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MINISTRY OF HEALTH

NATIONAL REPRODUCTIVE HEALTH STRATEGY

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LIST OF ABBREVIATIONS

ART	Antiretroviral Therapy
ARV	Antiretroviral
CBOs	Community Based Organizations
CSWs	Commercial Sex Workers
DHS	Demographic Health Survey
EmOC	Emergency Obstetric Care
EPHA	Ethiopian Public Health Association
ESOG	Ethiopian Society of Obstetricians and Gynecologists
FGAE	Family Guidance Association of Ethiopia
FGC	Female genital cutting
FHD	Family Health Department
FHI	Family Health International
FP	Family Planning
HAPCO	HIV/AIDS Prevention and Control Office
HEWs	Health Extension Workers
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HMIS	Management Information Systems
HSEP	Health Services Extension Package
HTP	Harmful Traditional Practice
ICPD	International Conference on Population and Development
IDP	Internally displaced people
IEC/BCC	Information Education and Communication/Behavioral Change Communication
HSDP	Health Sector Development Program
MCH	Mother and Child Health
MDGs	Millennium Development Goals
MOFED	Ministry of Finance and Economic Development
MOH	Ministry of Health
MYSC	Ministry of Youth, Sports and Culture
NCTPE	National Committee on Traditional Practice in Ethiopia
NGO	Nongovernmental Organization
PAC	Post Abortion Care
PLWHA	People Living With HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission
RH	Reproductive Health
STIs	Sexually Transmitted Infections
TB	Tuberculosis
TBA	Traditional Birth Attendant
TFR	Total Fertility Rate
UNAIDS	United Nations Programme of HIV/AIDS
UNFPA	United Nations Fund for Population Activities
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
YRH	Young People's Reproductive Health
WHO	World Health Organization

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This National Reproductive Health Strategy is the product of countless hours of consultations with a wide range of stakeholders at both the national and central levels. It is firmly grounded in the input of national-level experts, Regional Health Bureau (RHB) representatives, program managers and implementers, community members, non-governmental organizations (NGOs), and other members of the RH community. The Ministry of Health (MOH) is grateful to all those who participated in the consultations, and it hopes that such broad-based participation, support, and ownership continues throughout the Strategy's implementation process.

The MOH would also like to thank the Population Council for providing technical assistance throughout the strategy development process and for producing this important document. Special thanks are due to the members of the RH Task Force, particularly to members of the Coordinating Committee and working groups established to assist in the formulation of the National RH Strategy.

The MOH would like to acknowledge the financial and technical support of the UNFPA Field Office, and all individuals and institutions that contributed towards the successful preparation of the National RH Strategy for the country.

PREFACE (To be re-written by Dr. Tedros)

The Government of Ethiopia is committed to improving the reproductive health (RH) status of women, men and young people in this country. This Strategy reaffirms that commitment by setting forth a targeted and measurable agenda for the next decade.

The National RH Strategy builds on a number of notable initiatives undertaken to serve the health needs of all Ethiopians. Included among these is the 1993-health policy, which was followed by formulation of a comprehensive Health Sector Development Program (HSDP) in 1998, and the recent Health Services Extension Package (HSEP). As a vehicle for the implementation of the health policy, HSDP is a long-term strategic framework based on principles and concepts of the Sector Wide Approach. The HSEP is an innovative community-based approach directed at creating a healthy environment as well as healthful living by introducing a health extension service.

In this regard, the vision of the Government can only become a reality if the implementation process remains consensual, flexible, gradual and participatory. The development of the National RH Strategy builds on the existing health policy, HSDP, and the HSEP, while at the same time seeking to enhance the effectiveness of the health system in meeting the targets of the Millennium Development Goals (MDGs).

The National RH Strategy is the outcome of a continuous consultative process involving relevant governmental agencies, NGOs, stakeholders at the central and regional level, and community members across the country. As identified in these consultations, the National RH Strategy addresses a set of critical issues that are outlined in the four sections of this document. The first section addresses the Ethiopian context and the RH situation; the second deals with key RH outcomes and strategies for addressing them; while the third and fourth address the broader systemic issues and the key steps that will be required to transform strategic recommendations in to concrete actions.

At this juncture, it is important to emphasize that the National RH Strategy will require a logical, stepped implementation plan. Such a plan will help address the identified actions to achieve an optimum RH for all Ethiopians. The complimentary role of NGOs, donors and other stakeholders will be very useful not only in the preparation of the implementation plan, but also in participation of actual execution of activities.

Finally, on behalf of the Ministry of Health, I would like to take this opportunity to express my gratitude to all partners for their continued support in this endeavor. I also appeal to all of you to use this National RH Strategy as a guiding tool in your future activities.

Dr. Tedros Adhanom
Minister of Health

EXECUTIVE SUMMARY

This document is the culmination of a vision, formulated nearly seven years ago during a national assessment of reproductive health (RH) needs. Sponsored by the Ministry of Health and undertaken in collaboration with representatives of the RH community, the *Ethiopia RH Assessment* called upon the health community to identify RH needs and priorities; achieve consensus on the appropriate scope of RH services; and ultimately, "to coordinate the development of a national RH strategy".

Programmatically, this Strategy reflects three overriding priorities. It supports the nation's commitment to achieving the Millennium Development Goals (MDGs) by 2015; it responds to the socioeconomic and demographic realities that shape RH generally; and it reflects the notable advances realized in the health sector over the past decade. These objectives are subsumed within the Strategy's overall goal statement, which is to:

Build on the momentum occasioned by the Millennium Development Goals to garner the multisectoral support needed to meet the reproductive and sexual health needs of our culturally diverse population - one characterized by its youthfulness, geographic dispersion, conjugality, and persisting gender inequalities.

Guided by a national Coordinating Committee, the process of strategy formulation has been both thorough and exhaustive. It has included countless consultations with stakeholders at both the national and central levels, extensive literature reviews; the compilation of region-specific technical briefs, and the preparation of this report.

The contents of this report are organized into four major sections. The first section describes the social and institutional context influencing the RH of women and men in Ethiopia today. The discussion looks at poverty, perhaps the biggest single factor to undermine health and well-being. It also looks at the national educational system, the legal environment, and the sociocultural status of women. Lastly, there is a description of the national health care system, including the new Health Services Extension Program (HSEP), which seeks to make essential health care universally available through the a package of preventive, promotional, minimum curative and rehabilitative services.

The second section of the document forms the core of the National RH Strategy. Separate chapters address each of the following six priority health issues: the social and cultural determinants of women's reproductive health; fertility and family planning; maternal and newborn health; HIV/AIDS; RH of young people; and reproductive organ cancers. Each chapter begins with a narrative summary of the relevant health issue, drawing on published data as well as the concerns and opinions of health professionals, stakeholders in the RH community, and the general public. The summaries include three levels of analysis: the "community", which comprises the broader social and cultural context of each health issue; the "system", which looks at opportunities arising from the delivery of health care services; and "policy", which examines the institutional and normative frameworks within which decisions are made.

Guided by this summary statement, each chapter then turns to the formulation of a goal, the identification of realistic strategies for achieving that goal, and the specification of measurable, achievable, reasonable, time-bound targets by which progress towards the goals can be gauged. Each chapter concludes with a series of key actions deemed critical to achieving those targets.

Although the content of each chapter focuses on a single RH outcome, the strategies within them follow a common set of core principles or approaches. One approach prioritizes the role of household and community through awareness creation; local ownership; and the articulation of RH concerns with the broader social, economic and legal system. Another approach seeks better integration across the health sector and increasing efficiencies to better reach underserved populations. Integration plays an especially critical role since many of the traditional RH divisions already possess national strategy documents in one form or another. Rather than duplicate such efforts or offer watered-down alternatives, this strategy looks to build bridges and maximize the potential exploiting new synergies.

The third approach guiding strategy formulation is the desire to mainstream RH and ensure its place in the national development agenda. In this connection, the Strategy calls for greater advocacy and information - both to the community at large and to authorities who can influence opinion, change behavior, and deliver scarce resources.

Building capacity and utilizing scarce human resources constitutes the fourth core approach of this document. Many recommendations, for example, seek the introduction of activities for which staff straining is arguably inadequate. A recurrent theme throughout this Strategy, therefore, is the call for better training, more flexible training, and a training that balances rewards with the expectations and responsibilities new skill holders.

The final approach guiding strategy formulation is the need to respond to the demographic, cultural, geographic diversity that makes up Ethiopia today. Diversity is the hallmark of Ethiopian society and the present Strategy confronts this reality head-on. It encompasses, for example, new approaches to address the needs of rural populations. It takes into account the RH needs of aging populations, through increased efforts at cancer screening and prevention. And it calls for new approaches to the old rubric of “adolescent RH”, approaches that are needs-driven and segmented by age, marital status, and sex.

These five approaches, therefore, lie at the heart of the second section. They inform the identification of targets and activities; and they provide a level of consistency evident at each step in the transition from priority to strategy to target to actions.

To achieve the goals set forth in this Strategy, a coordinated and multisectoral effort will be required on the part of all relevant stakeholders, including a wide range of government agencies, NGOs, donors, and the private sector. The third section of this document, therefore, focuses on the programmatic prerequisites to a seamless and complete realization of this Strategy. Drawing on the findings from the third phase of the Health Sector Development Program (HSDP III), and on consultations at both the regional and central levels, this section focuses on the four elements. These include the need to prioritize RH at all levels; the responsiveness of program interventions to diverse social and cultural contexts; human resource development and capacity building; and lastly, HMIS, M&E, and Research. Each of these themes is discussed in detail and presented with a series of recommendations for action over the coming decade and a half.

Although this document represents the culmination of a long and exhaustive exercise, it remains nonetheless only the first step in a wider process that will see the strategy's activities and recommendations translate into concrete programs and initiatives. Arriving at this point will require a coordinated effort by the RH community, with the MOH occupying a special role as the Strategy's institutional home as well as operational lead.

The last section of this document, therefore, charts a path forward. It defines the role of the Ministry and partner agencies; it outlines the formulation of a costing and implementation plan and it describes a course of action that will see the Strategy's targets and recommendations translate into concrete programs and initiatives.

INTRODUCTION

The definition of reproductive health (RH) adopted at the 1994 International Conference on Population and Development (ICPD) represented a major step forward in current thinking about human sexuality and reproduction. Whereas previous views had revolved around demographic goals and programmatic targets, ICPD placed people's needs at center stage. Not only did it extend the domain of RH beyond the years of reproduction, it situated it within a broader socio-cultural context that included gender roles, respect and protection of human rights.

Widely accepted by governments and their development partners, this holistic approach has provided a useful framework for understanding the complexity of RH needs and the multiple factors that give rise to them. But it has also, because of its breadth and inclusiveness, made operationalizing RH concerns all the more difficult. As early as 1997, the government of Ethiopia began addressing these issues, conducting a national RH Needs Assessment to guide the country's implementation of the new RH paradigm (WHO, 1999). The assessment called for national and regional exercises to identify RH needs and priorities; craft a consensus on the appropriate scope of RH services; and develop strategies for the implementation of such interventions. Ultimately, it recommended that the MOH "coordinate the development of a national RH strategy…[and] reactivate the National RH Task Force" to assist in drafting that document (WHO 1999: 64).

