the program will require increasing domestic resources as well as continued donor support.

The government also will have to examine the broader sustainability of the health extension program. The HEWs with whom the delegation spoke were eager to increase their training and to acquire new skills. The government has outlined a plan for HEWs to receive higher degree levels and increased pay, but it will be critical to

²⁷ U.S. State Department Bureau of Democracy, Human Rights and Labor, "Country Reports on Human Rights Practices for 2013," <http://www.state.gov/j/drl/rls/hrrpt/humanrightsreport/index.htm#wrapper>.

²⁸ The 2011 DHS cites institutional deliveries at 4 percent among women in rural areas compared to 50 percent among women in urban areas, but the national average is 10 percent. See Central Statistical Agency (Ethiopia) and ICF International, *Ethiopia Demographic and Health Survey 2011*.

²⁹ Health Sector Development Program (HSDP), "HSDP IV Mid-term Review (MTR)," slide presentation, Addis Ababa, May 17, 2013.

³⁰ Draft IFHP Endline Survey obtained through e-mail message to authors. The endline report is still in draft form at the writing of this paper.

³¹ Ethiopian Government Portal, "Ministries and Agencies," April 2014, <http://www.ethiopia.gov.et/ministries-and-agencies>.

³² Federal Democratic Republic of Ethiopia Ministry of Health, "Ethiopia's Fifth National Health Accounts, 2010/2011," April 2014, 18.

recruit new HEWs so that a continuous cycle of hiring, growth, and career advancement is maintained.

In the family planning sphere, there are similar concerns about sustainability, especially since the government provides family planning free of charge throughout the country. Addressing the unmet need for family planning and expanding the contraceptive prevalence rate will require an ever-increasing supply of commodities. The Ethiopian government has an ambitious goal to increase contraceptive prevalence to 66 percent by 2015, from the current level of 28.6 percent.³³ Dr. Kesetebirhan Admasu, the minister of health, has already acknowledged the need to fill a 50 percent gap in domestic funding for family planning commodities.³⁴ In the delegation's meeting with the minister, he cited the looming issue of rising costs associated with rising demand for commodities. He said the government anticipates that 2 million implants will be inserted over the next three years at a cost of \$24 million. Currently, 20 percent of family planning commodities are supplied by the United States.

Globally, the U.S. government has emphasized the importance of transitioning health programs toward greater country ownership and program management. In addition to the gradual reduction of PEPFAR funding and transition of HIV/AIDS to Ethiopian government control, the next five-year round of funding for the IFHP includes a goal to “graduate” 50 percent of the *woredas* (districts) during that time period. The Global Fund will also be looking to reduce Ethiopia's share of funding as it implements a new allocation-based funding model that seeks to push more funding to countries with higher disease burdens. Given this changing donor landscape, it will be critical for USAID to work closely with the Ethiopian Ministry of Health, regional health bureaus, the Global Fund, and U.S. government implementing partners to develop clear criteria for and mechanisms to reach eventual graduation. Where there are more affluent populations that are able to pay for family planning services, plans for transition should include market segmentation to expand opportunities for social franchising and cost recovery in family planning programs. Family planning also should be included in the government's new social and community health insurance schemes. Ultimately, transition should be gradual, with an emphasis on long-term sustainability that preserves recent health gains and ensures the necessary monitoring and support going forward.

Engaging the Faith Community

Ethiopia has a strong religious tradition, with the majority of the population belonging to the Eastern Orthodox Church (estimated at 43.5 percent), as well as a substantial Muslim population (estimated at 33.9 percent) and Protestant denominations (18.6 percent).³⁵ Faith leaders are very influential in shaping social norms in Ethiopia. Increasingly, many religious leaders are educating their followers about the dangers of harmful traditional practices, such as early marriage, the importance of healthy

³³ Central Statistical Agency (Ethiopia) and ICF International, *Ethiopia Demographic and Health Survey 2011*.

³⁴ Kesetebirhan Admasu, “Africa: Be Bold, Do Not Shy Away—Girls and Women Have the Right to Access Family Planning Services,” AllAfrica.com, October 22, 2013, <http://allafrica.com/stories/201310221394.html>.

³⁵ Central Intelligence Agency, *The World Factbook*, “Ethiopia,” March 27, 2014, <https://www.cia.gov/library/publications/the-world-factbook/geos/et.html>.

timing and spacing of pregnancies, and HIV prevention and treatment. Although modern methods of contraception remain a sensitive topic for some religious leaders, the efforts by religious scholars, nongovernmental organizations, and even the government have helped address some of their family planning questions.

