WOMEN'S COMMUNITY LEADERSHIP PROGRAM

Program research and proposal

Mission statement

Vision

One million women thriving and free of poverty by 2040.

Mission

To provide grassroots empowerment, support and education to women living in extreme poverty. To support women with globally sourced and locally delivered lessons and training in order for them to create their own enterprises and become self-sustaining.

Whilst concurrently building the systems, beliefs and health solutions required to lift their entire community out of the cycle of poverty.

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Situation Analysis - Research

In order to develop a program that effectively addresses the issues and changes the lives of women living in extreme poverty in Africa, we first conducted in depth research both through thorough literature review and on the ground qualitative research trips. We addressed five core areas in our research: the state of Health, women, culture, business and innovation and education. Our literature review addresses the broader situation with an additional focus on the situation specifically in Ethiopia. Our research trips also specifically focused on Ethiopia. The reason for this focus being that Ethiopia will be our pilot location and also the country in which the organization has been founded.
Below is a summary of our findings.

Africa - Current situation

Health

We took the majority of our findings from the report published by the Lancet Commission on the future of health in sub-Saharan Africa: The path to longer and healthier lives for all Africans by 2030:

The report summarizes that:

"Sub-Saharan Africa's health challenges are numerous and wide-ranging. Most sub-Saharan countries face a double burden of traditional, persisting health challenges, such as infectious diseases, malnutrition, and child and maternal mortality, and emerging challenges from an increasing prevalence of chronic conditions, mental health disorders, injuries, and health problems related to climate change and environmental degradation. Although there has been real progress on many health indicators, life expectancy and most population health indicators remain behind most low income and middle-income countries in other parts of the world."[1]

*"Continuation at the current pace of progress, using models of service delivery and population health that are struggling with results, equity, and sustainability across the world, including in high-income countries, is a recipe for failure.
Therefore, we advocate an approach based on people centered health systems and inspired by progress, which can be adapted in line with each country's specific needs. Moreover, we believe firmly that better health will not only benefit countries' populations directly—it will also act as a catalyst, enabling successful pursuit of other development agendas summarized in the Sustainable Development Goals (SDGs)."*[2]

"Africa-based and home-grown solutions—with the realities of each country and each community embedded at their cores—are required, and each country needs to chart its

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[1] The Lancet Commission on the future of health in sub-Saharan Africa 2017: The path to longer and healthier lives for all Africans by 2030

[2] Ibid

own sustainable path to improve health outcomes. A framework shift is needed to deliver better health outcomes through people-centered health systems, with focuses on prevention, primary care, and public health.

Local generation and use of innovation will accelerate better health outcomes, reduce inequities, and have huge scope for prevention and care by harnessing the rapid growth in information and mobile technology in the African continent.

Leadership on Africa's health, scientific, and development challenges should come from Africans in close collaboration with the global community, including non-traditional development partners. In addition to alignment with the host country's priorities, harmonization of the different global and domestic health mechanisms is important to reduce transaction costs of service delivery and reporting.

A framework shift is needed to deliver better health outcomes through people-centered health systems and UHC.
Frameworks that rely on hospitals and individual care are unlikely to lead to achievement of greatly improved health for all Africans. A rapid expansion of new, African-bred approaches to people-centred health systems, focused on prevention, primary care, and public health, and supported by clinical referral systems and quality tertiary care is required to move to the next stage of better health. UHC should be designed with local values, sustainability, and equity in mind from the onset.

Closing health equity gaps should be a core concern for policy and action. Poor people in Africa still have disproportionately less access to health services and are more exposed to impoverishing expenditure compared to non-poor people. All efforts to improve health should explicitly address the serious inequities within countries. Health inequities are greatest among very poor people, rural populations, those who are marginalised or excluded from society, and those who live in humanitarian settings and conflict zones. A key priority is the reduction of out-of-pocket payments: despite overall progress during the past decade, some countries have had little reduction in their share of total health expenditure."[3]

The report identifies the following current needs within the issues of health in Africa. Although some may appear to be more cultural issues, the commission found these had a direct correlation to the health outcomes:

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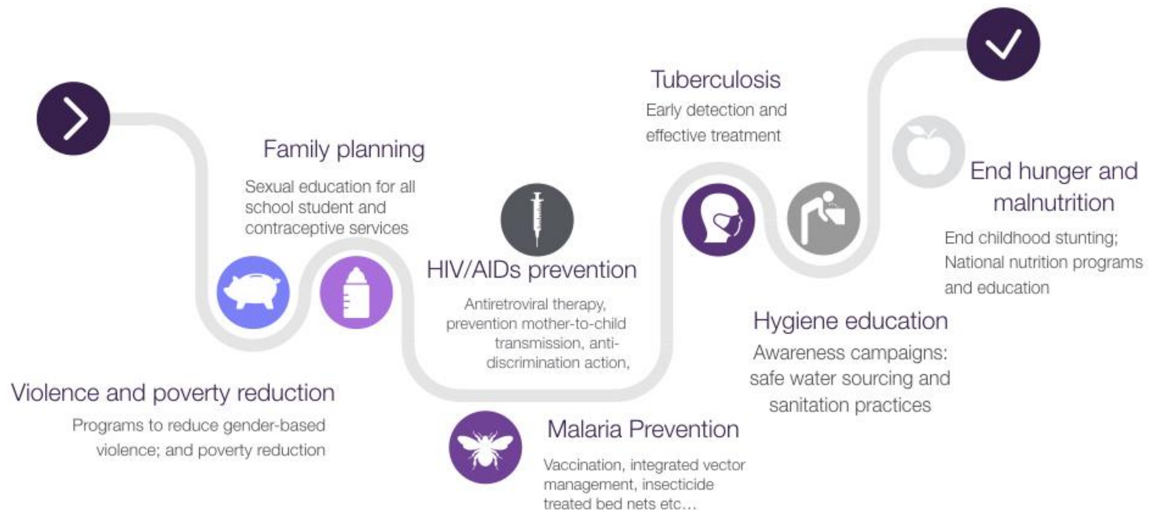
[3] The Lancet Commission on the future of health in sub-Saharan Africa 2017: The path to longer and healthier lives for all Africans by 2030



[4]

Major health Needs

- *“Family planning and contraceptive services, including targeted interventions for young women to raise age of first pregnancy;*
- *Comprehensive sexuality education for all children and adolescents;*
- *Secondary education for girls;*
- *Programs to reduce gender-based violence; and poverty reduction (strong link between wealth and fertility)*
- *HIV/AIDS: combination HIV prevention, antiretroviral therapy, prevention of mother-to-child transmission, anti-discrimination action, structural interventions, harm reduction;*
- *Malaria: integrated vector management, insecticide treated bed nets, case management with artemisinin based combination therapy, intermittent preventive treatment, vaccination;*
- *Tuberculosis: early detection and treatment, screen for co-infection with HIV;*
- *Early diagnosis and integrated management of hypertension, heart disease, diabetes, asthma, mental illness, and selected cancers; primary health care and access to essential medicines.*
- *End hunger and eliminate stunting, with a view to reduction of childhood stunting to 10% by 2025; end protein energy malnutrition, and micronutrient deficiencies, with a view to reduction of childhood underweight to 5% by 2025*

[4] The Lancet Commission on the future of health in sub-Saharan Africa 2017: The path to longer and healthier lives for all Africans by 2030

- *National nutrition programs and targeted public awareness campaigns; food security; legislation on marketing of breastmilk substitutes.*
- *Public awareness campaigns; rural household and health facility safe water supply and sanitation; sanitary infrastructure in schools, with separate facilities for boys and girls;*
- *Others: Campaigns targeting unhealthy diets, physical inactivity, dietary salt, and alcohol abuse."* [5]

Nutrition

Although there have been substantial reductions in low birthweight, childhood underweight, suboptimal breastfeeding, and vitamin deficiencies (burdens have declined between 37% and 85% in the past 25 years), these risk factors remain prevalent, especially in poor communities and in lower-income countries.

- *Half of children aged under 5 years in sub-Saharan Africa are iron deficient and a quarter are deficient in vitamin A.*
- *The prevalence of low birth weight ranges from 7–35%, and emaciation or wasting due to acute undernutrition ranges from 1–23%.*

Stunting in children aged under 5 years due to chronic undernutrition, which has a long-term effect on personal and cognitive development, ranges from 8% in the Seychelles to 58% in Burundi.[6]

Infectious Diseases

Infectious diseases remain the leading cause of morbidity and mortality in sub-Saharan Africa. Vaccines are also responsible for substantial falls in measles, mumps, and rubella. New vaccines being introduced in the African continent include a pentavalent vaccine, meningococcal and pneumococcal conjugate vaccines, and rotavirus vaccines, and a malaria vaccine is being introduced in pilot projects. However...

...epidemics of vaccine-preventable diseases continue to occur, particularly in fragile states, as a result of low vaccine coverage and interruption of immunisation programmes."[7]

Chronic Illness

"Financing and service delivery for chronic diseases and palliative care have received little attention compared to infectious diseases, leaving a gap which patients who suffer from complex comorbidities (eg, patients with HIV and mental health disorders) feel the most."[8]

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[5] Ibid

[6] The Lancet Commission on the future of health in sub-Saharan Africa 2017: The path to longer and healthier lives for all Africans by 2030

[7] Ibid

[8] The Lancet Commission on the future of health in sub-Saharan Africa 2017: The path to longer and healthier lives for all Africans by 2030

Mental Health
From our combined research we have identified mental health concerns as one of the biggest challenges faced when creating a program that addresses poverty in Africa. Below are some of the commission's limited finding on mental health in Africa:

"Scarce information on mental health in sub-Saharan countries suggests that mental health disorders are rising, and that the overall majority of treatable cases are untreated, with gross violations of human rights at times.
This treatment gap could be more than 90% for schizophrenia, psychoses, and other severe and disabling mental disorders, due in part to chronic underinvestment. In addition, several countries in Western and Eastern Africa are experiencing emerging drug use epidemics.

The burden of mental and substance use disorders is set to grow by 130%

Researchers have proposed novel training initiatives to tackle the substantial shortfall in service provision and workforce in this area, and a formal role for traditional practitioners remains largely unexploited."[9]

Secondary physiological effects of mental ill health
It is crucial that we are clear, both in our research and program planning and with our approach to the women and communities involved in our pilot program and beyond, that we address the negative secondary physiological effect of mental ill health. It is essential that we not only assess our participants' overall physical health including their brains, whilst also educate them on the negative impact their mental ill health can have on their entire physical health.

Societies, even in more modernized countries, perceive mental health to be separate of our bodily, physical health. This nonsensical perception causes the existing stigmas and shame around mental ill health to continue. The intended negative phrase "It's all in your head" typifies the objective approach people can have towards mental ill health. However, recent scientific research has shown that our minds and the health of our minds can actually be the determining factor in someone's overall physical health.
For example, we now know that loneliness is just as bad for our physical health as smoking fifteen cigarettes a day.[10] There for we need to educate people that although there can be illness in your brain it will never exist separately of general physical health there for it is never "all in your head" but rather – all in your body.

[9] Ibid
[10] L.Rankin Mind Over Medicine: Scientific Proof That You Can Heal Yourself

Mental and Physical Trauma

When considering the mental trauma which individuals living in extreme poverty experience every day, we must further examine the physical effect this constant trauma state is having on their bodies.

