

FRONTLINES

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MAY/JUNE 2012

AN HIV-FREE GENERATION
ON THE HORIZON

HELPING ETHIOPIANS
WITHSTAND LIFE'S STORMS

CELEBRATING A
**CHILD HEALTH
REVOLUTION**

Child Survival/Ethiopia Edition



INSIGHTS

From Administrator Dr. Rajiv Shah

OVER THE PAST decade, we've made tremendous strides to reduce child mortality across the world, thanks in large part to the scaled up distribution of proven interventions and new technologies that are making it easier to reach and save more children.

In Ethiopia, where families have had to contend with one of the highest rates of infant and child mortality in the world, we've seen a dramatic and rapid decline. Between 2006 and 2010, infant mortality decreased by 23 percent and under-5 mortality by 28 percent. These achievements are largely a result of Ethiopia's investment in a community health system and a cadre of 35,000 health workers who provide front-line care. In a nation where only 10 percent of births occur in health facilities, community health workers—skilled in birth attendance and equipped with affordable tools to save the lives of mothers and newborns—serve a critical role.

But despite this significant progress, one in 11 children in Ethiopia do not live beyond their fifth birthday. And across the world, 7.6 million children under age 5 die every year because they do not have access to basic life-saving interventions like vaccines and bed nets. An additional 370,000 children are born every year with HIV, transmitted by their mothers.

In order to realize the vision of ending preventable child deaths, we need to work more effectively and efficiently than ever before. We have to overcome barriers to greater success, transforming facility-dependent programs designed to treat diseases into community-driven programs focused on treating patients.

This effort begins even before the moment of birth. Through the President's Emergency Plan for AIDS Relief, we are ensuring pregnant HIV-positive women can give birth to an AIDS-free generation. On World AIDS Day in 2011, President Barack Obama announced that the drop in the cost of a year's supply of AIDS medication—from \$1,100 to \$335—allows us to provide lifesaving medication to 6 million people.

Because many infants die from asphyxia during their first "golden minute" of birth, our Helping Babies Breathe partnership is equipping midwives and caregivers with low-cost tools that can help newborns take their crucial first breaths. And thanks to the dramatic scale-up of malaria prevention and treatment efforts under the President's Malaria Initiative, we have seen extraordinary results in child survival around the world. In Senegal, child mortality declined by 40 percent in five years, largely because preventing children from contracting malaria creates a cascade of other lifesaving health benefits.

It is only recently that we began to understand the long-term societal consequences of widespread stunting—or how easily an effort like breastfeeding or child nutrition could fight this hidden hunger. To support these simple, effective

and lifesaving interventions, our 1,000 Days Partnership is shifting our nutrition efforts to focus on the critical window between a mother's pregnancy and her child's second birthday.

This past summer, when children arrived with their families at the Dadaab refugee camp in Kenya, they received polio, measles and pneumococcal vaccines at the point of registration. It was only recently the world came together to help ensure that children everywhere have access to the latest vaccines that will protect them against pneumonia and diarrhea, the two leading causes of global child death.

By working closely with countries and continuing smart investments in global health, we can bring the rate of child mortality in poor countries to the same level it is in rich countries. This tremendous achievement would not only save millions of lives, but would help nations accelerate economic growth through a shift in their population called the demographic dividend. As children live longer and family sizes decrease, the productive share of a population rises, with the percentage of those able to work—usually those between ages 15 and 64—much larger than the share of the very young or very old. Along with smart economic and labor policies, that demographic pattern can add as much as two percentage points of growth for years.

Development is full of problems we have few ways to solve. Helping children reach their fifth birthday is not one of them. ■

Visit the *Every Child Deserves a 5th Birthday* Campaign at <http://5thbirthday.usaid.gov>

“I realize that there are among us those who are weary of sustaining this continual effort to help other nations. But I would ask them to look at a map and recognize that many of those whom we help live on the ‘front lines’ of the long twilight struggle for freedom—that others are new nations posed between order and chaos—and the rest are older nations now undergoing a turbulent transition of new expectations. Our efforts to help them help themselves, to demonstrate and to strengthen the vitality of free institutions, are small in cost compared to our military outlays for the defense of freedom.”

—John F. Kennedy, Special Message to the Congress on Foreign Aid, March 13, 1962

FrontLines is published by the Bureau for Legislative and Public Affairs
U.S. Agency for International Development

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12 Your Voice: Winning the Battle Against Malaria

- 2 To the Finish Line: Ending Preventable Child Deaths
- 4 Children’s Saviors on the Front Lines
- 10 Vaccines Shot in the Arm to Drought-Distressed Young
- 16 Navel Glazers
- 18 Infant Circumcision: A Tipping Point for HIV Prevention
- 20 Interview with UNICEF Chief Anthony Lake

For more articles and enhanced features, visit www.usaid.gov/frontlines

INSIDE THIS ISSUE



26 Catching Ethiopians Before They Fall

- 24 Ethiopia: Land of Contrasts, Nation in Transformation
- 28 The Female “Army” Leading Ethiopia’s Health Revolution
- 32 Interview with Health Minister Dr. Tedros Adhanom Ghebreyesus
- 34 A Powerful Piece of Paper
- 38 Putting Local Wealth to Work in Ethiopia
- 40 Peace Brokers
- 42 The Education Alternative
- 44 Interview with USAID/Ethiopia Mission Director Thomas Staal

Cover: A young boy receives an oral polio vaccination at a USAID-funded medical clinic in Petionville, Haiti, July 13, 2010. In 2011, the U.S. Government vaccinated nearly 157,000 children under 1 year old in Haiti for routine childhood diseases.

Photo by Kendra Helmer, USAID



MESSAGE FROM THE
Assistant Administrator for Global Health

TO THE FINISH LINE: Ending Preventable Child Deaths

By ARIEL PABLOS-MENDEZ

WE ARE on the front lines of one of the quietest revolutions in human history. It is not marked by upheaval, bloodshed, frantic news coverage or impassioned debate.

In the last 50 years, we have revolutionized child health. In a half century of ever increasing population pressures, we are saving more children and, more importantly, a higher percentage of children than ever before. Our revolution has brought about happier parents, smaller households and children with the brightest futures yet.

In fact, between the time that President John F. Kennedy brought USAID into being and the moment you are reading this sentence, child mortality has dropped by an astonishing 70 percent globally.

The successes that we have had with child mortality run along well-documented lines. We have had success because we know what is causing children to die and we know what to do about it. It starts with giving mothers the power to get pregnant on their own terms, ensuring the healthy



Ariel Pablos-Mendez

timing and spacing of pregnancy. While mothers are pregnant, we ensure that their children do not get HIV or malaria and receive the proper nutrition to be born healthy and strong.

Once the baby is out in the world, we provide an extremely effective cadre of vaccines that provide immunity from a host of deadly diseases to over 100 million children a year. USAID deploys oral rehydration therapy to combat diarrhea, and now

almost a billion episodes of childhood diarrhea are treated with this lifesaving supplement every year.

There is a more sophisticated and capable network of health-care providers globally than ever before, and they treat more than 75 million cases of childhood pneumonia annually. Micronutrients that cost pennies are saving hundreds of thousands of children each year and are radically increasing the quality of life for many, many more.

The numbers have been dropping steadily for decades, and if we did nothing new, we would still see progress. But that is not enough. The moment to do more has arrived. It is time to create the next wave of the child-survival revolution. With greater political and financial commitment, we can parlay this progress into a shared vision to end all preventable child deaths.

The time is right for this call to action. With the tools that we have at our disposal and the research capacity that we have at our fingertips, we can make it so that a child born in sub-Saharan Africa has as equal an

opportunity to survive as one born in the United States. We need to marshal and sustain the political will to focus on the health of future generations.

Right now, new health-care interventions have created the opportunity to deliver highly sophisticated care at the community level. This new technology, which is either already in the field, like using mobile phones to deliver lifesaving information, or can soon be made available, like malaria vaccines that are currently in trials, has arrived at the same time that an increasing focus on girls' health, education and economic development

has made the community more prepared than ever to make a healthy future a reality.

Our country partners are delivering in ways they never have been able to before. India went without a new case of polio for the first time ever last year. Ethiopia has put together a cadre of community health workers (see page 28) that is a model for the developing world. The list goes on and on.

The most wonderful thing about our efforts in child health is the cascade of effects that it sets off. Healthy

children create smaller families. Smaller families have better economic outcomes and greater education. Healthy, well-educated families create healthy, well-educated children. With the proper encouragement, we can set off a reaction that pays dividends for generations to come.

Reaching our goal won't be easy. We need to harness the power of political will and the international community. Conflict-prone areas lag well behind peaceful neighbors on all health indicators. But for the first time in the course of human history, we can see the finish line. Now is the moment to sprint toward it with arms raised in victory. ■

***In the last
50 years, we have
revolutionized
child health.***



Girls at a community promotional event for insecticide-treated nets in Ghana.

Photo by Kasia McCormick

Community health worker Rosalina Casimiro, far left, meets with a family in Nampula province, Mozambique, to distribute kits for water purification that also include soap, condoms and guidelines for family health.

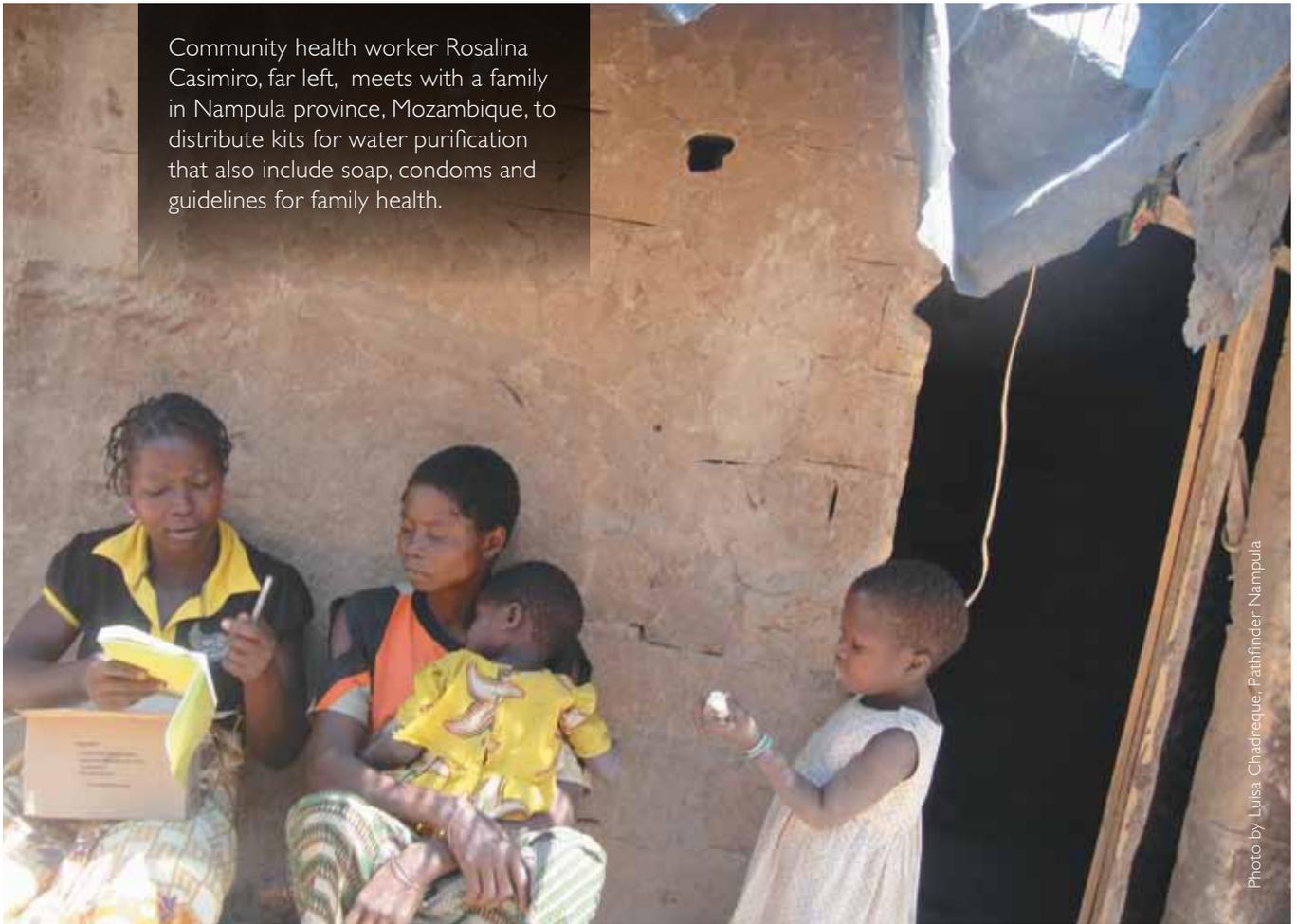


Photo by Luisa Chadreque, Pathfinder Nampula

Children's Saviors on the Front Lines

FRONT-LINE HEALTH workers are the first and often the only link to health care for millions of children in the developing world. They are the most immediate and cost-effective way to save lives, and foster a healthier, safer and more prosperous world. The developing world has experienced remarkable declines in maternal, child and infant mortality in recent decades, thanks in large part to the contributions

of those who bring the most basic health services and education into the communities of the world's underserved.

Millions of people are alive today because a midwife was by their side when they gave birth, or they were vaccinated as infants by a nurse, or because their families learned from a community health worker to adopt healthy behaviors like breastfeeding, hand washing, birth spacing and sleeping under a mosquito net.

While progress is being made thanks to the training and deployment of health workers in many countries, there are still too few health workers to reach the millions of families who urgently need care. Millions of children still die every year from preventable causes. The World Health Organization estimates a shortage of at

Every three seconds, a child's death is prevented thanks to care provided by a front-line health worker, but millions are still dying needlessly because they do not have access to a health worker.

least 1 million front-line health workers, particularly in Africa and parts of Asia.

A million more health workers could save many millions more if they had proper training and support.

Many of the interventions that have proven most effective in saving lives require health workers with some kind of training to deliver them. Front-line health workers do not need to be highly educated to be successful. Experience in many countries has shown that health workers with basic

schooling plus several weeks of well-designed training, followed by on-the-job supervision, can master the skills needed to diagnose and treat common illnesses, promote lifesaving health practices, and counsel families about family planning, nutrition and hygiene.

Some front-line health workers are midwives, nurses or private providers such as drug-shop dispensers. Many are community health workers who are selected by—and working in—their own communities. To ensure acceptance of these health workers by their communities, they must respond to local norms and customs. Some front-line workers are compensated for their work, either through the formal health system or by the communities they serve; others are volunteers motivated by non-monetary incentives, including flashlights and bicycles, as well as a sense of pride in their work, and increased status in their communities. Many female front-line health workers, in particular, note that their role has helped increase the respect they get from their families, friends and neighbors.

Major killers of children such as diarrhea, pneumonia, malaria and newborn complications can often be prevented or treated close to home by a well-trained health worker who is armed with basic tools and skills, and is part of a functioning health system.

“For more than 40 years, USAID has helped children throughout the world grow into healthy, productive adults.

Progress in child survival has long been, and remains among the Agency’s major accomplishments,” said USAID’s Deputy Assistant Administrator for Global Health Robert Clay.

USAID-funded initiatives save the lives of approximately 6 million children under 5 each year. The following stories from Madagascar, Kenya, Zambia and Bangladesh highlight some of

GO ONLINE

for additional articles
in this series.

How many die each year?

7.6 million children under 5 die every year, 3.1 million of them during their first month of life.

Major causes of death among children are pneumonia, which causes 1.6 million deaths each year, and diarrhea, which causes 1.3 million deaths each year. Malnutrition is estimated to contribute to more than one-third of deaths among children.

the health workers who are saving lives in their communities, and individuals whose lives have been touched—through USAID support—by these saviors on the front lines. ■

Members of the Frontline Health Workers Coalition contributed to the articles in this special section.



Laily Begum, left, pictured here with her husband and two young daughters, is one of 5,000 women in Bangladesh who have participated in the USAID-sponsored Healthy Fertility Study.

Keeping Mothers Safe to Be Mothers

Every day, approximately 1,000 women die from preventable causes related to pregnancy and childbirth. Ninety-nine percent of these deaths occur in developing countries.

ON OCT. 14, 2011, Odile Razafinganahary had just given birth to healthy twins in Itaosy, Madagascar, when midwife Agnes Haingo noticed that she was bleeding heavily. When two cotton cloths quickly became soaked with blood, the midwife knew she had to act immediately. After ensuring that no fragments of the placenta remained inside, Haingo began to massage the woman's uterus. When the bleeding continued, she

pressed firmly on Razafinganahary's abdomen, over the aorta, to help stanch the bleeding. As she worked, Haingo explained to the 22-year-old what she was doing, keeping her informed and reassuring her so the new mother wouldn't panic. After several minutes of compression, the bleeding finally stopped. Haingo learned the uterine massage and compression techniques last summer during a USAID-supported training.

The leading cause of death for women in Madagascar is postpartum hemorrhage. To reduce maternal and newborn mortality, the Maternal and Child Health Integrated Program (MCHIP), led by Johns Hopkins University affiliate Jhpiego through funding from USAID, has been training front-line health-care workers in basic emergency obstetric and newborn complications with a focus on preventing excessive bleeding after birth.

The MCHIP trainings focus on strengthening the interpersonal communication skills of doctors and midwives by continually reinforcing that they must always reassure the woman and describe what they are doing. Since September 2011, the program has trained 455 front-line health workers in Madagascar, reaching an estimated 20,000 women and newborns. ■



Photo by Susan Morfson, MCHIP

Odile Razafinganahary, right, holds one of her 5½ month old twins, Calist, while midwife Agnes Haingo holds Damas. The twins were safely delivered by Haingo in October 2011.



Photo by Bibiane Situma/AMREF

Esther Ouma with her son, Barrack.