The National RH Task Force, chaired by the MOH, has remained the driving force behind the development of a National RH Strategy - one that formulates a vision for the coming years and sets an agenda for achieving that vision as effectively as possible. Guided by a national Coordinating Committee established specifically for that purpose, the process of strategy formulation has been thorough and extensive. It has included ongoing consultations with senior technical experts, as well as extensive interviews with planners, community leaders, educators and other stakeholders from every walk of life, in every one of Ethiopia's eleven regions. It has included exhaustive literature reviews; the compilation of region-specific technical briefs; and the preparation of technical reports, detailing each stage of the strategy formulation process.

The National RH Strategy detailed in the following pages reflects three overriding priorities for the government of Ethiopia and the RH community more broadly. The first is the nation's commitment to achieving the Millennium Development Goals (MDGs), a framework for measuring progress towards sustainable development and eliminating poverty. Of the eight goals, three – improving maternal health, promoting gender equality, and combating HIV/AIDS stand at the core of the present strategy document. They do so because they encompass, directly or indirectly, the full spectrum of concerns identified by stakeholders during the strategy formulation process. They also provide an entry point to address variables and indicators that effectively cross-cut the entire domain of RH – issues such as fertility, gender, age of first birth, contraceptive prevalence, method choice, traditional practices, literacy and other factors with direct implications for the health of men and women throughout their lifecycles.

The second priority is the need to respond to the socioeconomic and demographic realities of Ethiopia today. Although "inclusion" remains a hallmark of the RH concept, the reality is that nearly 80 percent of Ethiopians live in rural areas; 60% are under the age of 20; nearly all are married by the age of 18; and few will ever reach their 55th birthday. The contents of this strategy, therefore, do not seek to exhaust the full range of activities theoretically subsumed under the rubric of reproductive and sexual health. It is, instead, a road map – one with a clear view of the journey's end; and one that reflects the cultural, socio-demographic, and political terrain that defines Ethiopia today.

The third priority is to build on the notable advances realized in the health sector over the past decade. As this document reveals, the last ten years have seen a decentralization of the health system, coupled with significant improvements in key health indicators such as contraceptive prevalence, total fertility, maternal mortality, nutritional status, and immunization. It has also been a period of considerable learning. Critical assessments and technical reviews have broadened our understanding of unmet health needs, weaknesses in the service delivery system, and many of the possible solutions available to tackle them.

If the past decade is any indication of what is to come, then the future certainly allows for much optimism. As noted previously, the year 2015 will mark nearly two decades of commitment to the new concept of reproductive health. It will be the culmination of a worldwide effort to meet the ambitious targets set forth in the MDGs, and it will conclude nearly 20 years of international support for our Health Sector Development Program (HSDP). It will also represent a critical vantage point from which to reflect upon the achievements of the new Health Services Extension Program (HSEP).

This Strategy, therefore, is guided by a goal that balances these three priorities. It highlights the role of the MDGs as a catalyst in identifying key health outcomes to be achieved over the coming decade and recognizes the environmental realities that will ultimately determine the most effective and efficacious paths to that end. It also builds on efforts by the African Union to help member states achieve the MDGs relating to maternal and newborn health. This *Road Map to Accelerate the Reduction of Maternal and Newborn Mortality in Africa* has been endorsed by the AU and signed by the Government of Ethiopia and other member states and is fully incorporated in this document.

Goal

Build on the momentum occasioned by the Millennium Development Goals to garner the multisectoral support needed to meet the reproductive and sexual health needs of our culturally diverse population - one characterized by its youthfulness, geographic dispersion, conjugality, and persisting gender inequalities.

SECTION I: REPRODUCTIVE HEALTH ENVIRONMENT

RH is a comprehensive concept that implies a broad range of health and non-health related interventions. Reflecting this holistic understanding, this section provides an overview of the larger social and institutional contexts that influence RH in Ethiopia, and it highlights the ways in which those conditions affect the RH status of women and men in the country.

Poverty

One of the most important factors influencing the RH status of Ethiopians is poverty. Ethiopia is one of the poorest countries in the world, with an estimated GNP per capita income of US$100 (World Bank, 2004: i). Even though the poverty head count in Ethiopia was reported to have declined marginally from 45.5% in 1995 to 44.2% in 2000, the absolute number of people living in poverty has increased steadily (World Bank, 2004: i). Today it is estimated that 47 percent of the population still lives below the poverty line (MOH, 2005a: 3).

To address this problem, the government has pursued a program of comprehensive economic reforms that has focussed on improving the social and economic infrastructure. This program has begun to show encouraging results, and over the past ten years, budgetary allocations for the health sector have risen from approximately 3% in 1996 to 6% in 2005 (MOH 2005a: 4). These increases are supported by fiscal decentralization and broad reforms in the administration and management of public finance.

Education

Numerous studies have shown that investments in education, particularly for women, lead to better child health, lower fertility and reduced maternal mortality. For that reason, the success of the RH initiatives outlined in this strategy relies heavily on ensuring high levels of awareness and education among the population at large. This is a notable challenge for a country like Ethiopia, where only 18.5 percent of women and 39.6 percent of men are literate (CSA and ORC Macro, 2001: 22).

Recognizing all Ethiopians' right to basic education, the government has endorsed several international instruments, such as the Convention of Rights of the Child and MDGs, which work towards ensuring gender parity in universal primary education. Ethiopia has made enormous strides towards meeting these commitments by increasing primary school enrolment three-fold over the past decade. The gross enrolment ratio in primary school reached 79% in 2004/05 (MOFED, 2005: 77). But important challenges still remain if the country is to achieve its ambitious goal of providing eight years of primary education for all, three years more than required under the MDGs. To do this, the country will not only have to provide for the existing backlog of children currently out of school, but it must also make accommodations for an estimated 19 million more school-aged children by the year 2015 (FDRE, 2004a: 2). Meeting this goal will require overcoming social and systemic challenges including: high attrition rates of teachers; poor quality of teachers; undeveloped institutions and infrastructure; shortage of adult literacy and education programs; and the overall lack of a supportive environment for educational attainment, particularly for girls.

Legal Environment

The 1994 Constitution grants all Ethiopians the right to public health services. The National Health Policy further refines the government's vision of, and commitment to, a more democratic and decentralized health system. The National Population Policy also sets forth broad conditions for improving social welfare, with a goal of harmonizing the rate of population growth and the country's capacity for development and rational utilization of resources. National penal and civil codes address issues more specifically related to patients' rights, abortion, rights within marriage, and rights to physical integrity. Harmful traditional practices (HTP) are discouraged in the Health Policy and in the 1994 Constitution, which guarantees women "… the right to protection by the state from harmful customs. Laws and practices that oppress women or cause bodily or mental harm to them are prohibited." (FDRE, 1994: Article 35). The new Penal Code has taken concrete measures to address HTPs. Abduction has been classified as a serious crime. Acts that bring about marriage before the age of 18 warrant criminal prosecutions against the perpetrators. Finally, detailed provisions have been included on crimes related to female genital cutting (FGC), perinatal harmful practices and domestic violence (FDRE, 2005: Articles 561 to 570).

While the Government of Ethiopia has adopted numerous laws and policies that advance women's social and reproductive rights, and is party to international instruments guaranteeing such rights, the implementation of these protections is constrained by low implementation capacity, low awareness among the general public and especially women.

Status of Women

The low status of women in Ethiopia underpins, and often directly undermines each of the negative RH outcomes addressed in this Strategy. Most Ethiopian women lack the reproductive and social self-determination needed to exercise their reproductive rights – a condition that, in turn, perpetuates their low RH and social status. Basic indicators clearly demonstrate the disadvantaged position of women within Ethiopian society. Women are half as likely to be literate as their male counterparts, 30 percent less likely to be employed, and marry on average, seven years earlier (CSA and ORC Macro, 2001: 22, 24-26, 77). Despite a biological tendency towards higher survival rates, girl children are 4 percent more likely to die during infancy than boys (NCTPE, 2003: 39). Between 60 and 80 percent of Ethiopian women have experienced some form of FGC, a practice with potentially severe health consequences.

Health care system

Primary responsibility for the delivery of health care services has traditionally rested with the public sector, and it has been estimated that nearly two thirds of all health care services are provided through government-owned facilities. In the last five years (2000-5), the number of public sector health facilities has risen dramatically: from 110 to 131 hospitals; from 382 to 600 health centers; and from 1,023 to 4,211 health posts. Over the same period, 2,393 health stations were either down-graded to health posts or up-graded to health centers (MOH 2005b: 3)

In recent years the role of the private sector has been growing, so that today facilities managed by non-governmental organizations, private for-profit clinics, traditional practitioners and rural drug vendors together make up about one third of all service provision.

This sector has been most influential in the area of family planning (FP), where NGOs and the national social marketing program have generated about a quarter of the total couple years of protection.

The main objective of public sector service provision, as stated in the National Health Policy is "to give comprehensive and integrated primary health care services in a decentralized and equitable fashion." This is built on the devolution of power to regional and *woreda* level governments, as well as on the meaningful participation of the population in local development. The policy also emphasizes the integration of RH/FP services in the health care system and inter-sectoral collaboration, particularly in the formulation and implementation of appropriate strategies to improve nutrition and provide safe and adequate water for urban and rural populations.

To ensure the delivery of primary health services throughout the country, the health care delivery system is being reorganized from a six- to a four-tiered system. This new system includes: (i) primary health care units (PHCU) comprising health centers and five satellite health posts designed to serve 25,000 people, (ii) district hospitals that give comprehensive care and training to catchments populations of 250,000 people; (iii) zonal hospitals providing services in the four basic specialities to 1,000,000 people and clinical training for nurses; and (iv) specialized hospitals that provide sub-specialist care and clinical training.

Recent assessments have identified systemic shortcomings that hamper the delivery of all health services, but especially those pertaining to RH , particularly in remote areas. To address these issues, the government is reinforcing the HSDP with a strong community-based component centered around the Health Services Extension Program (HSEP). The HSEP will make essential health care universally available through a package of preventive, promotive, minimum curative and rehabilitative services provided by Health Extension Workers (HEWs). Frequently described as a "flagship program", the HSEP includes four major components: i) Family Health, ii) Disease Prevention and Control, iii) Personal Hygiene and Environmental Health, and iv) Health Education and First Aid. Another critical issue is he accelerated expansion of health centers that mainly focus on curative services, especially emergency obstetric care (EmOC). Through effective implementation of HSEP, which constitutes the PHCU at the community level, the government intends to deploy two health extension workers (HEW) per *kebele* (5,000 population) by 2008.

SECTION II: STRATEGIES TO ADDRESS KEY REPRODUCTIVE HEALTH OUTCOMES

This section forms the core of the National RH Strategy. Outlining the strategic approach for improving RH in Ethiopia, it develops goals, strategies, targets, and key actions for each of the individual elements of RH addressed in this Strategy.

The six chapters in this section each begin with a narrative summary that builds on Ethiopia's rich body of published data, and incorporates the concerns and observations of health professionals, stakeholders in the RH community, and the general public. Each summary also introduces three levels of analysis to guide the formulation of strategic actions. These include the "community", which comprises the broader social and cultural context of each health priority; the "system", which looks at opportunities arising from the delivery of health care services; and "policy", which looks at the institutional and normative frameworks within which decisions are made.