To briefly summarize the neurological response that occurs during trauma: the brain communicates with all cells in the body through hormones and neurotransmitters; When the brain feels fear, anxiety, loneliness and all other 'trauma' related emotions, the Amygdala (the traffic police of the brain) turns on the Hypothalamus that triggers the adrenal glands to express stress hormones such as cortisol, norepinephrine and epinephrine. This adrenalin response otherwise known as 'flight or fight syndrome', although highly beneficial when saving someone in a moment of crisis, is a significantly damaging biological experience for the human body. The body is not equipped to go through this response on a regular basis and it can quickly begin to deteriorate organs and biological functions through the excess production of these hormones.

Those living in extreme poverty have been shown to be in that detrimental stress response more than 50 times per day.[11]

When cortisol is produced in excess in the body it causes:

- Insulin resistance causing unhealthy weight gain and obesity
- heightened blood sugar levels which can cause type 2 diabetes
- suppressed immune system function increasing risk of illness
- problematic digestion and food absorption causing ulcers and stomach disorders
- raised blood pressure and hypertension

Further to this excess, epinephrine creates an elevated heart rate which is highly detrimental to heart health overtime.

This trauma response, correlated with excess production of cortisol and other stress related hormones, has been directly connected with severely heightened risks of: cancer, diabetes, heart disease, dementia, high blood pressure, infection, addiction and other illnesses. Not to mention chronic depression and anxiety disorders.[12]

Therefore, when addressing physical health, the mental health of people in extreme poverty must be considered and used as a determining factor when assessing overall health.

Culture of child abuse/childhood trauma

There is another seriously concerning cultural health concern that has surfaced in our visits and cultural research of developing countries. This is the issue of widely accepted violence towards children as standard parenting and disciplining practices. It is our observance that this issue is potentially more silenced and unacknowledged than the general issues of mental health. However, it is our belief that this issue must be

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[11] L.Rankin Mind Over Medicine: Scientific Proof That You Can Heal Yourself

[12] Ibid

addressed and reversed for there to be significant change in the cycle of poverty in these countries.

It has been documented that in many developing countries it is accepted and standard behavior to discipline children with physical violence be it hitting with the hand, with sticks or with other painful objects.

The International Community and Physical Punishment
Internationally, there is increasing consensus that physical punishment of children violates international human rights laws.
Several United Nations treaties address violence towards children, with the United Nations Convention on the Rights of the Child (CRC or the Children's Convention, adopted in 1989) presenting one of the most comprehensive cases regarding the prohibition of physical punishment of children.

We know even infants experience physical pain. Various biochemical markers and their facial expressions indicate this. In an attempt to stop what is called legalized violence toward children, and in response to the emerging data, the United Nations proposed a ban on physical punishment of children. This is contained in the CRC. (More details in Appendix # 5)

Physical punishment is a serious public health problem throughout the world, and it profoundly affects the mental health of children and the societies in which we live.

There is substantial evidence that physical punishment is associated with increases in delinquency, antisocial behavior, and aggression in children, and decreases in the quality of the parent-child relationship, children's mental health, and children's capacity to internalize socially acceptable behavior. Adults who have been subjected to physical punishment as children are more likely to abuse their own child or spouse and to manifest criminal behavior (Gershoff, 2008).

As Psychology Today explains: Spanking is a euphemism for hitting. One is not permitted to hit one's spouse or a stranger; such actions are defined as the crime of assault. Nor should one be permitted to hit a small and more vulnerable child. Studies show that children who are hit identify with the aggressor and are more likely to become hitters themselves, that is, bullies and future abusers of their own children and partners. They tend to learn to use violent behavior as a way to deal with stress and interpersonal disputes.

The data documenting the associations between physical punishment and psychopathology and sociopathy can no longer be overlooked. (We have further outlined these finding is appendix #5)

In summary we now know that physical disciplining of children can negatively effect:

- **Behaviors** – they can act out, over-react, be hostile, impulsive, aggressive or defiant. They can also withdraw or run away. Drug and alcohol use can be a problem with older children.
- **Relationships** – they may avoid closeness and push people away. Children may also attach to peers or adults who may be unsafe for them, to try to develop an alternative secure base.
- **Emotions** – children often feel fearful, stressed, depressed, angry, anxious or ashamed. Emotional security is the foundation of healthy relationships later in life.
- **Learning** – they may not be able to concentrate at school because they are constantly on the lookout for danger.
- **Cognitions** – children may have low self-esteem and think negatively about themselves or people around them.
- **Development** – normal development can be impaired. They can look like they are regressing or acting younger than their age. This can be a subconscious way of trying to get to a state where they are safe and secure. It can also be a result of the harm to the brain's development caused by exposure to trauma.
- **Physical health** – a range of illnesses may be related to domestic and family violence. Headaches, stomach aches, stress reactions (for example rashes or immune system related illnesses) and sleep disturbances (for example nightmares, insomnia or bedwetting) are common.

Enterprise and Innovation

According to the International Monetary Fund (IMF) by 2035 the number of Africans joining the working age population will exceed that of the rest of the world combined, Africa is currently achieving a yearly economic growth of around 4.5%, a rate higher than predicted for the mature economies of the world. Amazingly, this is set against a backdrop of a Eurozone crisis, low growth and stagnant wages in the West and a slowdown in China. Africa's economic expansion is nothing short of remarkable. There is something unique about what is happening on the continent now.
Analysts believe that the majority of this boom is due to the growth of small and medium-sized enterprises (SMEs). Today, these small and growing businesses create around 80% of the region's employment, establishing a new middle class and fueling demand for new goods and services. The scale of this transformation should not be underestimated. The IMF's Regional Economic Outlook for Sub-Saharan Africa, released in April 2015, says: "Over the next 20 years … sub-Saharan Africa will become the main source of new entrants in to the global labor force." This is an emerging Africa that is absolutely determined to succeed. As a follow up to their bold commitment to

infrastructure investment, African governments have now turned to entrepreneurs to support future growth.[13]

One of the greater challenges however, is access to credit, which remains a hurdle for many SMEs in Africa. Addressing the issue has been a priority for governments and regional organizations for several years. Notable examples include the African Development Bank, which runs an SME program designed to support micro, small and medium enterprises. The four-year program provides $125 million of funding, combined with a $3.98 million technical assistance package granted by the Fund for African Private Sector Assistance. Also, a $250 million private equity fund was established by the FSDEA to support entrepreneurs that are struggling to make their projects bankable. Helping African SMEs to flourish is crucial not only for Africa but for the global economy, because it creates a growing middle class with disposable income, in tandem with market opportunities for new investors. As China's manufacturing output slows and the sanctions on Russia impact EU exports, Africa's increasing population and consumption may fill the gap left by stagnant wages in Europe and the US.[14]

Mobile Technology and access

We discovered, both from literature review and on the ground research that cell phones are a common possession and wide used across Africa. They are being used for commerce as well as communication - specifically in the younger generations:
"There are an estimated three mobile phones for every four people in sub-Saharan Africa, with variations across regions. Mobile phone-based money transfer services such as M-pesa (launched in Kenya in 2007) and others are revolutionizing business and power relations. Information and communications technologies can transform the work environment, introducing flexibilities that encourage positive lifestyles."[15]

Health and innovation

The Lancet commission also found a direct correlation to the state of innovation in Africa to its future health outcomes:
"Capitalizing on innovation is key to the future of health in sub-Saharan Africa and can support leapfrogging health improvements, by adopting more advanced technologies rather than following slow, classic paths. Innovative, low cost vaccines, diagnostics, therapies, and information technology applications have huge scope for prevention and care. Innovations in health professional education, health service delivery, and governance are also urgently needed, particularly those using information and communication technologies."

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13 The World Economic Forum 'Why SMEs are the key to growth in Africa https://www.weforum.org/agenda/2015/08/why-smes-are-key-to-growth-in-africa/

14 Ibid

15 The Lancet Commission on the future of health in sub-Saharan Africa 2017: The path to longer and healthier lives for all Africans by 2030

Mixed success of Microfinance Programs
Microfinancing in the forms of loans and credit have often been celebrated as an answer to poverty alleviation and women's empowerment in developing countries. However, recent studies done into the true impact of micro financing programs have shown very contradictory results that are essential for us to consider when planning investments into similar populations - of both money and human capital.[16]

In their report 'The Impact of Microfinance in Sub-Saharan Africa: A Systematic Review of the Evidence' Rooyan, Stewart and Wet found that *"The provision of "micro" financial services to the poor (those earning less than $2/day), in particular small loans of $50–$1000, has been hailed by advocates as an effective poverty alleviation and development tool. Known collectively as microfinance, these services include micro-credit, micro-savings, micro-insurance, and money transfers, and have been attributed with enabling micro-entrepreneurs to build businesses and increase their income, as well as improving the general economic wellbeing of the poor. Furthermore, microfinance has been credited with improving other financial outcomes (including savings and the accumulation of assets such as furniture or a sewing machine), as well as non-financial outcomes such as health, food-security, nutrition, education, women's empowerment, housing, job creation, and social cohesion. The underlying logic is that by providing financial services to the poor, for example in the form of credit or savings, they manage their money differently, investing, acquiring productive assets, increasing their skills levels, opening new businesses, etc.*

But various studies have questioned these positive impacts. Some indicate much more mixed impacts, such as benefits for the poor but not for the poorest; or helping the poor to better manage the money they have but not directly or sufficiently increasing income, empowering women, etc. or that money spent on microfinances could be better used more effectively for other interventions or that

a single intervention (such as microfinance) is much less effective as an anti-poverty resource than simultaneous efforts that combine microfinance, health, education, etc.

*Others allude to negative impacts (i.e., that microfinance does harm), such as the exploitation of women, increased or at best unchanged poverty levels, increased income inequality, increased workloads and child labor, the creati*on of dependencies and barriers to sustainable local economic and social development."[17]

"For those who choose to borrow, while microcredit "succeeds" in leading some of them to expand their businesses (or choose to start a female-owned business), it does not fuel an escape from poverty based on those small businesses. Monthly consumption, a good

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[16] C. VAN ROOYEN, R. STEWART and T. DE WET 2012, The Impact of Microfinance in Sub-Saharan Africa: A Systematic Review of the Evidence
[17] C. VAN ROOYEN, R. STEWART and T. DE WET 2012, The Impact of Microfinance in Sub-Saharan Africa: A Systematic Review of the Evidence

indicator of overall welfare, does not increase for those who had early access to microfinance, neither in the short run (when we may have foreseen that it would not increase, or perhaps even expected it to decrease, as borrowers finance the acquisition of household or business durable goods), nor, more tellingly, in the longer run, after this crop of households have access to microcredit for a while. Business profit does not increase for the vast majority of businesses, although there are significant increases in the upper tail."[18]

Their research has found that microfinance can help a very small number of women who succeed and continue to grow in their business. For the majority of those receiving financing, however, it is not a means of creating a successful enterprise nor lifting them and their families out of poverty

It should be mentioned that there can be many positive effects to communities and families who have access to micro financing. These can include:

- Long term restructuring of household consumption. ie. investing in home durable goods and restriction of temptation goods and expenditures on festivals and parties.
- Positive labor supply choices.
- Increasing abilities to make different intertemporal choices, including business investment.