Support from Clinic to Hospital to Home

In Kenya, 9.3 percent of women are infected with HIV. That figure is nearly 20 percent in Busia, one of the country's poorest districts.

ESTHER OUMA is a 25-year-old mother from Nangoga village in the Busia district of western Kenya.

“After marriage, I lost two babies due to what I thought was witchcraft. However, during my third pregnancy, I was visited by a [community health worker], who encouraged me to join a mother-to-mother support group. During the support group sessions, I learned that it is essential to visit an antenatal care clinic early in pregnancy. During one of the visits to the clinic, I was tested for HIV, and was found to be positive. I was counseled and encouraged to deliver

from a health facility to minimize chances of infecting our baby. As advised, I gave birth at the hospital and had a bouncing baby boy whom we named Barrack. During labor, I was given [the HIV drug] Nevirapine and after delivery our baby was also given antiretrovirals [ARVs].”

The World Health Organization recommends that HIV-infected mothers be put on ARVs so that, like Ouma, they can exclusively breastfeed their babies for at least six months, which is globally recognized to be a best practice for mothers and infants. Barrack was tested twice and was found to be

HIV-negative. He is taking Septrin to prevent the transmission of the disease.

Ouma attributes her health and that of her child to, in large part, the support she received from the community health worker. “I will forever be grateful to the community health worker, AMREF and the Ministry of Health,” Ouma said. AMREF, which stands for African Medical and Research Foundation, is an international health NGO with global headquarters in Kenya and U.S. headquarters in New York.

In 2004, 67 percent of the total population of 415,000 in the Busia district of western Kenya lived in absolute poverty. Malaria was the leading cause of health-facility admissions, and the HIV prevalence rate among pregnant women was approaching 20 percent.

With funding from USAID, AMREF implemented the Busia Child Survival Project from October 2005 through September 2010. Targeting 50,000 women of reproductive age and 30,000 children under 5, the project worked to increase access to and use of maternal and newborn care services, reduce HIV infections among newborns, and reduce malaria incidence among pregnant women and children under 5.

By using front-line workers to connect community members with the formal health system, notable improvements have been made in the Busia district. During the five-year project, the percentage of births attended by a midwife, nurse or doctor more than doubled, from 26 percent to 56 percent; mothers who knew how to prevent maternal-to-child transmission of HIV jumped from 23 percent to 84 percent; and children sleeping under insecticide-treated bed nets increased from 70 percent to 93 percent. ■

Coordinating Roles and Connecting with Care

In 2009, less than half of all births reported in Zambia were attended by a skilled birth attendant.

ALICE LONDAISHA is a traditional birth attendant in the Chantete Health Center at the far end of Lufwanyama district in Zambia. Chantete is a community with no public transportation and no motorized vehicles of any kind. In November 2011, Londaisha escorted a pregnant woman on foot for 5 kilometers to the health center for delivery, consistent with the new role for traditional birth attendants in the district.

Upon arrival she found that the center's trained nurse-midwife had travelled to Kitwe, a city about four hours away. Two community health workers were attending the facility in the nurse's absence.

When Londaisha took the pregnant woman to the labor ward to examine her, she found the woman was pregnant with twins—and both babies were in breech position. This was an

obstetrical emergency demanding care at a higher-level facility. Londaisha immediately alerted the health workers that the woman needed to be transferred to the hospital in Kitwe.

This coordination is a hallmark of the LINCHPIN project. The Lufwanyama Integrated Neonatal and Child Health Project in Zambia is implemented by the Lufwanyama district health management team and Save the Children under a cooperative agreement with USAID. The new approach teams birth attendants, community health workers and neighborhood health committees to improve access, availability and quality of newborn care and community case-management interventions.

“As a team, we decided we had to make personal contact with the nurse. But none of us had a cell phone, so one of us rushed to the nearby house of the teacher who let us use hers. We got in touch with the nurse, who called the Lufwanyama district health office to get the ambulance,” recounts Londaisha. “Throughout the four-hour journey, I stayed with the woman and monitored and reassured her. When we reached the [health office], a nurse-midwife was assigned to join us the rest of the way to Kitwe Central Hospital. The next day, the health center's nurse got in touch to let me know the twins had been delivered by caesarean section and that mother and babies were all fine.”

LINCHPIN is sharing lessons learned with the Ministry of Health and other partners at the national level, and is helping to coordinate the national effort to standardize community health-worker tools and job aids and improve monitoring and evaluation. ■



Photo by Save the Children

Community health workers provide check-ups for children under the LINCHPIN program.

Family Planning for Healthier Futures

If family planning and birth-spacing services were better promoted in countries with high birth rates, 32 percent of all maternal deaths and over 1 million deaths of children under 5 could be prevented.

WHEN HER FIRST child was only three months old, Laily Begum learned she was pregnant again. After giving birth, she had no idea that she could become pregnant before her menses returned, even though she was breastfeeding. Begum, 21, realized that within months she would be feeding and caring for a newborn infant and a 1-year-old daughter. After the birth of her second child, Begum was visited by a community health worker who provided information on how to delay her next pregnancy long enough to protect her health

and make it easier to properly care for and feed all of her children. From that visit, Begum and her husband decided to practice family planning.

Forty percent of the 186 million pregnancies that occur in developing countries each year are unplanned, and many of them occur within a short interval of a previous birth. Studies have shown that when children are born less than two years apart, mothers and their babies face increased danger. The Sylhet district in Bangladesh, where Begum lives, has among the worst health indicators for women and children. The maternal

mortality ratio is 471 deaths per 100,000 live births, the highest in the country.

In 2007, with USAID funding, Jhpiego and partners launched the Healthy Fertility Study in Sylhet district, a study designed to address unmet family planning needs in the postpartum period and provide a package of maternal and newborn interventions.

So far, the study results from 18 months postpartum have been promising: contraceptive use in the intervention area has increased 20 percent compared to the control area. In addition, through the promotion of the lactational amenorrhea method (LAM), which entails exclusive breastfeeding for six months, the practice and duration of exclusive breastfeeding has risen by 10 percent. Twenty-seven community health workers and eight community mobilizers have been trained in LAM since 2007 and have reached more than 5,000 women in Sylhet district. ■



Photo by Dr. Salahuddin Ahmed, Healthy Fertility Study

Bangladeshi women from Sylhet district serving as LAM (lactational amenorrhea method) ambassadors promote exclusive breastfeeding among their pregnant and postpartum neighbors and extended family members through household visits.



Howa Hassan, center, a blind Somali octogenarian refugee, sits with her grandchildren as one is vaccinated at a pediatric vaccination center at a Hagadere refugee site within the Dadaab refugee complex in Kenya's North Eastern province, Aug. 1, 2011.

Photo by Tony Karumba, AFP

Vaccines Shot in the Arm to Drought-Distressed Young

FROM THE TIME they are born until the age of 6, most children receive a long list of vaccines to protect them from debilitating illnesses.

The routine shots are even more important, physicians and development experts say, for young children caught in the grip of a crisis—be it an earthquake in Haiti, a coup in Côte d'Ivoire, once-in-a-century flooding in

Pakistan or, as was the case last year in the Horn of Africa, a brutal drought that sent them and their parents searching for food.

“Malnourished children are more susceptible to disease, and when they do get sick, they are more likely to suffer severe consequences, which can lead to higher death rates,” says Murray Trostle, the senior immunization coordinator for the Bureau for Global

Health’s Office of Health, Infectious Diseases and Nutrition.

Vaccination helps to stop that train wreck in its tracks, working to prevent children from becoming ill in the first place. “And given the crowded conditions in many [refugee] camps, if a communicable disease does get started, it will spread very quickly. Vaccination can slow this spread and protect many children,” says Trostle.

When USAID responds to any emergency around the world, vaccination campaigns are a core component of services provided on the scene if an assessment team concludes immunizations are necessary. The Office of U.S.

Foreign Disaster Assistance (OFDA) works in tandem with the World Health Organization and UNICEF to insure that vaccine supplies are distributed to wherever they are needed. The arsenal in this fight against the spread of disease contains vaccines that are targeted on diseases that have serious outbreaks in emergency situations, like measles.

So when a measles outbreak hit camps in Kenya late last year, USAID was ready, says Dr. Priya Shete, a public health adviser in OFDA.

Both children and adults were coming into makeshift health clinics with the telltale signs of measles, so protocols were adjusted to vaccinate not only children, but adults up to age 26. Usually children are the primary targets of such campaigns.

“In this context where adults and children are affected, it made more sense to build immunity in everyone,” Dr. Shete says. “We curb the spread of measles not only in the camps, but also in host communities.”

In addition to the measles vaccines, children in the camps received other routine immunizations. Most of their parents fled their homes without any record of prior immunizations for the children, which can complicate vaccine campaigns.

“I think what made the Horn of Africa response a little bit trickier than other responses is we were talking about three countries with significantly different capacities, different baseline immunizations rates,” Dr. Shete explains.

Kenya, for instance, has a relatively stronger record for childhood immunizations. But children who fled from Somalia, which is extremely isolated, could be expected to have received few of the shots that appear on the childhood immunization schedule. And

Ethiopia has been more of a mixed bag when it comes to immunizing children.

“In a humanitarian crisis, really, the key elements are to prevent those diseases that tend to surge in that crisis setting,” Dr. Shete says. “Measles is a big one for us.”

USAID FUNDING for the emergency vaccination campaign was pooled with donations from other countries and organizations by UNICEF, which conducted the on-the-ground vaccinations alongside various NGO partners.

Between September and December 2011, UNICEF reported providing measles vaccinations to 5.9 million children in Ethiopia between ages six months and 15—or 96 percent of the target population. It vaccinated nearly 200,000 children alone in the Afar region of the country. In Somalia, over a slightly different time period—between July and October—humanitarian agencies immunized just over a million children for measles in eight regions in the south and central parts of the country. And in Kenya’s Nyanza and Rift Valley, nearly 1.2 million children received vaccinations for polio during a four-day push in late September.

“It’s definitely a success just by looking at the number of children we reached with our partners,” Dr. Shete says.

Workers vaccinated nearly everyone they targeted in Ethiopia and Kenya. However, for Somalia, the vaccination numbers represent 44 percent of the children health workers had wanted to immunize. Here and in some other countries cultural factors and security concerns can come into play and prevent USAID and other organizations from reaching every child with vaccines.

Every parent should receive a health card that notes their child’s vaccinations,

and should be instructed on when booster shots are necessary and how to determine if there are any adverse side effects to the shots.

At the first pledging conference for the Global Alliance for Vaccines and Immunization (GAVI) in June 2011, donors committed \$4.3 billion. The funding will immunize more than 250 million of the world’s poorest children against life-threatening diseases by 2015, and prevent more than 4 million premature deaths. USAID Administrator Rajiv Shah announced a \$450 million commitment from the United States over three years, which is subject to congressional appropriation. With the pledge, the United States surpassed \$1 billion in commitments to GAVI for the purchase of vaccines since 2000.

The United States has played a lead role in GAVI since its inception, and is a world leader in support of every aspect of the vaccines value chain, including research, development, affordability, delivery systems and policy coordination.

The vaccines are considered safe for children even in their weakened states.

“Malnutrition is not a reason for not vaccinating a child,” Trostle says. “However, caution needs to be taken with some new vaccines as we do not have significant experience with the vaccine and malnourished populations.”

The short-lived measles outbreak likely indicates that children did not receive measles vaccinations in their hometowns. If not for the Horn campaign, some children may never have received their childhood vaccinations.

“It’s hard to say for sure, but I suspect that many of them would not have received the complete primary series of vaccinations,” Trostle says. “Since most do not have vaccination records, we really have no way of knowing.” ■

Photo by Maggie Halahan



Demonstrating the proper use of insecticide-treated nets in Senegal.

Your Voice: WINNING THE BATTLE AGAINST MALARIA

By *Tim Ziemer*

Your Voice, a continuing FrontLines feature, offers personal observations from USAID staff and development voices. Adm. Tim Ziemer is the U.S. global malaria coordinator.

I ARRIVED IN Afrancho—a farming community in Ghana’s Ashanti region—to the sounds of drumming and dancing. The morning sun shone down on the assembled crowd as we greeted the chiefs and queen mothers who were launching an insecticide-treated mosquito net (ITN) distribution and hang-up campaign. These local leaders, along with Ghana health services and NGO personnel, have proven to

be instrumental in mobilizing and educating the community about the importance of sleeping under ITNs to prevent malaria.

Malaria is primarily a disease of rural areas, affecting those residents who live in poverty and have only limited access to quality health care. Malaria does not threaten boys and girls in the United States, but across Africa, the lives of could-be future presidents, scientists and nurses are



Adm. Timothy Ziemer, U.S. global malaria coordinator, right, meets with Khombole district’s chief doctor and a Senegalese mother as she receives an insecticide-treated mosquito net to protect her children.

The Intolerable Burden

The President's Malaria Initiative (PMI), led by USAID and implemented with the U.S. Centers for Disease Control and Prevention, is a major component of the U.S. Government's Global Health Initiative (GHI), announced by President Barack Obama in May 2009. PMI was launched in June 2005 by former President George W. Bush to reduce the intolerable burden of malaria and help relieve poverty on the African continent.

Based on the 2008 Lantos-Hyde Act, PMI's goal was broadened to achieve Africa-wide impact by halving the burden of malaria in 70 percent of at-risk populations in sub-Saharan Africa. That equates to approximately 450 million residents. PMI now includes 19 focus countries (Angola, Benin, Democratic Republic of Congo, Ethiopia, Ghana, Guinea, Kenya, Liberia, Madagascar, Malawi, Mali, Mozambique, Nigeria, Rwanda, Senegal, Tanzania, Uganda, Zambia and Zimbabwe) and a regional program in the Greater Mekong subregion.

PMI supports four primary interventions to prevent and treat malaria: indoor residual spraying with insecticides; insecticide-treated mosquito nets; intermittent preventive treatment for pregnant women; and diagnosis of malaria and treatment with artemisinin-based combination therapy.

Over the past five years, many African countries have reported substantial progress in reducing their burden of malaria. In 11 PMI-supported countries with baseline and follow-up nationwide household surveys (Angola, Ethiopia, Ghana, Kenya, Madagascar, Malawi, Rwanda, Senegal, Tanzania, Uganda and Zambia), substantial reductions in all-cause mortality (ranging from 16 percent to 50 percent) have been documented in children under age 5. PMI is evaluating the contribution of malaria-control efforts to these declines in mortality, but there are strong indications that a substantial portion of the decline is due to malaria control.



Photo by Arturo Sanabria, JSI

A Zambian mother holds her children and an insecticide-treated net.

lost prematurely, and their hope for making an impact on the world is greatly diminished.

Preventive interventions, such as ITNs, are lifesaving in countries like Ghana, where malaria is a leading cause of mortality, and one in 12 children do not reach their fifth birthday.

Net ownership does not necessarily equate with net usage. According to the latest nationwide survey in Ghana, about half of the children under 5 years old who have access to a net in

their home do not sleep under it. Therefore, delivering ITNs is not enough: conducting follow-up educational activities to increase appropriate and consistent mosquito net use is also critical.

As I watched volunteers perform a drama about sleeping under mosquito nets, I was grateful for having slept under the protection of a bed net and having had access to medicine when I fell ill with malaria in Vietnam, where I lived as a child.

GO ONLINE

to read more about the President's Malaria Initiative and USAID's malaria work.



Photo by Maggie Hallahan

A mother receives the result from a malaria rapid diagnostic test.

In the past six years, the U.S. Government and partners have reached millions of people in sub-Saharan Africa with ITNs, as well as other prevention and treatment interventions. By preventing children from contracting malaria, we are making them healthier and more productive over the long run, and unburdening the health system to free up resources to address other critical needs.

Investing in malaria control is particularly powerful because of its enormous burden, and because the impact of malaria prevention and treatment efforts is quickly and dramatically evident.

We know what causes malaria, we know how to prevent it, and we know how to treat it. By working with

national governments to implement their malaria strategies; using available resources for effective prevention; and developing robust case-management programs to diagnose fevers, identify malaria and treat it with ACTs (artemisinin-based combination therapies), we can build upon the gains we've made in combatting malaria as a public health problem in Africa.

We have seen tremendous success against malaria, thanks to an infusion of resources, innovation and political will. World Malaria Day 2012 is a reminder that ending malaria as a major killer of children is now considered possible and it is vitally important that we sustain our momentum toward that goal. ■

Highlights from PMI's sixth annual report to Congress (April 2012) covering PMI's 19 focus countries.

- More than 28 million people were protected as a result of PMI-supported indoor residual spraying in FY 2011.
- More than 59 million insecticide-treated mosquito nets have been procured and more than 31 million distributed since PMI began.
- More than 116 million lifesaving antimalarial treatments have been procured and more than 92 million distributed since PMI began.
- More than 42,000 health workers were trained on case management in FY 2011.
- More than 34,000 health workers were trained on malaria laboratory diagnosis in FY 2011.
- More than 28,000 health workers were trained on the prevention and treatment of malaria in pregnant women in FY 2011.



Photo by Brant Stewart, RTI

A man applies insecticide to the interior walls of a house during an indoor residual spraying campaign in Rwanda.