As one Orthodox priest told the delegation, “Unknowingly, people say family planning is a sin. What is a sin is if you can’t feed your children or send them to school.” He continued: “From experience, we see that in families with limited children, they grow up well...women are physically stronger with spaced births.”³⁶

An example of an initiative to reach out to Orthodox priests about a range of important health issues was called the Development Bible. A project supported by external donors and the Orthodox Church, the Development Bible brings messages about health and development, including HIV and reproductive health, into training materials for priests. Important opportunities exist to further engage with religious scholars and religious leaders to advance information about the value of family planning for their communities.

Policy Options

Family planning is critical to advancing women’s and children’s health, as healthy timing and spacing of pregnancies reduces key health risks to both mother and child; it is also central to achieving broader U.S. goals in health and development. Ethiopia’s innovative HEP provides important lessons for other countries working to expand access to family planning and other basic health services. The United States should work with other interested countries to help adapt Ethiopia’s model for their own context, and how to sustainably scale up and finance such programs.

The findings of our bipartisan delegation underscore the importance of continuing U.S. global leadership on the basis of clearly defined terms, shared goals, and evidence of impact. New opportunities for integrating family planning with other health and development priorities should be actively pursued and operationalized. In the current U.S. political environment, the challenge will be to expand areas of bipartisan common ground around family planning, to cultivate new champions across the political spectrum, and to advance linkages between family planning and other health and development goals. Ultimately, a woman’s ability to time and space her pregnancies is directly linked to her ability to access economic empowerment opportunities, to educate and feed her children, and to keep herself and her family healthy—all goals that command wide support in the United States.

The Obama administration and the U.S. Congress should use upcoming opportunities in 2014 to demonstrate the U.S. commitment to prioritizing family planning as an integral component of women’s and girls’ health and development in U.S. policy. This means emphasizing the substantial and concrete impact that family planning can have on maternal health, child survival, and HIV/AIDS, as well as youth, food security, economic development, and education programs. The White House should take the lead to ensure that family planning is integrated across U.S. government health and

³⁶ Keshi Gebre Tsadkan, meeting with the CSIS delegation, Wukro, Ethiopia, February 18, 2014.

development programs, and is prioritized by each relevant U.S. government agency. Important upcoming opportunities include:

- At the African Leaders Summit in early August 2014, President Obama should ensure that women's and girls' health and development issues, including access to family planning, are an explicit part of the high-level discussions about youth, economic growth, and development in Africa.
- Secretary of State John Kerry should elevate the importance of family planning for women's and girls' health and empowerment as part of U.S. diplomatic, development, and security strategies. This includes:
 - engaging with the African Union leadership to include women's and girls' health and family planning as part of the next African Union summit in June 2014;
 - publicly recognizing that women's and girls' health and access to family planning are an essential part of the response to gender-based violence and post-rape care, and that access to family planning services should be one of the metrics by which success is measured;
 - supporting the inclusion of family planning targets and indicators in the post-2015 development agenda.

The U.S. Congress should engage on a bipartisan basis to examine the impact of family planning to inform policy decision-making on U.S. global health and development.

- Congress should host a series of briefings to educate members and staff on what family planning is, its health impact for women and children, and how family planning plays a key role in achieving other U.S. health and development goals (such as reducing child mortality, increasing food security, and promoting gender equality). These briefings create opportunities to hear from experts from countries where the United States has family planning investments, including programs with linkages to other health and development areas.
- Congress should prioritize resources for international family planning programs as well as for linkages between family planning and other health and development programs, such as maternal and child health, HIV/AIDS, gender equity and women's economic empowerment, humanitarian responses, and food security. This should include mechanisms to monitor progress and impact.

Opportunities in the U.S.-Ethiopia bilateral dialogue on health and development:

- USAID, CDC, PEPFAR, and the Global Fund should promote sustainability of their investments in health and development programs in Ethiopia. This means U.S. agencies should work closely with the Ethiopian Ministry of Health, Ministry of Finance, regional health bureaus, and U.S. government implementing partners to develop clear criteria for and mechanisms to move toward greater national sustainability. Plans being developed for eventual transition to greater Ethiopian government funding should include positive

recognition of progress and assurances that programs successfully initiated with U.S. assistance are sustained financially and programmatically.

- The U.S. government should support the work of a range of civil society, private-sector, and religious organizations in Ethiopia to advance women's health and development. The United States should continue to raise concerns about restrictions placed on these activities by the Ethiopian government, since participation by these groups will help increase access to and sustainability of family planning and other health and development programs for women and girls.