"The only mistake that the microcredit enthusiasts may have made is to overestimate the potential of businesses for the poor, both as a source of revenue and as a means of empowerment for their female owners."[19]

Culture

Population Growth

Sub-Saharan Africa's population is expected to rise from 1·02 billion people in 2017 to 1·42 billion by 2030. More than half of the world's population growth from 2017–50 will be concentrated in ten countries, and five of these are in sub-Saharan Africa, one being Ethiopia.
The Lancet commission believe that

"New solutions are needed; cities are growing so quickly that plans developed even a decade ago are now obsolete. Better convergence between urban planners' policies and the health sector is imperative and will require visionary leadership and effective governance, in addition to development of a stronger evidence base."[20]

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[18] Ibid

[19] C. VAN ROOYEN, R. STEWART and T. DE WET 2012, The Impact of Microfinance in Sub-Saharan Africa: A Systematic Review of the Evidence

[20] The Lancet Commission on the future of health in sub-Saharan Africa 2017: The path to longer and healthier lives for all Africans by 2030

Faith and belief systems
It is widely understood, across development research bodies focusing on Africa and specifically sub-Saharan Africa, that traditional religious belief systems, folklore and a lack of access to modern information and education can create significant barriers and challenges to communities adopting modern technologies, accessing modern health support and/or diagnosis. These beliefs can cause communities to blame 'curses' for health issues and other life failings as well as attributing 'miracle healings' for successes. These beliefs cause people to turn toward 'witch doctors' rather than modern professionals for help in times of crisis.

Relation to healthcare
The Lancet commission found that *"Not only do insufficient and sub optimally allocated resources compromise the health needs of populations with more complex health challenges in the world, but people's trust in health systems is shaken by frequent stock-outs of essential medicines and overstretched health personnel, particularly in low level health facilities and poor areas. In many cases, access to health services is further obstructed by cultural beliefs."*[21]

From these finding the Commission proposes *"the development of people-centered health systems, underpinned by the principles and values of public health and primary health care—including the values of respect, dignity, and compassion—as critical for a healthy future in sub-Saharan Africa."*[22]

People-centered health systems are the way forward. At the heart of health systems are people in varying and interdependent roles, and their interactions and relationships. Essentially "health systems are also human systems." [23]

It is their belief that:

"Young people in Africa will be key to bringing about the transformative changes needed to rapidly accelerate efforts to improve health and health equity across sub-Saharan Africa."[24]

Women and gender disparity
There is a myriad of cultural and societal systems that create challenges when attempting to empower women in Africa with resources, enterprises and income:

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[21] Ibdi

[22]The Lancet Commission on the future of health in sub-Saharan Africa 2017: The path to longer and healthier lives for all Africans by 2030

[23] Ibid

[24] Ibid

"In Sub-Saharan Africa it is often the case that traditionally women have fewer, if any, rights of inheritance. This leads to difficulties accessing land or finance.
In some places, women are regarded as being the equals of men, but their roles are nevertheless different. So, women traditionally look after the homestead, while men find jobs outside the home.
Women frequently have a high amount of work, such as gathering firewood or tending family fields. Household chores can be a huge burden, limiting a woman's ability to take on paid employment.
The care of children, the sick or the elderly is generally viewed as the responsibility of women. With poor access to childcare facilities or health and support services in many regions, caring for family members can take up a lot of a woman's time."[25]

Women in sub -Saharan Africa also face significant challenges in pregnancy and early marriage.

With just 11% of the world's population, Africa accounts for more than 50% of maternal deaths. The probability that a woman will die from a maternal cause is 1 in 31 in sub-Saharan Africa compared with 1 in 4,300 in developed regions (World Health Organization, 2010).

Women are also more likely to face difficulties in childbirth when they marry at a young age. The risk of death is even higher where girls do not have access to trained medical assistance, as is often the case in Africa. Many countries have a severe shortage of doctors/midwives and fewer than half of all births in Sub-Saharan Africa are attended by a skilled birth attendant."[26]

There are however encouraging steps being taken and major changes occurring as Women across African countries begin speaking up and taking roles in government and NGO advocacy:
"Some nations – such as Rwanda and Tanzania – have created a constitutional requirement for the government to include a certain number of women.
Even where there are no quotas, African governments are beginning to include more female politicians. In Liberia in 2006, Ellen Johnson Sirleaf, became the first woman to be President of a modern African nation. In 2012, Joyce Banda became Malawi's first female President.
This shows societies are changing. African women are increasingly able to choose their own course in life. It is no longer uncommon to find women running successful businesses in Africa alongside having a family. These women are happy to embrace a new set of challenges brought by such freedom."[27]

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[25] Our Africa: http://www.our-africa.org/women

[26] Our Africa: http://www.our-africa.org/women

[27] Ibid

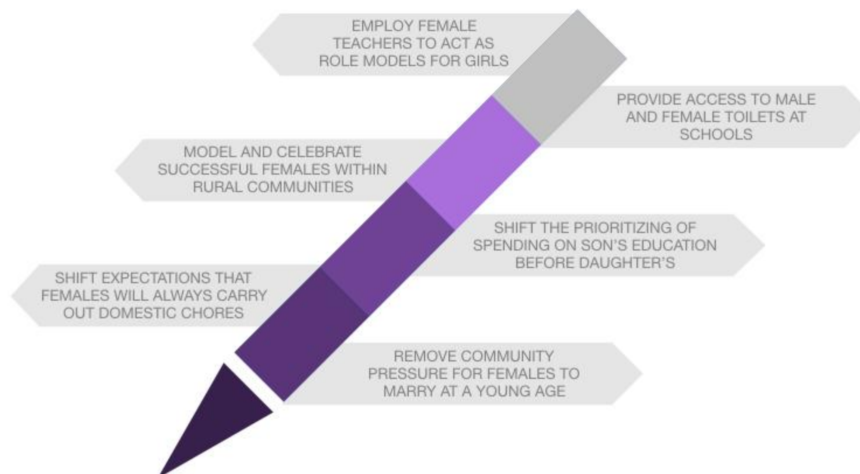
Education

According to research conducted by the United Nations Educational, Scientific and Cultural Organization (UNESCO):
"Of all regions, sub-Saharan Africa has the highest rates of education exclusion. Over one-fifth of children between the ages of about 6 and 11 are out of school, followed by one-third of youth between the ages of about 12 and 14."

"Almost 60% of youth between the ages of about 15 and 17 are not in school."[28]

Across the region, 9 million girls between the ages of about 6 and 11 will never go to school at all, compared to 6 million boys, according to UIS data. Their disadvantage starts early: 23% of girls are out of primary school compared to 19% of boys.[29]

Changes needed to immediately affect these statistics include those listed below:



[28] United Nations Institute for Statistics http://uis.unesco.org/en/topic/higher-education
[29] Idib

The benefits of educating women are now widely known to development organizations, but there is still a clear disconnect between organizational knowledge and acceptance in many communities.

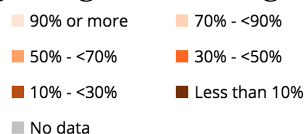
"The health of a nation also improves with the education of girls. When women are aware about good nutrition and diet, the benefits of breastfeeding and the importance of hygiene, the risks of disease and illness in families is much lower." [30]

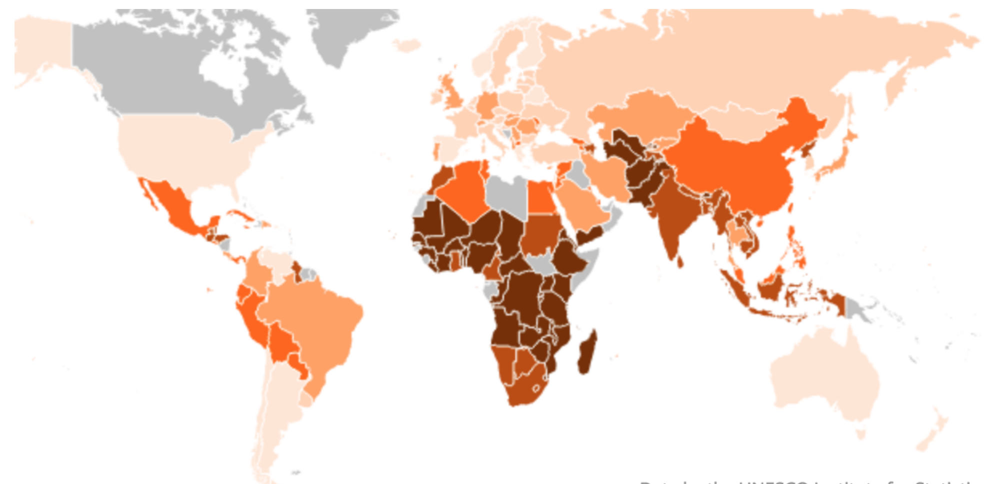
In many communities it will take shifting entire beliefs and cultural systems - most likely driven by acceptance and enforcement by patriarchal leaders- for this gender disparity to shift.

It may be a surprising statistic to many that *"Since the 1990s, more women than men complete tertiary education in most countries around the world. According to the most recent UNESCO data available, there were more female than male graduates from higher education in three-quarters (77%) of the 124 countries with available data. Despite improved access, women are less likely to continue into higher education levels and research fields."* [31]

"Globally, women outnumber men at the level of the Bachelor's degree (ISCED 6, first degree), with men accounting for about 47% of graduates and women accounting for 53% in countries with available data. Women also represent a higher share (54%) of Master's degree (ISCED 7) graduates." [32]

That being said, in spite of the data that exemplifies that women adapt to and succeed in higher education at a dominant rate to men, there is still a drastic shortage of women gaining access to higher education in Africa:





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[30] Our Africa: http://www.our-africa.org/women

[31] United Nations Institute for Statistics http://uis.unesco.org/en/topic/higher-education

[32] United Nations Institute for Statistics http://uis.unesco.org/en/topic/higher-education

Literacy Rates

In Sub-Saharan Africa:

- More than 1 in 3 adults cannot read.
- 182 million adults are unable to read and write.
- 48 million youths (ages 15-24) are illiterate.[33]
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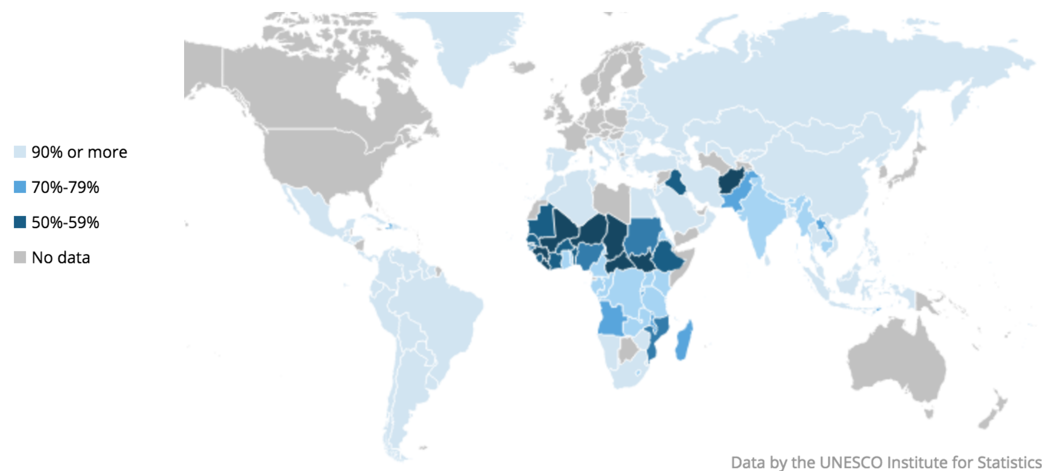
From the UNESCO global map of youth literacy levels, it is clear to see how drastically high the levels of youth illiteracy are in Sub-Saharan Africa compared with other countries:

