Assessing Political Priority for Reproductive Health in Ethiopia

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Introduction:

With the inclusion of Millennium Development Goal #5 (Improve maternal health)(1) in the year 2000, reproductive health and maternal mortality began to receive heightened global attention. According to the WHO, 358,000 maternal deaths happen every year, and millions more women are hospitalized from causes related to pregnancy and childbirth(2). Over 215 million women have an unmet need for contraception, and, in recent years, increases in contraceptive prevalence have stalled(3), and along with decreasing access to contraception, unsafe abortion is accounting for larger proportions of all abortions globally(3). Such trends not only indicate that progress in improving reproductive health for the worlds women is not happening fast enough, but that, in some instances, ground is being lost.

Shiffman Framework

In a series of papers beginning in 2007, Shiffman *et al* argue that cohesive, global, political support for the safe motherhood initiative has been difficult to achieve given the following key factors a) a perceived lack of severity; as compared to many other diseases, maternal mortality is a relatively infrequent event, and measurement challenges prevail in the field making it difficult to measure b) There is lack of agreement within the movement as to the 'best' interventions c) There exists a fragmented framework of how to advocate for safe motherhood on a global context(4-8). Shiffman and colleagues go on to argue that in order to generate either national or global political support for safe-motherhood, or reproductive health more broadly, four key factors need to be considered: 1) Actor power :policy community cohesion, strong leadership within political/policy community, strong institutions, civil society mobilization; 2) Ideas :internal agreement by

all involved actors on scope and frame of issue, and how to present it to the larger global or national community; 3) Political contexts:(awareness of and access to policy windows and advantageous political opportunities; 4) Issue characteristics: credible indicators, severity, and effective interventions.(8).

Evidence from a range of low-income countries(5, 9, 10) suggests that, in a politically supportive environment, dramatic declines in maternal deaths can be achieved through simple, cost-effective interventions(11). In the 1930's Malaysia, despite boasting a relatively strong economy, and Sri Lanka, a low-income country, were both plagued with extremely high maternal mortality ratios (500/100,000 live births and over 2000/100,000 live births, respectively)(12). Between 1930 and 1995, Malaysia and Sri Lanka both implemented comprehensive national strategies aimed at reducing maternal mortality, and succeeded in reducing to below 50/100,000 by 1995 (12, 13).

The remarkable declines in maternal mortality achieved by Sri Lanka and Malaysia serve as models for the future prioritization of maternal mortality and reproductive health generally. Such declines demonstrate that a) governments can successfully prioritize and establish an ongoing commitment to the reduction of reproductive health and b) governments can implement cost-effective, nationally appropriate, solutions by following through with their political and financial commitments. These models with some modification based on circumstance and culture, could be considered for replication by other countries with high MMRs, low contraceptive prevalence, and even inequalities in access to reproductive health services.

Individual countries which have been successful in reducing maternal mortality, regardless of interventions or financing mechanisms, have in common the national political prioritization of safe motherhood: governments have committed to reducing maternal mortality, dedicated financial and political resources, taken advantage of policy windows, mobilized and encouraged cross-sector collaborations, harnessed the energy of political champions, and effectively communicated the problem and the unique national program intended to solve it(5, 11, 14).

Shiffman and colleagues argue that effective domestic advocacy in the reproductive health arena must involve a multi-sector alliance which together develops a cogent, nationally appropriate plan, and works together to implement it(8).

Reproductive Health In Ethiopia

The second most populous country in Africa, 84% of Ethiopians live in rural areas, and 78% of the population lives on less than $2 per day(15). Mountainous terrain, scarce resources, and poor infrastructure place enormous restrictions on access to established health facilities for the large majority of Ethiopians. Ethiopian Total fertility rate has been estimated at 4.8 in 2011, and the use of contraceptives by married women is 29%(16). Lack of knowledge, cultural stigma surrounding abortion, and barriers to access of services contribute to persistently high rates of unsafe abortion and unsafe abortion related mortality. A ministry of health study estimated that abortion-related deaths in 2006 accounted for over 30% of maternal deaths in Ethiopia (17). While recent studies of maternal mortality rates and trends show some indication of improvement in some parts of the developing world, Ethiopian maternal mortality is not declining as would be needed to reach the MDGs. Ethiopia is among the top six countries contributing to the highest numbers of maternal deaths globally (18).