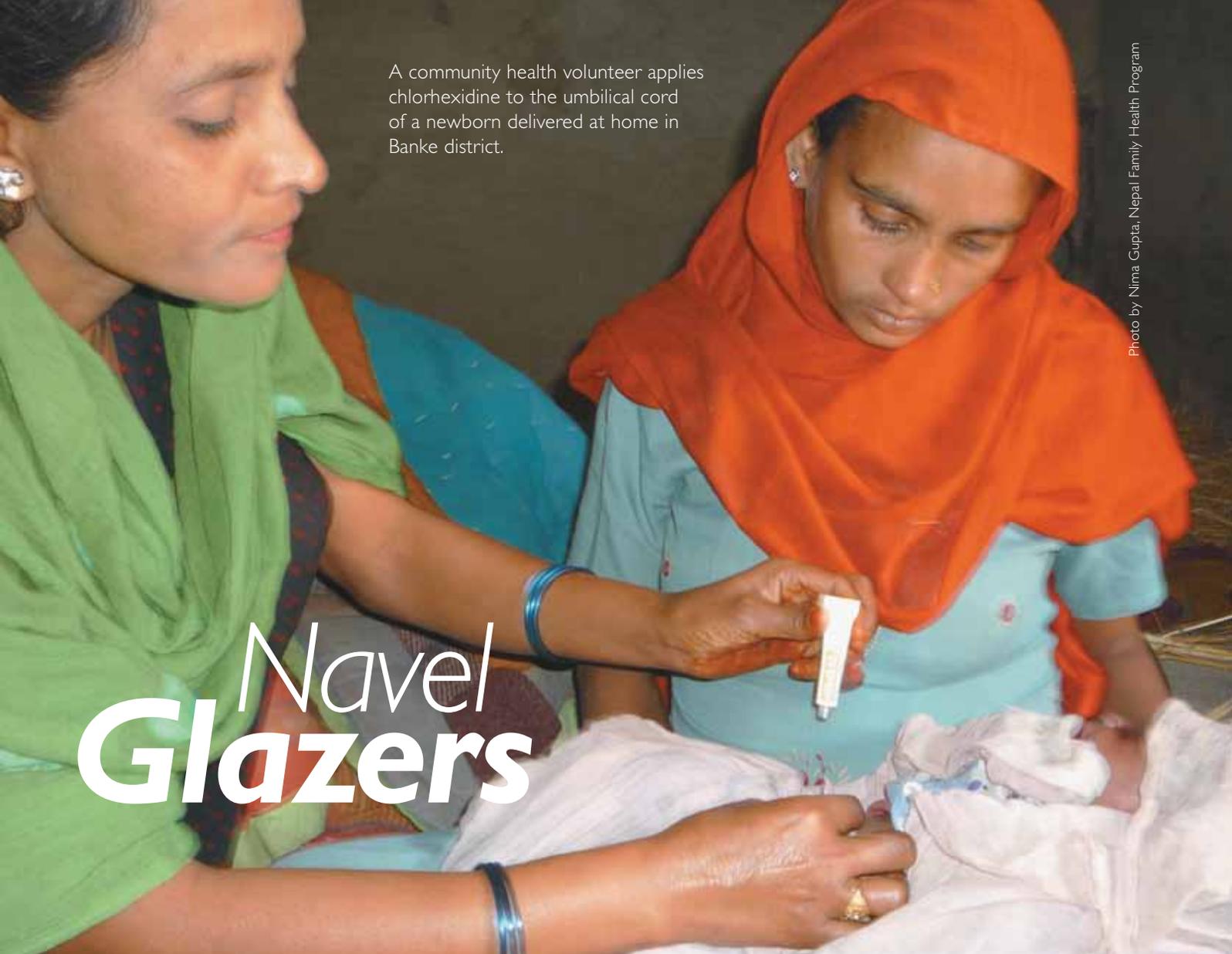


Photo by Nimra Gupta, Nepal Family Health Program

A community health volunteer applies chlorhexidine to the umbilical cord of a newborn delivered at home in Banke district.

Navel Glazers

By Karen Clune and Esther Lwanga

How an amazingly simple treatment—the application of an antiseptic umbilical ointment—is saving newborn lives in Asia and, if scaled up, could prevent up to half a million infant deaths worldwide.

WITH ONE in 19 Nepalese children dying before their fifth birthdays—and half that number dying before they even complete their first 28 days of life—finding successful interventions for newborn care has been critical.

Today, the 50,000-strong government health worker cadre known as Female

Community Health Volunteers (FCHVs) is helping turn the tide, saving newborns from potentially life-threatening infections through the application of a simple intervention—chlorhexidine.

Chlorhexidine, which can be administered topically as a gel or liquid, has been used extensively in health-care settings for decades as a pre-surgical and an oral antiseptic at

varying concentrations, and it is widely available globally. Since the 1970s, mothers and newborns in developed countries have received chlorhexidine-based cleansing solutions to reduce the development and transmission of infections. Because evidence was limited, however, that these approaches were valuable in reducing newborn umbilical cord infections, their use did not gain widespread acceptance.

The World Health Organization (WHO), in the late 1990s, suggested more studies were needed to assess the effectiveness of antiseptic medications for newborn cord care, particularly in

high-risk settings. Taking up that charge, USAID has been at the forefront in supporting research to demonstrate that a simple 4-percent chlorhexidine solution, when applied to the umbilical cord after birth, can prevent newborn infections and reduce newborn deaths.

The Agency, along with the National Institutes of Health and the Gates Foundation, funded the first completed study of neonatal and umbilical cord care with chlorhexidine in Nepal with over 15,000 infants. The results, published in 2006, found that use of chlorhexidine on the umbilical cord significantly reduces local cord infections and overall neonatal mortality.

Specifically, the results showed that, when applied to the umbilical cord stump on the day of birth and then daily over the first week of life, a 4-percent solution of chlorhexidine prevented infection and reduced neonatal mortality by around 24 percent more than care with soap and water or the standard dry cord care (not applying anything to the cord but instead keeping it clean and dry until the stump falls off).

Sulochana Jaisi, a new mother whose baby received the chlorhexidine treatment, explains: “Before the [chlorhexidine] program was initiated, we used to apply ash, oil and turmeric on umbilical cords We like it because we don’t need any help to apply the [gel], we can do it on our own.”

Local acceptance and ease of use are important factors in determining the effectiveness of any treatment; in Nepal, chlorhexidine has received encouraging marks in both. Other studies have shown how easy chlorhexidine is to administer by front-line health workers, a significant advantage

in a country where three-fourths of babies are born at home.

Swayed by the results of USAID-backed studies, Nepal’s Health Ministry approved a USAID-funded pilot program in four districts. In Banke, Bajhang, Parsa and Jumla, community health workers were trained to educate mothers and caregivers about the dangers of cord infection and introduced the umbilical ointment into the routine newborn care practice, applying it to the cord immediately after cutting or explaining how it is done.

Sita Shing, who has been a health worker in her community for over 25 years, uses a doll to show expectant mothers how to apply the solution. The doll is dressed in a traditional baby cloth called *Bhoto-Suruwal* to teach mothers the importance of avoiding hypothermia.

As part of the effort to scale up this intervention, this year USAID and its implementing partners negotiated with local pharmaceutical companies to procure chlorhexidine in bulk for less than \$0.15 per tube. The 4-percent chlorhexidine product was named *Kawach*, the Sanscrit word for shield, following informal polling amongst Nepali health professionals.

An 18-month pilot period to promote chlorhexidine proved successful at reaching a large number of Nepali mothers and families.

“[This] is a very important program because, after its implementation, the number of infected umbilical cord cases in my facility declined. I have also seen that fewer babies are dying in my VDC [village development committee],” explains Birendra Ghale, a health worker in charge of this peripheral-level health facility in

continued on p. 22

Saving Lives at Birth: A Grand Challenge for Development

Widespread access to technology has made it possible for virtually anyone to be an agent of change. USAID harnesses the power of this untapped repository of innovators and change agents to creatively think of new and better ways of doing business.

In March 2011, USAID, along with the Government of Norway, the Bill & Melinda Gates Foundation, Grand Challenges Canada and the World Bank, launched Saving Lives at Birth: A Grand Challenge for Development. Through this challenge, the first in a series of Grand Challenges for USAID, the partners issued a call to the global community for transformative ideas with the potential to save the lives of mothers and newborns in low-resource settings during the 48 hours surrounding birth in three key areas: technology, service delivery and demand. After defining the problem, the Agency crowd-sourced solutions, opening up the grand challenge to the world. USAID received more than 600 submissions from the global community, and narrowed them down to 77 finalists. In late 2011, 24 recipients of seed and transition-to-scale grants were awarded for those projects that demonstrated the most potential to scale up and sustain impact.

The partnership continues to push boundaries to accelerate substantial and sustainable reductions in maternal and neonatal mortality and stillbirths. In February 2012, the coalition launched a second global call for innovative solutions along with a new partner, the U.K.’s Department for International Development. Award nominees are expected to be announced in late summer.

The Grand Challenge model for seeking solutions to development problems is a new tool in the global health arsenal—one with the promise to yield tremendous gains against some of the world’s toughest global health challenges.

www.savinglivesatbirth.net

Infant Circumcision: A Tipping Point for HIV Prevention

By Emma Llewellyn

A nationwide early-infant male circumcision program in Swaziland is being hailed by some development experts as an important step forward in the worldwide effort to achieve an HIV-free generation.

ON JUNE 26 OF last year, Jabu Qwabe and Thokozani Mndzebele celebrated the birth of their new baby boy, Sihlelelwe, at a small hospital outside of Mankayane, Swaziland. Like all new parents, they immediately began to dream about their son's future—where he would go to school, what he would study, what his career would be. Above all, they dreamed for him to live a healthy life—which is why, before leaving the hospital, they made the decision to have Sihlelelwe circumcised.

As parents of a child in Swaziland—the nation with the world's highest adult HIV prevalence at 25.9 percent—their decision could very well save Sihlelelwe's life. Voluntary medical male circumcision has been found to reduce the risk of sexual transmission of HIV from women to men by as much as 60 percent.

The World Health Organization (WHO) and the Joint United Nations Program on HIV/AIDS, or UNAIDS, recommend voluntary adult circumcision in high HIV-prevalence countries like Swaziland to lessen the chance for HIV's spread. They, along with UNICEF, also recommend

early-infant male circumcision (EIMC) be implemented in parallel with adult circumcision programs.

Health officials say that not only will infant circumcision help protect boys from HIV when they become sexually active later in life, but that it also protects infants and boys from serious health complications such as urinary tract infections and paraphimosis, a condition that can lead to pain and swelling in the affected area, and may require surgery.

Three years ago, Swaziland's Ministry of Health turned those recommendations into action and launched a nationwide program with assistance from the President's Emergency Plan for AIDS Relief (PEPFAR) through USAID, UNICEF, PSI and Jhpiego, a development organization affiliated with Johns Hopkins University.

In less than three years, the program has provided 1,300 voluntary circumcisions to boys across the tiny independent kingdom within the borders of South Africa. USAID's support directly contributed to 1,226 of these procedures.

Infant circumcision is now offered for free in four health facilities in two of the four regions of the country, and coverage in each facility is about 25

percent of eligible baby boys. Three more facilities will begin providing EIMC in the first half of 2012, with more to be added during the latter half of the year. This network should service the entire country and the approximately 20,000 male infants born each year. The project is also training nurses to perform circumcisions—normally the purview of medical doctors only—to expand the number of infants offered the procedure.

“EIMC is a game-changing HIV intervention for Swaziland,” said Futhi Dlamini, EIMC coordinator for PSI/Swaziland. “It offers sustainability of services by being integrated in maternal and child health services. This program will be even more effective as parents become more accepting of EIMC and when nurses are allowed to perform the procedure.”

Parents are introduced to EIMC at antenatal care clinics and child welfare clinics as well as the maternity units (including post-natal ward) of health facilities. They are approached by nurses, midwives and patient educators who are all trained on the basic facts of EIMC.

One parent must sign the consent form for the procedure, but mothers are often not comfortable giving consent without the father. Parents who agree to have their sons circumcised say they do so to prevent HIV in the future or because someone else in the family—typically the father—is also circumcised.

Parents who decline the procedure often say they will let their son decide for himself, that the baby is too young or that circumcision is not traditionally performed.

Swaziland is a traditionally non-circumcising country. Therefore, the

introduction of early-infant male circumcision requires intensive community awareness and sensitization, training and buy-in of health care workers, and patience as the country begins to accept a new HIV intervention whose benefits become apparent in the long term.

To spread the word about the procedure to expectant parents and others in the country, USAID created the *Lugotjwa Lusemanti* campaign, which loosely translates to “bend the reed when it is green.” Through posters, brochures and media outlets, parents learned about the health benefits of circumcision and about why the ideal time for the procedure is soon after a boy is born, while he is still in a health facility.

The effort also recruited and trained volunteers to speak with expecting mothers, fathers and hospital staffers about infant circumcision. And, at Swaziland’s annual trade fair, the project hosted a special event called the “Baby Fair,” where mothers-to-be could attend a fashion show featuring pregnant models; visit stalls set up by local businesses selling baby-friendly products; and talk with peer educators about infant circumcision.

“I was scared of getting my baby circumcised, but after talking to some nurses, my boyfriend convinced me that it was the right decision to take

and that it would benefit the child in the long term,” said Qwabe.

Qwabe and her boyfriend, who have since married, first heard about the

members and friends to get their newborn baby boys circumcised early.

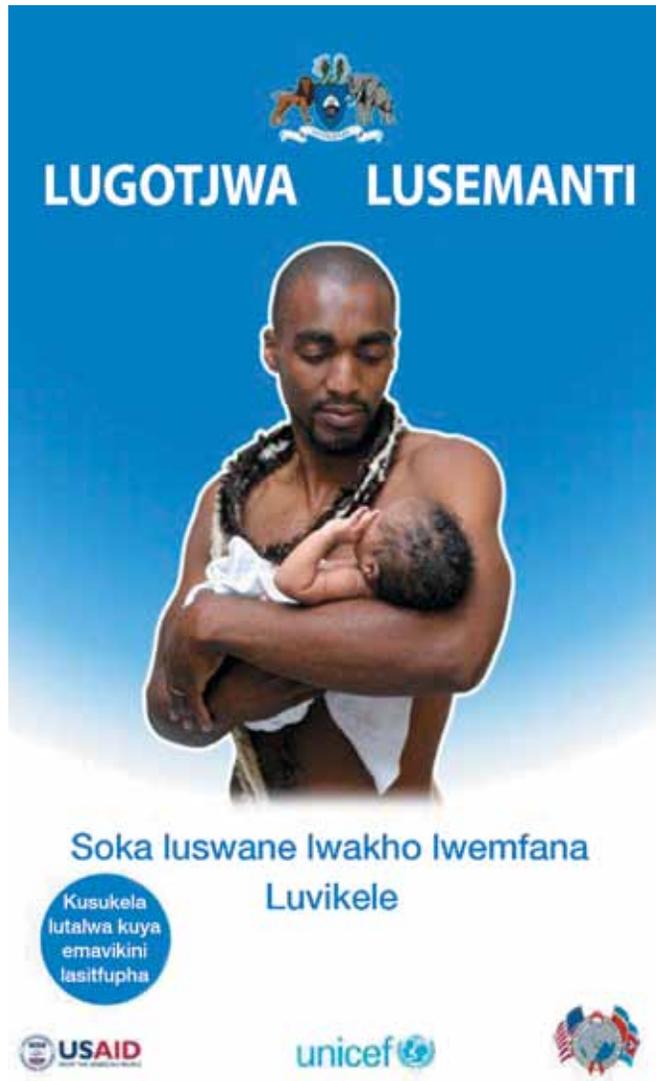
“The early-infant male circumcision (EIMC) project in Swaziland represents a real commitment by the government and the people of Swaziland to make a sustained effort in the push for an AIDS-free generation. Reaching infants at this critical stage reduces risk by completing the procedure before any sexual activity takes place, and results in fewer adverse effects for the individual,” said Emmanuel Njehumeli, senior biomedical prevention adviser in USAID’s Office of HIV/AIDS.

“We will not see an impact at population level in the next 15 years,” he continued, “but EIMC will allow us to maintain the impact that will be obtained with the adult voluntary medical male circumcision roll-out that is being supported by PEPFAR through USAID. The roll-out of EIMC in Swaziland also demonstrates that we observe a change in social norm in Swaziland that will have tremendous impact at population level, not just for HIV prevention, but also by averting other diseases.”

USAID has supported the roll-out of EIMC in Lesotho and Tanzania, with plans underway for

Mozambique as well. ■

Emma Llewellyn is the HIV services director for PSI/Swaziland.



Poster from the USAID/PSI early infant male circumcision campaign in Swaziland. The “Lugotjwa Lusemanti” campaign, which translates to “bend the reed when it is green,” uses posters, brochures and media outlets to teach parents about the health benefits of circumcision and why the ideal time for the procedure is soon after a boy is born.

campaign at the hospital when she went for check-ups. They found the procedure to be simple and quick and would now encourage their family

Interview with Anthony Lake, Executive Director, UNICEF



Photo by UNICEF/NYHQ2010-0697/Nar'kisz

Before his appointment as UNICEF's executive director in 2010, Anthony Lake served in various roles for the U.S. Government, including as national security adviser from 1993-1997. He has also served as the president's special envoy in Ethiopia, Eritrea and Haiti. Lake's experience in international development began in the 1970s as director of International Voluntary Services. For the past 10 years, he has been an adviser to the International Committee of the Red Cross and chair of the Marshall Legacy Institute.

FRONTLINES: What have been UNICEF's greatest achievements in child survival?

ANTHONY LAKE: There has been tremendous progress in child survival: The child mortality rate has dropped by 35 percent since 1990. That statistic represents around 4.3 million fewer children under the age of 5 dying from preventable causes. No single organization can claim credit for that achievement, and we still have a long way to go. But I am proud of UNICEF's role. In addition to our staff—whose work on the ground in more than 150 countries and territories has made an enormous difference—I believe UNICEF's most important contribution has been innovation. Technical innovation, of course, but also innovation in how we think about development.

That was the genius behind the child survival revolution in the 1980s, which my friend Jim Grant helped lead when he was UNICEF executive director. Jim

encouraged us to see child survival not only as a measure of a country's development progress, but also as a means of achieving that progress. He pushed us to extend the reach of our interventions for children with cost-effective solutions to huge problems. Some of the high-impact, low-cost innovations UNICEF helped pioneer then included: oral rehydration salts, greatly expanded vaccination campaigns, and developing supply chains to reach the most remote communities.

