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# Imperiling Progress: How Ethiopia's Response to Political Unrest Could Undermine Its Health Gains

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With each passing week, the political unrest and repression in Ethiopia is attracting new levels of global attention: from Feyisa Lilesa's protest sign at the Rio Olympics in August,<sup>2</sup> to recent clashes in Oromia where hundreds of protesters were killed by security forces and hundreds more jailed,<sup>3</sup> and now the government's declaration of a sweeping state of emergency for the next six months.<sup>4</sup>

There is little doubt that the inherent contradictions of Ethiopian rule—tight restrictions on human rights and governance while pursuing pro-poor policies—now threaten to derail its notable but fragile progress in women's and children's health. The current crisis also exposes the shortcomings of U.S. policy in Ethiopia; while providing substantial funding for health and development and maintaining close security ties, U.S. reluctance to hold its longtime ally accountable for its repressive tactics could put these investments at risk.

## The Success of the Health Extension Program

It is widely acknowledged that Ethiopia has made important advances in women's and children's health in recent years and that its innovative health extension program holds important lessons for other countries.<sup>5</sup> Through this model, Ethiopia has shown that integration of services and task shifting to lower-level health workers can lead to major improvements in maternal and child health and

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<sup>2</sup> Jeffrey Gettleman, "Ethiopian Runner Won't Return Home, but Doesn't Know Where to Go," *New York Times*, August 23, 2016, [http://www.nytimes.com/2016/08/24/world/africa/feyisa-lilesa-ethiopian-marathoner-wont-return-home.html?\\_r=0](http://www.nytimes.com/2016/08/24/world/africa/feyisa-lilesa-ethiopian-marathoner-wont-return-home.html?_r=0).

<sup>3</sup> "The downside of authoritarian development: Ethiopia cracks down on protest," *The Economist*, October 15, 2016, <http://www.economist.com/news/middle-east-and-africa/21708685-once-darling-investors-and-development-economists-repressive-ethiopia?zid=304&ah=e5690753dc78ce91909083042ad12e30>.

<sup>4</sup> Bill Chappell, "Ethiopia Declares Emergency, after New Outburst of Protests and Violence," NPR, October 9, 2016, <http://www.npr.org/2016/10/09/497292914/ethiopia-declares-state-of-emergency-amid-continuing-protests>.

<sup>5</sup> Established in 2003 by the Ethiopian government, the Health Extension Program was designed to expand access to primary care to the country's predominantly rural population and has since been scaled up in urban areas as well. The government has hired and trained some 38,000 health extension workers, young women with at least a 10th-grade education recruited from their communities, who serve as an entry point to the health system by providing a package of basic health services.

access to family planning. The results have been impressive and have contributed to important health gains: Ethiopia significantly increased the contraceptive prevalence rate (with use of modern methods climbing from 6 percent in 2003 to 40 percent in 2014)<sup>6</sup> and halved child mortality between 2000 and 2011.<sup>7</sup>

On a visit to Ethiopia in June as part of the CSIS Task Force on Women's and Family Health, we were able to meet with health extension workers, implementing partners supporting the health extension program, as well as government officials and donors. At a health post far off the paved road in the northern region of Tigray, we met a 26-year-old health extension worker named Ababa. She splits her time between working at her local health post (the lowest level of the health system) and visiting homes in the community, and is responsible for a range of services including vaccination and family planning services. She is also tasked with collecting health data and reporting this information to her supervisor based at the health center.<sup>8</sup>

Ababa has seen many improvements in community health during her seven years on the job, including a notable increase in facility deliveries and a corresponding reduction in maternal deaths. She proudly pointed to the rise in modern methods of family planning, saying, "It used to be so difficult to use family planning openly, because of opposition from religious leaders and husbands. But now they support it." She added, however, that some women still come for family planning discretely, without their husbands' approval.<sup>9</sup>

Nationally, rates of institutional delivery have improved as a result of health extension workers and the government's prioritization of community-focused health services. The Ministry of Health refers to "home delivery free *kebeles* [districts]," part of an effort to encourage women to give birth at facilities with the aid of a skilled provider. The minister of health, Dr. Kesete Birhan Admasu,<sup>10</sup> told us that the institutional delivery rate had risen to 72 percent, up from just 14 percent in 2012, and furthered that this year an astonishing 75 percent of women will give birth in a facility.<sup>11</sup> Other sources indicate that his figures are overly optimistic, and put the rate at 68 percent in 2016. It should be noted, however, that some observers are suspicious that the government's extensive social mobilization, including the Health Development Army and "model families,"<sup>12</sup> can be used as a way to coerce and monitor the population.