The reproductive health movement in Ethiopia has a rich history, beginning in 1993 with the population policy and, in 2005, a major milestone was achieved with the revision to the Ethiopian penal code decriminalized abortion; permitting abortion for a wide array of circumstances including: if the pregnancy is a danger to the life, health, or mental health of the mother, in cases of rape, incest, fetal impairment, or if a woman is under 18 and unprepared for childbearing(19, 20). While little is yet known about the public health implications of the abortion law reform, the Ethiopian abortion law permits women to have access to safe abortion services more readily than is possible in the vast majority of African countries.

Using the *Shiffman Framework* for political prioritization of reproductive health(8), this study seeks to assess the generation and institutionalization of political priority for reproductive health within the political systems of Ethiopia, understand the context through which such priority was developed, and identify the key factors that allowed for such significant legal and programmatic gains in the arena of reproductive health.

Methods

Between July 2010 and January 2011 17 in-depth interviews were conducted with key policy makers, government ministers, academics, and leaders of prominent non-governmental organizations in Ethiopia. Interviewees were selected from a list of key informants, centrally involved with or particularly knowledgeable about the reproductive health history and decision making processes. Informed consent was obtained from all interviewees, and to protect the privacy of all participants (and concurrent with study protocol) no names of individuals or organizations were recorded. Interview length was between 16 minutes and 1 hour and 8 minutes, with an average interview length of 38 minutes and 15 seconds. Interviews were transcribed between January 2011 and August 2011. The two investigators independently reviewed the transcripts of each interview, using a matrix approach to quantify the number of times that key words and themes arose in each transcript. Key words, major themes, and trends from the 17 interviews were categorized, and compared with the principal components of "Shiffman's Framework" for the generation of political priority to determine the relevance of that framework on the development of political priority for reproductive health in Ethiopia. The study protocol was approved by the Committee for the Protection of Human Subjects at the University of California, Berkeley(CPHS #: 2010-05-1443).

Results

1. Political Context

Reproductive health policies in Ethiopia changed significantly in 1992. Evidence from 1960s and 1970s established the links between population pressure and dwindling natural resources in the country. Respondents in our study alluded to "v*isible government commitment to address population issues*". At that moment in history, a window of opportunity was created; allowing for debates, thus enabling an environment where various actors could engage in discussions about reproductive health and attempt to influence decision makers. Six milestones capture respondent's depiction of the environment in which they worked at the time:

1.1 Newly Established Government (1992) creates task force for population policy.

The majority of respondents in this study noted that the newly established Ethiopian Government that came to power in 1992 began prioritizing reproductive health. A National Office for Population was established, and its director ranked as "minister"; giving the issues under the control of the office significant power within the administration.

1.2 *Population Policy is drafted.*

Numerous respondents described the task force for population, which received directives from the Prime Minister to draft the first national population policy. The main objective of the policy, described by one of the respondents, was: "*to balance rapid population growth with that of economic and social development in the country"*.
The population policy describes its rationale as to address the "Underdevelopment characterized by Ethiopian society in the following ways: i) Low productivity resulting in high rates of unemployment; ii) Low accessibility of basic social services such as health and education; iii) Food insecurity; iv) High prevalence of maternal, infant and child mortality attributed to the low status of women and high fertility and; v) Low life expectancy (20). The policy also had provisions for promotion and expansion of foreign aid for reproductive health in the country, and was released in 1993.