Youth Literacy Rates:

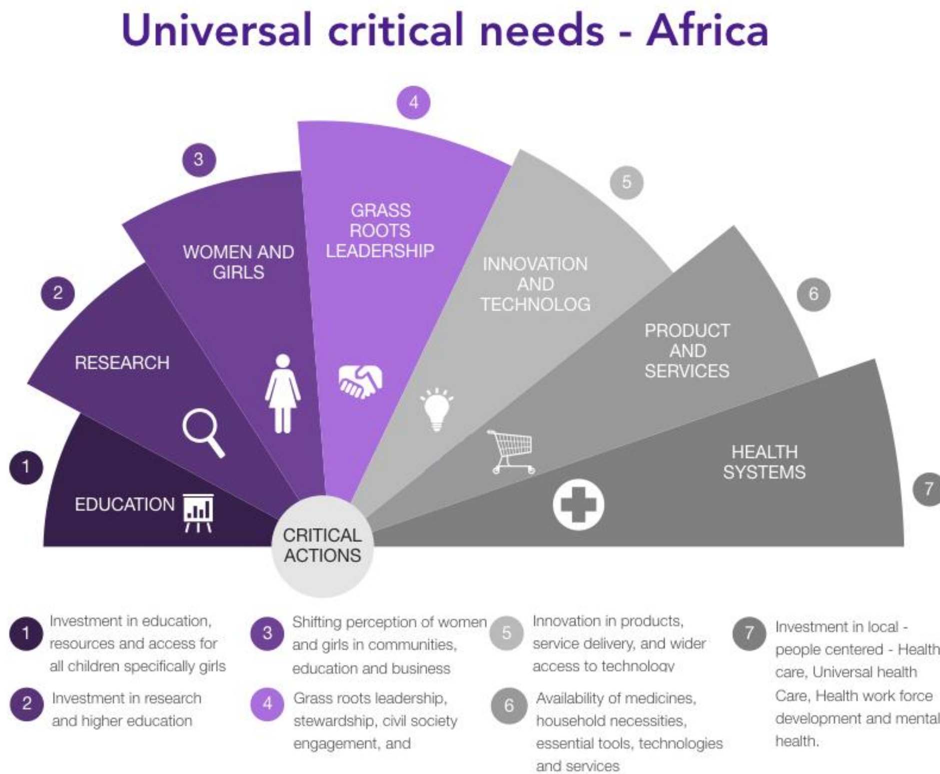


Despite the relatively low current literacy rates, these statistics show significant improvements in the literacy rates of years past. In sub-Saharan Africa, over twice as many surveyed youths have basic literacy skills (89% male and 75% female) compared with their elderly counterparts (42% and 36%). Sub-Saharan Africa has one of the biggest increases in youth literacy, globally, over the past 50 years.[34]

[33] United Nations Institute for Statistics "Adult and Youth Literacy Fact Sheet" 2014

[34] United Nations Institute for Statistics: "Literacy Rates Continue to Rise from One Generation to the Next" 2017

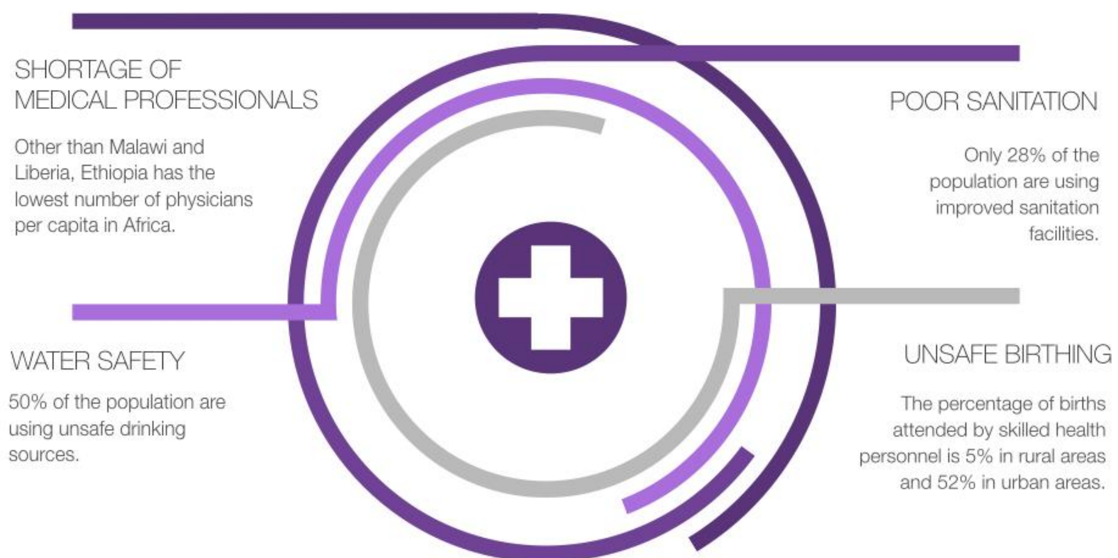
Universal Critical Actions
It is our opinion, echoed in part by the findings of the Lancet Commission, that building systems commensurate to the challenges of 21st century Africa requires action in the critical areas of (in no specific order):



Ethiopia - Current Situation

Our research trip and in depth situational analysis focused on the aforementioned areas specifically related to Ethiopia and the communities and individuals we met in a variety of regions of Addis Ababa - the capital city of Ethiopia. On our first trip we met with ten local volunteers who supported our information gathering and environmental research. They also connected us with ten women from a wide variety of areas, backgrounds and experiences who are currently living in extreme poverty (profiles of these women are available in the Appendix). We spent half a day with each of these women, learning, observing and asking questions of them in order to better understand their daily challenges, their strengths and their barriers to a better life situation.
Our analysis uncovered the following information and insight:

Health specific
From the Lancet commissions report we were able to learn specific statistics about health challenges in Ethiopia:



Medical Services and hospitals
Currently the condition of public and private health centers in Ethiopia is casually referred to as a '*one Doctor only'* condition with a very poor state of medical infrastructure, especially in the state-run hospitals. This is having a drastically negative effects on the scarce number of medical professionals.

- There are currently 411 government health centers and 5,540 Doctors who are thinly spread throughout the country.
- This makes the Doctor-patient ratio 1/17,000, which is better than what it was in 2014, 1/20,000 and in 2000 which was 1/48,000.
- Ethiopia was recently listed 4th worst of 25 countries with limited access to health care, having 22 Doctors for a million people which was even shocking compared to other very poor and war tormented countries like Somalia, 35; Guinea-Bissau, 45; Burkina Faso, 47 and Central African Republic, 50.
- For a country of nearly 100 Million people, the Ethiopian Medical Association (EMA) reported that it has only 2000 Ethiopian members including 200 Radiologists, 300 Pediatricians and 60 Psychiatrists. [35]

Public Hospitals
There are Eleven Public Hospitals in Addis Ababa. Simple medical equipment such as glucometer strips, disposable gloves, masks and alcohol are in short supply in the public hospitals, even in their emergency rooms. The corridors and hallways are often overcrowded with patients of contagious diseases who have to wait many hours to get to see a doctor and they most likely contract another additional disease in the process. For example:

- *Tikur Anbesa (Black Lion) Hospital*, the biggest specialized referral hospital in the country, admits an estimated 3000 patients daily who are seeking immediate treatment.
- *Zewuditu Hospital*, another state-run hospital, admits 128,998 patients on average annually having only 59 Doctors and 286 Nurses[36]

The quality and cost of public hospitals, differs greatly depending on the staff and purpose of the institution. For example

- Hawassa University Hospital - a teaching hospital: Patients pay 10 birr per day for a bed and other services come at a nominal cost but most care is delivered by students in training.
- Yirgalem General Hospital: Employs professional doctors. Patients pay 20 birr per day for a bed and other services are also more expensive.

Since most of the Ethiopian population cannot afford to get treatment at private hospitals, the waiting time at public hospitals is extreme.
The first woman we interviewed on our research trip said that there is a public health center nearby her home, but she does not trust it and questions the abilities of the staff working at the centers.

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[35] WHO Report, 2000
[36] Addis Standard magazine, December 2017

We spoke with a health professional who had recently visited the health centers inside Sidama zone in the south regional state, while working at Yirgalem hospital. His observation was that most of the health centers are not equipped with necessary materials and have no adequate health professionals. He also observed that the health center was only covered by one professional overnight.

Private hospitals

Private hospitals in Ethiopia are known for providing better services than state-run hospitals. They are admired for introducing every advanced medical treatment for the past two decades in the country. These have later been adopted by the public hospitals. However, their *'prohibitive costs'* make it difficult for the majority of Ethiopians to afford their services. Therefore, they are often viewed as 'greedy or over-priced merchants'.

It costs up to 5 USD to consult a doctor at a private hospital compared to less than one USD in a public hospital.

Some of the private hospitals are run more as businesses than service providers. It has been documented that they charge exorbitant amounts and order unnecessary investigation which cannot be afforded by the majority of the population.

One of the women we visited, who earns money begging on the streets, had chosen to purchase medications for her daughter's fungal infection from a Private hospital. She made this choice due to her lack of confidence in the diagnosis and treatment she would receive from a public hospital. The medication she purchased cost her $750 birr (the equivalent of one months rent.)

It has been documented that "there are many Ethiopians begging on the streets to be able to afford medical treatment whether from 'cheaper' public health service or 'expensive' private health care because they have neither the means to afford it nor the channel to voice their grievances"[37]

Most people believe that the private hospitals provide a far superior level of care with highly experienced physicians and better medical equipment which cannot be found in most of the public hospitals such as CT-Scans and MRIs. It is common for public hospitals to refer their patients to the private hospitals to be investigated with MRI, CT-Scans.

Public perception of healthcare

An additional challenge to the delivery of effective healthcare is the lack of health education and the prevalence of archaic beliefs that people use to explain illnesses and recovery. This is similar to the issues discussed earlier in the description of traditional cultural beliefs across Africa. Over 40% of the women we met claimed their illnesses were cured by the lifting of a curse or the application of holy water.

[37] Addis Standard magazine, December 2017

There is a positive increase however, in the number of women seeking modern medical treatment. Previously they preferred to be treated by traditional healers, the majority of whom - even in the major cities - would give birth with the assistance of a traditional birth attendant and no medical professionals.

Availability of Medicines and Vaccines

Due to the limited number of health institutions, there is poor distribution of medical supplies among regions with a drastic shortage in rural areas compared to urban areas. Access to medications is a constant challenge for both institutions and individuals in Ethiopia. This is due to:

- short supply as they are imported and expensive
- inadequate budget of health centers
- weak drug supply system
- poor logistic support for distribution
- irrational drug use.

