REPRODUCTIVE HEALTH matters

ISSUES IN CURRENT POLICY

Assessing political priority for reproductive health in Ethiopia

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Abstract: *Ethiopia is among the top six countries contributing to the highest numbers of maternal deaths globally. The Ethiopian total fertility rate was estimated at 4.8 in 2011, and the use of contraceptives by married women was 29%. Lack of knowledge, cultural stigma surrounding abortion, and barriers to access of services contribute to persistently high rates of unsafe abortion and abortion-related mortality. This study seeks to assess the generation and institutionalization of political priority for reproductive health within the political systems of Ethiopia. Interviews with key policy makers, government ministers, academics, and leaders of prominent non-governmental organizations in Ethiopia between July 2010 and January 2011 were conducted, using Shiffman and Smith's Framework, to analyse the key actors and ideas behind the shift towards prioritization of reproductive health in Ethiopia, as well as the political context and primary characteristics of the issues that propelled progressive action in reproductive health in that country. Some of the key lessons point to the readiness of the Ethiopian government to reform and to improve the socio-economic status of the population. The role of civil society organizations working alongside the government was crucial to creating a window of opportunity in a changing political climate to achieve gains in reproductive health. To our knowledge, this is the first time Shiffman and Smith's Framework has been used for reproductive health policies. We conclude that Ethiopian experience fits well within this framework for understanding prioritization of global health issues and may serve as a model for other sub-Saharan African countries.*

Introduction

The fifth Millennium Development Goal to improve maternal health by the year 2015,[1] put reproductive health and maternal mortality on the international health agenda once again. According to the World Health Organization (WHO), 358,000 maternal deaths happen every year, and millions more women suffer from pregnancy- and childbirth-related morbidities.[2] A 2014 study estimated that 57% of pregnancy-related deaths globally could be prevented with family planning alone due to reduced fertility and fewer pregnancies.[3] Despite increases in contraceptive use globally, there are still more than 215 million women with unmet need for contraception, most of them in low- and middle-income countries.[4] In addition to contraception access challenges, unsafe abortions – most of which occur in developing countries – contribute to high maternal mortality and morbidity.[5] Global disparities in access to reproductive health result in high rates of maternal mortality, and political action is needed to improve legal and programmatic frameworks. This study investigates political priority for reproductive health in Ethiopia using Shiffman and Smith's Framework. The case of Ethiopia can serve as an example of how political priority for reproductive health can be generated, leading to reform.

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; b) lack of agreement as to the "best" interventions to tackle maternal mortality; and c) the fragmented framework on how to advocate for safe motherhood in a global context. 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: cohesion and strong leadership within the political/policy community, strong institutions, and civil society mobilization.

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2) Ideas: internal agreement by all involved actors on the scope and frame of the 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.[6]

Evidence from a range of low-income countries[7–9] suggests that, in a politically supportive environment, dramatic declines in maternal deaths can be achieved through simple, cost-effective interventions. In the 1930s, Malaysia, despite boasting a relatively strong economy, and Sri Lanka, a low-income country, were both experiencing extremely high maternal mortality ratios (MMRs) (500/100,000 live births and over 2000/100,000 live births, respectively).[10] Between 1930 and 1995, Malaysia and Sri Lanka both implemented comprehensive national strategies aimed at reducing maternal mortality and succeeded in reaching an MMR below 50/100,000 by 1995.[10,11] This trend was seen in many more countries such as Mongolia, Egypt and Honduras, among others.[12–14]

The remarkable declines in maternal mortality achieved by these countries could encourage prioritization of reproductive health generally, and maternal health particularly, elsewhere. Such declines demonstrate that governments can successfully prioritize and establish an on-going commitment to improvements in reproductive health and implement cost-effective, nationally appropriate solutions by following through on their political and financial commitments. This model of political prioritization could also be important in high-income countries such as in the United States of America where the MMR is increasing.[15] With some modification based on circumstance and culture, these models could be considered for replication by other countries with high MMR, low contraceptive prevalence, and inequalities in access to reproductive health services.