1.3 International Conference on Population and Development (ICPD).

September 1994 was considered another important landmark by the majority of the respondents; opening another political window, by allowing supporters of the population policy to continue the discussions around reproductive health and attempting to align internal policies with the global reproductive health agenda. One responded described the situation at the time as:

> "*The population policy came out in…1993, ICPD was in September 1994… Certain interested groups, of course with the lead of the government, together went through the document and see the gaps, certain issues that have missed from that document"*

1.4 Wave of energy post ICPD, creation of new ministries.

Post ICPD, reproductive health issues continued to be at the forefront of the health care debate. Respondents noted that priority for reproductive health could also be sensed in time and resources devoted to increase collaboration between various ministries directly linked to population programs (i.e health, social affairs, education, information, and others). New offices in those ministries were established, staffed and a large awareness campaign involving the media begun.

1.5 NGO's begin working on Family Planning, INGOs are allowed in.

With one of the specific objectives of the population policy being the reduction of total fertility rate from 7.7 to 4.0 by 2015, and increase contraceptive use by 44% also by 2015, a new platform was created in which local and international NGOs could operate. The government started to allow distribution of contraceptive methods, forbidden by law until 1992.

1.6 Development starts to address population issues.

Working closely with the World Bank, the Government of Ethiopia evaluated how population growth could affect economic development and how could Ethiopia benefit from a more rapid fertility decline (21). The World Bank study concluded that the approach combining gender equity, family planning and population policy implementation, would reduce Ethiopia's population growth more rapidly that development efforts alone. A National Population Policy Plan of Action from 2008/2009 to 2015/2016 was created, to enhance implementation of the Ethiopian National Population Policy. The *Plan of Action* was also aimed at facilitating the integration of population issues with development activities, develop regional population action plans, and effectively monitor and evaluate all efforts. Key actions include reducing unmet need and increasing demand for family planning through information, education, and communication. One respondent remembers one instance during an event celebrating the world population day when a top Government official had to answer questions related to population:

…" We need to work to regulate sort of population growth, for which reproductive health needs to improve,… to have healthy and productive citizens, and so on. That is what he said. …to have these many people… the environment, the landscape, you see, is so – is not conducive to development.

2. Actor Power

Political priority for reproductive health in Ethiopia benefited from strong organizations and leadership concerned with health, rights, and development of Ethiopian society.

2.1 *Civil society development (NGO's, professional associations, women's; groups).*

Civil Society took on an enormously important role in developing cohesive advocacy strategies for reproductive health in Ethiopia. The Ethiopian Society of Gynecologists and Obstetricians and its partners undertook important research, which has informed the development of the policy – the legal framework and associated health policies. The Ethiopian women's' lawyers' association was at the forefront of advocating and creating awareness for the need for legal reform. However, the overall achievement is a result of many organizations. As described by one respondent:

"NGO community formed a steering committee and they were able to contact Parliamentarians and when the document came out for public debate, actually, it was the civil society organizations who organized hundreds of public debates, different levels, and were very instrumental in terms of providing evidence-based information to – to inform both the policy makers and the public that this is an issue worth pursuing. This is an issue that could save millions of lives in the Ethiopian country. And I think this is going to be recorded in history as a major achievement for the civil society organizations"

2.2 Grass roots movement is mobilized.

Mobilization of grass roots organizations became more visible beginning in 1993 with implementation of the population policy. Women's groups, youth groups and religious institutions received support from the government as well as national and international NGOs to foster dialogues in their communities. The Population Media Center expanded its programs to include issues on female genital mutilation, HIV/AIDs, maternal health

and family planning. The importance of the grass roots movement in Ethiopia is best characterized by one respondent:

> *"The women's' regional associations, the youth associations, the religious association the community leaders…were instrumental. Without them, you cannot really act... Simply air a radio program, a television program, cannot really change anything, cannot bring social change unless you involve this grass root level instrument."*