<sup>6</sup> Ethiopia Central Statistical Agency, *Ethiopia Mini Demographic and Health Survey 2014* (Addis Ababa: Central Statistical Agency, August 2014), [http://www.unicef.org/ethiopia/Mini\\_DHS\\_2014\\_Final\\_Report.pdf](http://www.unicef.org/ethiopia/Mini_DHS_2014_Final_Report.pdf).

<sup>7</sup> Ethiopia Central Statistical Agency and ICF International, *Ethiopia: 2011 Demographic and Health Survey: Key Findings* (Calverton, MD: CSA and ICF International, 2012), <http://dhsprogram.com/pubs/pdf/SR191/SR191.pdf>.

<sup>8</sup> CSIS interview, June 27, 2016.

<sup>9</sup> Ibid.

<sup>10</sup> In a cabinet reshuffle on November 1, Dr. Kesete Birhan Admasu was removed as minister of health.

<sup>11</sup> CSIS interview, June 30, 2016.

<sup>12</sup> As part of the government's efforts to promote healthy behaviors, Ethiopia has created "model families" or households that have adopted priority interventions. Part of a "health development army" of volunteers, these families support other households in adopting a package of essential health interventions. For more information, see Claire Provost, "Ethiopia's model families hailed as agents of social transformation," *The Guardian*, January 9, 2014, <https://www.theguardian.com/global-development/2014/jan/09/ethiopia-model-families-social-transformation-healthcare>.

According to Minister Kesete, the health improvements, especially increased use of modern methods of family planning, have caused one of the largest declines in maternal mortality rates in all of sub-Saharan Africa, second only to Rwanda.<sup>13</sup> The data to validate these claims are not yet publicly available, but if the upcoming Demographic and Health Survey (DHS) supports them, this would signify an enormous accomplishment.

## Looming Challenges and Partner Reliance

Sustaining these health gains presents significant challenges. Many involved in health in Ethiopia fear serious consequences if the health extension program's achievements are not consolidated, and if the current crisis and government crackdown undercut the health system's often-fragile capacity. One implementer described the concerns of many others, noting that "if the health extension platform crumbles, all the gains could be reversed. That's our biggest worry."<sup>14</sup>

Even if the health extension worker model is not undermined by the current political situation, it faces serious challenges. While the health extension worker program has helped to facilitate stronger linkages between their communities and the health system, a lack of basic infrastructure and supplies impedes further progress. There is no water at Ababa's health post, and it takes her 30 minutes to fetch water with a jerry can. The frequent disruptions in electricity and supplies and lack of medical equipment are persistent problems that impact everything from vaccine storage to the delivery of family planning services.

Transportation is another critical challenge. Without a sufficient number of ambulances or transportation options, the higher-level health facilities can be virtually inaccessible. Even when transportation is available, the often-difficult terrain and remote villages can present serious problems of access. We met a 35-year-old woman at a maternity waiting room in the Mahbere D'égo health center, who had walked for two hours to deliver there. She told us that the ambulance could not reach her village, since it was far off the road, so the health extension worker told her to make her way to the health center on her own. It was her third pregnancy, but her first time giving birth at a facility—she had been waiting for a week, and told us she had come to get medical help for her delivery so as "not to die."<sup>15</sup>

Key to strengthening the health system is improving the capacity of healthcare providers, especially through training and mentoring to strengthen their ability to identify serious problems and mitigate the impacts of high turnover. Despite targets for training midwives in basic emergency obstetric and newborn care, long-acting methods of family planning, and integrated management of maternal and childhood illnesses, gaps in skills remain due to high turnover rates, and even those who were trained are in need of refresher trainings. Through the U.S. Agency for International Development's (USAID) flagship Integrated Family Health Program (IFHP),<sup>16</sup> each *woreda* (the smallest unit of local

<sup>13</sup> CSIS interview, June 30, 2016.