Only 17% of rural communities in Ethiopia have sufficient sanitation services. This increases to 74% in urban areas but waste disposal is still a major challenge for the government and the public in all areas of the country.[38] While 75% of urban dwellers and 42% of rural inhabitants are within walking distance from a primary health facility, access to medicine and hygiene products is still a major challenge.

Mental Health Services and perception

There is only one hospital in the country that specifically treats mental health conditions. Needless to say this one hospital is overloaded with patients. Most recent information is that there are sixty psychiatrists in the country and they are limited mostly to the teaching hospitals. Professor Atalay Alem, the most well known psychiatrist in Ethiopia, said; “over 90% of people suffering from serious mental illness don't get the necessary treatment.”[39]

The perception towards mental health is predominantly negative and archaic. The majority of the population still relates mental health problems with evil spirits and curses. Most of the patients with mental health problem are treated at holy water sites, and taken to churches instead of psychiatric hospitals.

Due to the lack of awareness of mental health issues and the perception of the illnesses being related to evil spirits, patients are often arrested and sent to religious institutions for healing.
As Hiyawkal Gizachew put it;

[38] WHO Report, 2000

[39] The Ethiopian Herald, 2015

"In Ethiopia, psychiatrists are seen as helpers for "crazy" people. When most people in Ethiopia are faced with a problem, they tend to talk to their family members, neighbors, friends, or they go to church to talk to the priests and pray about it. Also, traditional healing plays a big role. In Ethiopia mental health issues are not talked about, or if it is brought up, it is always associated with "mad people" who walk around half naked on the street and talk to themselves. Mental illness is also seen to have supernatural causes such as spirit possession; people with mental illness are seen as violent and will never recover. These are myths that have a part of Ethiopian culture today. As a result, people don't seek professional help, whether they are experiencing minor or major mental illness."[40]

To further complicate the issue, people with mental illness don't usually seek professional help due to the stigma attached with it. They *"experience problems in the way they think, feel or behave to the point that these despair feelings, thinking and behavior interfere with their daily functioning. As a result, their relationship with family and friends are affected, as well as their employment."*[41]

Although mental illness is running rampant within the Ethiopian community, it is an issue no one is addressing:

- People are suffering from severe depression.
- The number of young adults committing suicide is increasing.
- Many people are abusing substances to cover up what they are feeling.
- Some are expressing it in aggressive and violent behavior.
- Divorce, domestic violence, parent-child conflict, and crime are increasing.

In a culture where mental illness is associated with "madness," it is not surprising that Ethiopians don't seek help. Stigma aside, mental illness is a major problem in the country and needs to be urgently addressed.

Misdiagnosis of mental health problems and pervasive cases of depression and anxiety.

During our first research trip we were alarmed to see the pervasive role that mental illness was playing in the lives of Ethiopian women who are 'stuck' in extreme poverty . All but one of the ten women we met with displayed signs of mental illness, including chronic depression and anxiety disorders. For a number of the women who were severely malnourished, it is difficult to assess whether their mental illness has caused their physical ill health or if their physical ill health has caused their mental illness. We suspect a dangerous combination of both.

Two of the women we visited, who were drastically underweight, had been diagnosed with mystery physical illnesses which we believe should be attributed to severe mental ill health and related conditions, such as chronic fatigue syndrome.

It was alarming and upsetting to learn that one of the women had been told by medical professionals that the physical weakness and joint pain she had been suffering that had

40 Ethiopian Review; Hiyawkal Gizachew; *Mental illness in the Ethiopian Community*, 2017

41 Ibid

led her to be bedridden for 6 months was caused by a snake bite she had suffered at 12 years of age and that her symptoms did not surface until she was a married adult.

We met with one young woman who, at first, appeared to be impressively independent, organized and generous although seriously isolated. On further study we have come to believe this is due to an undiagnosed and unsupported case of Obsessive Compulsive Disorder which has meant that she has not let others close to her during her adult life.

We also met with one young women whose mental ill health had created the unfortunate situation where she was 'taken advantage of' by young men and had fallen pregnant three times, being left to care for the children as well as her other family members.

These are only a few anecdotes of the exhaustive examples we saw where mental ill health is dominating the lives of women in extreme poverty in Ethiopia. We feel strongly that any efforts to empower women living in extreme poverty must directly address these issues and take an individualized approach with the support of trained mental health professionals.

Isolation and mental ill health
A major concern we identified for all of the women we met was their isolation from their community and other people. Most had no friends, some not even family who visited. As the 80 yearlong study conducted by Harvard University has shown, "Close relationships, more than money, are what keep people happy throughout their lives. Those ties protect people from life's discontents, help to delay mental and physical decline, and are better predictors of long and happy lives than social class, IQ, or even genes.[42]

This isolation is most likely triggering constant instances of stress/trauma response, causing an excess production of cortisol and other detrimental hormones in the body. When we consider that loneliness is twice as damaging to a person's health as obesity, the isolation of these women is a serious concern not only to their ability to maintain a business but also to their overall health.

[42] The Harvard Gazette, *Good Genes are nice but joy is better. 2017*
https://news.harvard.edu/gazette/story/2017/04/over-nearly-80-years-harvard-study-has-been-showing-how-to-live-a-healthy-and-happy-life/

Violence towards children – long term effects of childhood trauma

As mentioned previously is has been documented in our research of Ethiopia that it is accepted and standard behavior to discipline children with physical violence be it hitting with the hand, with sticks or with other painful objects.
There is a high likely hood that all of the women we intend to serve have been affected by physical discipline as children and young adults and therefore we must account for this in our work with them. We will also be working to reverse this behavior and ensure that they do not repeat this behavior in the upbringing of their own children. We must, however be sensitive to the delicate nature of this issue and mindful of how it is addressed both with those we serve and the wider community.

(More details to follow in parenting curriculum.)

Enterprise and Innovation

The United Nations Development Program (UNDP) has created, as part of Ethiopia's Growth and Transformation Plan (GTP II), the Entrepreneurship Development Program.
The country's strategy gives due emphasis to the promotion of domestic private sector development and stimulating the rapid growth of micro, small and medium businesses to create wealth and employment opportunities.
The GTP emphasizes the need to provide comprehensive support to MSEs and existing medium sized enterprises to unleash their full potential to create wealth and jobs, thereby helping to substantially reduce poverty.
However, many MSEs currently operate in the informal sector, which is disproportionately represented by women and the poor. Those people are paid substantially less than those in formal businesses and their contribution to the economic growth is limited.[43]
Below is a map of the numbers of SMEs that have been started through the program and their location within Ethiopia:

Despite the apparent success of many of these programs, there are still a number of significant barriers between those living in extreme poverty and their ability to maintain a thriving SME. These include:

- strong competition in the markets.
- high level of interest rates on loans.
- poor infrastructure.
- speed of debt payment by customers.
- unavailability of an appropriate property.
- state of the country's economy.
- low market demand for firms' roducts/service
- pricing of competitor products.
- unavailability of raw materials.

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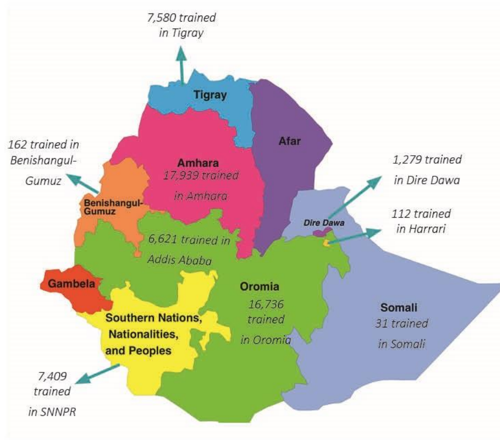
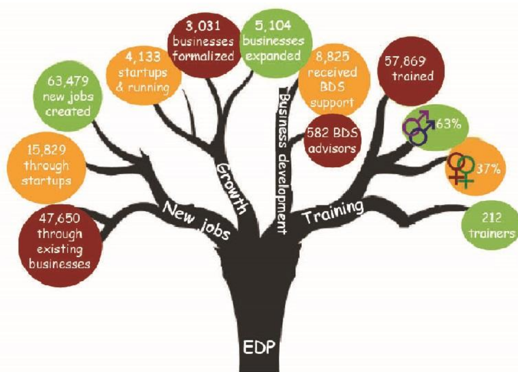
43 United Nations Developemtn Program - Ethiopia

http://www.et.undp.org/content/ethiopia/en/home/operations/projects/sustainableeconomicdevelopment/project_EDP.html

- attitude of banks and low availability of finance from lenders were rated as high barriers for small and medium business growth.[44]





All but one of the women we met with are the soul provider for their family. For two of the women, this has lead them to beg on the streets. One has kept this secret from her children, whereas one uses her child - who is severely disabled - to solicit donations.

Another of the women works in construction for as many days of the week as she can be away from her chronically ill family members. The two most physically able women both pursue small cash jobs when they become available, but both would welcome the opportunity to work and own their own business.
A number of the other women are too ill and physically weak to work and have been relying on the support and kindness of their community to survive.

Education

In Ethiopia, the gross enrollment rate in primary education is 87% for both girls and boys combined. This decreases to 38% in lower secondary. In Ethiopia, the primary net enrollment rate is 68% and the primary completion rate is 47%.
The percentage of out of school children in a country shows what proportion of children are not currently participating in the education system and who are, therefore, missing out on the benefits of school. In Ethiopia, 32% of children of official primary school ages are out of school.

- Approximately 34% of boys of primary school age are out of school compared to 31% of girls of the same age.
- Nearly 44% of female youth of secondary school age are out of school compared to 42% of male youth of the same age.
- When measuring the school enrollment of youth at both primary and secondary school age, the biggest disparity can be seen between the poorest and the richest youth. [45]

44 Amentie C*, Negash E and Kumera L ‘Barriers to Growth of Medium and Small Enterprises in Developing Country: Case Study Ethiopia

45 Education Policy and Data center - EPDC NEP_Ethiopia

Literacy
The Literacy rate of the entire population for Ethiopia is 49.1%
This can be divided into:

- males: 57.2%
- female: 41.1% (74.5% in Urban and 30.9% in Rural areas)
- Youth: Male 63% and Female 47%

The majority of the women we met with had dropped out of school at third grade and have very little confidence with reading. For many of them, this was their initial objection to taking on an enterprise.
One of the women graduated high school, has an accounting degree and had previously worked for The Ethiopian Revenue and Customs Authority before she fell ill, but has not been strong enough to work since. To generate a much-needed source of income, she would like to sell the house she currently owns but is not able to due to dual ownership with her husband who has deserted the family.

All of the women with whom we met, who had or were caring for children, showed an intense interest and determination to have their children receive a quality education. One of the women, who was keeping her begging secret from her daughters, walks her children to and from school every day - two hours each way. She does so because of her desire to have her children have a quality education and have a successful future.

Availability and cost of food and essential supplies

The cost of basic foods in bulk purchase is cheaper than buying foods and other goods at local stores.
E.g;

- A Quintal of onion can be found from 600-800 Ethiopian Birr from bulk purchase but from local stores it would reach up to 1000 Ethiopian Birr.
- A quintal of wheat can be bought with 900 Ethiopian birr from bulk purchase but from local stores it would reach up to 1,200 Ethiopian Birr.