2.3 *Collaborations develop*

Critical to the social movement for reproductive health in Ethiopia the various sectors of civil society collaborated with the professional associations and health providers to generate, create awareness and understanding of the issues affecting reproductive health in the country, and ultimately made the best case with available information. The leadership exercised by the presidents of the OB/GYN society, midwifery society, Women's' Lawyers Association, and Family Guidance Association of Ethiopia proved extremely important as these champions for reproductive health were successful at uniting the policy community, were able to collaborate with the governmental institutions and establish coordinating mechanisms with Family Health department at the Ministry of health and others. A clear understanding of collective power of organizations to affect change is better described as:

> *" I have seen that international organizations, civil society, seems very much concerned about maternal and child survival and promotion of family planning, and what you see from different directions, it is so positive".*

2.4 *Civil society and government align behind the issue.*

The government and civil society were able to work together to focus on improving maternal and reproductive health. The population policy provides a framework for program implementation with defined responsibilities for both governmental and non-governmental organizations, including academic and research institutions. Many respondents spoke about the important coordinating role of the government, especially the role played by the Ministry of health. As one responded put it:

"...Both civil society, the international/local organizations, and the government, in terms of the policies, they are in sync"

3. Ideas

The positioning of problems concerning reproductive health in Ethiopia helped attract support both internally and externally. Respondents spoke to the manners in which those involved in the process recognized and described it in the following ways:

3.1 Understanding of population issues as potentially catastrophic for the country

Around 2 million people are added every year to the population in Ethiopia, and the country remains one of the least urbanized with more than 80% of the population living in rural areas. The inballance created by the pace and distribution of population growth has raised concerns, especially related to environmental degradation and use of natural resources(22). The national population policy addresses these and other more specific issues related to the health and wellbeing of women and children. Special focus is also given to adolescents and young adults. All of the issues were communicated in palatable language for politicians, and focused on the potential impact on poverty, and adolescents' reproductive health needs as the future for country. The gravity of the matter is best described by one respondent:*"...the population programs also make or break...the country's progress and development."*

3.2 Understanding of empowerment as necessary

Despite a well-argued rationale for the issues within the population policy based related to high fertility, and maternal health and mortality, this important policy document has an entire section of the status of women, entitled *" The Situation of Women".* The section clearly describes how the low social and economic status of Ethiopian women was having a direct impact on fertility levels. In addition, it links the status of women to lack of education, and prevailing unfavorable (for women) family laws, leading to high numbers of unwanted pregnancy, and low labor force participation. The policy explicitly

refutes all forms of discrimination against women, including existing practices differentiating social roles for men and women(20).

4. Issue Characteristics

Two main issues seemed to have been the center of attention and probably facilitated political support for reproductive health in Ethiopia.

4.1 Understanding of the Issue, Generation of Solutions.

Both civil society and Government appreciate the need to prioritize reproductive health to help improve the social and economic conditions of Ethiopians. They also acknowledge that the excess mortality due to poor reproductive health conditions can be improved with current evidence-based strategies. Attesting to the understanding of the problem and the ability to deploy solutions to solve it two respondents put it:

> *"Some of the diseases in this country are preventable. What you need is really education, awareness creation, information, in that regard"*

> *"Reproductive issue not only instrumental in saving lives, saving lives of mothers and the children, it is also directly or indirectly contributing to the progress of the country. And this you balance overall population in this country.*

In Ethiopia, the major provider of reproductive health services is the public sector supported by NGOs. These services are integrated in the primary health care system. At village level, services are primarily provided by Health Extension Workers (HEWs), a public program aiming at increasing access to services(23). HEWs family planning work is supported by community-based reproductive health agents (CBRHAs), and private-sector supported social marketing of contraceptives(24).