Guided by these priority issues, the discussion then turns to the formulation of a goal statement, the identification of realistic strategies for achieving that goal, and the specification of targets through which progress towards the goals can be gauged.

At the end of each section, a table is presented that highlights key actions deemed critical to achieving those targets. Responding broadly to the delineation of priority issues, each table clusters actions according to the three levels of analysis - community, systems and policy.

Point of Departure

At one level, strategy formulation focuses on the prioritization of goals and the identification of activities through which those goals can be realized. But there is another, less formal dimension to the process, where the notion of "strategy" implies more than just a means to an end. It also signifies the "point of departure" or, put another way, the general "approach" underlying the choice of means. The present National RH Strategy encompasses at least five such strategic approaches.

The first approach prioritizes the household and community as vehicles for change. Whether the goal is to build local support for birth preparedness efforts, combat harmful traditional practices, or ensure educational and economic opportunities for all, family and community are key. They also lay at the heart of the new HSEP, which seeks to deliver health services to where they are needed most. This focus on household and community, therefore, manifests itself at various levels: in the emphasis placed on awareness creation; on the importance of local ownership; and on the efforts to better articulate RH with the broader social, economic and legal system.

The second strategy employed in this document is to seek more effective integration across the health sector. One recurrent theme to emerge from the discussion is the inextricable link between RH and the health sector more broadly. Facilities are shared, staff are shared, resources are shared, and opportunities (both realized and lost) are shared. By tapping the unexploited synergies among traditional health divisions, this Strategy seeks to maximize economies of scale, increase efficiencies and reach out to underserved populations. PMTCT programs for example, are the epitome of effective integration across traditional boundaries,

in this case maternal health and HIV/AIDS. But opportunities also exist to address the multi-faceted needs of young people, to link interventions in maternal and neonatal health, and to provide more traditional RH services to those living with HIV/AIDS.

The third strategy guiding this document is to mainstream RH and ensure its place in the national development agenda. This is achieved through calls for advocacy and information - both to the community at large and to those authorities who can influence opinion, change behavior, and often deliver scarce resources. The Strategy also seeks to institutionalize RH at all levels of society. It calls upon, for example, the educational, legislative and law enforcement sectors in to ensure gender equity and the eradication of harmful practices. And it calls on an expanded and very active role for the Bureau of Women's Affairs, professional associations, and other bodies standing at the forefront of efforts to improve the health and well-being of the country.

The forth strategy is to build capacity and utilize more effectively scarce human resources. Many of the recommendations put forth in this document seek the introduction of activities for which staff straining is arguably inadequate. This is true both at the service delivery level as well as in the areas of planning and administration. A recurrent theme throughout this document, therefore, is the need for better training, more flexible training, and a training that balances rewards with the expectations of those with newly acquired skills and responsibilities.

The fifth and final strategy reflected in this document is to confront head-on the demographic, cultural, geographic diversity of Ethiopia – a diversity that belies simple solutions or single approaches. Throughout the present National RH Strategy, emphasis is placed on understanding factors that effectively differentiate society and their RH needs. This is manifest in the segmentation of populations that, in the past, have often been treated as an undifferentiated group. The historic focus on facility-based services, for example, has in the past often excluded pastoral populations, urban migrants, displaced populations and those in conflict situations. Diversity is the hallmark of Ethiopian society and the present Strategy confronts this reality head-on. It encompasses, for example, new approaches to address the needs of rural populations, through expanded health extension. It takes into account the RH needs of aging populations, through increased efforts at cancer screening and prevention. And it calls for new approaches to the old rubric of "adolescent RH", approaches that are needs-driven and segmented by age, marital status, and sex.

These five strategies, therefore, are at the heart of the current document. They inform the identification of targets and activities; and they provide a level of consistency evident at each step in the transition from priority to strategy to target to actions.

THE SOCIAL AND INSTITUTIONAL PARAMETERS OF WOMEN'S HEALTH

Women's health is directly affected by the social and institutional context in which they live. Issues such as their low socioeconomic status, HTPs, especially FGC, early marriage, and low female literacy, all have a direct negative impact on women's health. The issues and strategies outlined below affect and cross-cut all aspects of RH, extending well beyond what can be addressed by the health sector alone. The success of efforts to improve the RH of all Ethiopians hinges on the removal of these constraints.

FGC affects between 60 and 80 percent of Ethiopian women[1]. Despite common perceptions that it is largely limited to the Muslim community, it is present in some form in every region of the country (NCTPE, 2003: 112). Approximately three percent, primarily in Somali, Afar, and Harari, experience the severest form of FGC, Type III or infibulations, where both the clitoris and *labia minora* are removed and the *labia majora* are stitched together (NCTPE, 2003: 90). But regardless of the severity of the procedure, the practice of FGC undermines RH, limiting both a woman's ability to enjoy a satisfying and healthy sex life and contributing to a host of negative health outcomes. (NCTPE, 1998: 56-57). In the longer-term, infection is a constant concern, leading to complications such as pelvic inflammatory disease and infertility. The health risks are far greater for women who experience Type III FGC, as they are more likely to experience infertility or obstetric complications ranging from obstructed labor, perineal tears, and fistula, to maternal and neonatal mortality (NCTPE, 2003: 105-107).

Another cultural practice contributing to the low social and health status of women is early marriage. The average age of first marriage for women in Ethiopia is 16 – one of the lowest in the world. Men are encouraged to marry much later, at an average age of 23. This age gap between husband and wife contributes to significant power disparities at the household level. Confined to domestic duties from an early age, young women often experience significant psychosocial problems related to their lost mobility and inability to pursue educational or vocational opportunities. As a result, almost half of all early marriages end in divorce or separation, with the newly separated woman often migrating to urban areas in search of work (NCTPE, 2003: 145). There, many turn to commercial sex, significantly increasing their reproductive and sexual health risks. But RH risks are also high for girls who remain married, as pregnancy-related complications are substantially higher in physically immature women (Mensch, Bruce, Greene, 1998: 73).

Other practices having a negative impact on women's status and RH include polygamy, wife inheritance, marriage by abduction, exchange and other forms of forced marriage. In addition to violating women's constitutional rights, these practices bring with them important RH risks, including the increased likelihood of contracting HIV/AIDS and other STIs.[2]

[1] Existing data differs regarding FGM prevalence rates. A 1997 national survey on harmful traditional practices reported that 60 percent of women throughout the country practiced FGM, whereas the 2000 DHS identified that number as around 80 percent (NCTPE, 2003: 87). Despite the differences, both numbers attest to the fact that FGM is widely practiced in the country.

[2] According to article 34.2 of the 1994 Federal Constitution, "marriage shall be entered into only with the free and full consent of the intending spouses."

The low value placed on women's education in Ethiopian society adversely affects both maternal and child health. Female literacy in Ethiopia is low - only 18.5 percent, compared to 40 percent of men (CSA and ORC Macro, 2001: 22). While primary school enrollment stands at nearly 67.6 percent of all eligible girls, the rate drops to 17.9 percent for secondary school (MOH, 2005b: 9). Such high drop-out rates correspond directly with age of marriage, suggesting that once married, adolescents abandon education in favor of domestic duties. This not only limits their range of future social and economic opportunities, but it also has substantial negative ramifications for their health and that of their families. Research demonstrates a direct link between women's education and fertility, with more educated women bearing fewer and often healthier children (Jejeebhoy, 1995). Women who have completed secondary school are over three times more likely to seek professional antenatal care than women with no education, and 18 times more likely to receive skilled delivery assistance. Child survival rates are also favorably affected by mothers' education, as children of educated mothers are significantly more likely to receive basic immunizations and skilled care for common childhood illnesses (CSA and ORC Macro, 2001: 112, 119, 128, 132, 137). Finally, education increases women's awareness of harmful traditional practices such as early marriage and FGC (NCTPE, 2003: 144, 112).

And lastly, research suggests that violence against women, within and outside of marriage, is common. Indeed, 85 percent of Ethiopian women agree that a husband can be justified in beating his wife if she creates problems such as burning the food, neglecting the children, arguing, or refusing sex (CSA and ORC Macro, 2001: 32). Young unmarried women also commonly experience rape or other gender-based assault, suggesting that violence is also a common RH concern for adolescents (Erulkar et al., 2004: 17).

Priority Issues

Community Level

- Community members do not universally recognize the negative physiological and psychological consequences of FGC and other entrenched customs such as polygamy, wife-inheritance, discriminatory eating practices, early marriage, domestic violence and abduction.
- Many HTPs are perpetuated by those whose vested interests they serve; including males, kin groups, and FGC practitioners.
- There is little awareness and poor implementation of laws that protect women against HTPs, such as the 1994 Federal Constitution, National Policy on Ethiopian Women, the Population Policy, the Revised Penal Code, and the Revised Family Law.

Systems Level

- The health system is not adequately accessible or responsive to victims of sexual violence, and is only now learning to coordinate with law enforcement in terms of referral and reporting practices. Meanwhile, law enforcement and courts are reluctant to enforce existing provisions protecting the reproductive rights of women.
- Little is known about the extent and nature of FGC-related complications, especially those associated with Type III, thereby frustrating attempts to develop appropriate health interventions in areas where this type is prevalent.
- Efforts to close the gender gap in education are hampered by a lack of interventions geared to girls, including the presence of women teachers, initiatives to retain female students, and programs for addressing the special challenges of out-of-school girls.

Policy Level

- Only four of the country's eleven regions have adopted Regional Family Laws, which provide legal bases for protecting women's rights at the local level.
- Existing legislation does not adequately address violence against women, especially violence that occurs within marriage.

Goal:

To improve the reproductive health status of women and eliminate HTPs.

Strategies

Strengthen the legal frameworks that protect and advance women's reproductive health rights. To ensure the full application of existing laws, and the development of further protection, this strategy encompasses efforts to institutionalize women's rights at the local level, integrate them into regional-level planning activities, and to develop synergistic opportunities with women's groups to ensure that courts and police enforce such protections.

Targets:

By 2006, ensure that all regions have the technical support needed to establish regional task forces on RH/FP.
By 2010, ensure that all new law enforcement recruits are trained in the protection of women's rights, especially those pertaining to FGC, gender-based violence, and early marriage.
By 2015, ensure the existence of functional and operational working groups on women's issues in all *woredas.*

Prioritize the attainment of two indicators recognized to have the greatest impact on the reproductive health and well-being of women: age of marriage and educational attainment

Targets:

By 2015, increase the median age of first marriage from 16 to 18.
By 2015, increase the female literacy rate from 18.5 percent (2000) to 40 percent.
By 2015, increase the female gross secondary school enrollment ratio from 16 percent (2000) to 40 percent.

Reduce the acceptability of all forms of FGC. An important step in eradicating FGC is limiting the social incentives perpetuating the practice. Focusing efforts at the community level, this strategy works to alter social norms by providing information and testing the feasibly of alternatives to FGC, including alternate rites of passage and new income generating opportunities for FGC practitioners. Sharing lessons learned and best practices are also necessary.

Targets:

By 2010, complete at least two pilot studies that explore alternatives to replace FGC.
By 2015, double awareness of the harmful consequences of FGC from 34 percent to 68 percent.