For many of the countries that have been successful in reducing maternal mortality, national political prioritization of safe motherhood may have been a facilitating factor, regardless of interventions or financing mechanisms. In many cases, 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.[6,13,16] Shiffman and colleagues argue that effective domestic advocacy in the reproductive health arena must involve a multi-sector alliance. This alliance will then develop a cogent, nationally appropriate plan and will work together to implement it.[6]

Reproductive Health in Ethiopia

In Ethiopia, the second most populous country in Africa, 84% of the population live in rural areas and 78% live on less than US$2 per day.[17] Mountainous terrain, scarce resources, and poor infrastructure place enormous restrictions on access to established health facilities for the large majority of Ethiopians. The Ethiopian total fertility rate was estimated at 4.8 in 2011, and the use of contraceptives by married women was 29%.[18] Lack of knowledge, cultural stigma surrounding abortion, and barriers to access of services contribute to persistently high rates of unsafe abortion and abortion-related mortality. A Ministry of Health study estimated that abortion-related deaths in 2006 accounted for over 30% of maternal deaths in Ethiopia.[19] While recent studies of maternal mortality ratios and trends show some improvement in some parts of the developing world, Ethiopian maternal mortality has not declined sufficiently to reach the target of MDG 5; Ethiopia is among the top six countries contributing to the highest numbers of maternal deaths globally.[20]

Even though this paper is not meant to offer a historical review of the Ethiopian political environment regarding reproductive health, it is important to highlight a few important events. The ruling party that reformed the population and abortion policies had a Marxist ideology and secular orientation, and during its 17 year struggle for power highlighted the importance of improving the living conditions of all Ethiopians. A more detailed account of the political reform timeline for relevant policies and programs in Ethiopia, data sources, and initiatives can be found in Sarah Jane Holcombe's dissertation "Agenda-Setting: Ethiopia's 2005 Reform of its Law on Abortion."[21]

The reproductive health movement in Ethiopia has a rich history, with the 1993 Population Policy playing a pivotal role (called simply the Population Policy throughout this paper). The Population Policy was crafted during the Transitional Government following the Imperial and Military regimes in Ethiopia, where population and demography had

virtually been ignored as an issue of national interest. The Population Policy recognized the relationship between chronic food and resource shortages and population growth in the country. The policy's goal was "to harmonize the rate of population growth with that of the economy." [22] Among its many objectives were the goals of reducing the high fertility rate from 7.7 to 4 and increasing the modern contraceptive prevalence from less than 5% to at least 44% among married women of reproductive age. Prior to this policy, the Ethiopian Government had actively discouraged contraceptive distribution and use. Therefore the Population Policy brought about drastic reform to the reproductive health care sector.[23]

Another milestone was passed in 2005 with the revision of the Ethiopian penal code, which decriminalized abortion, permitting it for a wide array of circumstances including in case of danger to the life, health, or mental health of the mother; in cases of rape, incest or foetal impairment; or when a woman is under 18 and unprepared for childbearing.[21,23,24] 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 Shiffman and Smith's Framework for political prioritization of reproductive health,[6] this study seeks to achieve the following aims: 1) assess the generation and institutionalization of political priority for reproductive health within the political systems of Ethiopia, 2) understand the context through which such priority was developed, and 3) 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 (NGOs) in Ethiopia. All interviewees were Ethiopian nationals, professionally active during the period of population policy reform. Interviewees were purposefully 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 the study protocol), no names of individuals or organizations were recorded. Interview length was on average 38 minutes. Interviews were transcribed between January and August 2011. Two investigators independently reviewed the transcripts of each interview. Key words, major themes, and trends from the 17 interviews were categorized and compared with the principal components of Shiffman and Smith's Framework for the generation of political priority (actor power, ideas, political contexts, and issue characteristics) to determine the relevance of that framework for the development of political priority for reproductive health in Ethiopia. Themes outside of the framework that emerged from the interviews were also analysed. Examples of such themes include demand for family planning services, role of media in demand generation, role of communities, services for adolescents and unmarried women and other programmatic implementation areas. Information from these themes that supported Shiffman and Smith's Framework was included in the results section. Relevant policy documents in addition to Ministry of Health official statements, reports, communications between Regional Health Bureaus and Ministry of Health, as well as other Ministries, were reviewed and used to verify information gathered during interviews. Personal communications such as speeches by high-level officials as well as essays on the subject matter or statement made to the media were also reviewed and assessed for political climate and level of discussions at the time of the population policy reform. All significant documents are referenced in relevant sections of the article. In addition to the process of verification using the various documents, the information presented in the results section was mentioned by the majority of the respondents. 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