UNICEF continues to work at innovating. Sometimes that means repurposing existing technology to help us reach the hardest-to-reach places. Just look at what is being done with SMS texting and other mobile technology. We are using this now in the field to record and transmit data that helps us track the spread of diseases. It's helping us expedite HIV test results and start treatment that can prevent the transmission of HIV from mother to child and extend mothers' lives. It's enabling us to record births in remote places, and to reunify families

during conflicts and natural disasters. It even helps us to monitor the outcome of our own programs, for instance, tracking the delivery of school materials.

Some of our more innovative work has been recognized—Devex recently named UNICEF a Top Development Innovator, based on a poll of thousands of development professionals. We're encouraged by the recognition, but we also have to work to earn it, working collaboratively with our partners.

I say collaboratively because, if innovation is key to the new child survival revolution, partnership is certainly the key to innovation. Partnerships with cell phone manufacturers, software programmers, telecom companies; partnerships with other agencies like USAID; above all, partnerships with governments. For only they can take these innovations to scale.

FL: UNICEF is working with USAID and other global actors to focus and sharpen strategies to reach the end of preventable child deaths.

What has to happen to make this lofty goal a concrete reality?

Lake: Equity. We may never literally end all preventable child deaths, but we can come close. To do so, as a practical matter, we have to help nations with the highest infant mortality rates vastly reduce them, with a much sharper focus on reaching the most disadvantaged children. It is also, in any case, the right thing to do; and it is also cost-effective.

Traditional development thinking has held that attempts to reach the very poorest, especially in remote areas, are too costly and too difficult. But new technology and innovations such as those I just mentioned are making it easier to reach the most deprived. So in 2010, UNICEF tested the traditional thinking in an extensive modeling exercise. Our study shows that, in fact, the additional results that you achieve in those communities outweigh the additional costs of getting into them. Indeed, our modeling shows that in the poorest countries with the highest child mortality rates, for every additional \$1 million invested, an equity strategy averts up to 60 percent more children's deaths.

These findings are especially significant now, in a time of continued fiscal austerity. Focusing on the most disadvantaged is right in principle and right in practice.

Now we need to do a better job analyzing the data—looking beyond national averages that often conceal children in greatest need. According to our analysis, within a majority of the countries on track to meet Millennium Development Goal 4—reducing child mortality—gaps between rich and poor children are actually widening. That's simply wrong.

FL: What do you count as the simplest interventions that can make the

biggest difference on closing the gap between developing and developed countries on child survival?

Lake: Let me start by saying that the old distinctions between “developing” and “developed” nations are eroding. The majority of the world's poor now live in middle-income countries. Many industrialized nations face difficult challenges, too. And some of the lowest-income countries are among the most innovative. So we need to consider more universal goals, and focus on finding the most effective—and the most cost-effective—ways to reach the children in greatest need.

Very often, these are also the simplest ways. Consider micronutrients, such as vitamin A, iodized salt, iron and zinc. These are inexpensive, easy to deliver interventions. And yet, they have the power to help prevent stunting in millions of children. Stunting is a condition caused by a lack of essential nutrients during the critical period of pregnancy and up to the age of 2. Children who are stunted suffer from irreversible physical and cognitive harm, with tragic consequences for those children and for their societies. In 2008, the Copenhagen Consensus—a group of leading economists, including Nobel Prize winners—concluded that the provision of micronutrients was the single most cost-effective means of improving global welfare.

Vaccination is another highly cost-effective intervention. It provides an enormous return on investment, regardless of how it is measured, whether in terms of deaths averted, fewer illnesses or lower health costs. Too little attention has been paid to the critical importance of vaccination since we achieved so-called “universal” in 1990. At the time, “universal” meant around 80 percent. But we

declared victory too early. We are still only at around 85 percent globally, and we have to accelerate the pace if we're going to achieve our child survival goals. Never forget that diseases that were nearly defeated—such as polio—can come back if we don't finish the job.

FL: What are three issues poor children face today that most people would be surprised to know?

Lake: The first is the issue I just mentioned: stunting, which truly is one of the most under-recognized and under-addressed issues children face. One hundred eighty million children are already afflicted by this condition. If they were all concentrated in one place, it would constitute a massive emergency and compel immediate action. Stunting occurs even in food-secure nations such as India, where 48 percent of the children under the age of 5 are stunted. In some places, stunting is so common that it is actually mistaken for genetic heritage. And yet, very few people—even development and medical professionals—have even heard of it. This is beginning to change, but we have a long way to go.

The second surprising issue is urban disparities. The world is rapidly becoming urbanized. Within a few years, half of the world's children will live in cities and towns. While many people still think of a rural child when they think of a poor child, children in the poorest urban communities are often just as deprived—of nutrition, clean water, adequate sanitation, access to health care, education and protection. But their situations are often masked by data showing that urban children are generally better off. So we need to do a much better job of analyzing data and

continued on p. 23

Navel Glazers

continued from p. 17

Banke, which lies at the base of the Himalayas, bordering India. “In addition, traditional practices of applying different kinds of substances, which are often harmful, have been replaced.”

BEGINNING IN 2007, two additional randomized controlled trials of chlorhexidine efficacy were launched in Bangladesh and Pakistan. The USAID-funded work, in collaboration with the Saving Newborn Lives program, found that chlorhexidine cord cleansing reduced the risk of mortality in newborns by between 20 percent and 38 percent, respectively. In 2010, the neonatal mortality rate in Bangladesh was 31 per 1,000 births; in Pakistan, the rate was 43 per 1,000 births.

In South Asia, where newborn infections range from 12 percent to 26 percent, the widespread use of chlorhexidine could potentially save 200,000 newborn lives.

Following the success of its own pilots, in 2011, the Nepalese Government announced it will scale up the use of chlorhexidine nationwide. Says Dr. Naresh Pratap KC, director of the Health Ministry’s Family Health Division: “The Government of Nepal is proud to have implemented the intervention from the pilot stage through scale-up ... and I believe that this intervention will help us achieve [Millennium Development Goal] 4 by reducing neonatal deaths in Nepal.”

John Snow Inc. (JSI), with a grant from the USAID-sponsored Saving Lives at Birth Grand Challenge (see

sidebar on page 17), is working within the ministry to accelerate this scale-up with the goal of mainstreaming chlorhexidine in all districts nationwide. JSI also will work to ensure the product’s availability, as well as continue to increase awareness and delivery of the intervention.

The newly published research from Pakistan and Bangladesh has increased national, regional and global interest in this intervention. Additional studies are currently underway in Tanzania

involvement in local trials provided an important means of engaging African scientists and policymakers in a dialogue about the potential benefits of cord cleansing with chlorhexidine.”

Chlorhexidine also has been included in the ongoing U.N. Commission on Life-Saving Commodities for Women and Children, and USAID is supporting a WHO expert review of this new evidence. This could potentially lead to changes to its umbilical cord-care guidance.



Photo by Nima Gupta, Nepal Family Health Program

A community health volunteer in Banke district counsels a pregnant woman on the use of *Kawach*, or chlorhexidine, during a home visit.

and Zambia to test its effectiveness in those settings.

Says Saul Morris, senior program officer at the Bill & Melinda Gates Foundation: “The Bill & Melinda Gates Foundation decided to fund two trials in Africa because we wanted to confirm the exciting results emerging from South Asia. In sub-Saharan Africa, there are some differences in the etiology [cause] of neonatal sepsis as compared to South Asia and overall rates of bacterial colonization of the umbilical stump are lower. We felt that these differences justified confirmation of value-for-money in these settings, and we also felt that

AN ESTIMATED one-third of the 3.5 million neonatal deaths that occur each year globally are due to preventable severe infections. A baby’s umbilical cord is a common entry point for bacteria to invade the surrounding tissue as well as the baby’s bloodstream. In both Asian and sub-Saharan African cultures, women often rub harmful substances such as mustard oil, ash or turmeric powder on the cord stump of newborns, believing that this

may reduce infections. Studies have shown that mustard oil and other substances increase the risk of infection.

In its 1998 guidelines, the WHO recommends clean and dry umbilical cord care. However, it also says that: “In settings where the risk of bacterial infection is high, it may be prudent to apply an antiseptic to the cord per local preference.”

Chlorhexidine may just be that prudent solution the WHO had in mind. Experts now say that the little tube has the potential to reach large populations and avert an estimated 500,000 neonatal deaths per year. ■

Anthony Lake

continued from p. 21

mapping urban areas—both within and beyond slums—to find out who and where the most disadvantaged children are. This information will help governments and all of us better target our efforts and better achieve results.

There are certainly more than three issues people would be surprised to know. But the third one I'll mention also surprised me when I first came to UNICEF: the lack of birth registration, especially among the most disadvantaged and marginalized children, such as those from indigenous groups, children with disabilities, and, of course, girls as compared with boys. Only half of all children under 5 are registered in developing countries. Why is this important? Lack of birth registration can cause a lifetime of exclusion and deprivation, making it harder for children who are already at risk of being left behind to go to school, or to get medical treatment, or to be reunited with their parents in emergencies. And again, a cost-effective intervention—the simple act of registering a birth, made more simple now by things like mobile technology—can yield lifelong benefits.

FL: Is there a real role for technology, such as simple laptops, to help poor children catch up with their peers in the developed world? What are the challenges to and costs of making this work effectively?

Lake: Technology is already playing an enormous role in development and, increasingly, in our ability to reach the poorest children. And as I mentioned earlier, it goes well beyond laptops—SMS texting and other mobile communications are connecting children and communities to a world of information and increasing their access to critical services. And in Uganda, not



Anthony Lake converses with a family outside a health center in Ethiopia in June 2009, before taking up his post with UNICEF, as part of a trip with ONE.

Photo by ONE/Morgana Wingard

everyone has a cell phone, of course, but there are telephone booths all over the country—so we are developing a program to adapt mobile apps for telephone booths.

The first challenge is to re-purpose technology that the private sector is developing and apply it to our own purposes. The second challenge is to take these innovations to scale. This is one of UNICEF's highest priorities—and, as with all of our goals, it depends on partnership.

The majority of the most promising innovations have come about through partnerships—collaboration with the private sector, governments, academia and, most importantly, communities themselves. For example, the Digital Drum—a solar-powered computer kiosk for rural children and communities in Uganda—was mostly developed in a collaboration, often virtual, that linked UNICEF staff, technologists, academics and designers from Solomon Islands, South Africa, Suriname, Uganda and the United States of America. Its development, in fact, may have been one of its greatest innovations, for the process inspired a great deal of thinking about access to information in rural contexts.

Time magazine named the Digital Drum as one of the best inventions of

2011—and UNICEF is proud of that. But regardless of who creates an innovative new use of technology, the point is to share it, to build on it, and to extend its reach. Because the sooner we can roll these innovations out in cooperation with others, the more children's lives we can improve and save.

FL: During your travels as head of UNICEF, has a child said something that you'll never forget, the proverbial "out of the mouths of babes" statement that sticks with you?

Lake: More than their words, I think of their laughter. I've met children in horrible circumstances: in drought-ravaged areas in Africa ... in monsoon-flooded parts of Pakistan ... in earthquake-flattened communities in Haiti or Japan. In places where there is almost nothing, children always find a way to laugh and play ... with balls and dolls they make from rags and bits of things they find, wherever they are. They are incredibly resourceful. And the more I meet these children and their families, the more I understand that they are not simply victims in need of our pity. They are courageous, hard-working survivors, in need of—and deserving of—our support. An inspiration. ■

Ethiopia: Land of Contrasts,

By Nena Terrell

ETHIOPIA IS AMONG the 10 poorest countries in the world but also among its fastest growing economies. These two facts combine to make it a compelling focus for U.S. development assistance. There is great need, tremendous potential and measurable progress. These confounding facts also make USAID's portfolio of humanitarian and development programs in Ethiopia one of the largest and most complex in Africa.

Agriculture and rural development is the engine of Ethiopia's growth and a healthy, educated population is the driver of the country's transformation.

This issue of *FrontLines* features programs in Ethiopia that reinforce the impact of each to promote food security and agricultural sector growth, family health, basic education and peaceful resolution of conflicts—key elements for sustained development—and provide insight into how USAID supports a nation's best efforts to progress.

In a country like Ethiopia, modern comforts are still challenges for many people, particularly those in rural areas where 85 percent of the population

resides—things like piped water, easy transportation, electricity and Internet access. Progress is evident: Looking back just five years, now far fewer children are dying before age 5, more people are food secure, most children start school, many miles of roads cover the country, and numerous diverse businesses and banks are growing.

With over 80 million inhabitants, the second most populous country in Africa is composed of diverse ethnic groups and religions. Among the most prominent are orthodox Christian and Muslim. Over 80 percent of the country's population resides in rural areas and relies on subsistence agriculture. Geographically, Ethiopia covers a land mass equivalent to the U.S. states of Texas, Oklahoma and New Mexico. Its topography ranges from the highlands with its capital, Addis Ababa, the third highest in the world, to the Rift Valley and dry lowlands, including the lowest point in Africa below sea level, the Danakil Depression.

Situated in the Horn of Africa, just across the Red Sea from Yemen, bordered by Kenya, Djibouti, Somalia, Sudan, South Sudan and Eritrea, the country plays a pivotal role in regional peacekeeping and security. A healthy and

prosperous Ethiopia has a great contribution to make to stability and economic progress in the Horn of Africa and, as such, is an important trading partner and security ally for the United States.

The stories on the following pages narrate how USAID programs impact the lives of Ethiopian farmers, health-caregivers, teachers, parents and entire communities around the country.

DESPITE THE regular and increasingly more frequent cycle of droughts in parts of the country, the number of beneficiaries requiring emergency food aid or other humanitarian assistance has dropped from 15 million in 2003 to approximately 5.6 million, due largely to Ethiopia's Productive Safety Net Program (PSNP) (see article page 26). Operating since 2005, PSNP has changed the way chronic food insecurity is addressed. Under the program, USAID, along with other donors and the Ethiopian Government, now provides predictable and timely transfers of cash and food in exchange for building public works—terracing hill-sides against erosion, or building check dams, canals, or access roads—that protect natural resources, provide irrigation, or ease access to markets.



1. A traditional hut, or tukul, sits atop a hill in Lalibela, the historic highland Ethiopian town known for its rock-hewn monolithic churches. Photo by Kelly Ramundo, USAID 2. Two health extension workers at Endamariam Health Post in Enticho, Tigray. Photo by Nena Terrell, USAID 3. Ethiopian Somali women gather their milk daily to sell in town. Photo by Nena Terrell, USAID 4. A view of the northern Ethiopian landscape near Hauzen in Tigray, close to the border with Eritrea. Photo by Nena Terrell, USAID

Nation in Transformation

Another important contribution to food security is guaranteeing that farmers and their dependents enjoy the fruits of their labor. USAID's cooperation with the government, the sole landowner in Ethiopia, on land administration and certification (see article page 34) has led to 165,000 households—including households headed by women—receiving land use rights. The heads of these households are confidently making investments in their property, and productivity gains are following suit.

Additionally, the U.S. Feed the Future initiative has expanded USAID's already established technical assistance and training for cooperatives, allowing small-scale farmers

to pool their scarce resources and knowledge. Now, these farmers routinely outperform farmers working on their own.

Access to credit is another critical element for growth among small entrepreneurs. USAID's Development Credit Authority, through guarantees with private banks, opens up credit to farmers and rural entrepreneurs (see article page 38), and, importantly, to women borrowers, who face barriers when asking private banks for loans.

As Ethiopia endeavors to harness the untapped potential of its agricultural sector to create food security, jobs and growth, it also struggles to meet the health-care and education needs of its growing population and labor force.

Ethiopia's Health Extension Program (see article page 28) is a model closely watched by countries all over the continent. USAID's Integrated Family Health Program works side by side with these

health workers in 286 districts of the country covering over 32 million people. Largely as a result, Ethiopia has decreased under-5 child deaths by 28 percent—saving over about 80,000

children a year—since 2005.

With support from USAID and other donors, Ethiopia has achieved 95 percent enrollment in primary school over the past 15 years, yet an estimated 3 million primary school-aged children and over 20 million youth are outside the formal school system. USAID has worked with under-served communities to build Alternative Basic Education Centers, where students not only access education for the

first time, but are also often outperforming students in the formal system (see article page 42).

Lastly, peace and progress are inextricable, and so USAID's work to mitigate conflict and promote good governance is integral to its work. In particular, the southern half of the country is vulnerable to largely resource-based inter-communal conflict and administrative boundary disputes. The Negele Peace Accord, (see article page 40) shows how USAID's conflict resolution program has had great success in assisting local government and communities to negotiate and consolidate peace agreements and to ensure that administrative actions "do no harm."

In Ethiopia, much progress has been made since the overthrow of the communist dictatorship, known as the Derg, in 1991. With each round of gains, there are successive challenges. Today, through the U.S. Feed the Future, Climate Change, and Global Health Initiatives, and through support to basic education, public accountability and conflict resolution, USAID is working with many international and Ethiopian partners to accelerate Ethiopia's transformation away from extreme poverty toward prosperity. ■

GO ONLINE
to read **USAID**
country strategy for
Ethiopia and to
see a **slideshow**.

ETHIOPIA (all data represent 2011 unless otherwise noted)

Population: 82.9 million (2010)
Population living at national poverty line: 38.9% (2009)
Population growth: 2.6% per year (2007)
Total fertility rate: 4.8 children per woman
Contraceptive prevalence rate: 28.6%
Maternal mortality rate: 676 per 100,000 live births
Under 5 mortality rate: 88 per 1,000 live births
Unemployment: 20.5% (2009)
No formal education: women—51%; men—33%

Literacy: women—38%; men—67%
Stunting (under 5): 44%
HIV prevalence: 1.5%
TB prevalence: 394 per 100,000 (2010)
Malaria incidence: 1.3% per 100
Ownership of goods:
41% of households own a radio;
25% own a mobile phone;
42% of urban households and
1% of rural households own a television
GDP per capita: \$358 (2010)

Sources: Demographic and Health Surveys, World Bank, Ethiopian Census, World Health Organization, Malaria Incidence Survey



4



© CIA

ETHIOPIA

CATCHING

Photo by Nena Terrell, USAID

A beneficiary of the USAID-supported Productive Safety Net Program living near the Mai-Aqui site, in Tigray, Ethiopia, gushes about its success. Able-bodied beneficiaries receive food aid or cash in exchange for labor towards public works. However, those in the community unable to do physical labor also receive assistance.