4.2 Recognition of the problem despite challenges with measurement.

Nearly all respondents mentioned the need for better measurement strategies, more timely data, and better indicators. Despite that, there was overwhelming acknowledgment of the importance of reproductive health as priority. Decisions are made with available information and a broad recognition of the scope of the problem and its implications. For

example, despite limited data on cause specific maternal mortality, but aware of the high level of unwanted pregnancies, unsafe abortion and other traditional harmful practices were recognized as contributors to maternal deaths. As a signatory of the Convention to eliminate all forms of discrimination against women (CEDAW), Ethiopian civil society advocacy efforts lead to a review of the 1957 penal code addressing abortion(19). A new revised penal code was published in 2005. Referring to the level of priority required for reproductive health one respondent concluded:

> *"But still I feel, you know, that reproductive health is still and must remain as a priority. Not only for reproductive health issues but also for economic and development situations."*

Discussion and Conclusions

Our analysis of 17 in-depth interviews with leaders of the reproductive health field in Ethiopia shows that political priority for reproductive health in that country has experienced a long, but ultimately fruitful trajectory that fits well within the framework for political priority established by Shiffman, et al in 2007. The four principal components of Shiffman's Framework: 1) Actor power; 2) Ideas; 3) Political Contexts; 4) Issue Characteristics, have each been described in detail through the in-depth interviews we conducted. We posit that *Political Contexts* helped to establish an environment ripe for change: The first national policy on population was drafted in the early 1990's, with the primary objective of balancing rapid population growth with economic and social development. *Actor Power* then began to play a strong role with the expansion of reproductive health services throughout the country. Contraceptive promotion, previously banned by law, began to be encouraged, allowing local and international NGOs to expand reproductive health service provision especially for the improvement of maternal and child health. The *Ideas* that were able to take hold in such an environment were aided by a cohesive understanding of the scope and framing of the issue. Since the early 1990's, the Government of Ethiopia, its donors, civil society and other stakeholders have collaborated in a concerted effort to prioritize reproductive

health, from the development of a comprehensive population policy to passing legislation to change the penal code with respect to abortion in 2005. Many transnational and national linkages and domestic political factors influenced the prioritization of reproductive health particularly given the unacceptably high maternal and child mortality. Finally, the *Issue Characteristics* of reproductive health in Ethiopia were crucial for the political prioritization of reproductive health. An increasingly obvious link between population growth and poverty in the country; a number of studies demonstrating the enormous cost to health and health systems of maternal mortality from unsafe abortion, especially among young women, and an improved understanding of the importance of safe-abortion services for all women, collectively served as catalysts toward the concrete political prioritization of reproductive health in Ethiopia.

Shiffman notes in a 2007 analysis of priority setting for safe-motherhood in 5 developing countries that political priority often follows the trajectory of political transitions; citing Nigeria as an example where a shift towards democratization may have generated shifts in public opinion, and aided in the setting of political priority for safe motherhood in 1999. It is interesting to note that in Ethiopia, a democratic transition occurred after the collapse of the Derg regime in 1991, allowing for a shift in public consciousness, the opening of political space for new ideas, and creating an opportunity for the introduction of new population policies.

It is important to note that there is evidence of the impact of Ethiopia's population policy. Improvements have been reported in girls' education with enrollment in 2006 at 77%; total fertility rate has declined from 5.5 in 2000 to 4.8 in 2011, with Addis Ababa showing below replacement level fertility since 2005; and the contraceptive prevalence almost doubled from 15% in 2005 to 29% in 2011(16). Despite these and other achievements, many respondents also mentioned the challenges to implement the policy: lack of human and financial resources being the main constraints.

This paper has argued that the development of political priority for reproductive health in Ethiopia fits well within the framework established by Shiffman et al for understanding prioritization of global health issues. This paper does, however, have some limitations. Notably, the interviews conducted for this study were qualitative in nature, and cannot be said to be statistically representative of any larger group than the

interviewees themselves. Additionally, while the investigators used their best knowledge of the field and attempted to identify key players from a wide variety of sectors involved in reproductive health in Ethiopia, it is possible that some sectors may have been missed, and all opinions have not been fully represented. Despite its limitations, this paper does make an important contribution to the understanding of how political priority for reproductive health was generated in Ethiopia, and may serve as a model to follow for other countries that may be interested in generating political priority for reproductive health issues in their own contexts.

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