Findings from our study within the four principal component categories of Shiffman and Smith's Framework, and themes found outside of the framework specific to programmatic implementation, are presented below.[6]

1. Political Context

Shiffman notes in a 2007 analysis of priority setting for safe motherhood in five developing countries

that political priority often follows the trajectory of political transitions.[8] In a different article with Okonofua, Shiffman demonstrates that Nigeria is an example of a country 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.[16] It is interesting to note that Ethiopia followed the same pattern; a democratic transition occurred after the collapse of the Derg regime in 1991, allowing for a shift in public consciousness, opening the political space for new ideas, and creating an opportunity for the introduction of new population policies.

Reproductive health policies in Ethiopia changed significantly in 1992. Trends in population level data gathered in the 1960s and 1970s, as well as projections, established the links between population pressure and dwindling natural resources in the country, which prompted government action leading to the Population Policy in 1993. Respondents in our study alluded to "*visible government commitment to address population issues.*" At that moment in history, a window of opportunity was created, allowing for debates and enabling an environment where various actors could engage in discussions about reproductive health and attempt to influence decision makers. Six milestones capture respondents' depictions of the environment in which they worked at the time of policy reform in 1993 and soon after: the creation of a task force for the Population Policy by the new government; the drafting of the 1993 Population Policy; the effect of the International Conference on Population and Development (ICPD); the wave of energy post-ICPD; the intensification of family planning work done by NGOs; and economic development polices taking rapid population growth into account. An emerging theme in this study was the creation of a task force for population policy. The newly established Ethiopian Government that came to power in 1992 began prioritizing reproductive health due to the aforementioned recognition of limited resources and rapid population growth. A National Office for Population was established, and its director ranked as "minister." This gave the issues under the control of this office significant political weight within the administration, showing great enthusiasm for reform among those in and out of government, a departure from the regressive policies of the previous regime.

PETER BARKER / PANOS PICTURES

Work-based community health programme, contraception education and distribution, Ethiopia

Respondents described how the task force for population policy received directives from the Prime Minister to draft the first national population policy in great detail. The main objective of the policy, according to one of the respondents, was "*to balance rapid population growth with that of economic and social development in the country.*" In the 1993 Population Policy, the rationale for addressing Ethiopia's "underdevelopment" is described in the following ways: 1) low productivity resulting in high rates of unemployment; 2) low accessibility of basic social services such as health and education; 3) food insecurity; 4) high prevalence of maternal, infant and child mortality attributed to the low status of women and high fertility; and 5) low life expectancy.[23] The policy also had provisions for promotion and expansion of foreign aid for reproductive health in the country and outlined how foreign assistance should be channelled to carry out the policy's objectives.

The majority of respondents considered September 1994, the date of the International Conference on Population and Development, to be another important landmark in drawing attention to reproductive health in Ethiopia. Ethiopia's Prime Minister at the time, Tamrat Layne, gave a plenary speech at ICPD, and sent a significant delegation. This conference opened another political window by allowing supporters of the 1993 Population Policy to continue the discussions around reproductive health in an effort to align internal Ethiopian policies with the global reproductive health agenda. One respondent described the situation at the time in the following way:

"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 [Population Policy] document and saw the gaps, certain issues that were missing from that document."

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 apparent in the time and resources devoted to increase collaboration between various ministries linked to population programs (e.g., health, social affairs, education, information and women's affairs). New offices in those ministries were established and a large awareness campaign involving the media began.

With two of the specific objectives of the Population Policy being the reduction of the total fertility rate from 7.7 to 4.0, and the increase of contraceptive use by 44% by 2015, a new platform was created in which local and international NGOs could operate more freely to achieve these goals. However, it is important to note that some NGOs were already working on family planning, as described in a blog by the Minister of Health. On the blog "Health In Ethiopia," a post on February 22, 2012 by Dr. Kesete-Birhan Admasu, current Minister of Health, addressing the progress in family planning, gives credit to the Family Guidance Association of Ethiopia (FGAE) for pioneering the provision of modern family planning services since its establishment in the late 1960s and under difficult circumstances. In fact, the Population Policy document mentions FGAE by name and encourages other NGOs to expand family planning services.