Key Actions

Actions at the Community Level
Create awareness at the community level
▪ Develop and implement innovative informational campaigns to heighten awareness of:
▪ The existence and details of the new Family Law and Penal Code
▪ Risks and negative health consequences of early marriage, FGC, and the feasibility of alternative options
▪ Benefits associated with girls schooling
▪ Laws protecting and promoting women's rights
Target messages to high-risk groups
▪ Develop special IEC and advocacy campaigns for Somali, Afar, and possibly other regions that specifically address the risks associated with Type III FGC and the health services available to address them.
▪ Develop special IEC and advocacy campaigns that enlist as agents of change: women who have refused to be cut; FGC practitioners; young married couples, etc.
▪ Enlist religious and other community leaders to institute and apply cultural sanctions or disincentives that discourage FGC, especially Type III
Actions at the Systems Level
▪ Develop innovative strategies, including incentive programs, to keep girls in school
Increase human resource capacity through appropriate training
▪ Train front-line health care providers in management and referral of FGC complications
▪ Provide training on FGC-related complications to relevant NGOs, CBOs, FBOs, and those traditionally called upon to attend to high-risk situations such as childbirth.
▪ Include in the HSEP training curriculum appropriate pre-service instruction on the identification, management, and referral of FGC-related complications; and provide in-service training to HEWs who did not receive such instruction during their pre-service training
▪ Provide in-service training to those HEWs serving populations in the Afar and Somali regions, covering the skills needed to manage and refer complications relating to Type III FGC
Actions at the Policy Level
Enforce existing laws restricting HTPs
▪ Encourage community involvement in monitoring and reporting infractions
▪ Sensitize judges, prosecutors, and law enforcement agencies on existing laws, and strengthen their capacities
▪ Develop practical strategies for garnering the support of law enforcement bodies to monitor and enforce existing laws
Undertake new policy initiatives
▪ Conduct formative research on the health consequences of FGC (especially Type III), the role of traditional and other practitioners in providing and addressing the consequences of FGC; the feasibility of preventative interventions, such as alternative rites of passage, and alternative income generation activities for FGC practitioners.
▪ Formulate and coordinate a national initiative to achieve the FGC-related objectives contained in this National RH Strategy. The initiative must set targets for reduction by age-cohort, type and region; it must establish realistic time-frames; it must compile accurate baselines to assess progress; and it must adopt reliable methodologies to monitor the frequency of new cases
▪ Advocate for provisions on eliminating FGC in all regional RH Strategies
Expand multisectoral coordination
▪ Employ the framework of the National RH Program to bring about multisectoral involvement and collaboration to strengthen efforts to improve the status of women in conjunction with the MYSC, Ministry of Health, Ministry of Women's Affairs, and Ministry of Justice at regional and central levels

FERTILITY AND FAMILY PLANNING

Between 1990 and 2000, total fertility in Ethiopia declined from 6.4 to 5.9 births per woman.[3] This is a significant achievement by any standard, but the current rate still remains high. In rural areas, women bear an average of 6.4 children – nearly double that of their urban counterparts (CSA and ORC Macro, 2001: 37). Population growth, meanwhile, remains around 2.7 percent annually, making Ethiopia Africa's second most populous country with an estimated population of 77.4 million in 2005 (Population Reference Bureau 2005).

Contributing to declines in total fertility has been the decade-long increase in contraceptive knowledge and prevalence, though a clear gap exists between the two. Although nearly 84 percent of the population are aware of at least one FP method, utilization of contraceptive services is relatively low (CSA and ORC Macro, 2001: 48). Recent data indicates that contraceptive prevalence ranges from 13.9% (CSA, Measure DHS and ORC Macro, 2005: 10) to 25.2 percent (MOH 2005b: 3) – a marked contrast to the estimated 4.8% cited in the 1990 National Family and Fertility survey. While this is a notable increase, internationally, Ethiopia's current prevalence still remains low, and the country's unmet need for contraceptives remains around 36 percent (CSA and ORC Macro, 2001: 91).

High parity restricts women's educational and economic opportunities, thereby limiting their potential for empowerment broadly, as well as their ability to safeguard the health and economic well-being of the family and community at large. Low educational attainment further perpetuates high fertility, as these women tend to have less knowledge of and access to FP options. Unwanted pregnancy also contributes to unsafe abortion. A recent national study suggests that up to 78 percent of unwanted pregnancies were attributable to contraceptive non-use, incorrect use, or method failure (Mekbib et al, 2002: 19-20). And finally, high fertility also affects the well-being of mothers and their children. Maternal mortality and morbidity are strongly associated with high parity and early childbearing (CSA and ORC Macro, 2001: 102).

Although FP remains a sensitive issue in certain communities, there is widespread consensus that population growth is a major contributing factor to land shortages, environmental degradation, and by extension, food-insecurity. It is also seen to strain the capacity of government and non-governmental organizations to provide important social services such as schools, health care, clean water and sanitation. Indeed, among the RH outcomes discussed in this document, high fertility ranks second only to HIV/AIDS as the greatest perceived threat to individual and social well-being.

Priority Issues

Community Level

- Traditional values, high infant mortality, the desire for large family size, and early marriage fuel high fertility and represent serious constraints to birth spacing and/or limiting.
- Social and economic status of women undermines their desire and ability to regulate fertility.

[3] In the 1990 National Household Survey, the reported figure of 6.4 was subsequently adjusted to 7.7. The unadjusted figure has been used here to remain consistent with the reported figure of 5.9, cited in the 2000 DHS.

- The agricultural basis of the majority of Ethiopian society enhances the value of children as a labor force and source of support in the old age.

Systems Level

- Though the vast majority of FP services in Ethiopia are delivered through public sector facilities, demand greatly exceeds supply; and this gap undermines access to contraceptive services.
- Poor logistics management, recurrent stock-outs of contraceptive commodities, and lack of a broad method mix undermine the quality and utilization of FP services.
- User misinformation and poor integration of RH services discourages method compliance and continuation.

Policy Level

- The national FP program is weakened by the lack of budgetary allocations for contraceptive procurement.
- Resource and institutional constraints at regional and central levels undermine effective coordination between the governmental and non-governmental sectors. In addition to giving rise to redundancy, poor coordination makes it difficult to address gaps in the provision of FP services.
- The National Population Policy should be integrated with the National RH Strategy, reaffirming the policy, while broadening its attention to post-ICPD concepts of RH.

Goal

To reduce unwanted pregnancies and enable individuals to achieve their desired family size.

Strategies

Create acceptance and demand for FP, with special emphasis on populations rendered vulnerable by geographic dispersion, gender, and wealth.

Target:

- Increase contraceptive prevalence to 45 percent by the year 2010.[4]
- Increase couples' approval of FP to 75 percent by 2015.[5]
- Ensure awareness by 80 percent of the adult population of the link between infertility on the one hand, and STIs or post-abortion complications on the other.

Increase access and utilization of quality FP services, particularly for married and unmarried young people and those who have reached desired family size. This strategy encompasses a system-wide approach to service provision; one that enhances and maximizes referral systems; that segments contraceptive users by such factors as willingness to pay; and that maximizes the involvement of the public, private and NGO sectors. The strategy also

[4] This target is in accordance with that contained in the 2005 "Plan for Accelerated and Sustained Development to End Poverty" (PASDEP). (MoFED 2005: 73), and represents more than a three fold increase over the current level of contraceptive prevalence (13.9 percent) as reported in the 2005 DHS (CSA, Measure DHS and ORC Macro, 2005: 11).

[5] This target represents a 50 percent increase from 2000 levels of 48.6 (CSA and ORC Macro, 2001: 71).

entails the formulation and systematic implementation of an efficient logistics management system at both regional and central levels.

Targets:

- Increase demand satisfied to 80 percent.[6]
- By 2007, ensure that adequate supplies of contraceptives are available in-country to meet the current demand for public sector FP services
- By 2007, reduce to 10 percent the number of public sector health facilities experiencing contraceptive stock outs within a 12 month period.
- By 2015, at least three FP methods are available to all households.

Delegate to the lowest service delivery level possible, the provision of all FP methods, especially long-term and permanent methods, without compromising safety or quality of care.

Targets:

- By 2008, include long-term FP service provision in the job-description of mid-level health workers.
- In 2010, conduct a mid-term comprehensive review of existing legislation and policies to identify service delivery barriers, appropriate mechanisms for enforcement, and potential areas for revision.

[6] "Demand satisfied" reflects the difference between unmet need and the contraceptive prevalence rates.

Key Actions

Actions at the Community Level
▪ Develop and implement innovative informational campaigns to heighten community awareness about the relationship between STIs, abortion, and infertility
Enlisting religious leaders to promote FP:
▪ Seek the support and collaboration of religious institutions in creating awareness of the importance of FP; the RH needs of young people, especially those who are married; and the negative health and social consequences associated with early marriage.
▪ Use the authority of religious leaders to institute and apply cultural sanctions or disincentives to early marriage, such as discouraging the blessings of such marriages by priests.
Actions at Systems Level
Ensure the seamless integration of FP services from the community to health center levels:
▪ Establish mechanisms to facilitate the transition from current health extension efforts, which rely heavily on community-based agents, to the outreach activities of HEWs
▪ Ensuring the presence of at least two HEWs and/or community-based agents in every *kebele* with the training, knowledge, and skills needed to provide basic FP services and refer for long-term and permanent methods
▪ Improve pre- and in-service training on FP to health care providers.
▪ Improve community-level referral systems
▪ Ensure availability of long term and/or permanent methods, either on-site or through appropriate referral systems, to all women who wish to stop childbearing
▪ Provide pre-service training to all mid-level health workers on long-term and permanent methods of FP
▪ Ensure that STI detection and treatment services are fully integrated into existing RH programs
▪ Incorporate emergency contraception as an integral part of the national contraceptive method mix
Providing youth-friendly FP services through the public sector
▪ Train all service providers to meet the special needs of young people, especially those who are married and those in rural areas.
▪ Increase access and acceptability of public sector FP services for young people through the incorporation of convenient schedules and youth-friendly settings.
▪ Ensure the availability of coital-dependent contraceptive methods, including EC
Developing norms and standards for service provision
▪ Design and implement an efficient RH commodities security system that facilitates the timely transfer of accurate information; transparency within and among levels (from the *woreda* to the center[7]); and efficient procurement to reduce costs and maximize economies of scale
▪ Establish a minimal contraceptive method mix for each service delivery level
Actions at the Policy Level
Conduct research to improve RH
▪ Identify, test and pilot strategies for increasing access to FP options by married adolescents.
▪ Conduct operations research to assess the feasibility of cost-recovery in contraceptive distribution
▪ Rationalize the current national method mix through strategic assessment of contraceptive needs in order to maximize commodity procurement and distribution by method type, brand and sector
▪ Document and demonstrate to the appropriate government agencies, the costs/benefits to the health sector of eliminating import tariffs on RH commodities procured for non-commercial purposes
Rationalize resource allocation and availability
▪ Seek out sources of new donor funding for commodity procurement
▪ Allocate, as part of the FMOH and regional budgets, funds for procuring no less than half of key contraceptive stocks for public sector use.
▪ Enhance contraceptive security through effective use of social marketing

[7] The center includes both Family Health Department and Pharmaceutical Administration Supply and Services (PASS)

MATERNAL AND NEWBORN HEALTH

Ethiopia's rates of maternal and newborn morbidity and mortality are among the highest in the world. Current estimates of maternal mortality stand at 871 deaths per 100,000 live births, or 25,000 maternal deaths per year (CSA and ORC Macro, 2001: 110). Direct obstetric complications account for 85 percent of these deaths as well as countless chronic conditions. The most important factors leading to death include: abortion (32 percent), obstructed labor (22 percent), sepsis (12 percent), hemorrhage (10 percent) and hypertension (9 percent) (MOH 2003: 15). Meanwhile, a host of other long-term conditions disable women who survive delivery-related complications, such as fistula, chronic pelvic pain, depression and exhaustion. Fistula is especially common in Ethiopia, primarily due to the frequency of adolescent pregnancy combined with neglected prolonged labor. Other indirect causes such as HIV/AIDS, anemia, TB, malaria, and malnutrition, also underlie maternal death rates.