The Ethiopian government's efforts to increase access to family planning through the Health Extension Program is unique and offers important lessons for other countries. Despite multiple enduring challenges, Ethiopia has made measurable progress in advancing family planning information and services. The United States has made important and targeted contributions to this program, which have been integral to its success. Through sustained effort, Ethiopia has the opportunity to further expand the benefits of family planning to advance women's and children's health, as well as to reach broader health and development goals.

Appendix: Delegation Agenda

Delegation Members

Ms. Gretchan Blum, Legislative Aide, Office of Senator Mark Kirk (R-IL)

Dr. Jennifer Dyer, Executive Director, Hope through Healing Hands

Ms. Janet Fleischman, Senior Associate, CSIS Global Health Policy Center

Ms. Kristin Dini Hernandez, Legislative Director, Office of Representative Charles Dent (R-PA)

Ms. Alisha Kramer, Program Manager and Research Assistant, CSIS Global Health Policy Center

Ms. Sara Nitz, Legislative Assistant, Office of Representative Karen Bass (D-CA)

Mr. Tom Walsh, Senior Program Officer, Bill & Melinda Gates Foundation

Monday, February 17: Addis Ababa

Meeting with the First Lady of Ethiopia, Ms. Roman Tesfaye

Working Lunch: Ethiopia Scene Setter

Mr. Haddis D. Tadesse, Country Representative, Bill & Melinda Gates Foundation

Meeting with Peace Corps and Peace Corps Volunteers (PCV)

Mr. Daniel R. Baker, Director of Programing and Training

Ms. Helen Jones, third year health PCV

Ms. Laura Still, third year health PCV

Working Dinner: U.S. Investments in Family Planning and Health in Ethiopia

Dr. Nwando Diallo, Deputy Country Director, CDC

Dr. Carmela Green-Abate, Coordinator, PEPFAR

Dr. Jeff Hansen, Country Director, CDC

Mr. Joshua Karnes, Health Team Lead, USAID

Tuesday, February 18: Tigray Province and Mekelle

Site Visit: Gemad Health Post, Gemad Kebele

Ms. Mihret Gebrehiwot, Health Extension Worker

Meeting with Pathfinder International: the Integrated Family Health Program (IFHP)

Dr. Mengistu Asnake, Chief of Party, IFHP; Country Representative, Pathfinder International

Mr. Awala Equar, Regional Program Manager, IFHP

Meeting with Religious Leader

Keshi Gebre Tsadkan, Christian Orthodox Priest

Meeting with Religious Leaders, St. Frumentius Abba Selama Kessate, Berhan Theological College

Mr. Tesfaye Hadera, Dean

Mr. Mekonnen Tesfay, Vice Dean

Mr. Assefa Reda'e, Bible for Development Coordinator

Wednesday, February 19: Tigray Province and Mekelle

Site Visit: Agulae Health Center

Mr. Tirete Zeleke, Director

Working Lunch: Addressing Young Women's Health and Education in Universities

Ms. Senait Gebreegziabher, Gender Office Head, Mekelle University

Thursday, February 20: Addis Ababa

Working breakfast: Engagement of the Faith Community in Ethiopia in Women's Health Issues

Dr. Samson Hailegiorgis, public health expert and theologian

Site Visit: Gandhi Memorial Hospital

Working Lunch: Implementing Family Planning Programs—Partner's View

Population Council—Annabel Erulkar, Country Director

CARE—Esther Watts, Program Director

Last 10 Kilometers—Wuleta Betemariam, Project Director

JHPIEGO—Hannah Gibson, Country Director

FHI360—Francis Okello, Deputy Country Director

Marie Stopes International—Nils Gade, Country Director

Working Dinner: Donor Perspectives

UK Government—Kassa Mohammed, Health Advisor for DFID Ethiopia

Dutch Government—Bouwe-Jan Smeding, First Secretary Health

David & Lucile Packard Foundation—Yemeserach Belayneh, Ethiopia Country Adviser

UNFPA—Sabine Beckmann, Program Coordinator

Friday, February 21: Addis Ababa

Meeting with Reuben Brigety, U.S. Ambassador to the African Union

Meeting with Patricia M. Haslach, U.S. Ambassador to Ethiopia; and officials from USAID, CDC, and PEPFAR

Meeting with Minister of Health, Dr. Ketemariam Admasu

Working Dinner CSIS Delegation Internal Debrief



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