Provision of family planning services could be considered weak in the early stages of implementation of the Population Policy, especially in rural areas where the majority of Ethiopians live. No significant events were mentioned between 1993 and 2004 by the interviewers and the review of policy documents did not produce any relevant results. However, in 2004 there was a major breakthrough in the public sector with the government launch of the flagship Health Extension Worker program. Family planning is one of the components of maternal and child health provision through the Health Extension Program (HEP). HEP is an innovative health service delivery program that aims at universal primary health care coverage. The program gives priority to the prevention and control of communicable disease with active community participation, with the goal of providing equitable access to basic health services.

There was a general agreement among interviewees that relationships between health, reproductive health, national and international NGOs and the government and its policy framework were harmonious by 2004,[25] a situation that did not prevail in other sectors such as agriculture or human rights and democratization. In summary, the government created a hospitable policy and programmatic space for national and international NGOs to contribute to improving population and reproductive health status.

Working closely with the World Bank, the Ethiopian Government evaluated how population growth could affect economic development and how Ethiopia could benefit from a more rapid fertility decline.[26] The World Bank study concluded that an approach combining gender equity, family

planning, and population policy implementation would reduce Ethiopia's population growth more rapidly than development efforts alone. A *National Population Policy Plan of Action* for 2008–2009 to 2015–2016 was created, which strove 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, developing regional population action plans, and effectively monitoring and evaluating all efforts. Key actions include reducing unmet need and increasing demand for family planning through information, education and communication. One respondent remembered one instance during an event celebrating World Population Day when a top government official commented on the implications of rapid population growth on the environment and natural resources. The government official emphasized that rapid population growth would make development difficult to achieve in Ethiopia and for that reason the country needed to focus on improving reproductive health.

2. Actor Power

Political priority for reproductive health in Ethiopia benefited from strong organizations and leadership concerned with health, rights, and the development of Ethiopian society. It was also a key issue among many in government leadership positions. In an unpublished work on impressions of Africa's development, Meles Zenawi, then Prime Minister of Ethiopia, stated, "Unless Africa's agricultural technological capability increases, population growth is likely to create a Malthusian reckoning. Africa's Agriculture has reached a dead end."[27] This is a clear recognition of the threats posed by rapid population growth.

Civil society took on an enormously important role in the 2000s, developing cohesive advocacy strategies for reproductive health in Ethiopia. The Ethiopian Society of Gynaecologists and Obstetricians and its partners undertook important research that informed the Population Policy's development, which included the legal framework and associated health policies. The Ethiopian Women Lawyers' Association was at the forefront of advocating for and creating awareness around the need for legal reform. However, the overall achievement is the result of efforts by many organizations. As described by one respondent:

"[The] NGO community formed a steering committee, and they were able to contact Parliamentarians and when the [Population Policy] 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 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."

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 dialogue in their communities. The Population Media Centre 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 associations, the community leaders…were instrumental. Without them, you cannot really act… Simply air[ing] a radio program, a television program, cannot really change anything, cannot bring social change unless you involve this grass root level instrument."

The collaboration between civil society, professional associations, and health providers was critical to the social movement around reproductive health in Ethiopia. It generated awareness and understanding of the issues affecting reproductive health in the country, and ultimately made the best case for providing these services with the available information. The leadership exercised by the presidents of the OB/GYN society, midwifery society, Ethiopian Women Lawyers' Association, and Family Guidance Association of Ethiopia proved extremely important. These champions for reproductive health were able to unite the policy community, collaborate with governmental institutions, and establish coordinating mechanisms with the Family Health Department at the Ministry of Health and others. A clear understanding of the collective power of organizations to affect change is described in the following quote:

"I have seen that international organizations, civil society, seem very much concerned about maternal

and child survival and promotion of family planning, and what you see from different directions [actions taken by these organizations], it is so positive."