<sup>14</sup> CSIS interview, June 29, 2016.

<sup>15</sup> CSIS interview, June 27, 2016.

<sup>16</sup> IHFP is implemented by Pathfinder International and John Snow, Inc.

government) began budgeting for supervision and training. But the needs in this area surpass IFHP's efforts.

Verifying health data in Ethiopia is particularly challenging. A complication involves the vertical donor funds that require separate reporting mechanisms, resulting in extreme fragmentation; one donor expressed frustration that "you can't look across systems."<sup>17</sup> USAID, for example, requires its own reporting and tracking, and that capacity for data collection is built and retained in the implementing partners, not within the health system.

In many of these areas, health centers rely heavily on implementing partners, such as IFHP funded by USAID and the Last 10 Kilometers Project supported by the Bill & Melinda Gates Foundation and USAID, for training, mentorship, technical support, and logistics. Yet fundamental challenges remain in transferring these responsibilities to the government health system. Although the government has been asking for foreign donors and implementers to hand over these responsibilities, many donors hold serious doubts about the government's delivery capacity and continue to funnel health funding through implementers. One implementer reflected on the difficulties of "graduating" health facilities and getting implementers to the "backseat."<sup>18</sup> These efforts are also complicated significantly by the ongoing unrest.

## Meeting the Needs of Ethiopia's Youth, Especially Adolescent Girls

Nearly half of Ethiopians are under 15. This young population poses stark challenges to the educational and health infrastructure, as well as pressure for jobs and services. While nearly half of women and 40 percent of men have received no formal education, there are 30 million Ethiopians currently in school. Success in reducing child deaths means that there are more young people who need to be reached with important services than ever before. And there is still much more to do, particularly around the health and wellbeing of adolescent girls. Poverty and gender inequality continue to increase the risks of early marriage and childbirth, unintended pregnancy, and school dropout among young women.<sup>19</sup>

One of IFHP's goals in supporting the Health Extension Program is to train peer educators in sexual and reproductive health services and establish youth-friendly services in health centers across a number of regions. Since 2008, peer educators trained under IFHP have worked to support and scale up services outlined in the National Adolescent and Youth Reproductive Health Strategy.<sup>20</sup> We were able to speak with peer educators at Rahya health center, who outlined some of the biggest challenges facing young people, ranging from healthcare-specific issues to entrenched cultural

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<sup>17</sup> CSIS interview, August 19, 2016.

<sup>18</sup> CSIS interview, June 29, 2016.

<sup>19</sup> While we heard that child marriage is less frequent now in some parts of the country, Ethiopian women are often married by the time they turn 17. Family planning use among 15- to 19-year-old girls is under 10 percent, despite the fact that 60 percent have had sex by the time they turn 18.

<sup>20</sup> Federal Democratic Republic of Ethiopia, Ministry of Health, *National Adolescent and Youth Reproductive Health Strategy, 2007–2015* (Addis Ababa: Ministry of Health, n.d.), [http://countryoffice.unfpa.org/filemanager/files/ethiopia/ayrh\\_strategy.pdf](http://countryoffice.unfpa.org/filemanager/files/ethiopia/ayrh_strategy.pdf).

norms. They noted the lack of a separate space for young clients, which discourages teenagers from seeking services for fear of being seen by people they know. Few unmarried adolescents are counseled on family planning, which is closely related to negative provider attitudes. Menstruation was cited as a major issue related to education, as it often interferes with school attendance. And while things are changing, early marriage, sexual violence, and abduction remain all too common.

## The Evolving Donor Landscape

The Ethiopian government has attracted substantial donor support. At roughly \$3.6 billion per year,<sup>21</sup> it is the largest recipient of health and development assistance in sub-Saharan Africa. This level of support is based on what many donors see as Ethiopia's commitment to advancing health and development, combined with its high levels of poverty and disease. Yet sustainable financing for health will also require mobilizing Ethiopian domestic resources, especially as donor support is predicted to decline in the coming years. The government is working to improve its community-based health insurance scheme,<sup>22</sup> which the Ministry of Health claims already covers close to 20 million people, but far more resources will be needed.