High maternal mortality rates are also directly related to low infant survival rates; and the high neonatal mortality rate of 58/1,000 live births, reflects the often-tenuous state of the mother at the time of birth (CSA and ORC Macro, 2001: 102). These deaths account for over half of all infant mortality, with 60 percent occurring within the first 24 hours after birth. Directly associated with the availability and quality of obstetric services, the major causes of neonatal mortality are infections (32 percent); birth asphyxia (29 percent); and complications associated with low birth weight (24 percent) (MOH 2003: 23).

A key factor contributing to both high maternal and newborn mortality is the low rate of skilled care during pregnancy and delivery. Nationwide, the vast majority of pregnant women, almost 60 percent, never seek any type of antenatal care (MOH, 2005b: 17). Only 9.7 percent of births are attended by a skilled professional, while nearly 85 percent are attended by an untrained traditional birth attendant or relative (CSA and ORC Macro, 2001: 113, 118). Not only are complications more likely to occur during these unattended births, they are more likely to be fatal for mother and newborn due to delays in seeking skilled emergency obstetric care (EmOC), in reaching the health facility, and/or to receiving a timely intervention even after reaching the facility.

Priority Issues

Community Level

- Relative to other negative health outcomes, maternal mortality is not widely perceived to be a major personal health risk. Many communities are resigned to accepting a certain level of maternal and newborn mortality as a natural occurrence.
- Certain traditional practices increase the likelihood of obstetric complications and infant death. These include early marriage and pregnancy, Type III FGC, discriminatory feeding practices for women and girls, including dietary restrictions during pregnancy, inadequate exposure of infants to sunshine, unclean delivery, self-delivery, unhygienic treatment of umbilical cord, delayed initiation of breast-feeding.
- Low awareness of danger signs and symptoms during pregnancy, labor, delivery, and post-partum contribute to delays in seeking and receiving skilled care.
- Poverty and the low status of women discourage households from investing limited resources in skilled prenatal care, delivery assistance, or postnatal care.

- High fertility preferences common in much of the country encourage women to bear children early and often.

Systems Level

- Access to primary health coverage, skilled delivery, emergency obstetric and newborn care is low. Weak referral systems, too few ambulances, and a lack of serviceable roads constrain access further. Pastoral populations are especially underserved by predominately facility-based service delivery systems.
- Limited human resources (especially midwives) hamper efforts to provide adequate services, especially in rural areas. Inadequate training and remuneration have led to high attrition and turnover among public sector health care professionals.
- Public facilities routinely confront shortages of supplies and equipment for obstetric care, which are often attributable to insufficient budgets and weak management skills.
- The needs of the newborn are also often overlooked, despite the fact that high infant mortality contributes indirectly to the desire for larger family sizes.

Policy Level

- Despite national efforts to strengthen maternal and neonatal health, poor coordination between the center and regions has often led to a duplication of ongoing RH initiatives. The lack of synergy derives from the absence of a common strategic goal, and the lack of an institutional framework for assessing project proposals using a common set of criteria.
- Existing Ministry policies and procedures constrain the delivery of key EmOC services by mid-level personnel (midwives and health officers), despite the fact that these levels make up the bulk of health center staff.

Goal

To reduce maternal and neonatal mortality in Ethiopia.

Strategies

Empower women, men, families, and communities to recognize pregnancy-related risks, and to take responsibility for developing and implementing appropriate responses to them. Increased knowledge and awareness is essential for reducing delays in seeking health care and in reaching a health facility. Communities and individuals must be empowered not only to recognize pregnancy-related risks, but they must also have the capacity to react quickly and effectively once such problems arise.

Targets:

- By 2009, ensure the presence of one functioning health committee in every *kebele*, with procedures for supporting pregnant women in emergency situations.
- By 2010, ensure that 80 percent of all households/families recognize at least three danger signs associated with pregnancy-related complications in areas where HSEP is fully implemented.

Ensure access to a core package of maternal and neonatal health services, especially in rural areas where health facilities are limited.[8] To meet the maternal health needs of Ethiopia's rural population, primary emphasis must be placed on delivering basic community-based maternal and neonatal services, most notably through HEWs and mid-level service providers. Community-based health care workers must be able to refer complications to appropriate facilities; and hospitals must be adequately equipped and staffed to provide EmOC services.

Targets:

- Increase to 60 percent the proportion of births attended by skilled health personnel either at home or in a facility.[9,10]
- Increase national antenatal care coverage levels to 70 percent.[11]
- Equip one health post per 5,000 population to provide *essential* obstetric and newborn care.[12]
- Equip one health center per 25,000 population to provide *basic* EmOC and newborn care. [13]
- Equip one A-Type health center or district hospital (250,000 population coverage) to provide *comprehensive* EmOC. [14]
- Reduce maternal mortality to 350 deaths per 100,000 live births by 2015.[15]
- Decrease the proportion of abortion-related deaths from 32 percent of all maternal deaths to 10 percent by 2015.
- Reduce neonatal mortality to 18 deaths per 1,000 live births by the year 2015[16]

[8] The core package will include: focused antenatal care, essential obstetric care (including the prevention and management of abortion), post-partum and neonatal care, and PMTCT plus.

[9] Under this objective, the term "skilled attendant" refers to people "with midwifery skills who have been trained to proficiency in the skills necessary to manage normal deliveries and diagnose, manage, or refer obstetric complications. They must be able to recognize the onset of complications, perform essential interventions, start treatment, and supervise the referral of mother and baby for interventions that are beyond their competence or not possible in the particular setting." (UNFPA, 2004: 20).

[10] This objective represents a six-fold increase from the current 9.7 percent (CSA and ORC Macro, 2001: 119).

[11] The 2003/04 antenatal care coverage rate stands at 42.1 percent (MOH, 2005b: 17).

[12] Essential obstetric care includes focused antenatal care, clean and safe delivery, essential newborn care and recognition of complications and early referral.

[13] Basic EmOC services include administration of antibiotics, uterotonic agents, and anticonvulsants, perform manual removal of placenta, perform removal of retained products of conceptions (e.g MVA), and perform assisted vaginal delivery.

[14] Comprehensive EmOC includes all basic EmOC services plus surgical procedures, particularly caesarian section and safe blood transfusions. This target is based on recommendations from the Health Sector Millennium Development Goals Needs Assessment (FDRE, 2004b: 9).

[15] This target reflects a three-quarters reduction in the 1995 maternal mortality rate of 1,800, as cited in the 2004 United Nations Millennium Development Database (FDRE, 2004b: 12).

[16] Assuming that neonatal mortality will continue to comprise approximately 31 percent of under-five mortality, this target reflects a two-thirds reduction in the 1990 under-five mortality rate of 200 per 1,000 as cited in the Ethiopia National Strategy for Child Survival (CSA and ORC Macro, 2001: 102; FDRE, 2004b: 8).

Create an environment supportive to safe motherhood and newborn health.

Target:

- By 2006, begin implementation of the "Reduce" advocacy model (MOH 2003) and the African Union *Road Map to Accelerate the Reduction of Maternal and Newborn Mortality in Africa.*
- Establish multisectoral committees within each region to build on the strengths, capacities, and resources of various institutions to create the framework within which safe motherhood and newborn health can be promoted.[17]

[17] These committees would be comprised of representatives from women's groups, government institutions, and NGOs.

Key Actions

Actions at the Community Level
▪ Support community initiatives to promote RH by encouraging rural communities to take responsibility to identify and implement innovative solutions and support networks for effective communication and transport to EmOC services.
▪ Develop and implement innovative informational campaigns to heighten community awareness of:
▪ the negative health and social consequences of HTPs associated with pregnancy
▪ pregnancy-related danger signs and the benefits of seeking skilled care
▪ services available to address the negative health consequences of HTPs
▪ importance of antenatal care to prevent disease, manage existing medical conditions, ensure proper nutrition and micronutrients, prepare for biths/emergencies, and detect early warning signs
Enlist religious and other leaders to promote RH at the community level
▪ Seek the support and collaboration of religious and other local institutions to creating awareness of the importance and ethical acceptability of FP; and RH needs of young people, especially those married.
▪ Use the authority of religious leaders to discourage early marriage
Actions at the Systems Level
Ensure the seamless integration of maternal health services from the community to facility level:
▪ Establish mechanisms to facilitate the transition from current health extension efforts, which rely heavily on community-based agents, to the outreach activities of HEWs
▪ Improving community-level referral systems
▪ Ensure the availability of basic equipment needed for maternal and newborn/child health care.
Increase human resource capacity through appropriate training
▪ Include in the HSEP training curriculum appropriate pre-service instruction on maternal health and the skills needed to attend normal deliveries; manage simple obstetric complications; and detect and refer more severe complications
▪ Include in the HSEP training curriculum appropriate pre-service instruction on essential care for neonates, including hypothermia, resuscitation, or sepsis. Training should also highlight the connections between maternal and newborn health
▪ Within the context of the HSEP, provide in-service training to HEWs who did not receive appropriate pre-service instruction on maternal and newborn health
▪ Increase the number of midwives trained per year; and amend the midwifery curriculum so that graduates can satisfy the requirements of a "skilled birth attendant".
▪ Increase the number of health officers trained on comprehensive EmOC.
Developing norms and standards for service provision
▪ Update and implement service provision guidelines that specify the roles and responsibilities of service providers at each level of the health system.
▪ Launch multisectoral initiatives to formulate norms and protocols for the treatment of victims of sexual violence, including provisions for EC, prophylactic ART, psychosocial and legal support.
Actions at the Policy Level
Enhance coordination within the health sector
▪ Employ the framework of the National RH Program to bring about multisectoral involvement and collaboration to strengthen RH service provision overall
▪ Develop strategies for the appropriate provision of PAC at all levels of the health system, in conjunction with relevant NGOs
▪ Strengthen the technical and financial capacity of RHBs to coordinate regional health initiatives across the NGO and public sectors
▪ Develop a National Maternal and Neonatal Mortality Reduction Strategy to prioritize objectives in safe motherhood and identify the sustainable, high-impact interventions required to achieve them.
▪ Following the endorsement of National Maternal and Neonatal Mortality Reduction Strategy, establish review mechanisms at national and/or regional levels to assure that new health initiatives reflect strategic priorities, are compatible with existing RH initiatives, build on best practices, and incorporate elements (sustainability) deemed essential for long-term success.