The government and civil society were able to work together to focus on improving maternal and reproductive health. The population policy provided 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 respondent put it:

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

3. Ideas

The positioning of problems concerning reproductive health in Ethiopia helped attract support both internally and externally. Respondents spoke of the manner in which those involved in the process recognized and described it in the following ways: *understanding of population issues as potentially catastrophic for the country* and *understanding of empowerment as necessary.*

Around 2 million people are added to the population in Ethiopia every year, and the country remains one of the least urbanized in Africa, with more than 80% of the population living in rural areas. The imbalance created by the pace and distribution of population growth has raised concerns, especially related to environmental degradation and use of natural resources.[28] The Population Policy came about to address these and other more specific issues related to the health and wellbeing of women and children. Special focus was also given to adolescents and young adults. All of the issues were communicated in palatable language for politicians and focused on the potential impact of population growth on poverty and adolescents' reproductive health needs. One respondent best describes the gravity of the matter:

"…The population programs also make or break… the country's progress and development."

In addition to a well-argued rationale for the importance of the issues of high fertility and maternal health and morbidity within the population policy, this important policy document also has an entire section focused on the status of women, entitled *"The Situation of Women."* The section clearly describes how the low social and economic status of Ethiopian women has a direct impact on fertility levels. In addition, it links the status of women to lack of education and family laws that are unfavourable for women, leading to high numbers of unwanted pregnancies and low female labour force participation. The policy explicitly denounces all forms of discrimination against women, including existing practices differentiating social roles for men and women.[22]

4. Issue Characteristics

The main factors that probably facilitated political support for prioritizing reproductive health issues in Ethiopia were: understanding the issue in its context, generating solutions and recognition of the problem despite challenges with measurement.

Both civil society and government appreciated the need to prioritize reproductive health to improve the social and economic conditions of Ethiopians. They also acknowledged that the excess mortality due to poor reproductive health conditions could be averted with current evidence-based strategies. Many interviewees conveyed an understanding of the problem and the ability to deploy solutions to solve it, as two respondents stated:

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

"Reproductive issues [referring to both population policy and abortion] [are] 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 [with] this [strategies to improve reproductive health] you balance [stabilize] overall population [growth] in this country."

In Ethiopia, the major provider of reproductive health services is the public sector, which is supported by NGOs. These services are integrated in the primary health care system. At the village level, services are primarily provided by Health Extension Workers, a public sector cadre developed to increase access to services.[29,30] HEWs' family planning work is supported by community-based reproductive health agents and private sector-supported social marketing of contraceptives.[31]

Nearly all respondents mentioned the need for better measurement strategies, more timely

data collection, and better indicators. Despite that, there was overwhelming acknowledgment of the importance of prioritizing reproductive health. Decisions were 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, the high level of unwanted pregnancies, unsafe abortions and other traditional harmful practices were recognized as contributors to maternal deaths. With Ethiopia a signatory of the Convention to Eliminate All Forms of Discrimination Against Women (CEDAW), Ethiopian civil society advocacy efforts resulted in a review of the 1957 penal code addressing abortion.[32] A new revised penal code was published in 2005 granting legal access to abortion in cases of rape, incest, to save a mother's live, foetal impairment and for minors. 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 history that fits well within the framework for political priority established by Shiffman and Smith in 2007. The four principal components of Shiffman and Smith's Framework: 1) actor power; 2) ideas; 3) political contexts; and 4) issue characteristics, were each 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 1990s, with the primary objective of balancing rapid population growth with economic and social development. However, it took almost 15 years before the National Plan of Action 2008/2009 – 2015/16 was drafted. Even though programmatic activities did take place during this time, this period of over a decade might signify still some resistance and/or the absence of a better window of opportunity in the late 1990s to announce a national plan of action to enhance implementation of the policy. A major breakthrough in the provision of family planning services in the public sector took place in 2004 with the government launch of the Health Extension Worker program. Even though HEWs work on general maternal and child health issues, provision of family planning is central to their work.[29,30]

Actor power then began to play a strong role with the expansion of reproductive health services throughout the country. The strength of actors was also more visible in the 2000s with many civil society organizations, including professional associations, actively participating in the debate and this could have contributed to family planning being at the forefront of reproductive health discussions in the country in the early-mid 2000s. Contraceptive promotion, previously banned by law (but not necessarily discouraged), began to be strongly encouraged, allowing local and international NGOs to expand reproductive health service provision, especially for the improvement of maternal and child health. The government also allowed advertising about contraception, even though this was criminalized until reform of the Penal Code in 2005. A cohesive understanding of the scope and framing of the issue aided the *ideas* that were able to take hold in such an environment.