ETHIOPIANS BEFORE THEY FALL

By Kelly Ramundo

Despite one of the region's worst droughts, no famine struck rural Ethiopia last year. The drought's impact was lessened by a food-and-cash-for-public-works program USAID supports and helped design. Today, one of Africa's largest social safety nets does not just protect against chronic food insecurity, it helps communities weather the future.

IT IS DECEMBER 2011, and life goes on as normal in the arid highlands of Tigray, the northern Ethiopian region whose burnt sienas, giant cactus flowers, and peaks and canyons could easily be confused with those of the American Southwest. Here, donkeys carry grain and pull packs on the side of the road. Farmers work their fields. There is no sign of a crisis.

Normality is not typically a measure of success, but in this case, and in this particular region, it is. Beginning in early 2011, a severe drought decimated parts of East Africa, leading to a June declaration of famine in parts of Somalia.

The drought was considered in some parts of the region to be one of the worst in 60 years, affecting more than 13.3 million people in the Horn of Africa.

The month before the official drought declaration, USAID's Famine Early Warning Systems Network (FEWS NET) warned:

"This is the most severe food-security emergency in the world today."

In Tigray, a region held hostage to annual alternating dry and wet seasons, the impact has been minimal. The reason, according to many who live there, is a riff on the same theme: Because of "safety net," they say, things are OK.

"Safety net," which several Ethiopian ethnicities know by its English term, refers to the flagship food-security program designed by the Ethiopian Government, USAID and other donors after another severe drought hit the country in 2003.

The Productive Safety Net Program (PSNP), as it is officially called, originated as part of a new approach to address chronic food shortages through scheduled food or cash transfers to chronically food-insecure populations in exchange for labor on public works projects.

"The food ensures families living on the edge are not forced to sell off their assets, mainly livestock, in order to feed

their families. The labor, the quid pro quo for those fit enough to partake, is channeled into public-works projects designed to improve communities as a whole," says Dina Esposito, director of USAID's Office of Food for Peace.

As a result, crucial infrastructure—roads, watersheds, canals, terracing, irrigation systems, schools and health clinics—has been built or rehabilitated with the labor of the food insecure.

According to USAID/Ethiopia Mission Director Tom Staal, as the program was being designed in consultations led by the Ethiopian Government, donors realized the need to not just respond to crises as they happened, but to build up resilience among the most vulnerable communities, giving them the ability to weather the inevitable dry stretches on their own.

"Before PSNP, those in chronic need were provided assistance through emergency programs," says Scott Hocklander, chief of USAID/Ethiopia's Office for Food Assistance and Livelihood Transitions.

"While this food aid saved lives, it did not contribute to development activities or address the root causes of food insecurity."

Today, because of the safety net, approximately 8 million people receive assistance in a timely and predictable way.

In a visit to the Awda Guanga watershed site, in Tigray, Priest Berihu

continued on p. 46

A mother holds her child at their “model home” in a village outside Enticho Tigray, Ethiopia, served by the Endamariam Health Post. These model-family volunteers are part of the Ethiopian Government’s Women’s Development Army, taught by health extension workers to teach neighbors good health, nutrition and hygiene practices like latrine building, hand washing and cooking in a separate space.

The Female “Army” Leading Ethiopia’s Health Revolution

By Kelly Ramundo

A fleet of 35,000 front-line extension workers and their “model” families are helping carry out Ethiopia’s mission to provide universal access to basic health services and are empowering communities to take charge of their own health from the grassroots.

ETHIOPIA, Africa’s second most populous nation, is also overwhelmingly rural. Bucking the global trend of mass migration to cities, over 80 percent of Ethiopians still live in hard-to-reach areas. This isolation presents a formidable

challenge for the government’s health sector, which, to complicate matters further, suffers from a severe shortage of doctors and health professionals. In a country of over 80 million, there are only 2,152 physicians—one for every 36,000 people.

Around a decade ago, the infant mortality rate in Ethiopia was nearly 10 percent, and the rate of those dying before their fifth birthday topped 16 percent, both statistics among the world’s highest. At a time when world leaders were gathering to set ambitious targets to raise the bar on global health with the Millennium Development Goals, Ethiopia’s numbers demanded attention.

And while progress in child health has been made—over the past five years, the under-5 mortality rate has decreased by 28 percent, from 123 to 88 deaths per 1,000 live births—the Ethiopian Government still considers

the death rate intolerably high as one in 11 children today still do not live beyond their fifth birthday.

Finding answers to several questions was considered central to making greater gains: How do you bring quality health services to rural villages? How do you empower families to take charge of their own health? How do you encourage pregnant women to seek preventive care and dissuade them from potentially dangerous home deliveries? After babies are born, how do you ensure they are fed properly, and are vaccinated to survive those tenuous first months and years of life? How do you give mothers the information they need to improve their family's health, including the benefits of birth spacing? When government-sponsored care is available, how do you encourage deeply traditionally people to use it?

While these basic questions barely warrant a second look within developed health systems, to the Ethiopian Health Ministry, they often represent a matter of life and death.

THE GOVERNMENT'S response, according to Ethiopian Health Minister Tedros Adhanom Ghebreyesus, has been to methodically construct a "women-centered" health system "by linking leaders at the national, regional and district levels with women's groups in every village across the country."

The plan was officially rolled out in 2003 in the form of the landmark Health Extension Program (HEP). The government would first train a fleet of young women for a year to provide basic, largely preventive, primary health services to rural villages, and then deploy them in pairs around the country to alert communities to unhealthy practices and empower

families to take charge of their own health. The program was designed to tackle both the rural access problem and the health-sector workforce gap.

The HEP works like a countrywide referral network, rippling up from its foundation at rural health posts (home base for the extension workers), to the larger, better-equipped health centers, each serving around 25,000 people. At the top of the pyramid are the country's 122 hospitals, each staffed with at least one doctor.

Additionally, as of last year, Ethiopia's front line—the health extension workers—began to count on even deeper levels of grass-roots support when the government-named "Women's Development Army" was formed. These community-level volunteers are trained by the health extension workers to focus more intensively on sparking local behavior change. They make regular rounds to check on neighbors and encourage practices like latrine building and setting-up separate cooking spaces. They are from "model families" and serve as living examples that the health extension workers' messages are being heard.

"These model families influence other families to follow suit, and the changes seen at the community level are phenomenal," says Jeanne Rideout, health team leader for USAID/Ethiopia, which funds the Integrated Family Health Program (IFHP), a five-year project providing technical, managerial and financial support to the Health Extension Program.

The government has a lot riding on this network of women. "These development teams are being empowered to monitor health and well-being. Through the aggressive social mobilization of this

massive army of health extension workers and local development teams, we are determined to bring about the fundamental grassroots change needed to achieve our MDG targets," wrote Tedros in the forward to the Health Sector Development Plan IV, the government's road map to improving health in the next five years.

WUBALEM BEZABIH, 25, and Fetelwork Gezahegn, 28, are two of the roughly 35,000 health extension workers the government has trained under the program to date. Their base camp, Remeda Health Post in the Southern Nations, Nationalities, and People's Region (SNNPR) of Ethiopia, is a small concrete structure. From there, the women provide basic primary health care and outreach for around 5,000 villagers.

Managing the post involves rotating on daily foot patrols to educate villagers on basic practices and services that are often lifesaving interventions in rural communities.

"The really basic things are what's most important for the rural people; in other words, vaccinations, antenatal care, sanitation, nutrition—helping people to understand the importance of hand washing; simple malaria prevention like bed nets and spraying; and the need for pit

latrines," says USAID/Ethiopia Mission Director Tom Staal. "This is what health extension workers can do. They're not doctors. But just these basic interventions can help prevent 90 percent of health-care issues for most families."

Bezabih and Gezahegn display the books where they meticulously record the day's interventions—the number of children who presented with fever,

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to watch a video
on the **USAID**

Integrated Family
Health Program.

Boosting Health Center Coffers

Ethiopia has over 80 million people to care for, but only modest government revenues to finance health care. In fact, the Ethiopian Government pays only around 20 percent of the total costs of providing care in the country, while international donors pick up over 40 percent with the rest coming out of patients' pockets.

For the past decade, USAID has been working closely with the Ethiopian Government to reform the way health care is financed in the country, moving away from its chronically underfunded, centralized model of support. A major success has been registered in the area of health-care financing.

"What we did over a period of five years was help to get [the government] aware and comfortable with allowing health centers and, in some cases, hospitals, to collect fees—very minimal, but certain fees for certain non-life-saving interventions," says USAID Mission Director Tom Staal.

"So there is now a small consultation fee roughly equivalent to 50 cents at health centers and one dollar at a hospital to pay for items like aspirin, a blood test and certain basic services," he explains, although there are complete waivers for the extreme poor.

The program, which was first rolled out in 2004 in the Southern Nationalities, Nations and Peoples' Region (SNNPR) but is now implemented to some extent in all of Ethiopia's regions and city administrations, has three elements: permitting the country's health facilities to collect fees; allowing the health facility to keep that money (without losing their government revenue); and helping the centers make strategic use of the funds by involving the community in local governance boards.

Staal explains: "We worked with the government to set up a committee that includes officials from the facility, local government officials, and a community member to manage the fees by agreeing on approved expenses. What we found is that they were able to use those funds to upgrade facilities—put in a water tank, a generator for electricity, clean up the facilities, fix the broken windows, some additional staff training."

What happened next, explains Staal, follows the logical supply-demand paradigm: Since quality of care has improved, more people sought out care, closing the utilization gap that has been a major challenge to improving health care in the country. With rising numbers of patients, the health centers took in more revenue.

"At one health care facility I visited recently," says Staal, "they were saying that they were actually able to hire specialists at the hospital, which they could never afford before. And they were able to pay them at a salary rate higher than the government rate. So that's pretty exciting for a rural hospital to be able to get that sort of specialty," he says, especially considering that Ethiopia is one of a number of countries categorized as having a health-sector workforce crisis.

Other health centers, like Buge Health Center in the SNNP Region, have used extra funds to expand their labor services. "We have seen significant improvements in the quality of service recently," says supervising Health Officer Ayelech Getachew. "Before we had no oxytocin," she says of the drug to prevent post-partum hemorrhage, a major killer during childbirth. "After we were trained by the Integrated Family Health Program on how to use it, we purchased it with the money we retained from provision of services."

"This is really turning things around," says Staal.

diarrhea or cough that month; how many women sought family planning and how many are educated on it; how many children were screened and treated for slow growth; and a directory of their area's pregnant women and their check-up schedules.

Throughout the country, including in the six regions where IFHP supports the Health Extension Program, all health extension workers record and report data in the same way, facilitating the government's ability to measure progress.

The women boast about their accomplishments: "In this *kebele* [Ethiopia's smallest administrative area], malnutrition has gone down. There have only been four cases out of 1,012 kids," explains Gezahegn. Challenges persist, however. Because this health outpost has no running water, the health extension workers often haul it on foot. "Sometimes you get tired," Bezabih admits. "When you get to a rural home and the people are not there."

Many of the country's extension workers are trained to perform clean deliveries. In November 2011, Bezabih and Gezahegn safely delivered three babies. Their goal, however, is to encourage the community's women to make the 3-kilometer journey to the more sophisticated health center where mothers and infants have a better chance of surviving a complicated delivery.

AT THE SECOND rung of the HEP are the health centers, managed by the equivalent of physician assistants who go through three years of state-sponsored training. At the Buge Health Center, in Damot Gale *woreda* in SNNPR, 27-year-old Ayelech Getachew oversees 24 staff. The resident health officer explains that, like the health extension workers she works closely with, a large part of her

staff's job involves convincing the surrounding populations to use their services. "Before our community sensitization and training, they explain, 10 or 11 women came here to deliver per month. Now it's 25," she said.

Like most health centers, Buge now boasts a trained midwife, deployed as part of a new government initiative to provide a skilled birth attendant at each center.

Twenty-five-year-old midwife Kasech Negash enters the Buge antenatal room and explains that the health center staff encourage women to make at least four visits to the health center before delivery.

Zergu Tafese, IFHP's manager for SNNPR, explains just one of the harmful deep-seated practices midwives and health officers are trying to curb. "Traditionally, in Ethiopia, people used to [wash] newborn babies in cold water. Midwives are counseling mothers to delay baby washing for at least one day," he explains.

Adding to these health professionals' ever-growing arsenal of skills and knowledge, IFHP, implemented by USAID partners Pathfinder and John Snow Inc., recently sponsored training in integrated management of newborn and childhood illnesses, which addresses all major causes of child death in an integrated fashion. Now one provider can treat respiratory infections, malaria or diarrhea as well as screen for malnutrition in a single visit. The center also offers women information about various methods of contraception that can help limit the size of their families. "Anyone coming for family planning gets HIV tests," Getachew adds.

It is this kind of integrated care—promoted by health-care professionals up and down the referral network—that is the lynch pin of USAID support to the Ethiopian Government's efforts to reform the health sector countrywide, as well



Wubalem Bezabih and Fetelwork Gezahegn, center, are two of Ethiopia's roughly 35,000 health extension workers, trained under the country's flagship Health Extension Program, which is supported by USAID. The two women work at the remote Remeda Health Post in the Southern Nations, Nationalities and People's Region.

Photo by Kelly Ramundo, USAID

as to the Obama administration's greater Global Health Initiative worldwide.

AS ONE OF the two largest bilateral donors to Ethiopia's health system (the other is the U.K. Department for International Development), USAID is also the largest supporter of its effort to integrate a vast number of diverse but desperately needed services under one umbrella.

USAID/Ethiopia's Integrated Family Health Program was launched in 2008 as an effort to bridge and streamline two separate programs, one concentrated on child health and the other on reproductive health. Today it operates in six of Ethiopia's nine regions and 283 districts, or woredas, covering almost 32 million people. At its core, the program supports the government's mission to offer the country's women, who are the primary caretakers in Ethiopian society, a range of health and education services—including maternal, newborn and child health, and family planning—as a package deal.

"Integration means addressing all a person's health concerns in one visit. Before, if a woman brought her child for immunization, a provider would not necessarily ask her about family planning, or screen her child for poor growth," says USAID's Rideout. "Now, health services are set up to address all the person's needs, not just the issue that initially brought them to the facility."

ALTHOUGH ETHIOPIANS still face a wide range of development challenges, including access to safe water and sanitation; and in some areas, harmful traditional practices such as female genital mutilation and early marriage, health-sector reform is starting to transform peoples' lives, especially in the area of child health.

Between 2000 and 2010, the under-5 mortality rate was cut in half, from 166 deaths per 1,000 live births to 88.

continued on p. 47

Interview with Dr. Tedros Adhanom Ghebreyesus, Ethiopia's Minister of Health



Dr. Tedros Adhanom Ghebreyesus has led Ethiopia's Ministry of Health since 2005. An internationally recognized malaria researcher, and often cited as a visionary in the field of global health, Dr. Tedros recently spoke to USAID about his government's efforts to reform the country's health system, some areas of major success and the road ahead.

FRONTLINES: You were chair of the Global Fund to Fight AIDS, Tuberculosis and Malaria, chair of the Roll Back Malaria campaign, and you've been described by former President George W. Bush as one of the best health ministers in the world. What is your advice on how to become a world leader in health?

DR. TEDROS: I think what I agree is that we have the best strategy, and also a very strong political commitment by our government. That's what is really making things happen.

FL: What are your impressions of working with USAID over the past five or 10 years?

Tedros: Our working relationship with USAID is really something that I am grateful for. From the start, we set our own priorities. We set where we would like to be and how to get there. And I'm really glad that USAID supports us

based on that: It is helping us to make progress and to get good results.

When I work with USAID, we focus on two things. One is saving lives now, but at the same time we are building the system for the future. Our partnership has been based on this understanding, and it has been key to our progress. And as a result, Ethiopia is not only saving lives now, but also building our health system.

For instance, USAID has helped us in building a new health-management information system; in building a new pharmaceutical finance and supply system; and also in building up health-care financing (see article page 28). USAID's support in crafting the new health insurance bill is much appreciated. These new systems are preparing the health sector for the future. I really cherish our partnership, and I'm very grateful for the support we are getting.

FL: Ethiopia has made major investments in front-line health workers,

hiring and training roughly 35,000 female health extension workers who've contributed significantly to better health outcomes in rural areas. How do you plan to ensure the quality of the health workers, retain them and develop a career pathway for them?

Tedros: Their retention has been considered right from the start, when we started the health extension program (see article page 28). We made sure that the health extension workers actually come from the rural communities, from their respective villages. If we cannot find a high school graduate from a rural village, then we take one from a neighboring village or from the same district. So that's helping, and the attrition is less than 5 percent.

We have also developed a strategy for health extension workers to move up the career ladder, earn higher salaries and progress. The good-performing ones and the bright ones can get additional better training to earn a degree, become

a nurse, a health officer, a midwife, a nurse practitioner or even a physician.

FL: What about the dearth of doctors?

Tedros: Yes, there is a serious shortage. We believe the root cause of the problem is a mismatch between supply and demand. Of course, brain drain contributes to the shortage, but we don't believe that brain drain is the main cause. The main cause is not training enough and not supplying enough, even though the demand is really high.