HIV/AIDS

It is estimated that 4.4 percent or 1.5 million Ethiopian adults are currently infected with HIV. Prevalence rates are much higher among women (5.0 percent) than men (3.8 percent), highlighting an increased social and physiological vulnerability to the disease for females. HIV/AIDS strikes the most economically productive members of society, with the highest infection rates found between the ages of 15 and 49. While the epidemic appears to have plateaued at 12.6 percent in urban areas, it continues to increase steadily in rural areas, where infection levels are projected to rise from the current 2.6 to 3.4 percent by 2008 (MOH, 2004c: 7). Because approximately 85 percent of the country's population is rural, national infection rates, if unchecked, could soar in the coming decade (NIC, 2002).

The magnitude of the epidemic is felt at both individual and societal levels. As the number of people living with HIV/AIDS (PLWHA) increases, greater demands are placed on the country's health sector. In 2003, there were an estimated 123,000 cases of AIDS, a number that continues to rise as life-extending anti-retrovirals become more widely available. Although only 6 percent of AIDS sufferers seek professional care, in 2003 this translated into 7,614 patients, many of whom required costly treatments and imported drugs. Over half of these patients were male, despite the higher rates of infection among women, reflecting important gender biases in access to care (MOH, 2004c: 10, 15, 17, 11). This suggests that most women with HIV/AIDS do not receive sufficient care, including gender-specific interventions such as prevention of mother to child transmission (PMTCT) and relevant contraceptive options.

The epidemic has also spawned a generation of AIDS orphans. The country currently has the seventh highest number of AIDS orphans in the world (UNAIDS, 2004). In 2003 alone, an estimated 539,000 children lost at least one parent to AIDS (MOH, 2004c: 24). If current trends persist, by 2007 there will be approximately 1.8 million AIDS orphans, which could grow to 2.5 million by 2014 (MOH, 2002: 30). Outside their parents' protective care, and most frequently supported by poor relatives, the physical, educational, or health needs of these orphans are not routinely met. As recent studies demonstrate, AIDS orphans are much more likely to drop out of school or repeat classes than those not affected by the epidemic (MOH, 2004c: 19).

High infection rates among the most productive segments of society are also directly undermining the country's development efforts. Absenteeism, mortality, and rising AIDS-related medical costs have significantly constrained growth in the wholesale, retail, manufacturing, agriculture, and public service sectors. The education sector is especially hard-hit by the epidemic, as death rates among teachers increased 5 percent between 1998 and 2001 (MOH, 2004c: 19). Similar conditions are seen in the health sector, as decreased staff productivity contributes to labor shortages and increased service delivery costs.

In 2004, the Government of Ethiopia published its Strategic Plan for Intensifying Multi-Sectoral HIV/AIDS Response, a four-year plan of action for reducing the transmission of HIV/AIDS and improving the lives of those already affected by it. The present document fully endorses the objectives outlined in the plan and the strategies chosen to achieve them. But at the same time, it recognizes that with HIV/AIDS programs gradually taking center stage, the marginalization of key RH services does become an increasing risk. A key challenge for the coming decade, therefore, will be to re-position the broader RH movement within this new reality. Part of the strategy will be to identify new synergies; but another part

will be to assess changes in the RH environment (increases in desired family size; contraceptive decision making among PLWHA) and learn to respond more effectively to them.

Priority Issues

Community Level

- Despite widespread knowledge of HIV/AIDS, personal perceptions of risk are low. This is substantiated in research carried out among both adults engaged in unprotected sex, and sexually active youth (MOH 2004c: 14).
- While women and girls are more susceptible to HIV infection, lower educational levels, poverty, higher workloads, and social isolation limit knowledge of their risk and their ability to seek relevant services.
- The lifestyles of certain special populations enhance vulnerability to HIV/AIDS. These populations include commercial sex workers (CSWs), truckers, migrant workers, street children, internally displaced people (IDP) and soldiers.

Systems Level

- In many rural areas, existing behavior change and communication (BCC) activities are viewed as urban-focused and not locally relevant.
- Inadequate coordination in HIV/AIDS service provision frustrates attempts to provide uniform, integrated coverage. Linkages between NGOs, CBOs, FBOs, private sector and public activities are especially limited, and HIV/AIDS is not sufficiently integrated into other RH (and especially MCH) activities.
- Low coverage of the health system and limited programmatic provisions for HIV/AIDS, constrain the public sector's ability to ensure widespread access to prevention, treatment and care services.
- Despite ongoing service delivery efforts, the needs of women with HIV/AIDS, including PMTCT, FP, and post-abortion care, are not sufficiently met. Such efforts also fall short of addressing many of the socio-cultural factors that underlie women's greater risks, including early marriage, polygamy, wife inheritance, abduction and rape.
- Involvement of PLWHA in prevention and advocacy efforts, though expanding, is constrained by persisting stigma and discrimination.

Policy Level

- The 2004 Ethiopian Strategic Plan for Intensifying Multi-Sectoral HIV/AIDS Response highlights the limited linkages between current RH and HIV/AIDS activities (MOH, 2004d).
- There have been delays in the development and enforcement of legislation regarding HIV-related discrimination and criminal behavior, sexual violence, confidentiality and employment.

Goal

To reduce HIV infection and improve the quality of life of those living with the disease by optimizing the synergies between RH and HIV/AIDS initiatives.

Strategies:

Exploit opportunities within current RH and HIV/AIDS programs to access populations whose needs would not otherwise be met under existing service delivery arrangements. By targeting services to those at greatest risk, most RH programs have oriented themselves towards clearly defined sectors of the population. HIV/AIDS programs for example, have been successful at reaching men, CSWs, and more recently, young people; while maternal health and FP programs have traditionally focused on women, and especially women in union. Where there is overlap among the target populations of different RH programs, there is often ample opportunity to integrate the corresponding services. But where overlap is limited, integration becomes difficult. And nowhere is that gap more evident than between HIV/AIDS and mainstream RH services.

An important strategy in the coming decade, therefore, will be to link HIV/AIDS and RH interventions in order to access populations who might not otherwise be reached separately. Already, headway has been made on this front by initiatives to prevent mother-to-child transmission of HIV/AIDS through the framework of existing maternal health services. Similarly, attaching RH services onto existing HIV/AIDS programs could better access groups (such as men, youth, and CSWs) not typically served under "mainstream" RH programs.

Targets:

- By the end of 2007, implement a national Services Provision Assessment (SPA) to establish baselines for setting targets and measuring changes in the integration of facility-level RH and HIV/AIDS services
- By the beginning of 2008, use baseline figures to set targets for increasing, by 2015, the number of:
  - Mothers attending antenatal care who receive PMTCT services.
  - STI clients referred to VCT.
  - ART clients counseled and referred for FP services.
  - FP clinics providing VCT services.
  - workplace programs providing both HIV/AIDS and FP services.

Maximize opportunities to transfer knowledge and best practices across RH and HIV/AIDS fields. Despite the overlap between HIV/AIDS and other RH services, the two fields have, for a variety of programmatic and historical reasons, developed largely in parallel to one another. Nowhere is this more evident than in the area of infection prevention where new knowledge and concerns arising out of HIV/AIDS initiatives have yet to impact fully service delivery in RH. Through sharing best practices, and better communication among practitioners and planners, this strategy seeks to improve the quality of care, for both users and providers.

Targets:

- Between 2008 and 2015, ensure universal knowledge of post-exposure prophylaxis by all cadres of RH care providers.
- Between 2008 and 2015, ensure universal knowledge of infection prevention techniques for RH services by health care providers.

Key Actions

Actions at the Community Level
▪ Encourage the transfer of knowledge and best practices from urban-based HIV/AIDS programs to rural initiates and associations.
▪ Target messages to high-risk groups, by developing new, innovative approaches to HIV/AIDS awareness that appeal more effectively to different categories of young people, especially those in rural areas, and marginalized groups such as street children and CSWs
▪ Secure the support and collaboration of religious institutions in creating awareness of HIV risks, prevention and testing services
Creating awareness at the community level
▪ Develop and implement innovative informational campaigns to heighten community awareness of:
▪ Risk of HIV transmission within couples, with special emphasis on male transmission to their wives
▪ Gender disparities in the utilization of services for detection and management of HIV/AIDS
▪ High infection rates in the 15 to 24 age group, especially among married girls and young women
▪ Utilization of condoms and observance of dual protection
▪ Relationship between STIs, abortion, and infertility
Actions at the Systems Level
▪ Introduce VCT services at all hospitals and 80% of health centers.[18]
▪ Introduce PMTCT services in all hospitals and 70% of health centers.[19]
▪ Support and build on social marketing initiatives to promote condom use
Provide youth-friendly HIV/AIDS services through the public sector
▪ Increase access and acceptability of public sector RH services for young people
▪ Train service providers to meet the special needs of young people
Increasing human resource capacity through appropriate training
▪ Include in the HSEP training curriculum appropriate pre-service instruction on youth-friendly FP services to married and unmarried young people, with emphasis on condom use
▪ Include in the HSEP training curriculum appropriate pre-service instruction on identification and referral of patients in need of ART
Developing norms and standards for service provision
▪ Revise all existing HIV/AIDS service delivery guidelines at regular intervals to keep pace with the current state of the epidemic
▪ Establish a minimum service delivery package for every level of the health care system
▪ Revise monitoring and evaluation systems to more accurately capture data on HIV transmission and the utilization and effectiveness of public sector services.
▪ Launch multisectoral initiatives to formulate norms and protocols for the treatment of victims of sexual violence, including provisions for EC, prophylactic ART, psychosocial counseling, and legal support
▪ **Actions at the Policy Level**
▪ By the end of 2006, RH Task Force, MOH and HAPCO to jointly sponsor a one week seminar on re-positioning RH in the era of HIV/AIDS.
▪ Allocate, as part of the regular budgets of the FMOH and regions, funds for procuring a significant proportion of ARV stocks
▪ Revise the 1998 Federal Policy on HIV/AIDS and develop a minimum service package for integrating HIV/AIDS/STI and RH services
▪ Employ the framework of the National RH Program to expand youth-friendly services, including HIV/AIDS prevention, testing and care in conjunction with the MYSC, HAPCO and relevant NGOs

[18] This activity corresponds to the objectives established in the Draft HSDP III (MOH, 2005a: 47).

[19] This activity corresponds to objectives established in the Draft HSDP III, and the HIV/AIDS Millennium Development Goals Needs Assessment (MOH, 2005a: 60; FDRE, 2004c: 11)

RH OF YOUNG PEOPLE

While approximately 60 percent of Ethiopia's population falls between the ages of 10-29, few national programs or policies are specifically targeted towards addressing their most pressing RH needs (CSA, 1998: 14) [20]. Currently, a number of national and local NGOs have stepped in to fill this gap, but these programs tend to serve primarily urban populations, many of whom are also enrolled in formal schooling. With 84 percent of the country's youth and adolescents residing in rural areas, and only 15 percent enrolled in school, the vast majority of young people remain underserved. Even within urban areas, new research suggests that existing coverage is limited, with only 12 percent of young people sampled in Addis Ababa visiting youth centers and only 20 percent reached by peer educators (Erulkar et al., 2004: 22). In addition, most programs for young people in Ethiopia, as well as in sub-Saharan Africa generally, tend to deliver generic, age- and gender-blind messages that fail to recognize the distinct needs of girls versus boys at different ages, as well as the unique needs of married adolescent girls.