Since the early 1990s, 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. Key individuals in positions of power during times of significant change in reproductive health policies and programs (1990s-2000s) were instrumental to achieving intended goals. To comply with the purpose of this paper, no individuals have been mentioned by name. Nonetheless, evidence exists that the Government of Ethiopia has continued to be committed to reproductive health since the publication of the Population Policy in 1993. Many transnational and national linkages, as well as domestic political factors, influenced the prioritization of reproductive health, particularly the unacceptably high maternal and child mortality. The government's stance could help signal to other sub-Saharan African nations, especially those who are the poorest and maintain high fertility rates, the importance of prioritizing reproductive health policies to achieve social and economic goals.

Finally, the *issue characteristics* of reproductive health in Ethiopia were crucial in its political prioritization. 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.

There is evidence of the impact of Ethiopia's population policy. Improvements have been reported in girls' education, with enrolment at 77% in 2006; 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 contraceptive prevalence almost doubled from 15% in 2005 to 29% in 2011.[18] Despite these and other achievements, many respondents mentioned the challenges in implementing the policy, including lack of human and financial resources as the main constraints, possibly one of the many reasons why it took almost 15 years for the publication of the National Plan of Action.

This paper argues that the development of political priority for reproductive health in Ethiopia fits well within the framework established by Shiffman and Smith for understanding prioritization of global health issues. The paper does, however, have some limitations. Since the interviews conducted for this study were qualitative, our results are not 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 and documents 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, the paper makes 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 sub-Saharan Africa countries interested in generating political priority for reproductive health issues in their own contexts. Some of the key lessons point to the readiness of Ethiopia for reform, with a new government that was ready to act on improvements in the socio-economic status of the population, and the effectiveness of civil society organizations working alongside the government. This collaboration seemed key to creating an important window of opportunity in a changing political climate to achieve gains in reproductive health.

This paper also contributes to the body of evidence that the four key factors analysed are important to generate political support for reproductive health. Although used in the past for maternal and child health policies, to our knowledge this is the first time Shiffman and Smith's Framework has been used for reproductive health policies. We believe these results have broader implications for countries in sub-Saharan Africa going through political reform or planning new reform of reproductive health policies.

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References

1. World Health Organization. United Nations Millennium Development Goals. Available from:. http://www.un.org/millenniumgoals/reports.shtml. 2013.
2. WHO, UNICEF, UNFPA, The World Bank and the United Nations Population Division. Trends in Maternal Mortality: 1990 – 2013. World Health Organization, 201456.
3. Homer CSE, Friberg IK, Dias MAB, et al. The projected effect of scaling up midwifery. Lancet, 2014;384(9948):1146–1157.
4. Cleland J, Conde-Agudelo A, Peterson H, et al. Contraception and health. Lancet, 2012;380(9837):149–156.
5. Sedgh G, Singh S, Henshaw S, et al. Legal Abortion Worldwide in 2008: Levels and Recent Trends. International Perspectives on Sexual and Reproductive Health, 2011;37(2):84–94(Available from: https://www.guttmacher.org/pubs/journals/3708411.html).
6. Shiffman J, Smith S. Generation of political priority for global health initiatives: a framework and case study of maternal mortality. The Lancet, 2007;370(9595):1370–1379.
7. Koblinsky MA, Campbell O, Heichelheim J. Organizing delivery care: what works for safe motherhood? Bulletin of the World Health Organization, 1999;77(5):399–406.