There is a public bulk purchase store owned by the government called አለበጅምላ. However, this store is unable to satisfy the need of the entire population and in some places, the store is corrupt and does deals with larger merchants rather than the general population.

Although bulk food purchasing is cheaper than purchasing from local stores, it has added costs of transportation and logistics. For the general population to shop at these stores they would need easy access to the stores and the ability to transport the large goods - both of which most people living in extreme poverty do not have.

When we asked the women whom we met with how much money they spent on food and basic supplies per month, they were embarrassed to say they did not know and explained they spent whatever they had, and it changes per week depending on what money was available. Most said they bought basics such as grain and flour each month and if there was ever left over money they would purchase luxury items such as oil or sauces. Very few ever have the level of money needed to purchase meat or fresh

vegetables. All of the women purchase their goods from local stores where all items are marked up.

Existing organizations and declarations:

In creating a women's empowerment and enterprise program in Africa, there are a number of organizations and political declarations, in both in Africa and specifically in Ethiopia, worth noting in our analysis of the existing environment. These include:

Declarations:

- The Chronic Disease Initiative for Africa, a regional hub to enhance collaborations between local and international researchers to develop and evaluate models of chronic disease care and the prevention of their risk factors in Africa
- The Maputo Declaration, the African Charter on Human and Peoples' Rights, and the Continental Framework on Sexual and Reproductive Health and Rights;
- Addis Ababa Declaration on Population and Development beyond 2014

Government Focus on investing in Women's empowerment and enterprise:

- The Ethiopian government has also given key priority to increase women's economic participation in both the first and second Growth and Transformation Plan (GTP), periods and designed its policies and plans in a way to ensure and maximize women's participation and benefits.
- According to Tsige Tadele, Adviser to the State Minister of Women and Children Affairs, the government has attached utmost priority to address women's social, economic and political challenges and implementing various programs in the view to support low-income women and girls to achieve self-reliance.[46]

Organizations:

Association for Women's Sanctuary and Development (AWSAD) (Ethiopia/Africa)
AWSAD supports women to rebuild their lives after experiencing violence. They have a safe house with counseling, training, legal aid and medical care. It is the first women-only shelter for survivors of violence in Ethiopia, supporting hundreds of women, girls and their children every year. In the care of the organization, the women and girls gain the confidence and skills needed to rebuild and improve their lives once they leave the shelter.

Center for Accelerated Women's Economic Empowerment (CAWEE) (Ethiopia/Africa)
The vision of CAWEE is to create a class of globally competitive women entrepreneurs in Ethiopia.

[46] Make Every Woman Count 2018, ETHIOPIA: More Synergy In Empowering Women www.makeeverywomancount.org

Addis Continental Institute of Public Health (AC-IPH) (Ethiopia)
Addis Continental Institute of Public Health (ACIPH) is an independent center of excellence for public health research and training located in Addis Ababa.

Siiqqee Women's Development Association (Siiqqee) (Ethiopia)
Siiqqee brings together marginalized women to train them in practical work skills and provide them with information on their rights.

Network for Ethiopia Women Associations (NEWA) (Ethiopia)
NEWA is a non–profit, non-partisan, non-confessional, and non-governmental organization. It is involved in empowerment of Ethiopian women and advocates for their involvement in decision making.

Circus in Ethiopia for Youth and Social Development (Ethiopia)
Circus in Ethiopia was established to contribute to the national effort in creating awareness and bring behavioral change in relation to HIV/AIDS, gender issues and other cross cutting issues. Circus Ethiopia currently conducts a number of projects including: circus art development, information, communication and education/behavior.

Union of Ethiopian Women Charitable Associations (UEWCA) (Ethiopia)
UEWCA is working for the improvement of economic and social status of women/girls and children and is focused on economic empowerment by creating access for women to income generating activities.

Mujejegwa Loka Women Development Association (MLWDA) (Ethiopia)
Mujejeguwa Loka Women Development Association (MLWDA) was established in 1996 when it started working on community health related issues of Gumuz (region in western Ethiopia) women and advocacy to enable women to deliver in their homes, challenging a harmful practice of giving birth in forests. The association strives to empower the Gumuz people socially, economically, and politically and to protect the rights of children.

Good Samaritan Association (GSA) (Ethiopia)
GSA works to address the Ethiopian women and marginalized sections of the population to become free from poverty and their attainment of acceptable standard health and education service. It exists to work towards achieving improved quality of life of the most marginalized and discriminated segment of the community through participatory, integrated development initiatives, health education, basic skill training and other development schemes.

Ethiopian Women with Disability National Association (EWDNA) (Ethiopia)
The Association focuses on the issues affecting the lives of women and girls with disabilities in Ethiopia and works to build their capacity, skills, opportunities and inclusion in society.

What is needed in this space?
Although there is much positive work being done in the space of empowering women and education as well as great advances in the numbers and success of small enterprises there is much more work to be done in order to meet the sheer demand and some specific elements that need to be address and integrated. These include:

- Systemically addressing how the mental ill health of those in poverty is keeping them trapped in the poverty cycle as well as causing them to suffer from other serious physical illnesses.
- Addressing how childhood trauma is perpetuating generational poverty and preventing communities from escaping the poverty cycle.
- Approaches to these issues that reflect the advances in technology that we are experiencing in other parts of the world and learning ways that we can integrate new technologies into these cultures with a sensitivity to the local comfortability and access.

Major conclusions from qualitative research

From our personal visits with the ten women who were selected as case studies, these are the most significant conclusions that were drawn:

Mental Health crisis
There is a potential epidemic of mental ill health in Ethiopia amongst those living in extreme poverty. This serious issue seems to be currently unrecognized and unaddressed in any formal way by government or health workers.
Women are suffering:

- Chronic depression, anxiety disorders
- Weakness due to depression, malnutrition and starvation
- Pervasive Fear and anxiety due to circumstances
- Isolation due to mental ill health and misdiagnosis

We suspect the dangerous stigma surrounding mental illness, as discussed earlier, is keeping this issue from being properly addressed.

Lack of hygiene and basic health knowledge.
There was a serious lack of basic knowledge and access to education on simple hygiene and health topics. for example:

- They attribute negative health to a ‘curse’ and healing to the application of Holy water.

- Basic health problems are cause for a woman to be cast out of a community and labeled as ‘cursed’ and this will cause her partner to abandon her and their children.
- When doctors have diagnosed the women and their children, they have accepted the diagnosis without question - despite, what seems to foreign visitor to be, highly questionable explanations and treatments.
- There is no soap or water near toilet facilities and the introduction of hand sanitizer was a surprise and fascination to all we shared it with.

<u>No contact with a world beyond their challenging lives</u>
These women have a very limited circle of people and community around them, usually limited to family and service workers. For the women who are ill and physically weak this may be more due to their inability to meet others as they are home/bedridden.
We attribute this general isolation to a number of negative factors:

- Their health diagnosis and others fear of catching the curse or simply the illness.
- A mistrust in people other than their family, specifically other women. (A number of the women claim to have no female friends and spoke about being cheated by other women.)
- Their need to be caring for their family and children at all times.
- Their financial anxiety and depression related to their circumstances.
- Their commitment to ensuring their children have a better life than theirs and placing all of their focus and time into the children.

This isolation is causing a number of negative ramifications that we observed including:

- Increased levels of depression and anxiety when faced with ‘outsiders.’
- Heightened lack of trust for others.
- Lack of contact with outside world, information, knowledge and resources.
- Lack of support for basic needs with simple solutions.
- Inability to see a life outside of the one they are currently ‘stuck’ in.
- Lack of modeling of other women who are supporting themselves and their families through more promising means.
- Limited understanding or concept of possible revenue streams/jobs etc.
- Ill physical/bodily health due to loneliness

It is our firm belief that any program that aims to provide tools and education to women in extreme poverty in Ethiopia with the goal of them creating their own small businesses must addresses the mental and physical health as well as environmental challenges these women face. It will take a long term commitment to these women to support them in shifting their beliefs about themselves, their health and their circumstances to ensure they have the best chance at succeeding as self-sustaining small business owners.

Scaling to meet population growth

In light of the alarmingly fast population growth in Ethiopia, it is highly preferential that any pilot program be created and tested for rapid scale. To ensure that the program could scale at a rate that would ‘keep up’ with the population growth, we must test for cultural and environmental differences from the outset by selecting a diverse group of women based on traits such as

- geography

- age
- family environment
- education level
- current income
- marital status

SWOT Analysis

Strengths

- Ethiopia is experiencing a continuing increase in the level of acceptance and support for women who are creating their own enterprises and SMEs.
- The success of the many enterprises within the Ethiopia GTP serves as evidence to potential investors and supporters of the value of small enterprises.
- There is significant demand and need for small enterprises that solve societal issues, such as local health delivery and bulk food purchasing.
- We have direct access to extremely resilient and strong women who are determined to create a better life for their children.
- We have been able to identify mental health as a crucial factor within the success of any empowerment programs and thereby will be able to address and combat this from the outset.
- We have also identified the issue of childhood trauma to be a significant cultural influence and influence on the success of women in extreme poverty and there for can address this in our training and program.
- We have a strong network of Ethiopian nationals available to us who would like to support and help these women and forward the mission.
- We have access to and skills avail to use innovative technologies such as open sourced education and virtual reality training to help them gain skills and also work on their social anxieties.

Weaknesses

- The strength of spiritual and cultural beliefs of both the women and the communities that contradict modern diagnosis and perception of mental illness.
- The education and literacy rate of many of the women and how they see that affecting their abilities.
- As a new entity the staff will be predominantly volunteer and therefore we cannot ask them to be available for the women for the length of time we would prefer.
- The women have numerous and significant immediate worries, challenges and responsibilities that they may prioritize over the long term experience of acquiring new skills.
- Confronting issues of childhood trauma and abuse is highly taboo and most likely will be met with serious aversion