This limited access to targeted RH care and services for young people contributes to, and exacerbates, many of the RH problems outlined above. Over a quarter of all pregnant youth and adolescents feel that their pregnancies are mistimed, reflecting this population's limited access to FP as well as their vulnerability to broader social problems such as early marriage, nonconsensual sex, and sex work (CSA and ORC Macro, 2001). These unwanted pregnancies entail significant risks for maternal health, including high rates of delivery-related complications and high abortion rates. Additionally, because of the risky, often unprotected and non-voluntary nature of their sexual activities, adolescents and youth are most likely to contract HIV and other STIs, so that the highest infection rates in the country are currently seen among young women between the ages of 15 to 24.

Priority Issues

Community Level

- While the risks associated with HIV/AIDS and early marriage tend to be widely recognized by communities, other health and psychosocial risks facing young people are not well understood.
- Poverty, limited educational opportunities, and threats of early marriage encourage rural-to-urban migration that often brings with it new sets of RH risks such as commercial sex and sexual violence.
- Addiction to substances like chat and alcohol alters economic and social priorities. Among young men, such addiction is believed by the community to increase the likelihood of unsafe sexual behavior, while at the same time diverting scarce household resources away from basic social, material, and health needs.

Systems Level

- The needs of young people, like other marginalized groups, are not adequately addressed within the health system, in part because their needs are typically seen to derive from social, rather than health reasons. Furthermore, scarce resources at the regional and zonal levels mitigate against the provision of adequate services to this subpopulation.

[20] In this document, "young people" refer to those between the ages of 10-29. This encompasses both the category "youth" (15-29) as defined in the National Youth policy, and "adolescents" (10-19) as defined by the World Health Organization.

- Government RH services are perceived by youth to be unfriendly. The current facility-based health care structure does not meet the unique service and informational needs of young people; nor does it effectively segment them by factors known to have a profound effect on their RH needs - factors that include marital status, age, educational attainment, household income levels, employment status, and urban or rural residence.
- There is a lack of coordination between NGOs, the private sector and public providers of RH care for young people.

Policy Level

- At the regional level, there is no institutional framework for adequately addressing RH issues for young people. From the center to regions, there are few focal persons for adolescent and youth RH, or structures in place to ensure that it is integrated into ongoing programming activities.
- There is no national strategic framework for addressing the RH needs of young people in a systemic and coherent manner. This absence undermines efforts, both regionally and centrally, to plan and budget for these special RH activities.
- Although legislation is in place to prevent many of the practices that undermine the RH of young people, including the Revised Penal Code and the National Policy on Women, enforcement is often weak. This is especially so in areas where these practices are most prevalent.

Goal

To enhance the reproductive health and well-being of the country's diverse populations of young people.

Strategies

Segment the design and delivery of all youth RH-related interventions and policies by gender, age cohort, marital status, and rural/urban residence. The definition of young people employed by this strategy (10-29 years) masks significant differences in RH needs, and the kinds of interventions needed to address them. This is especially true in Ethiopia, where early marriage and childbirth, a predominantly rural population base; and strong gender-based proscriptions on behavior give rise to different sets of RH needs, and very different sets of constraints to addressing them.

Targets:

- By 2006, develop a National Adolescent and Youth RH Strategy.
- By 2007, develop regional implementation plans for the National Adolescent and Youth RH Strategy

Address the immediate and long-term RH needs of young people, with priority given to married women between the ages of 15-19 and their partners, and young people generally between the ages of 10-14. Most Ethiopian women leave school by the age of 14, are married by the age of 16 (and therefore, are sexually active), and give birth to at least one child by the age of 19. (World Bank, 2005: 100; CSA and ORC Macro, 2001: 77, 45) And yet current youth RH efforts are dominated by interventions targeting a markedly different youth profile, those who are unmarried and in school.

While reaching these traditionally-served groups remains important, this strategy seeks to redress past imbalances by re-focusing attention on two groups whose RH needs have not thus far been adequately addressed: young people up to the age of 14 and adolescents who are married and sexually active.

Targets:

- Increase the median age of first intercourse for women in the age cohort 20-49, from 16.4 to 17 by 2010, and to 18 by 2015.
- By the year 2015, decrease by 20 percent, HIV prevalence among women in the age cohort 15-24[21].

Strengthen multisectoral partnerships to respond to young women's heightened vulnerability to sexual violence and non-consensual sex. Efforts to encourage behavior change and responsible decision-making play an indispensable part in meeting the RH needs of young people. But to the extent that many RH risks derive from factors beyond their control, focusing on the behavior and attitudes of young people alone will not be enough.

This strategy, therefore, seeks to build on the strengths of the RH community, public institutions, and civil society by creating a shared understanding of the health risks facing young women and responding in a coherent and synergistic manner. These linkages will work to heighten overall awareness of the risks facing young people with an aim towards fostering more effective responses to them. The strategy encompasses broad-based efforts to limit young people's vulnerability, to deter those seeking to exploit it, and, when necessary, to respond with appropriate health, psycho-social and legal services.

Targets:

- By 2007, establish multisectoral committee for the development and implementation of national protocols and standards on the treatment of victims of sexual violence, with provisions for the needs of young people.
- By 2010, establish multisectoral youth RH committees in every region.

[21] Because prevalence rates among young women are disproportionately high, and on the increase, reducing prevalence among this group would represent a significant achievement in efforts to halt the spread of HIV/AIDS among adults and newborns. Current estimates of prevalence for females 15-24 stand at 4.1% nationally (11.4 in urban areas, and 2.5 in rural areas), which is the highest of any age group. A 20 percent decrease would reduce that rate to 3.28 percent in 2015. Because the onset of sexual activity commonly takes place between 15-29, prevalence rates among this age group can also serve as a proxy for the rate of new infections. As a result, lower prevalence rates for this cohort would reflect an actual decrease in the number of cases that is not mitigated by other factors, such as higher survival rates due to ART, which obscure the numbers of new infections among older cohorts.

Key Actions

Actions at the Community Level
Creating awareness of RH at the community level
▪ Develop and implement informational campaigns to heighten community awareness of:
▪ Risks and negative health consequences of early marriage/early intercourse
▪ Utilization of condoms and observance of dual protection
▪ High HIV infection rates in the 15 to 24 age group, especially among married girls and young women.
▪ Support community initiatives to promote youth RH, by encouraging the transfer of knowledge and best practices from urban-based HIV/AIDS programs to rural areas.
▪ Develop new, innovative approaches to HIV/AIDS awareness that appeal more effectively to different categories of young people, especially those in rural areas, and marginalized groups such as street children and CSWs.
Actions at the Systems Level
Provide youth-friendly services through the public sector
▪ Increase the numbers of trained professionals undertaking community outreach on contraceptive use (especially condom use and negotiation skills), and the frequency of their visits.
▪ Target groups demonstrating the highest unmet need, such as married girls and their partners in rural areas and CSWs and street children in urban areas.
Integration of and HIV/AIDS services
▪ Build the capacity of non-health related youth centers to offer referral services for RH care and information, especially for FP and VCT
▪ Expand STI prevention and treatment to curtail the longer-terms risks of HIV transmission, infertility, and reproductive organ cancers
Increasing human resource capacity through appropriate training
▪ Through pre-service training of all primary health care providers, ensure adequate transfer of knowledge and skills regarding young people's RH needs and youth-friendly service delivery
▪ Include in the HSEP training curriculum appropriate pre-service instruction on the provision of confidential and youth-friendly FP services to married and unmarried young people, with emphasis on condom use
▪ Provide in-service training on youth-friendly service provision for those HEWs who did not receive appropriate instruction during their pre-service training
Developing norms and standards for service provision
▪ Develop and implement standardized protocols to ensure the provision of quality services within the public sector, appropriate to the needs of different categories of young people
▪ Launch multi-sectoral initiatives to formulate norms and protocols for the treatment of victims of sexual violence, including provisions for EC, PEP, psychosocial counseling, and legal support
Actions at the Policy Level
Enforce existing laws regarding the minimum age of marriage
▪ Encourage community involvement in monitoring and reporting infractions and during litigation
▪ Develop practical strategies for garnering the support of law enforcement bodies to monitor and enforce existing laws
▪ Sensitize judges, prosecutors, and law enforcement agencies on existing laws and, strengthening their capacities to apply them
▪ Seek greater collaboration among the health sector, law enforcement, and courts to facilitate referrals, collection of evidence, and securing testimony
Explore new opportunities
▪ Develop a National Adolescent and Youth RH Strategy
▪ Conduct operations research to identify, test and pilot strategies for increasing access to FP options by married adolescents
Expand multisectoral coordination
▪ Employ the framework of the National RH Program to promote alternatives to early marriage, such as education and income generating activities for girls, in conjunction with other Ministries and NGOs

REPRODUCTIVE ORGAN CANCERS

A comprehensive approach to RH implies meeting the reproductive needs of women and men at all stages of their lives. One important need, often overshadowed by the more traditional aspects of RH, is the detection and treatment of reproductive organ cancers (ROCs) which tend to affect women (and men) later in life. This is also true in Ethiopia, where ROCs are a widespread, but rarely acknowledged problem.

It is estimated that 500,000 new cases of ROC occur every year worldwide, the majority (80 percent) taking place in the developing world (Parkin, Pisani, Ferlay, 1993). In developing countries, including Ethiopia, cervical cancer is more common and is the leading cause of death from cancer among women (Chirenje et al., 2001).

Studies suggest that HIV positive women are at increased risk of cervical cancer, as are women who have an early sexual debut (Koutsky et al., 1992; Temmermann et al., 1999). In Ethiopia, where the HIV/AIDS pandemic is growing and a significant proportion of the people living with HIV/AIDS is young, it is very likely that deaths due to cervical cancer will increase. Epidemiological studies have also consistently shown a strong association between the risks of acquiring cervical cancer, exposure to *Human Papilloma Virus* (HPV) and factors linked to early sexual activity such as early marriage, young age at first pregnancy, large total number of pregnancies, short mean interval between pregnancies, and multiple sexual partners. As highlighted above, all these risk factors are highly prevalent in Ethiopia.

Despite its prevalence, ROCs are not addressed as a major public health problem at any level of the health care system. Nationwide, there is no organized ROC prevention, education, screening, or curative care program, nor is there is any national policy to address this issue. Thus, the high proportion of both cervical and breast cancers, if diagnosed at all, are diagnosed too late for meaningful intervention. In countries where there is a well-organized cancer prevention and control program in place, medical knowledge is now sufficiently advanced to allow for the prevention of at least one third of all cancers; and the treatment of a further third, especially cervical and breast cancers. For many Ethiopians whose cancer is detected too late for treatment, no palliative care is available, either in the formal health care system or in alternative schemes like home care and hospices. Nevertheless, the country is well-positioned to begin screening services and to improve the lives of those with ROCs. Opportunities exist in terms of the physical and human resources, which are readily available through established teaching hospitals and interested NGOs, and the financial support that is available through a host of international organizations and foundations.

Priority Issues

Community Level

- Individuals and communities are not aware of the risks that predispose them to ROCs, or the potential for their detection and treatment.

Systems Level

- Nationwide, there is no organized ROC prevention, education, screening, or curative care program in the public sector.

Policy Level

- Little is known about the scale of the problem, which makes it all the more difficult to formulate meaningful policies and/or develop practical strategies for dealing with it.

Goal

To reduce the risk of developing ROCs, provide early detection and treatment, and improve the quality of life of those suffering from them.