8. Shiffman J. Generating political priority for maternal mortality reduction in 5 developing countries. American Journal of Public Health, 2007;97(5):796–803.
9. Shiffman J. Can poor countries surmount high maternal mortality? Studies in Family Planning, 2000;31(4):274–289.
10. Pathmanathan I. Investing in maternal health: learning from Malaysia and Sri Lanka. The World Bank, 20031–206. (Report No.: 25901. Available from: http://documents.worldbank.org/curated/en/2003/12/8188495/investing-maternal-health-learning-malaysia-sri-lanka).
11. Ronsmans C, Graham WJ. Maternal mortality: who, when, where, and why. The Lancet, 2006;368(9542):1189–1200.
12. Yadamsuren B, Merialdi M, Davaadorj I, et al. Tracking maternal mortality declines in Mongolia between 1992 and 2007: the importance of collaboration. Bulletin of the World Health Organization, 2010;88(3):192–198.
13. Shiffman J, Stanton C, Salazar AP. The emergence of political priority for safe motherhood in Honduras. Health Policy and Planning, 2004;19(6):380–390.
14. Shiffman J, del Valle Garcés AL. Political history and disparities in Safe Motherhood between Guatemala and Honduras. Population and Development Review, 2006; 32(1):53–80.
15. Agrawal P. Maternal mortality and morbidity in the United States of America. Bulletin of the World Health Organization, 2015;93(3):135.
16. Shiffman J, Okonofua FE. The state of political priority for safe motherhood in Nigeria. BJOG: An International Journal of Obstetrics and Gynaecology, 2007;114(2):127–133.
17. The Population Reference Bureau. PRB 2014 and 2015 World Population Data Sheets. Washington, DC2015. (Available from: http://www.prb.org/DataFinder/Geography/Data.aspx?loc=278).
18. Central Statistical Agency [Ethiopia], ICF International. Ethiopia Demographic and Health Survey 2011. Addis Ababa, Ethiopia and Calverton, Maryland, USA: Central Statistical Agency and ICF International, 2012430.
19. Ethiopian Ministry of Health. Health and Health Related Indicators. Addis Ababa, Ethiopia: Ministry of Health, 2007.
20. Hogan MC, Foreman KJ, Naghavi M, et al. Maternal mortality for 181 countries, 1980–2008: a systematic analysis of progress towards Millennium Development Goal 5. Lancet, 2010;375(9726):1609–1623.
21. Holcombe SJ. Agenda-Setting: Ethiopia's 2005 Reform of its Law on Abortion, Chapter 1, Ethiopia's 2005 Reform Of Its Law On Abortion: Agenda-Setting, Advocates, And Implementation. [Doctoral Dissertation]Berkeley, CA: University of California, Berkeley, 2015.
22. Office of the Prime Minister, Addis Ababa Ethiopia. The National Population Policy of Ethiopia. 1993. (Addis Ababa).
23. Hailemariam A, Alayu S, Teller C. The National Population Policy (NPP) of Ethiopia: Achievements, Challenges and Lessons Learned, 1993–2010. In: Teller, Hailemariam, editors. The Demographic Transition and Development in Africa. Netherlands: Springer, 2011. p.303–321 (Available from: http://link.springer.com/chapter/10.1007/978-90-481-8918-2_15).
24. The Criminal Code of the Federal Democratic Republic of Ethiopia. Proclamation No. 414/2004, Section II, Articles 545 – 552. 2005. (Addis Ababa).
25. Rahmato D, Bantirgu A, Endeshaw Y. CSOs/NGOs in Ethiopia: Partners in Development and Good Governance. Addis Ababa, Ethiopia: Ad Hoc CSO/NGO Task Force, 2008.
26. Bank TW. Ethiopia - Capturing the demographic bonus in Ethiopia: gender, development, and demographic actions. The World Bank, 20071–192. Report No.: 36434. (Available from: http://documents.worldbank.org/curated/en/2007/06/8208537/ethiopia-capturing-demographic-bonus-ethiopia-gender-development-demographic-actions).
27. Zenawi M. African Development: Dead Ends and New Beginnings. [Unpublished Masters Thesis]. 2006.
28. Ringheim K, Teller C, Sines E. Ethiopia at a Crossroads: Demography, Gender, and Development. Population Reference Bureau, 2009. (Available from: http://www.prb.org/Publications/Reports/2009/ethiopiacrossroads.aspx).
29. Banteyerga H. Ethiopia's health extension program: improving health through community involvement. Medical Education Cooperation with Cuba. MEDICC Review, 2011;13(3):46–49.
30. Teklehaimanot HD, Teklehaimanot A. Human resource development for a community-based health extension program: a case study from Ethiopia. Human Resources for Health, 2013;11(1):39.
31. Prata N, Gessessew A, Cartwright A, et al. Provision of injectable contraceptives in Ethiopia through community-based reproductive health agents. Bulletin of the World Health Organization, 2011;89(8):556–564.
32. Ashenafi M. Advocacy for legal reform for safe abortion. African Journal of Reproductive Health, 2004;8(1):79–84.