Ethiopia is one of the first four countries for the Global Financing Facility (GFF),<sup>23</sup> a new financing mechanism for reproductive, maternal, newborn, child, and adolescent health (RMNCAH) to transition countries approaching middle-income status away from donor funding and toward International Development Association (IDA) credits and low-interest loans. A GFF Trust Fund has also been established, funded by Canada, Norway, and the Bill & Melinda Gates Foundation; the World Bank expects that every \$1 in Trust Fund grants will leverage \$4 in IDA financing. Nevertheless, as one donor put it, "GFF is not a PEPFAR [President's Emergency Plan for AIDS Relief] for MCH; it relies on government systems."<sup>24</sup>

The minister told us that given the ambitious goals outlined in the latest health sector transformation plan (HSTP),<sup>25</sup> the donors should focus on health outcomes as opposed to accounting for how each dollar is spent. He sees this as part of a "responsible transition" away from donor support, noting that declining donor support "has the potential to reverse the gains we've made over many years. . . . Instead of cutting the budget, we should ask how can we sustain the gains and what are the additional investment requirements."<sup>26</sup> The minister referred to Gavi's approach<sup>27</sup> in transitioning countries away from support for vaccine purchase, and believes that progressive increments on co-financing responsibilities should be the way forward. Another donor in Ethiopia put it this way: "The

<sup>21</sup> Development Assistance Group Ethiopia, "ODA [official development assistance] to Ethiopia," <http://dagethiopia.org/new/oda-to-ethiopia>.

<sup>22</sup> USAID Health Finance and Governance Project, "Ethiopia Scales Up Community-based Health Insurance," 2015, <https://www.hfgproject.org/ethiopia-scales-community-based-health-insurance/>.

<sup>23</sup> Global Financing Facility, "Introduction," <http://globalfinancingfacility.org/introduction>.

<sup>24</sup> CSIS interview, August 19, 2016.

<sup>25</sup> Federal Democratic Republic of Ethiopia Ministry of Health, *Health Sector Transformation Plan 2015/16–2019/20* (Addis Ababa: Ministry of Health, October 2015), <http://www.moh.gov.et/documents/26765/0/Health+Sector+Transformation+Plan/5542a23a-9bc7-46a2-8c1f-8b32c2603208?version=1.0>.

<sup>26</sup> CSIS interview, June 30, 2016.

<sup>27</sup> Gavi, the Vaccine Alliance, "Transition Process," 2016, <http://www.gavi.org/support/apply/graduating-countries/>.

single most important challenge facing Ethiopia is what they need to do for donors to phase out. . . . The lack of qualified leadership is striking.”<sup>28</sup>

## Looking Forward

The next six months will be decisive for Ethiopia, and much is at stake. The country could descend further into a spiral of bloodshed and repression, or the ruling party could engage with communities to address political conflicts and regional grievances and to allow independent voices to be heard. So while the extraordinary transformation that Ethiopia has seen since 1991 is undeniable—from a war-ravaged country to a rapidly growing, regional leader—the ruling party’s authoritarian instincts may ultimately be the undoing of its much-lauded achievements.

The current crisis presents serious risks to advancing women’s and children’s health, since the ongoing violence and extensive restrictions associated with the state of emergency could disrupt access to health services and reverse the fragile gains. But there are also considerable risks for the United States; after years of supporting Ethiopia’s health system and economic development, and working closely with the government on regional security issues, the United States may now have to confront the cost of its acquiescence on human rights and governance in the name of development and security. At this critical juncture, the United States should send a clear message that the U.S.-Ethiopian partnership to advance the nation’s health and development requires a demonstrable commitment to all human rights.

As an Ethiopian health expert wondered when we met in June: “Is there a price to pay for [the country’s transformation] in terms of individual liberty and civil society?”<sup>29</sup> The current crisis answers his question with a sobering “yes.”

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<sup>28</sup> CSIS interview, June 30, 2016.

<sup>29</sup> Ibid.