Opportunities

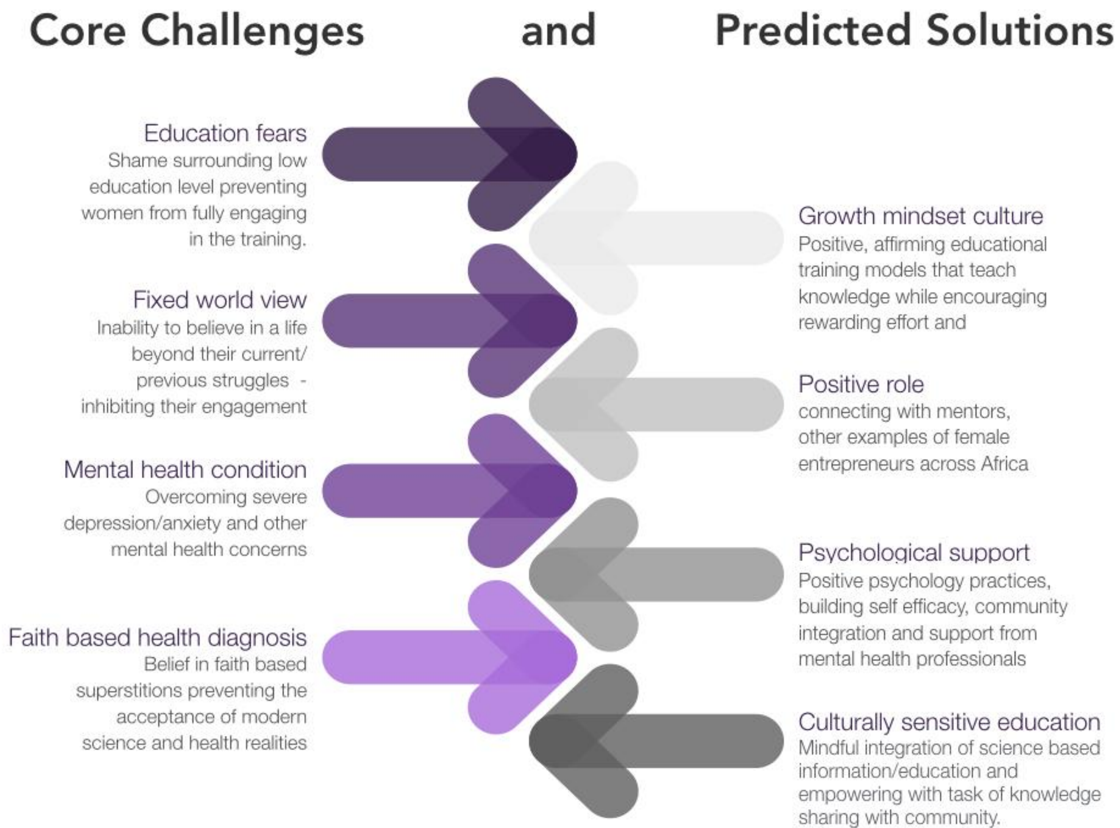
- Develop income generating entities for the women and ensure that they are self-supporting and they can sustain themselves without outside financial assistance.

- Support the women to discover their natural, entrepreneurial, academic and leadership qualities.
- Create strong friendships and partnerships between the women, their mentors and other women in the program.
- Rebuild the women's trust in others and willingness to participate in active communities.
- Connect mental health workers with the women in order to relieve them of their current situation and suffering.
- Garner support and create a strong committed community of Ethiopian nationals to provide training and help fund the program.
- To be the first NGO in Ethiopia to use such innovative technologies to work with our women which will not only develop PR but also funding for the program.
- To be the first Trauma sensitive and inclusive organization in Ethiopia

Threats

- The Mental and physical ill health of women may create a barrier to their involvement and engagement in the program and their enterprise.
- The cultural and spiritual beliefs of the women. Their communities may be a stronger voice than any new information and/or training provided by the program.
- Our efforts to address childhood trauma and the culture of child abuse may be met with animosity and contention by local influential people and organizations.
- The women will not overcome their perception of themselves as '3rd grade educated' to be able to engage in the learning and improve their education sufficiently.
- The societal perception of women, may create significant barriers and hurdles to the women's effort and may cause them to 'give in' to the negative feedback.

Core challenges when building a women's enterprise and empowerment program in Ethiopia:



The Program

Goals - Pilot Program

Goal One
To ensure that ten women from diverse areas and experiences in Ethiopia have established their own small business and are generating sufficient income to lift out of extreme poverty by January 2020.

Goal Two
To provide bulk foods and basic household items to ten women in Ethiopia in combination with a financial literacy and household management training between January 2019 and 2020.

Goal Three
Create an educational empowerment program by January 2020 that equips women in Africa with the knowledge, resources and self-confidence needed to ensure they can develop a self-sustaining, income generating enterprise.

Goal Four
Create the logistics and infrastructure required to support the rapid expansion of the educational empowerment program and continued support of program participants who have created their income generating enterprise by January 2020.

Goal Five
Create efficient and affordable delivery systems to provide both bulk foods and basic household needs, medical needs and care to marginalized communities and individuals by January 2020 that are scalable and can embrace rapid expansion.

Goal Six
Create the first leadership program in Africa that successfully uses both innovative technology and the guidelines of trauma sensitive care to lift women out of extreme poverty by January 2022.

Our Programming goals represented in the SDGs
On September 25th 2015, countries adopted a set of goals the Sustainable Development Goals (SDGs) to end poverty, protect the planet and ensure prosperity for all as part of a new sustainable development agenda. Each goal has specific targets to be achieved over the next 15 years.

Thirteen of the seventeen goals are directly related to our areas of focus:

[47]

Poverty SDGs
SDG 1: End poverty in all its forms everywhere
SDG 8: Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all
SDG 10: Reduce inequality within and among countries
SDG 16: Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels

Education SDGs
SDG 4: Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all

Health SDGs
SDG 2: End hunger, achieve food security and improved nutrition and promote sustainable agriculture

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[47] UN Sustainable Development Goals
http://www.un.org/sustainabledevelopment/sustainable-development-goals/

SDG 3: Ensure healthy lives and promote well-being for all at all ages
SDG 6: Ensure availability and sustainable management of water and sanitation for all

Girls SDGs
SDG 5: Achieve gender equality and empower all women and girls
SDG 10: Reduce inequality within and among countries

Community Enterprise development SDGs
SDG 9: Build resilient infrastructure, promote inclusive and sustainable industrialization and foster innovation
SDG 11: Make cities and human settlements inclusive, safe, resilient and sustainable
SDG 12: Ensure sustainable consumption and production patterns
SDG 16: Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels
SDG 17: Strengthen the means of implementation and revitalize the global partnership for sustainable development.[48]

[48] UN Sustainable Development Goals http://www.un.org/sustainabledevelopment/sustainable-development-goals/

Programming

Year One - Pilot Program January 2019-2020

Participants

We have selected ten women living in extreme poverty in the city of Addis Ababa who we believe have the current life circumstance and personality traits needed to respond well to the educational and empowerment elements of the program as well as being able to adopt and implement the trainings.
From our first trip we identified Almaz Gebis and Etenesh Mohammed (full profiles in Appendix #2) as a strong example of the profile required for the program.
The traits we were looking for in our participants were:

- Basic education levels and an aptitude for learning.
- An eagerness to create a different future for themselves and/or their children
- No major physical ailments and/or disabilities
- Ability to travel on public transport
- Mental health problems that are manageable and not immediately prohibitive

Profiles of Pilot Participants

1. Shitu Dereje. 21 years old
2. Samrawit Alemayehu. 27 years old
3. Meseret Tilahun 26 years old
4. Lemlem Damte. 31 years old
5. Gelane Rebuma. 22 years old
6. Almaz Gebis. 21 years old
7. Etenesh Mohammed. 25 years old
8. Mistre Haile. 28 years old
9. Gete Mussie. 40 years old
10. Fikrte Ashenafi 30 years old

You can read the profiles, see pictures and view a location map of the 10 women selected for the Pilot Program in Appendix #2

Supporting towards Self sustaining

For the duration of the pilot program (or until they have become self-sustaining in the first year) the women will be supported in their basic needs, rent and an additional small stipend. This has been provided in order to:

- Model bulk purchasing and food/supplies delivery and teach portion control and planning.
- Drastically reduce the amount being spent on basic household items.
- Ensure their engagement and continued participation in the program.
- Teach budgeting and saving.
- Encouraging a healthy relationship with money

- Shift their brains and body out of survival related trauma mode so that they can think clearly and productively as well as improving their other health outcomes.

Our goal is to have the women feel a sense of pride from saving and not having to ask their community or strangers for support, but instead to be earning money through their participation.

The hope is to have the women shift from 100% support by the 6th month mark of the pilot year and begin to generate their own income. We will begin to decrease the amount of financial support provided accordingly whilst still fully supporting with mentorship and training.

Training/Education

The ten women will take part in a year-long education and practical training program that will work on a number of learning areas listed below. The specific curriculum for each area will be developed in participation with the ten women, in order to address their specific educational needs, between August 2018 and December 2018.

- Basic Literacy
- Basic mathematics
- Household Budgeting and money management
- Health delivery and Hygiene practices
    - Relevant and simple medical knowledge and tasks
    - Basic Hygiene knowledge and practices
- Business basics
    - Budgeting and growth projection
    - Suppliers and logistics
    - Customer relations, pricing etc
    - Material sourcing and inventory management

Each of the four areas will come with an official accreditation that the women will receive when they have obtained a certain level of learning, defined in the initial curriculum development stage.

Practical Business Training

As the women are developing their skills in the areas mentioned above they will be receiving basic practical training as well. During the program development period in 2017, they will have identified areas of business that are exciting and interesting to them and our team will work with them once the pilot program has started to develop a small business in one of those areas.

Within the ten women, we will also be encouraging a number to consider:

- Local delivery of health treatments

- Delivery of bulk goods and household items.

The mentors and trainers will work with the participants on identifying the exact knowledge base and practical experience required for their small business.

Empowerment Program

In concert with the educational training, the women will take part in a yearlong empowerment program to address the negative and counterproductive beliefs they have about themselves and their situation. This program will directly address the underlying mental health challenges the women experience, while teaching them tools and new ways of thinking in order to create a brighter and more successful future, both in their business and in their personal life.

This program will be undertaken with the direct support of their mentor and other program staff.

It will include practices and elements such as:

Graduation from the Program

At the conclusion of the year, the women who have completed the trainings and achieved a defined number of accreditations will receive an official graduation certificate and all will take part in the Graduation ceremony. This will be set up to reward effort above all else, but still celebrate the attainment of knowledge and any early business success.

Equipment/Resources

Each of the ten women is provided with:

- Program shirts
- A program badge
- Cell phone (if they do not currently have one)
- Basic learning kit (stationary etc)
- Small Business Starter kit - contents to be defined once they select their business type.
- Basic household needs - delivered once or twice a month.

When at the training center they will have access to:

- A laptop computer with the internet
- Books
- Relevant training materials
- Childcare and a safe place for their children to stay
- Full support from program staff and volunteers

Collection and Delivery of Trainings

As well as the in-person trainings that will be delivered by the volunteers and paid staff, the majority of lessons and curriculum will be provided by videos that are viewable on the laptops in the center.

These videos will be open sourced by the greater community of Ethiopia and abroad - specifically Ethiopian nationals.

The videos will serve in the place of textbooks or writing tasks. Instead the women will watch the videos as many times as needed before they have mastered a new skill or understanding.

The volunteer staff and mentors will provide supplementary support by answering questions and further explaining concepts.

We have selected this form of learning for a number of reasons including:

- Independent learning: The women can learn at their own speed without the constant need for a tutor or volunteer to be present
- The women can be familiar and confident with topics before discussing
- The videos will expand their world view and sense of connection with others in a safe forum
- These videos allow for rapid expansion as it removes the need for one teacher per woman and/or per lesson to a group.
- This also shares the program with the wider global community, creates positive PR and garners support for the project and the women

How the open sourcing of videos will work.

- Towards the end of 2017 we will launch a website and make a general call out for support in collecting training videos from willing volunteers around Ethiopia and the world.
- On the organizations website there will be a portal for volunteer video trainers who can access a list of topics that require a 10-minute training video. Within the

topic selected, there will be specific requirements, frameworks and directives such as what materials are available to the women for use etc.
- The volunteer video trainers will then record their training video per the requirements and submit it through the website for approval and/or notes for revision.
- Once our team members have approved the video it will be added to the list of available trainings under its correlated subject.