Résumé

L'Éthiopie est parmi les six pays qui enregistrent le nombre le plus élevé de décès maternels dans le monde. En 2011, le taux de fécondité total en Éthiopie a été estimé à 4,8 et l'utilisation de contraceptifs chez les femmes mariées était de

Resumen

Etiopía es uno de los principales seis países que contribuyen a las tasas más altas de muertes maternas del mundo. En el año 2011, se estimó que la tasa de fertilidad total de Etiopía era de 4.8, y el 29% de las mujeres casadas usaban un

29%. Le manque d'information, la stigmatisation culturelle entourant l'avortement et les obstacles à l'accès aux services contribuent à maintenir à un niveau élevé les taux d'avortement non sécurisé et de mortalité liée à l'avortement. Cette étude souhaite évaluer la création et l'institutionnalisation de la priorité politique à la santé génésique au sein des systèmes politiques éthiopiens. Des entretiens avec des décideurs clés, des ministres, des universitaires et des responsables d'organisations non gouvernementales de premier plan en Éthiopie ont été réalisés entre juillet 2010 et janvier 2011, à l'aide du cadre de Shiffman et Smith. Il s'agissait d'analyser les acteurs majeurs et les idées étayant la priorité nouvellement accordée à la santé génésique en Éthiopie, ainsi que le contexte politique et les principales caractéristiques des questions qui ont motivé une action progressiste dans la santé génésique de ce pays. Certaines des principales leçons désignent la volonté du Gouvernement éthiopien de réformer et d'améliorer la situation économique de la population. Le rôle des organisations de la société civile, qui ont travaillé aux côtés du Gouvernement, a été capital pour créer une fenêtre d'opportunité dans un climat politique changeant afin de réaliser des bénéfices en santé génésique. À notre connaissance, c'est la première fois que le cadre de Shiffman et Smith était utilisé pour les politiques de santé génésique. Nous concluons que l'expérience éthiopienne s'ajuste bien à ce cadre pour comprendre la priorisation des questions mondiales de santé et pourrait servir de modèle à d'autres pays d'Afrique subsaharienne.

método anticonceptivo. La falta de conocimientos, el estigma cultural en torno al aborto y las barreras para obtener servicios contribuyen a las tasas persistentemente altas de aborto inseguro y mortalidad relacionada con el aborto. Este estudio busca evaluar la generación e institucionalización de prioridad política para la salud reproductiva en los sistemas políticos de Etiopía. Entre julio de 2010 y enero de 2011 se realizaron entrevistas con formuladores de políticas, ministros gubernamentales, académicos y líderes de prominentes organizaciones no gubernamentales en Etiopía, empleando el Marco de Shiffman y Smith para analizar los actores clave y las ideas que impulsan el cambio hacia dar prioridad a la salud reproductiva en Etiopía, así como el contexto político y las principales características de los asuntos que propulsan acción progresista en salud reproductiva en ese país. Algunas de las lecciones clave señalan la preparación del gobierno etíope para reformar y mejorar la condición socioeconómica de la población. El rol de las organizaciones de la sociedad civil que trabajaron con el gobierno fue esencial para crear una ventana de oportunidad en un clima político cambiante con el fin de alcanzar logros en salud reproductiva. Según nuestros conocimientos, ésta es la primera vez que el Marco de Shiffman y Smith ha sido utilizado para políticas de salud reproductiva. Concluimos que la experiencia etíope encaja bien en este marco para entender la priorización de los asuntos de salud mundial y puede servir como un modelo para otros países de África subsahariana.