So our government designed two strategies: One is a flooding strategy, and the second is a retention strategy. In the flooding strategy, we're trying to really produce enough to satisfy the demand. And in the retention, we're introducing financial and nonfinancial incentives to keep them. Based on that strategy, our enrollment of medical students increased from 300 six years ago to 3,000 this year. The past three years, we have been enrolling an average of 1,400 per year. So we hope in the coming five, six years, the crisis will really start to abate significantly and stabilize.

FL: Can you describe the new tool at the health extension workers' disposal: the Women's Development Army?

Tedros: Yes, these groups—they could be women's groups or other groups—are mobilizing communities, speeding up the scale-up of best practices through peer support. The communities themselves can help each other.

For example, a major obstacle to improving maternal mortality is discouraging traditional home births. When I visited Tigray recently, I was really encouraged by what I saw. Institutional delivery has really soared significantly. I was trying to go through the records of the health

extension workers, and I really couldn't believe it. A few years ago, institutional delivery was less than 10 percent. But now in some villages, more than 50 and even up to 70 percent are giving birth in health facilities. We can see the benefits of really working with women's groups in creating this environment of peer support.

FL: Aren't you also starting a new program for midwives?

Tedros: Yes, we started acceleration training, and we enrolled more than 1,600 last year. And in the next two years, we will, I think, finish the accelerated training by training between 5,000 and 6,000 more. That is part of the flooding strategy.

We use the same strategy to train health officers, who manage our country's health centers. In just four, five years we trained over 5,000. We're training some of them on emergency lifesaving surgery interventions, like Caesarean section, to save mothers, because we don't have enough surgeons or OB/GYN specialists in the country. So this is exactly the type of task-shifting we were talking about: from surgeons or OB/GYN specialists to health officers or non-physician clinicians.

FL: Given there is still more work to be done in the area of child survival as well as maternal and newborn health, what is your vision or plan for the next five years?

Tedros: I would split it into two. The 2011 DHS [Demographic Health Survey] result was released in March, and showed that under-5 mortality had declined dramatically from 123 deaths per 1,000 live births to 88. So, for us, this is really a good incentive to help us to even aspire for more.

Our first objective is an ambitious and compelling child survival goal. And what we're aspiring for in Ethiopia is to achieve more than the MDGs by 2015. We're expected to reduce under-5 mortality from the existing 88 to 67 per 1,000 live births but we believe that we can even reduce it even more. So it means we are revising our MDG targets. We think we could go down even to between 40 and 50.

But of course, although the under-5 mortality has declined dramatically, neonatal deaths have only declined very modestly. And they contribute up to around 42 percent of the total under-5 mortality. So another focus will be, of course, on newborn deaths.

But this is not about child survival alone; this is about maternal health and survival, another area where we really haven't made progress. Especially in Ethiopia, considering the situation, I think taking [maternal and neonatal health] together as a pair is key, focusing on care during pregnancy, delivery, and then during the crucial month post-delivery which is really the most risky both for the mother and for the child.

A mother should not lose her life while giving life, and the practical step towards realizing that is for all deliveries to be at a health-care facility, supported by a skilled health professional. So the two combined—the first months from pregnancy to the first months of the child's life—is very critical.

I think if we can really implement the new strategy we have started, we will improve the maternal situation in Ethiopia. And we're very excited and very hopeful. This is not simply dreaming, but believing that it's possible. We have a practical solution to make it happen. ■

GO ONLINE
to read the full
interview.

A Powerful Piece of Paper

By Karol C. Boudreaux

A USAID-backed land-certification scheme has not only transformed property rights for men and women alike, but has also addressed declining agricultural productivity, resource degradation and conflict over boundaries. With certificate in hand, new rights-holders agree: "There is nothing better than land."

KIMYA AHMED NEVER imagined how a simple piece of paper would change her life. But that is exactly what happened after she and her husband received a formal certificate of land use from the government in 2004.

After converting from insecure occupants to secure rights-holders, the Ahmeds decided to further invest in the small patch of farm. In doing so, they increased the variety of crops they grew and improved their yields and income.

Similar stories have been playing out across Ethiopia ever since the government, with Agency support, began implementing a pilot land-certification scheme back in 2005 to promote property rights and to address serious problems of declining agricultural productivity, resource degradation and conflict over boundaries.

The rationale was simple: If people had more secure user rights to the land

they worked, they would take better care of it. With more productive land, the country's overall food and economic security would improve as well.

The Government of Ethiopia is the owner of all land in the country, and regional governments have primary authority over who gets to use the land. For decades, farmers living and working a plot had very little security and limited protection against either Imperial-era landlords or the Marxist government. They were conditioned by a long history of unequal land holdings, and susceptible to unforeseen land seizures and nationalization and repeated land redistribution.

These factors made life hard and unpredictable for poor smallholder farmers, who make up the majority of Ethiopia's population. It also turned out to be

devastating for the country's agricultural productivity. Lack of security among millions of smallholder farmers was contributing to the misuse and overuse of land-based resources. A hostile social and legal environment meant farmers had few incentives to invest time or effort improving or conserving their land or in planting more lucrative perennial crops. With low yields, people were often hungry.

A PROFOUND SHIFT in land tenure arrangements began in 2002 when the government stopped redistributing land. This change created a window of opportunity. Starting in 2004, USAID officials worked with the Ethiopian Government to pilot a program to give landholders clear use rights in selected regions, including allowing them to lease the land to others for income.

GO ONLINE
to see a video
on land tenure
in Ethiopia.



Three young women in Wendo Genet proudly display their land certificates.

“This was an experiment in Ethiopia but one that has worked: Smallholders have land certificates, tenure security has increased, and so has investment and output. Now there are fewer violent land conflicts and better resource management. The impacts on women have been particularly measurable,” said Gregory Myers, a USAID senior land tenure specialist, who designed the project.

From the outset, USAID’s Land Tenure and Administration Program, carried out by implementing partner Associates for Rural Development Inc., worked in the four most populous regions of the country—Amhara; Oromia; Tigray; and Southern Nations, Nationalities, and People’s Region (SNNPR)—developing a legal and policy framework to secure rights, to train land administration officials, and to survey, register, and certify land-use rights for men and women. The project also supported the development of new proclamations and regulations to implement the new laws.

With new laws in place, the process of identifying and registering rights to land could begin. Working with elected village land committees, district-level officials determined which families had claims to which parcels. Landholders were required to be present for these determinations and to identify the boundaries of their land with neighbors present as well. These holdings were certified when everyone agreed that the plot boundaries were accurate. In cases where parties disagreed and the land committees could not mediate the dispute, councils of elders resolved cases so certification could move forward.

The pilot Ethiopian Land Tenure and Administration Program ran from

She Has Land Rights Too

Dararo Gubaro, a grandmother and a widow, heads her household in Wendo Genet district of SNNPR. She has seven dependents at home and earns money for her large family by renting her plot. She can do this with a sense of security because the land certificate is in her name and includes her photograph.

Her situation is not unique. Twenty percent of households in Ethiopia are headed by women.

On average, Ethiopian women have smaller, poorer quality plots of land and less access to support from extension agents, credit, and good-quality agricultural inputs. When widowed or unmarried, they are vulnerable to claims by other relatives or in-laws. By securing their rights to land through the government’s Land Administration Program, women have gained an important economic and social base to build on. Women may, in fact, be the biggest winners from this collaboration between USAID and the Ethiopian Government to secure land rights for the country’s poor.

This advance legally empowers women by recognizing their rights to control and manage assets; with control comes greater decision-making authority to the benefit of households and communities.

As one wife in Debeso, in SNNPR, told visitors in January: “I will use my certificate to further my own money management and access credit so that I am able to buy goats and sheep.”

Says USAID Gender Adviser Caren Grown: “Recognizing land and inheritance rights is an important step in the direction of greater gender equality in many countries. Ethiopia’s example reflects the goals of USAID’s new Gender Equality and Female Empowerment Policy.”



Dararo Gubaro is a widow and head of a large household in Wendo Genet district of SNNPR. Her land certificate allows her to sublet her plot to earn income.

2005-2008 and trained hundreds of local men and women to survey and register rights to over 700,000 land parcels in the four regions. Originally, plots were marked off using eye measurements or with ropes, both inaccurate methods for identifying claims. With Agency support, the project shifted to surveys using simple hand-held GPS devices. Information gathered in the field was then downloaded onto computers to create parcel maps. These

records were archived both manually and electronically for easier retrieval.

Under the certification scheme, after boundaries are plotted and registered, landowners receive a paper certificate that includes a parcel map of their land. The certificate gives them the right to use and profit from the land or even sublet it, and to transfer the certificate to offspring, regardless of gender.

USAID/Ethiopia Mission Director Tom Staal considers the lease and

inheritance provisions of the land tenure program keys to its success.

“Through this program, we were able to provide a sense of ownership,” he explains. “First of all, by identifying the exact boundaries of the line, which helped reduce conflict. Second, by giving them a piece of paper, so they feel secure. Thirdly, so the wife’s name is on the landholding certificate as well as the husband’s; and fourthly, to ensure they are allowed to sublet the land, which is also very significant.”

The leasing provision has become an added boon to rural economies and a special help for women-headed households. Women can now earn income from their land without having to partake in the backbreaking work of hand-weeding fields, a special, disproportionate burden for women in Ethiopia (see sidebar on previous page).

Since 2008, USAID’s follow-on Ethiopia Land Administration Program, also carried out by Associates for Rural Development, has provided expanded support to cover another 100,000 Ethiopian households. The new project has helped two dryland regions, Somali and Afar, develop land-use and land-administration proclamations better suited to their unique needs. These areas are home to many of Ethiopia’s pastoral communities and the project has worked with these regional governments to develop regional pastoral land policies.

Because it is so important for people to understand their rights when laws change, efforts to increase public awareness were scaled up and the important work of building capacity among public-sector officials, including judges—who now had new laws to implement—and land administrators grew.

Today, USAID and the Ethiopian Government are full-fledged partners in implementing the Land Administration Program in six regions of the country, and thousands of families benefit from this alliance to strengthen property rights.

Any concern the Ethiopian Government may have had at the outset, according to Staal and Myers, was allayed when the program started producing results.

In Wendo Genet district in SNNPR, for example, beneficiaries of the program explain that, because they have land certificates, they are more inclined to conserve land, water and wildlife. Farmers no longer encroach on the nearby forest, and they practice terracing to avoid erosion.

With greater predictability and stability, productivity is improving on certified land. According to Staal, in the 32 pilot districts that implemented the land tenure program, over the last three years, yields have increased between 11 percent and 40 percent per acre with no other inputs.

“Just that piece of paper. And why?” asks Staal. “Because people now feel secure about their land rights. So they put in an irrigation system. They do some terracing. They do some water harvesting. And their land becomes more productive.”

Formalization of clear boundaries has also had the added benefit of reducing conflict between neighbors. Matthias Chebo, administrator of one of the sub-districts in Wendo Genet, reported: “Now we spend more time farming and less time fighting.”

Today, smallholder farmers like Kimya Ahmed are able to do something that was unthinkable just a few years ago: invest in land with confidence. “We are



Photo by Nena Terrell, USAID

In Wendo Genet district of Sidama zone in SNNPR, Altaye Menu, land administration expert for the regional government, center, reviews the district’s land registry as Fitsum Aberra, surveyor, left, and Yeshitela Mekonnen, registrar, look on.

working well now,” she says. “We are growing maize, corn, potatoes, onions, tomatoes and other cash crops. When the crops are ready, we harvest, and then again we sow. We bring fertilizer and manure.”

Better crop yields mean their children are better fed and it means the Ahmeds have a surplus to sell at market. Having a formal land certificate has also allowed the family to access credit more easily. Ahmed and her husband have used their newfound access to credit to buy livestock. Instead of relying solely on crops, their portfolio is now diversified: their cattle and goats provide milk which they sell at market.

“There is nothing better than land. The benefits of land are so great. We have no problem with food; we never lack for food. This is how I am educating my children today. This is how I meet the needs of my family,” says Ahmed, whose daughter enrolled in a university.

Other donors are working to help expand and extend land certification across the country. The World Bank, Finnish Aid, and the Swedish International Development Agency are all helping to strengthen rights to use and benefit from land and land-based resources, leveraging the U.S. Government’s relatively small investment of \$12.2 million over eight years to create larger-scale benefits and support a collaborative approach to this issue.

Most importantly, these efforts reflect the Ethiopian Government’s desire to scale up land administration and certify millions more households, empowering more of its citizens with legal rights to use, trade and inherit land so they can contribute to the development of a more resilient and food-secure Ethiopia.



Photo by Amie Silverstein, Links Media

Kimya Ahmed and her husband have used their land certificate to increase agricultural production and access credit to buy livestock. They sell the surplus from both at the market to support their children’s education.

“USAID’s land-administration support was instrumental in strengthening legal frameworks, capacitating land institutions, improving tenure security of the rural people through land certification, and increasing awareness on land-use rights and obligations. We expect our partnership with USAID to continue with more lingering land-administration activities in the future,” said Tigistu Gebremeskel, director of Ethiopia’s Land Administration and Use Directorate, part of its Ministry of Agriculture.

Says Staal: “[This program] was something that the government was concerned about because they have a very strict policy about no private

land ownership. But we showed them that this was still working within their system. And now the government agrees this is a fantastic program, and they want to take it nationwide. To me, that’s the kind of transformation where we can leverage a relatively small amount of input to really make a huge change around the country.”

Building on this strong foundation, USAID is continuing to invest in land tenure efforts in Ethiopia. A new project focusing on improving tenure security in pastoral areas will help address important Ethiopian and U.S. Government priorities related to rural resilience and economic growth. ■



Putting Local Wealth to Work in Ethiopia

Abebaw Gessese, the owner of a poultry farm in Mojo, Ethiopia, received a \$132,000 loan from Dashen Bank thanks to a USAID guarantee. He used the loan to build his own feed processing plant, to buy his own truck, and to construct an additional barn. Today Abebaw Gessese produces over 5 million eggs a year and enough chicken meat to feed 108,000 people.

Photo by Morgana Wingard

By *Stephanie Grosser*

ABEBAW GESSESE IS a poultry farm owner in the rural town of Mojo, a few hours south of Ethiopia's capital. Poultry farming, however, wasn't always Gessese's profession. He majored in accounting at Addis Ababa University and spent a decade working in the Development Bank of Ethiopia before deciding to take the risk that every entrepreneur must take: giving up the security of a constant paycheck to pursue a dream.

You could say that starting a farm was in Gessese's blood. Both of his parents are farmers, and he grew up looking after the family's cattle and sheep. After seeing firsthand the growing yet unmet demand for poultry in the capital, he knew starting a poultry farm could be the answer for improving his life, his two children's future, and his community. While he was determined to push forward and successfully acquired a certificate to lease land

from the Oromia regional government (in Ethiopia, the Government owns all land; see article on page 34), Gessese lacked the financing for his poultry business.

A lack of access to credit for farmers and other small businesses is widespread in most developing countries. Yet in Ethiopia, and in many

other low-income countries, a majority of the population farms or resides in rural areas. Although they are central to these countries' economic advancement,



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small farms and agribusinesses often face a devastating impediment to growth: a lack of access to financing. Banks are hesitant to lend to sectors they perceive as being too risky.

In response, USAID's Development Credit Authority has established risk-sharing agreements with local banks in developing countries around the world. The agreements state that USAID will share risk on loans made by these banks if they increase their lending to sectors that require financing and are central to local USAID priorities. Put another way, USAID will partially reimburse banks—typically 50 percent—for defaults on these loans. As a result, banks are able to boost their lending and expand into new sectors that they traditionally perceived as being too risky.

"DCA is mobilizing private financing in Ethiopia and around the world by fundamentally changing the risk-return ratio for banks. By sharing risk, we can get banks to make investments they wouldn't normally make," said Ben Hubbard, director of USAID's Development Credit Authority.

In Ethiopia, USAID has established 11 guarantee agreements with five local private banks since 2004, opening up \$66 million in credit to entrepreneurs like Gessese at a cost of \$7 million to USAID. These entrepreneurs are not solely farmers. They range from tourism entrepreneurs to importers. The money is put aside in the U.S. Treasury in case of defaults. But of all the \$32 million in DCA loans made in Ethiopia, defaults have only been 2.5 percent.

After USAID signed a guarantee agreement with Dashen Bank, Gessese's local financial institution, his fortunes started to change. With USAID's

guarantee and Gessese's land certificate in hand, the Bank felt comfortable approving the loan. He was not alone. An additional 74 entrepreneurs in Ethiopia's agriculture sector have benefited from USAID's guarantee.

With a five-year, \$132,000 loan received in 2007, Gessese was able to increase his output and start producing his own inputs, such as chicken feed, directly on the farm. Today, his farm produces over 5 million eggs and 60,000 broiler chickens annually, providing a much-needed affordable source of protein for local customers. Due to increased production at his farm, Gessese expanded the number of his employees from 20 in 2007 to 50 today.

This community benefits in other ways. Gessese explains: "One impact of my business on my community is that, before, they did not have clean water. We installed a mechanical well,

and now water is free to over 200 households in the community who no longer have to walk long distances to access water. This helps them to have pure water and improve their health." He is also now able to send his children to a better school.

By empowering local banks to lend to the agriculture sector and people like Gessese, USAID is helping countries become reliant on their own food supplies.

Says USAID Ethiopia Mission Director Tom Staal: "In Ethiopia, we are working closely with the Government's Agricultural Growth Plan through our Feed the Future Initiative to open up space for the private sector in improving technology, value chains and rural development. As countries develop local agricultural capacity, they become less dependent on food aid and foreign assistance." ■



Photo by Morgana Wingard

Abebaw Gessese lets the community use his water pump for free. Before these women had access to the pump, they had to walk 6 kilometers to purchase clean water.

Peace Brokers

By Jennifer Westervelt

USAID-sponsored reconciliation efforts usher in historic truce accord in Ethiopia's pastoral south.