Strategy

Understand the magnitude of the problem and identify cost-effective interventions for ROC screening, diagnosis and treatment.

Target:

- By the end of 2006, conduct a national assessment to determine the frequency and type of ROCs prevailing in the country. Results to be used to design appropriate interventions and measure their impact.
- By the end of 2006, launch appropriate cost-effective cervical and breast cancer prevention and treatment demonstration (pilot) projects/programs in five selected areas in the country
- By 2008, develop a national plan for implementing ROC prevention and control activities.

Key Actions

Actions at the Community Level
Creating awareness of ROCs at the community level
▪ Develop culturally-appropriate print and audiovisual materials on the detection and treatment of ROCs, particularly on cancers affecting women (e.g. materials on self-breast examination, early signs and symptoms of cervical/endometrial cancer, and cervical cancer screening).
Actions at the Systems Level
Increase human resource capacity through appropriate training
▪ Ensure adequate transfer of knowledge and skills on the identification, treatment, and palliative care of ROCs to all doctors and nurses.
Developing norms and standards for service provision
▪ Establish multidisciplinary technical advisory groups on ROC prevention at the national and regional levels.
▪ Introduce cost-effective cervical and breast cancer prevention, screening and treatment demonstration pilot projects in five selected areas in the country.
Actions at the Policy Level
Undertaking new policy initiatives
▪ Conduct a national assessment to determine the frequency and type of ROCs.
▪ Develop a national plan for implementing reproductive organ cancer prevention and control
Expand multisectoral coordination
▪ In collaboration with NGOs, create innovative fora for encouraging multisectoral communication on RH issues, including ROCs, such as launching a national RH website, newsletter.
▪ Identify and coordinate with national and international major stakeholders involved in the control and treatment ROC

SECTION III: Strengthening Supporting Systems in the Health Sector

To achieve the goals set forth in this Strategy, a coordinated and multisectoral effort is required on the part of all relevant stakeholders, including a wide range of government agencies, NGOs, donors, and the private sector. The MOH, however, occupies a special role in the implementation of this Strategy, serving as its institutional home and operational lead. As such, it is critical to ensure that necessary systems are in place, and properly functioning, within the health sector. Consultations at both the regional and central levels consistently highlighted a core set of institutional issues needed to support the seamless and complete realization of this Strategy. Drawing on the analysis of similar systemic constraints contained in the HSDP III, these issues are outlined below.

PRIORITIZING RH

Although the concept of RH has gained much currency in the last decade and a half, it still remains low on the agenda of many key decision makers. This is seen in national-level planning efforts such as the HSPD III, where RH is only now beginning to be addressed for the first time in the program's ten-year history; and at the regional level, where health efforts continue to be dominated by single-issue strategies.

Several factors contribute to the low priority afforded RH. First, as in many other countries, discussions with key policy makers, administrators and many health care providers suggest that the concept of RH is not widely understood. At both central and regional levels, RH is often perceived as simply the sum of what were formerly vertical programmes for addressing maternal and child health, sexually transmitted diseases or FP. Second, for those who do understand the concept, its breadth and conceptual complexity make it difficult to operationalize. Finally, institutional inertia, either due to ambivalence towards the new concept or to vested interests in maintaining vertical programs, has undermined the RH approach at the regional levels. In settings where human and financial resources are limited, incentives are lacking to restructure programs in accordance with new theoretical approaches.

To increase the priority given to RH issues among key decision-makers, RH must have strong advocates and proponents at both the regional and central levels. This strategy recommends the following activities, aimed at encouraging this type of broad-based support:

- Encourage local leaders and decision makers to allocate resources necessary for the implementation of RH programmes.
- Communicate and disseminate to key decision-makers the lessons learned from RH interventions undertaken within the country and elsewhere.
- Assist regions in developing regional RH Strategy implementation plans, drawing on the resources and skills available at the central level.

RESPONDING TO DIVERSE SOCIAL CONTEXTS

Few countries can match the cultural, geographic and economic diversity of Ethiopia. With well over 100 different ethnic groups, and up to 200 languages, it is sometimes referred to as a "museum of peoples". Given this diversity, it is inevitable that gaps will arise between the unique needs of local populations and the capacity of broad-based institutionalized systems to address them. Within the health sector, at least two such gaps are recognized as having impacted directly on the provision and utilization of RH services.

The first gap exists among pastoralist communities, especially those located in the newly emerging regions of Somali, Afar, and Gambella. While these populations are highly mobile, the health services provided them are overwhelmingly static and facility-based. This discrepancy between the needs of the community and the structure of the health system is exacerbated by the fact that pastoralists face increased health risks due to their social marginalization, poverty, and in Somali and Afar, a proclivity to practice Type III FGC. Although no definitive data on the health status of these populations exists, they are believed to have some of the highest fertility and mortality rates in the country.

Secondly, the increasing frequency of internal migration, both temporary and permanent, poses another set of critical challenges for the health system. Along the major transport routes and urban centers, migrant workers, truck drivers, and IDPs, are all highly vulnerable to RH risks such as STIs or HIV/AIDS. Their transient nature, however, makes them difficult to reach – particularly through static and traditionally female-centered RH services. Rural-to-urban migrants, especially young women fleeing early marriage, face a broad array of RH risks in their new communities, including rape and recruitment into sex work.

In the past few years, growing awareness of these gaps have prompted a number of remedial actions. These include new initiatives by the Ministry of Federal Affairs; the establishment of a multi-agency board and technical committee by the Ministry of Health; the preparation of health service extension packages tailored to pastoralists (including mobile services); calls for an expansion of outreach services; and the establishment of new satellite health posts. All of these actions, however, are limited to the needs of pastoral populations.

Given the moral imperative of the national health care system to meet the RH needs of all citizens, the present National RH Strategy recommends that top priority be placed on:

- Understanding better the unique needs of local populations;
- Designing and implementing appropriate health service systems to address them;
- Establishing multisectoral initiatives to open dialog on this issue among HSDP partners and NGOs.

The strategy also supports the call by the HSDP III to develop a plan of action in consultation and collaboration with relevant sectors in all the regions.

HUMAN RESOURCE DEVELOPMENT AND CAPACITY BUILDING

The formal health sector is but one of many partners involved in the effort to improve the sexual and RH of Ethiopia's 77.4 million people. Its role in that effort, however, is pivotal and highly dependent on the availability and effective utilization of adequate skilled human resources.

Assessments carried out under HSDP and the present strategy formulation process suggest that the role of health care professionals in program implementation is becoming increasingly undermined by their heavy burden of work, low motivation, and inadequate training. Staff shortages; low remuneration; the lack of incentives to improve skills; burdensome administrative procedures; and limited opportunities for professional growth are all cited as key factors contributing to high staff turnover and poor quality health care provision.

While the inadequacy of existing human resource reverberates throughout the health system, its impact on meeting the RH priorities identified in this strategy, is most evident in two areas. The first is the interface between the community and formal health sector. Existing health care staff are predominantly urban-based with the result that rural areas face a continuous shortage of human resources. Midwifery skills are particularly lacking with larger regions having less than one midwife per 100,000 people. Provisions under the HSEP to bring on board a new cadre of HEWs will go a long way to meeting the RH needs of Ethiopia's rural communities. Because their success will depend on good management skills, community based task-oriented training must be an indispensable component of HEW training activities.

The second area to feel the impact of inadequate human resources is at the planning level of RHBs. At present, most RHBs are not adequately staffed to handle the technical and managerial requirements of a functioning regional RH program. Some of the larger regions, for example, have only one or two staff available to manage the coordination of all regional RH activities. And other regions have less than that – often the result of combining RH with other technical fields for which financial resources are more abundant (i.e. immunization).

In line with the HSDP III, the present National RH Strategy recommends that top priority be placed on overcoming the shortage and high turnover of skilled human resources. To do this, it recommends:

- Building the capacity of health training institutions to improve the quality of their training, and to ensure that its content reflects the ever-evolving needs of the health sector.
- Increasing the output of health professionals (especially diploma-level midwives) through public sector training institutes and through greater collaboration between the public sector and private training institutes.
- Developing incentive packages that not only address the fundamental issue of appropriate remuneration, but that also look at opportunities for professional advancement.

HEALTH MANAGEMENT INFORMATION SYSTEMS (HMIS), MONITORING AND EVALUATION (M&E) AND RESEARCH

For the better part of the last decade, concerns have been raised over the lack of a national HMIS to collect, record and analyze key service delivery data for management purposes. The absence of such a system has been particularly notable in the area of RH since so many health-related indicators at the regional level derive from the provision of RH services.

In recent years, some notable developments have been undertaken to redress this situation. These include the simplification of health sector reporting formats at a national level, the establishment of a national HMIS Advisory Committee, the design of an integrated HMIS and M&E package; and the recruitment of skilled specialists to put that package into practice. But despite such advances, the lack of a coordinated, strategically focused leadership, a shortage of skilled human resources, and the absence of integrated and harmonized reporting formats continue to impede the realization of an operational HMIS.

The same is true with respect to M&E. Despite the establishment of steering committees at central and regional levels, M&E remains plagued by the absence of functional linkages across central, regional and *woreda* levels; the inability to sustain timely and complete reporting; and at even more fundamental level, the lack of agreement over key indicators for monitoring sector performance.

Finally, in the area of research, there is concern at all levels over the continued emphasis on description and diagnosis, rather than on strategies to put in practice what is known through greater operations research. Concerns have also been expressed over poor coordination and the limited funding resources available for research.

In line with the recommendations submitted as part of the HSDP III, the present National RH Strategy recommends that top priority be placed on the establishment of an efficient, integrated HMIS/M&E package at all levels of the health system by 2010.

SECTION IV: THE WAY FORWARD

The National RH Strategy contained in these pages is the product of a multisectoral, multidisciplinary effort to formulate a vision for the future, and identify objectives that will make that vision a reality. It is the result of exhaustive consultations with individuals from every walk of life, in every one of Ethiopia's regions. And it is the synthesis of key findings from nearly a decade's worth of reviews, assessments and evaluations on RH in the country.

But for all that has gone into this effort, the present document still marks only the beginning of a wider process that will see the strategy's activities and recommendations translate into concrete programs and initiatives. It also marks the beginning of an iterative process that will see key stakeholders watch for changes in the external environment; identify the strengths and weaknesses of their programs; and make adjustments so that RH programs are always as effective as possible.

In order to chart an effective, and meaningful course of action, the Ministry of Health will coordinate implementation of the National RH Strategy and assume responsibility for its execution, supervision and monitoring in collaboration with key stakeholders and the broader membership of the RH Task Force.

The next major step in the process of strategy implementation, therefore, will be to formulate an implementation plan with active input from the Regions. This process will make possible meaningful cost estimates that are in line with existing allocations for HSDP III and the realization of the MDGs. Every opportunity will be taken to facilitate resource mobilization and the buy-in of key national and international partners. To help this effort, priority will be given to the dissemination of results at the central and regional levels. The MOH will also establish an inter-agency group under the auspices of the National RH Task Force, which will serve as a forum for multi-sectoral dialogue on strategy implementation.

One of the most important steps to be taken by the MOH will be periodic assessments of strategy implementation. This will help identify program strengths, weaknesses, and, if necessary, the need for adjustments. Furthermore, steps will be taken to establish a system of RH indicators incorporated in the national HMIS to ensure effective monitoring of RH services.

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