ADUSTY TOWN IN the Somali region of Ethiopia, Hudet had been the focal point of a longstanding conflict. For decades, four clans—the Gari, Guji, Gebra and Borena—had competed over scarce resources and fought over a vast territory along the disputed borderlands between Ethiopia's Somali and Oromiya regional states.

Clashes among the groups had regularly escalated into violence that destabilized pockets of the region. Historically, these clashes included cattle-raiding and revenge-killing, driven by competition for control over key resource areas that support local livelihoods, as well as a culture that often rewards displays of violence. In 2009, a particularly devastating conflict over access to key resources among these communities resulted in many deaths and large-scale displacement.

But by July 2011, this tension and conflict were no longer apparent in Hudet. Women in brightly colored dresses and headscarves went about their business, kids chased each other down the road, and a teenage boy ambled through town with his herd of cattle. A Somali couple had opened a modest, new hotel, evidence of the peace that had ushered in investment.

For the previous two years, USAID and Mercy Corp's Strengthening Institutions for Peace and Development program had been supporting

government, traditional institutions and the wider community to build peace among the four clans of the Somali and Oromo people who make their living as pastoralists or farmers in these remote, arid lands.

The program, part of USAID's focus on good governance and conflict mitigation, supports Ethiopia's peace-building goals at both the national and local levels. The Negele Peace Accord is an example of USAID's broader efforts—extending across much of the southern half of Ethiopia—to strengthen the collaboration of government (federal, state and local) and community actors

in mitigating and preventing future episodes of violent conflict.

With support from USAID and Mercy Corps, government and community institutions led peace-building trainings, consultative meetings, and dialogues with clan elders, religious leaders, women, and youth groups to address the complex conflict issues that most people had come to see as intractable.

Slowly, perceptions shifted; people began to view peace as a possibility and ceased to see violence as a necessity. Key leaders from the clans began drafting a peace accord, which they repeatedly submitted to their communities for feedback and revision. After a year of community and government consultations, clan leaders ratified the final draft, and previously conflicting communities began successfully implementing a shared set of laws. The clans began to openly share natural resources, markets, and services in the former contested territories, improving their overall



Traditional leaders of Borena, Gabra and Guji clans sit together during ratification ceremony of the Negele Peace Accord, following a two-year peace-building process.

Photo by Mercy Corps

livelihood options. Social and economic interaction flourished.

“When we agree and collaborate, not only our peace but our total well-being is improved. This way is better and also brings a solution to our problems,” observed Abba Gada Dambibo, a representative of the Guji.

These were unprecedented, historical accomplishments for the people of the Borena, Gabra, Guji, and Gari clans, a combined population of more than 82,500 people. Ethiopia’s minister of federal affairs and the Somali and Oromiya regional vice presidents placed their signatures on the peace accord along with the clan leaders.

“This agreement shows determination from all parties, and even if conflict arises, it is stated here that it will be resolved peacefully. This is a great success for you and a lesson for other communities,” said Federal Affairs Minister Shiferaw Tekle-Mariam.

Over 800 people came to the ratification ceremony in Negele Borena. They walked, took buses, and drove from all over the country. Most made camp together outside the town, sharing food and stories late into the night. In their speeches, Shiferaw and the Borena clan leader reiterated the core reason that they believed this peace would last: Unlike previous, unsuccessful reconciliation efforts that were initiated by the government, this time the momentum came from the community.

IN THE MONTHS following, the peace accord was put to a test: A drought affecting the area was becoming increasingly more severe. Droughts

put stress on available food and drinking water as well as grazing land and water for livestock, threatening the very livelihoods of the population.

Based on an assessment of the drought situation in the conflict-affected area in July 2011, the water points in the communities were almost dried up, with most of the villages relying on water trucking. Communities were rapidly



A camel trader with his herd in a Somali region livestock market. USAID recently helped broker a peace deal among the four clans of the Somali and Oromo people who make their living as pastoralists or farmers in these remote, arid lands.

losing their livestock assets, with many households at risk of losing their entire herds, meaning they would have little options for recovery even when rains returned. Women, children and the elderly were suffering from lack of livestock products, particularly milk and ghee, and general food shortages in local markets.

However, Gari clan elders explained their livestock were surviving—the peace accord permitted herders from all the clans to take livestock deep into Borena territory, to the only grazing land

that had received decent rainfall. “We are so interdependent that if someone believes there are issues that should lead us to fight, it is out of ignorance,” said Borena clan leader Abba Gada Guyo.

They were sharing other resources, too, and the market in Hudet was functioning again, offering commodities that people desperately needed. A follow-up study demonstrated that the trust that resulted from the peace process and accord meant that communities in this area were better able to cope with the 2011 drought as compared to their neighbors.

When disagreements threatened to reignite old tensions between clans, the elders and local government officials from concerned communities used conflict prevention and negotiation training to find a path forward.

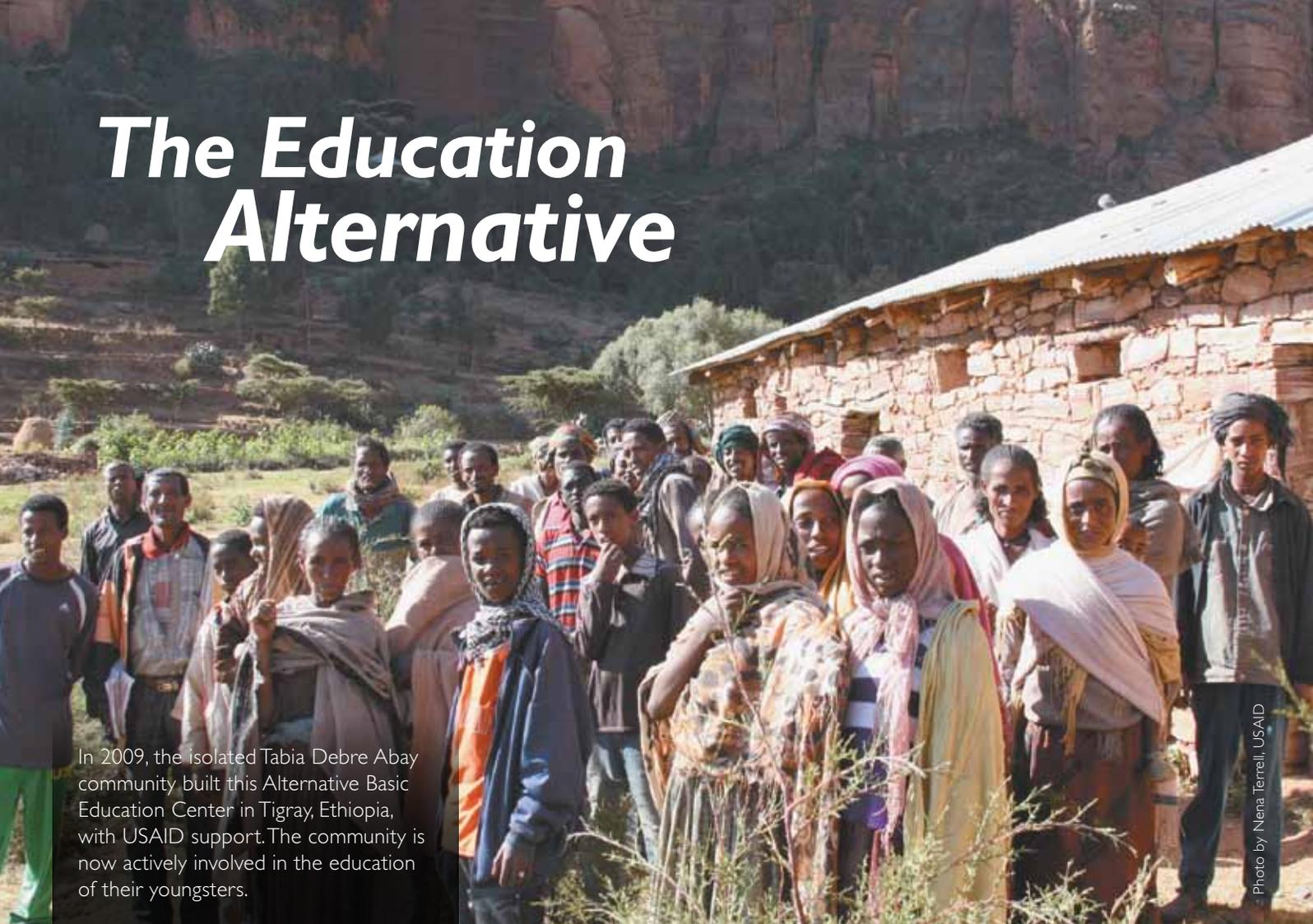
Abba Gada Dambibo articulated the wisdom gained from the conflict prevention and mediation training: “If we agree and collaborate, not only our peace but our total well-being will be improved.”

Said USAID/Ethiopia Mission Director Tom Staal: “It was clear that, although the difficult environmental and political factors that drove conflict in the region for generations had not necessarily improved, the communities’ willingness and capacity to jointly cope with those challenges had.”

As one elder explained, “These problems have been going on since our grandfathers. We don’t expect them to be solved in a year.” ■

Jennifer Westervelt is with Mercy Corps.

The Education Alternative



In 2009, the isolated Tabia Debre Abay community built this Alternative Basic Education Center in Tigray, Ethiopia, with USAID support. The community is now actively involved in the education of their youngsters.

Photo by Nena Terrell, USAID

By Kelly Ramundo

Through an innovative USAID-sponsored project, over a quarter of a million rural Ethiopians living beyond the reach of the formal system now have access to basic schooling. In just 10 years, the “it-takes-a-village” model is outperforming some of the country’s more established schools.

IN ETHIOPIA, as in much of sub-Saharan Africa, pens are a treasured commodity. Give a child a pen and you will see a smile worth all the Western world’s Christmas mornings.

Yet lack of basic school supplies just begins to scratch the surface of the country’s educational woes. Historically, most Ethiopians have not had formal schooling. Twenty million youth and 30 million adults have not been taught basic skills.

While huge advances have been made in recent years in getting students into classrooms, literacy remains abysmally low due primarily to poor teaching and lack of materials. Dropout rates are on the rise. Only a quarter of the country’s boys and less than 20 percent of its girls continue to study beyond primary school. But at least, some argue, these children have schools to attend.

Over four-fifths of Ethiopia is rural, but some parts are so sparsely populated

they fail to qualify as dots on a map. For the kids living far off the grid, a several-hours hike to the nearest state-sponsored school is often the only option. Not surprisingly, many forgo it. Five-to-8-year-old legs are not made for that kind of daily round-trip journey, nor is it a safe or reasonable option.

This lack of access to basic education can be an added stress on poor, rural parents—those subsistence farmers already struggling under the combined yokes of poverty, food insecurity and a cruel, whimsical climate.

If education is, in fact, the path towards greater economic growth, as Organization for Economic Cooperation and Development studies have shown, these unreachable kids need a clearer shot at breaking the vicious poverty cycle.

Says Allyson Wainer, the Agency's education officer in Ethiopia, "Reaching the most remote areas of the country with education that is both relevant and of high quality will have a great impact on improving the livelihoods of families in these areas."

IN 2002, USAID began a program to help the Ethiopian Ministry of Education fill the void where the government was unable to provide official basic education and where formal education was not necessarily relevant. The pilot brought improvised schools to about 350 out-of-school children in off-the-beaten-path communities in SNNPR (Southern Nations, Nationalities, and People's Region) that had never had them. Since then, the program has grown to cover around a quarter of a million of these children in underserved areas. The Government of Ethiopia has adopted both the model and the curriculum, and is reaching millions of children with the USAID-piloted model.

The schools, known officially as Alternative Basic Education Centers, or ABECs, are built by community members on communal land with materials funded by USAID. They are managed by villagers via elected community committees and usually include elders, women, and those with some level of education. USAID, through its partners PACT and, in Tigray, Relief Society of Tigray (REST), provides the committee members with training so they can effectively manage the ABECs.

Committees also identify the best candidates for teachers, who come from the community. As part of the program, USAID provides the teachers with intensive training, pays the salaries of teachers and supervisors, and supplies

learning materials in collaboration with local education offices.

The model was intended to ensure that entire communities were invested in the education of their young people.

In the Debre Abay ABEC, in the arid northern Tigray region, the model appears to be working. On a Thursday morning in December 2011, scores of villagers mill around the school, periodically checking in on a building holding three classrooms built by the community over a two-month period in 2009. Debre Abay is a 10-minute walk along a cactus-dotted gorge from the nearest point a vehicle can reach. The closest government school is two hours away on foot.

Inside one of the classrooms, around 40 third-graders sit in clusters atop clay-colored rocks arranged to provide relatively flat sitting areas. All are barefoot and a few scribble with twisted ink cartridges pilfered from the long-gone plastic shells. They seem eager to learn, their hands flashing up into frantic finger snapping when the teacher asks a question they know.

Letay Gebremariam is the 23-year-old facilitator (or teacher) at Debre Abay. An ABEC curriculum includes specially designed courses in literacy, English, environmental science, health, agriculture, history, geography and math, which are taught using examples and topics that are relevant to the lives of families in the peripheral areas of Ethiopia.

Gebremariam grew up in the community and remembers the grueling round trips to school that she made each day for eight years. To continue her education after the eighth grade, she had to rent a room in the nearest town. "It was hard. I used to walk four hours. I used to be tired," she recalls of her primary education.

Gebremariam considers it crucial that students who follow in her footsteps have

it easier. "If there wasn't a school nearby, these kids wouldn't come to school," she says. In all, 121 children, grades one through four, call this basic concrete structure school. Around half are girls.

Facilitators, who are chosen by the committees based on their knowledge of both the language and culture of the community, must have a minimum of a 10th grade education. They receive intensive short-term professional training to become certified to begin teaching at the ABEC.

According to USAID's Wainer, one of the best things about ABECs is that the teachers come from the community and are keenly aware of the culture, language and way of living for students and families. The program pays their monthly salary and they are granted a scholarship to continue their professional training during the summer in one of the teacher training colleges.

Upon the program's completion, USAID hands over both the ABECs and the teachers to the local government for conversion to formal schools, at which point the facilitators are recognized as teachers and join the payrolls of the Ministry of Education.

USAID has handed over 550 centers, which have all expanded to operate as full-fledged formal primary schools. Currently, 301 centers are being managed by USAID and partners, and will be handed over by the project's end in August 2014.

Built on the low-lying communal land central to where offshoots of families often live and farm high in the surrounding hills, ABEC education is anchored in intense community involvement.

Hailesellassie Teklehaimanot, a father of seven, is a community mobilizer in the Debre Abay area. He is a subsistence farmer by day, but his volunteer role is to preach the power of education to his

continued on p. 48

Interview with Thomas Staal, USAID/Ethiopia Mission Director



Thomas Staal, USAID's mission director in Ethiopia, joined the Agency in 1988 as an emergency program officer in Sudan. Since then, he has worked in Kenya, the West Bank and Gaza, Iraq, and as mission director in Lebanon. In Washington, D.C., he has served as the deputy director of the Office of Food for Peace and as director of the Iraq Reconstruction Office. This fall, he will return to Iraq as mission director.

FRONTLINES: Just looking at the names of Ethiopia's last two country strategies is pretty telling. "Breaking the Cycle of Famine" was from 2004-2010. The current one, from 2011-2015, is called, "Accelerating Transformation Toward Prosperity." Can you just talk a little bit about that transformation?

TOM STAAL: Yes. I was very interested in coming to Ethiopia because I knew a lot about the former strategy. I spent five years in Khartoum and six years in Nairobi in a regional position where I came to Ethiopia quite a bit. And I was the deputy director of Food for Peace in Washington for a year when Ethiopia's Productive Safety Net Program (see article page 26) was put together.

One of the things that excited me was that we have a very integrated approach here across the spectrum—from OFDA [USAID's Office of U.S. Foreign Disaster Assistance] to food aid to development—to really address famine in a way that gets people out of that cycle. They

had made huge progress on the old strategy. I was very excited about coming here to develop the next strategy, and build on the former strategy.

The 2011 drought illustrated that the cycle of famine has been broken in Ethiopia. Even though the drought was as big as any in the last 20, 30 years, there was no famine. Now we need to continue that progress and transformation so that we're really moving forward towards prosperity.

With programs like PSNP (Productive Safety Net Program) and others, we've made sure that people have some resilience so they can bounce back from shocks like drought. Now the next step is to actually build assets and move beyond—and that means transformation. Our strategy is designed to support and complement the Government of Ethiopia's five-year strategy called the "Growth and Transformation Plan."

FL: Is there a project or an accomplishment that you are most proud of?

Staal: The Productive Safety Net Program is one. Our land certification program (see article page 34) is another very exciting project. It was a pilot that we helped to initiate. Working within Ethiopia's political-economic-social context, we found a way to provide a sense of ownership for people even if they can't buy and sell the land. We felt it's very critical for people to feel secure about their land, enough to invest in it. That has been a problem over the years: People rent their land from the government, but they never know when it could be taken away from them.

So, through this program, we were able to work with the government to provide that sense of ownership. The program delineates the precise boundaries of the property, provides a certificate, which includes both the husband's and wife's names, and allows people to sublet the land.

Results have been profound: In the 18 pilot districts that implemented the land certificate program over the last three

years, there's been between an 11 to 40 percent increase in yield per acre. The security that comes from having the certificate results in people making improvements on their land such as terracing, water harvesting and irrigation. Thus, their land becomes more productive.

FL: You've also had some real successes in rural education in a program the government was also initially wary of.

Staal: Yes: the ABECs [Alternative Basic Education Centers] (see article page 42) is a program the government was very nervous about because they are not considered official schools. But they permitted us to pilot the program in 550 villages where there had never been a school. In over four years, the kids in those schools ended up getting better grades than the kids in the regular government schools.

So now the government has accepted it, endorsed it—they've taken on those first schools that we did and are now paying the teachers—actually turned them into teachers; before they weren't even officially called teachers.

FL: Let's turn to health care. It seems USAID has been crucial in helping the Ethiopian Government provide some level of basic health to the underserved throughout the country.

Staal: Well, you do have to give a lot of credit to Health Minister Dr. Tedros Adhanom. He's a dynamic guy, a real visionary, a real leader—he's probably the top minister of health in all of Africa, and is internationally recognized.

So, when it comes to the health extension worker program, (see article page 28) it's been his vision and his determination to make it happen that has

ignited so much success. But, of course, USAID has been very involved in the training, in the rollout, especially at the community level.

Up until about six years ago, the vast majority of Ethiopians—over 85 percent live in rural areas—most of those people had no access whatsoever to any health facility of any kind until this program started.

What is most important in rural areas is the basic, preventive health activities such as vaccinations, antenatal care, family planning, sanitation, nutrition, hygiene—helping people to understand the importance of washing your hands, using pit latrines and sleeping under your bed nets. The health extension workers are not doctors or nurses but they can address most of the basic health-care issues that really make a difference in the health of women and children.

FL: I know we have been seeing real progress in food security and health. But what are some of the challenges you're facing?

Staal: First, let me address a couple of non-political challenges. The country is still over 80 percent rural. Just getting out there and getting services to people is still a huge challenge. We've got this great health extension worker program, but that still doesn't mean a woman having a difficult childbirth can get to a health-care facility.

Real capacity, both in the government and in civil society, is another challenge. There aren't enough educated, trained people to do things. That's true in many other countries, too. But here, where you still have literacy rates of less than 50 percent, and even lower among women, that's a huge challenge. The government's ability to just

manage these massive programs is a major challenge.

And then basic income affects the government. Because people can't pay much in taxes, the government doesn't have much money. So for instance in the health sector, donors are providing over 40 percent of funding. A lot of great things are happening, but we can't just turn it over to them and walk away.

The other two overarching challenges are, one, on the economic side, you still have a government whose policies are focused on government control of the economy. For example, seed distribution and fertilizer distribution is done, primarily, by the government; so is major transport.

So the whole economy is really managed quite tightly by the government, and we believe it needs to open up. The government is the only Internet provider, and less than 5 percent of the population has access to the Internet. There's only one cell phone provider, and that's the government. And cell phone coverage is limited, and particularly in rural areas. So the private sector doesn't have an opening to take advantage like you see in Kenya, where mobile banking is taking off. Mobile banking assumes people have a cell phone.

We believe that the private sector could add a lot here in almost all aspects of the economy, but it has difficulty finding an opening.

The leadership of the country has a very well thought out reason for this. It's an economic philosophy that argues, when you have such an undeveloped country, the government needs to play a strong and controlling role to bring people up out of that poverty. I think they also believe that if you open up the floodgates too quickly for market capitalism, it's going to create chaos and

continued on p. 49

Safety Net

continued from p. 27

Gebremichael, a local beneficiary and community leader, describes a stark difference from before the PSNP came to town. “It is obvious that, before the safety net program, we had a lot of problems. I didn’t have capacity to provide my family with food,” says the 48-year-old father of two.

“Before the project, we depended on rain once a year. When there was good rain, we had good income. If the rain fails, income also fails. Drought was common,” he explains. “After safety net, this all turns green,” he says, a nod to the community’s new irrigation channels and combined 235 motor pumps that draw from it.

Today, Berihu is far from the struggling subsistence farmer of years past. While he used to grow only cereals, the agricultural assistance provided by REST, or Relief Society of Tigray, the local NGO implementing the PSNP and its follow-on programs in the region, taught him how to plant correctly, how to use water better, and how to cultivate

cash crops (green peppers, tomatoes, lettuce, garlic, onions and cabbage).

Instead of being forced to sell off valuable assets, he eventually multiplied them. With loan assistance also provided by the program, he bought improved seeds, a beehive, tools, fertilizer and an ox.

Berihu is now a PSNP graduate, meaning he no longer needs the monthly food or cash injections to provide for his family during the dry season. Graduation is the ultimate goal of the Productive Safety Net Program. In this sense, the safety net is merely the opening number of a two-act play: It aims to protect individual assets and create community assets so Ethiopians can then stand and prosper on their own.

IN 2011, USAID, AS the PSNP’s largest single bilateral donor, supported 2 million of the 7.4 million chronically food-insecure individuals that fall under the country’s PSNP umbrella, providing them food for three to six months in 65 districts, and also funding public work projects in 40 of these districts.

The PSNP donors—a group that also includes the World Bank, the U.K. Department for International Development, the European Commission, the Canadian International Development Agency, IrishAid, the World Food Program, the Swedish International Development Cooperation Agency, and the Royal Netherlands Embassy—and the Ethiopian Government would like that number to decline as the program continues to generate sustainable improvements.

According to Staal: “The idea is that with programs like PSNP and others, we’ve made sure that people are not falling into the hole, and have some resilience so they can bounce back. But now the next step is to actually build assets and move beyond—and that means transformation.”

An early sort of transformation can be seen close to the surface in places like Awda Guanga. Berihu is old enough to remember the horrible drought of 1984, which claimed up to 1 million lives, mostly in Tigray. He says: “I remember a lot of people dying. I remember the impact on our home.”

Since 2005, the majority of the chronically food insecure have been removed from the emergency caseload in Ethiopia.

That is not necessarily the case in neighboring Somalia where no similar safety net exists due to decades of brutal conflict and a lack of governance. At the height of the 2011 crisis, more than 3.3 million Somalis were in need of lifesaving assistance. Hundreds of thousands fled their homes, and more than half of the children who arrived at refugee camps in Kenya and Ethiopia were severely malnourished.

Recent impact assessments of Ethiopia’s PSNP indicate that participating households have maintained and, in many cases, increased their household assets and are bridging the food gap.



Photo by Kelly Ramundo, USAID

An irrigation canal at the Awda-Guanda watershed, a USAID-supported Productive Safety Net Program site, in Awlaelo district, Tigray, Ethiopia. Program beneficiaries receive food aid or cash in exchange for labor towards critical public works.

Just for Grads

If the goal of the Productive Safety Net Program is to help families preserve their assets during lean times and climatic or price shocks, a USAID-funded successor program aims to diversify and multiply them, graduating people from safety-net support altogether.

The new five-year GRAD program, which stands for Graduation with Resilience to Achieve Sustainable Development, aims to help 50,000 PSNP households in Amhara, Oromiya, Tigray and SNNPR turn the page on food insecurity altogether by linking them up to microfinance services and functioning markets, value chains and other agricultural investments in the more productive, neighboring areas—those supported by USAID under the U.S. Feed the Future initiative.

GRAD does so through a host of resiliency and sustainability strategies such as women's empowerment, climate change adaptation, nutrition support, and modernization of agricultural extension.

"The GRAD Project is a perfect complement to the innovative safety net program led by the Government of Ethiopia. Our additional support will strengthen the financial skills and resources of vulnerable Ethiopians and, most importantly, lift them from a life of poverty," says USAID/Ethiopia Mission Director Tom Staal.

Formal assessments aside, those who have witnessed the PSNP's impact firsthand over the past few years are the best testament to the program's undeniable success.

"I feel like this [current] drought has illustrated just how we have broken the cycle of famine," Staal said. "You had a drought that's as big as any in the last 20, 30 years—maybe bigger in terms of Ethiopia—and yet there was no famine. So we've broken that cycle. And now we need to continue that transformation so that you're really moving forward towards prosperity." ■

Health Workers

continued from p. 31

Contraceptive use in this time period nearly quadrupled. Although Ethiopian women still have an average of 4.8 children each, the total fertility rate is down from 6.4 in 1990 and 5.4 in 2005.

The Health Ministry's initiative to train 9,000 skilled midwives and deploy them to health centers by 2015 is expected to continue to bring maternal, infant, and child morbidity and mortality numbers down further as the battalion of female health professionals grows and gets trained.

And importantly, the Women's Development Army—the force of community-based volunteers—is continuing its advance. "It is now taking over much of the education function that the health extension workers used to do, because the volunteers are such staunch believers in the process," says Rideout.

The Ethiopian Government is not settling for mild success. It has set ambitious targets for maternal and child health for the five-year period from 2011 to 2015. Among its targets are bringing maternal mortality down from 676 to 267 per 100,000 live births and further reducing under-5 mortality rates from 88 to 67 per 1,000.

ALTHOUGH THE Health Extension Program is less than a decade old, it has brought basic health care within reach of some 67 million rural residents for the first time: Roughly 85 percent of the population is covered.

"Up until about six years ago, the vast majority of Ethiopians had no access to a health facility of any kind," says Staal.

The number of health centers has quadrupled from 668 to under 3,000 over the past five years, and the number of health posts has more than doubled over the past six years to over 15,000.

As Ethiopians receive more reliable health care, and learn to use it more dependably, health indicators are expected to follow suit.

Staal credits Ethiopian Health Minister Dr. Tedros Adhanom as the general behind the health army's rise: "He's a dynamic guy, a real visionary, a real leader ... and is internationally recognized. When it comes to the Health Extension Program, it's been his vision and his determination to make it happen that has ignited so much success."

USAID has been behind the Health Ministry every step of the way. The Agency has supported health-worker training and implementation of integrated care up and down the referral chain, especially at the community level. U.S. Government health-sector support in 2010 also provided crucial medicines, vaccinations and supplies as well as management and infrastructure support for the ministry nationwide.

Tedros calls the relationship a functioning partnership, mainly because the United States is supporting the Ethiopian Government's own priorities. "We set where we would like to be and how to get there. And I'm really glad that USAID supports us based on that: It is helping us actually to make progress and to get good results," he says, adding: "When I work with USAID, we focus on two things. One is saving lives now, but at the same time we are building the system for the future. Our partnership has been based on this understanding, and it has been key to our progress." ■

Education

continued from p. 43

neighbors. He regrets not having gone to school past the seventh grade. “I never had this opportunity,” he says.

Falling within the country’s poorest 10 percent—those that receive food and cash in exchange for work as part of Africa’s largest social safety net program (see article page 26)—Teklehaimanot sees education as the best way for his children to forge a better future.

“As you can see, our place is very rugged,” he explains. “In most cases, we can’t support our families. I wish for my kids to engage fully in the education system – especially the girls.”

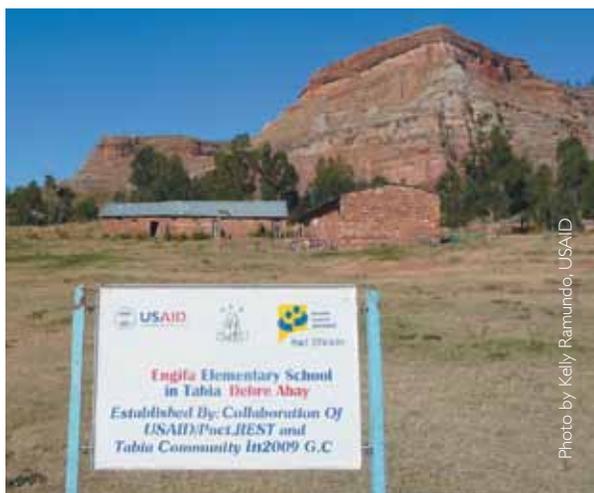
In Ethiopia, girls’ educational performance is not on par with that of boys. In 2011, the gross enrollment of girls in primary school was 93.2 percent, while that of boys was 99.5 percent. Girls also repeat more than boys. The gender gap in enrollment and repetition rates is wider in rural areas.

“USAID continues to place a special emphasis on girls’ education and on creating female leadership in the education sector,” says Wainer.

IN DEBRE ABAY, alternative education ends at the fourth grade—children must walk the two hours to the official school to continue learning in grade 5. Not surprisingly, some still drop out, mainly for poverty-related reasons, including the families’ need for their children’s labor or their inability to pay for room and board near the schools. If all goes according to plan, though, the Debre Abay ABEC will convert into a formal government-sponsored school

after two years and will expand to a complete primary school (grades 1-8) as resources from the community and local government allow.

USAID Mission Director Tom Staal explains the process which allows such an easy hand-off: “USAID links the school management committee to the local education office right from the start. The local government has five



ABEC students who continue their educations in town are performing well with their peers from the formal school system, sometimes even outperforming them. Additionally, over 95 percent of the kids from ABECs continue their education in the formal government schools.

“At the start, the government was wary of the ABEC program,” explains Staal. “They said, ‘These aren’t real schools, why should we support this?’ And we said, ‘Let us just try some.’ And we did it in 550 centers. The kids in those centers ended up succeeding in completing first-cycle primary grades (grades 1-4) in just a three-year period. This happened because education in ABECs is both intensive, relevant to communities’ needs and closely supported and managed by community-elected committees.”

A USAID-sponsored Alternative Basic Education Center provides accessible schooling for youngsters from the rural Tabla Debre Abay community, in Tigray, Ethiopia. The closest formal school is a two-hour walk.

years to plan on putting the new school and the teachers into their budget, so it is always a success.”

He says the program also complements the Agency’s basic education strategy, “which is to focus on the quality of teaching and learning outcomes for early grade reading, and which our assessments show, is extremely low in the country’s 27,000 primary schools.”

Back in Debre Abay, Teklehaimanot is desperately hoping this formal conversion will happen sooner rather than later. “I’m hoping in the future the school will be extended ... so my 10-year-old can stay here,” the concerned father says.

Until then, the community can take solace in one thing: Those graduated

and other donors plays a large role. Aside from providing the school-building materials, the Agency also provides text books, pays teachers, assigns education supervisors who closely look after the program, and builds the capacity of committees to manage the program from the community side.

But also, he explains, the education-starved communities fully embrace the new opportunity. “These are communities that never had any kind of school whatsoever. And they are extremely eager to have it. So there’s a much stronger commitment from the community. And you put the two together, and that’s what you come up with.” ■

Staal

continued from p. 45

inequality; you're going to have oligarchs becoming millionaires and poor people not really benefiting. They feel they need to control that growth. There's some validity there. So the question becomes, how do you slowly turn on the spigot? It's not that easy. And that's where we disagree with the government; we think the spigot could be wider open than they will currently allow.

FL: But still, growth has been impressive, right?

Staal: It has, exactly. But it's been mostly financed by the government itself. And that makes us worried about the foundations of growth. The growth over the last five years is there; the government says 11 percent, the IMF [International Monetary Fund] says 7 or 8 percent. Either way, it's great. But what's the foundation for that? Does it have clay feet? Could it all fall apart easily?

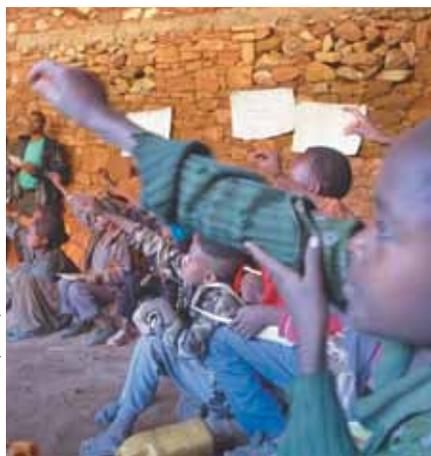


Photo by Kelly Ramundo, USAID

Third graders raise their hands at a USAID-sponsored Alternative Basic Education Center providing accessible schooling for youngsters from the rural Tabia Debre Abay community in Tigray, Ethiopia. The closest formal school is a two-hour walk.

Right now, we're concerned because inflation is very high. And that's an indication that there's a problem. Economists will say that inflation is a tax on the poor. When there's 40 percent inflation, then poor people are not able to take advantage of economic growth because they're having to pay more and more for basic necessities.

FL: And the political challenges?

Staal: Again, it's an issue of control. The government wants to be able to control political space very carefully. In order to gradually move themselves into a democratic, open political system, they believe you can't just go from zero to a hundred miles an hour in one step. So the question becomes, how do you do that in a way that allows space to gradually open, but still in a controlled fashion?

We feel the government is going too slow, and if anything, has taken backward steps in the last few years after the 2005 election. Many thousand people were arrested and jailed, and they really cracked down on political parties. Since then, they've enacted several new laws which have tightened up political space within the society. There's a new anti-terrorism law, a new media law, and a new charities and societies law that constrain civil society. So now, even reporting on terrorism can be equated with supporting terrorism. We agree that you need to crack down on terrorism, but it needs to be done right, in a way that doesn't jeopardize basic human rights.

FL: Ethiopia is obviously a very strategic country for the United States. Can you talk a little bit about not only its influence in the region, but also

about its relationship as an important U.S. ally?

Staal: Obviously, if you look at the neighborhood—Somalia in the south, Eritrea in the north, Sudan and South Sudan in the west, Yemen right across the pond—it's a pretty unstable neighborhood. Regardless, Ethiopia has been very stable. They've also been very cooperative with us on terrorism against groups like al-Shabab and al-Qaida, and on piracy.

And generally speaking, Ethiopia has supported our stance at various international fora in terms of the kinds of issues that the United States is concerned about, especially in Africa: climate change, the regime in Libya, genocide issues in Rwanda. They're good partners in that sense, and, obviously, we don't want to jeopardize that relationship. But we do have concerns about the human rights issues here. There have been arrests of journalists and opposition party members that we've raised concerns about.

FL: So you don't want to hold progress hostage in some areas because of less progress achieved in others?

Staal: Well, there are two issues. One is that our programs are focused on the needy people. And there we're having a real impact. So, you don't want to jeopardize all the good things you're doing there. Secondly, it's important also to note that our money does not go through the government directly. We're working with NGOs and contractors. So although we're very much lined up with government development policies and supportive of their programs, we can track our money very carefully. ■

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Each year the EVERY ONE Race and the Great Ethiopian Run promote a half-marathon along the Rift Valley's Lake Awassa. USAID sponsored the race in 2011 to mark its 50th anniversary in Ethiopia and to promote the goal of the EVERY ONE Campaign and other USAID health programs focused on ending maternal, newborn and child mortality.

Photo by Nena Terrell, USAID