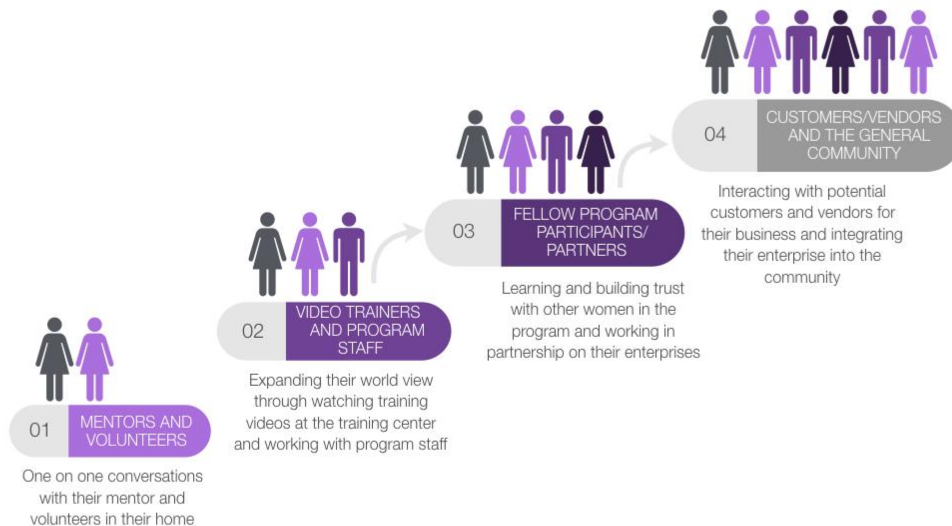
Community Integration plan

In order to address the dangerous effects, the women's isolation is having on their overall health and to improve their general quality of life, we will be incorporating a structured plan to help integrate them into their community and to support them in addressing any social and relational anxiety. This plan will have the women taking incremental steps towards having more contact with people and groups.
The goal of this plan is to:

- rebuild trust of others
- reduce social anxiety
- increase their sense of human connection.
- Decrease their levels of anxiety
- build friendships and partnerships
- ensure they can interact well with customers, vendors etc...

Technology for connection

We will also be using the innovative technology of Virtual Reality to help the women adjust to social settings from the safety of the training rooms and their homes before they are required to be there in person.



Educational and organizational models

Below are the essential elements of the program that extend beyond the direct framework and systems.

Core Values

The Founders of The Women's Community Leadership Program have defined the following values as fundamental to all areas of the organization:

ISIRIKA

Women's Community Leadership Program embodies the spirit of Isirika in all of its work. Isirika is a Maragoli word that means 'caring, together, for one another' or equal generosity. It embraces full community support, inclusion and a breaking down of all barriers to see all humans as humans and equal.[49]

[49] Musimbi Kanyoro 2017, www.globalfundforwomen.org

Participation Model

We believe it is essential that the women participating in the program -specifically the pilot program - are involved in all stages, from planning, activation and evaluation as well as being involved in a constant feedback loop with the team.
The participants hold an equal 'seat at the table' in regard to their training. Their opinions are solicited, heard and treated with respect.

This belief is founded in the spirit of celebrating everyone's genius, regardless of current circumstances or beliefs in one's capabilities. Put simply, there is no one in the world that knows our participants better than they know themselves - in this instance, they are our experts.

The framework used within the program to create powerful feedback loops is based on The Participation Handbook for Humanitarian Field Workers. Though as they explain, it is first and foremost 'a state of mind – that sees people affected by a crisis as social actors with skills, energy, ideas and insight into their own situation. Local people should be agents of the humanitarian response rather than passive recipients.[50]

Participation provides the basis for a dialogue with people affected by a crisis, not only on what is needed, but also how it might best be provided. It can help to improve the appropriateness of the humanitarian response by, for example, identifying priority needs and by ensuring that local capacities are taken into account. It can reinforce the quality of assistance by stimulating exchange and feedback between aid agencies and affected people at all stages of the intervention. [51]
Participatory methods also provide a structure for dealing with complaints if people feel that their needs are not being met, are being met badly, or that the assistance is causing more harm than good.

Participation is an integral part of a humanitarian organization's accountability to those who are intended to benefit from their operations.

We look forward to having constant dialogue with all of the women who enter our program, to learn from them, learn with them and provide the greatest support possible based on their feedback.

Participation - Practically

Examples of the women being equally involved in their program include:

- Regular meetings with their mentor and the CEO during the planning phase of August - December 2018 to design learning specific to them.
- Weekly visits and/or calls with their mentor to provide direct feedback on the program.
- Working with their mentor to define their small business focus area.
- Involvement in the sourcing and delivery of their own bulk goods. etc.

[50] Participation Handbook for humanitarian field workers *Involving crisis-affected people* in *a humanitarian response*

[51] Participation Handbook for humanitarian field workers - *Involving crisis-affected people* in *a humanitarian response*

<u>Growth Mindset - Celebrating Failure</u>
The Women's Community Leadership Program embraces and celebrates failures. Although the women must eventually reach a certain level of mastery to obtain their accreditations, the process is one that rewards effort, trying and learning lessons through errors, mistakes and failures.

This approach to learning is often referred to as having a 'growth mindset.' As the psychologist who developed this concept, Carol Dweck explains:

"In a growth mindset, people believe that their most basic abilities can be developed through dedication and hard work—brains and talent are just the starting point. This view creates a love of learning and a resilience that is essential for great accomplishment. Students who embrace growth mindsets—the belief that they can learn more or become smarter if they work hard and persevere—may learn more, learn it more quickly, and view challenges and failures as opportunities to improve their learning and skills."[52]

It is our belief that celebrating effort and resilience (to get back in there and try again) will have far more beneficial effects on the end learning of the women than if we were to only reward the 'right answer.'
Therefore, within in each accreditation there is a number of marks that can be received for reporting failures and describing the lessons learned by them.

We have chosen to foster this approach with our participants because we have observed that they are surrounded be constant negative feedback loops and their fear of failure may be keeping them from taking positive risks and taking on new challenges.

We also stand to learn from their 'failures' in order to provide better guidance, trainings and support.

<u>Extra-Curricular programs</u>
As well as participating in the required areas of learning, we will encourage the women to take part in or take home extracurricular activities such as:

- Art Activities
- Meditation
- Yoga
- Physical exercise
- Field trips
- Game days
- Cooking classes
- Crafting, ie jewelry making, etc.

[52] EDGlossary - Growth Mindset: https://www.edglossary.org/growth-mindset/

These activities provide a forum for creative expression, stress relief, confidence in new skills, interpersonal connection and expanding world view. Although none of these are compulsory, mentors will actively encourage participation.

Mentoring

Each one of the 10 program participants will be partnered up with their own mentor - a female volunteer who has experienced some level of success in business and who is passionate about supporting other women to succeed.

The importance of the mentoring relationship cannot be underestimated. Social Economist Robert Putnam has identified meaningful mentorships as the most significant determinant in the success of those from underserved communities.

The mentors' role is foremost a friend to support the participant through her process of learning. Although involved in the trainings as a support, she is not a teacher nor authority figure. She will be the participants first call when she is having trouble or needs some extra help. The mentor will work very closely with the volunteers and staff to ensure that her participant friend has all that she needs in order to succeed in the program.

Mentors commit to working with the women for a minimum of one year to create a safe relationship of trust with them and the program participant.

Positive psychology - Educational and Organizational

The work of The Women's Community Leadership Program is all founded on the tenets of positive psychology. Positive psychology is the scientific study of the strengths that enable individuals and communities to thrive. The field is founded on the belief that people want to lead meaningful and fulfilling lives, to cultivate what is best within themselves, and to enhance their experiences of love, work, and play.[53]

We embrace a positive organizational Culture as well as using Positive Education delivery systems and frameworks.

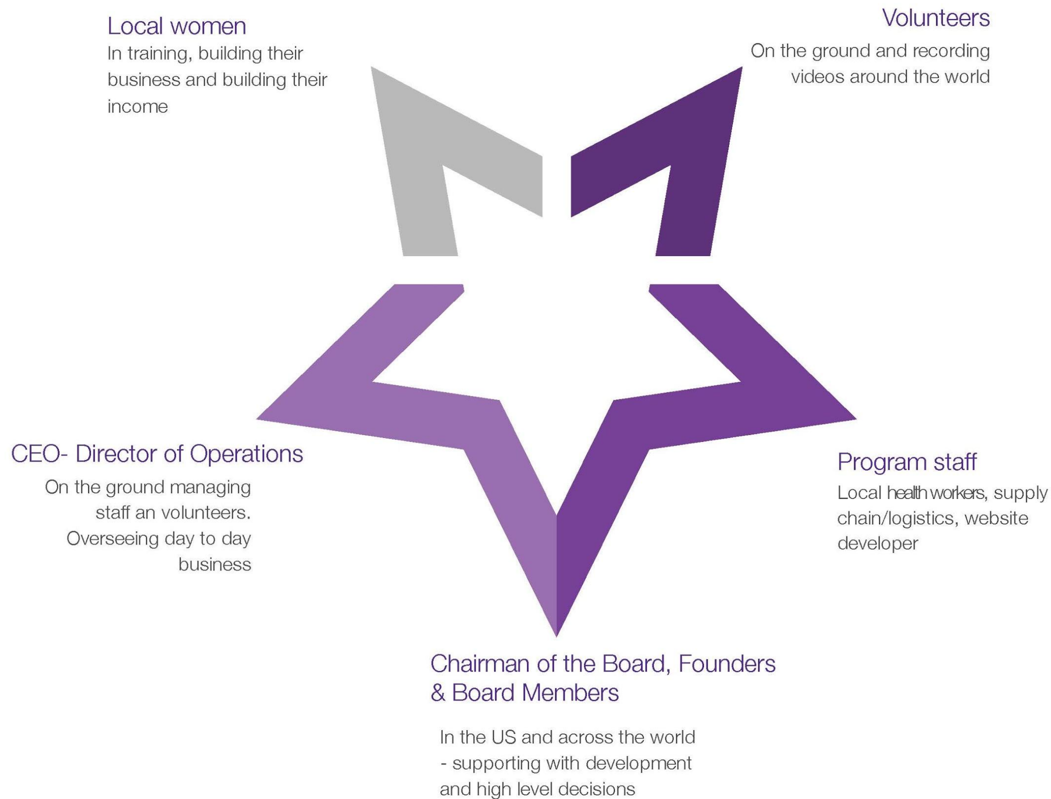
This includes fully integrated practices and focuses on:

Gratitude, mindfulness, resilience, grit, empathy, compassion and learned optimism.

[53] The Positive Psychology Center https://ppc.sas.upenn.edu/

Organization Team - Staff and Volunteers

The Women's Community Leadership Program will have a small staff of paid team members and a strong volunteer network for the first few years of its development.



We have chosen to form the organization as a US 501c3 working internationally and specifically in Africa. We made this choice due to the freedom this would afford us to focus on areas such as mental wellness and women's empowerment without having challenging restrictions and/or opposition from local officials.

During the planning year, the Founders will work together to create the infrastructure and funding required to have a staffing structure similar to this:
August 2018-December 2018

- 1 Full time paid Founder and CEO
- 1 Part time paid mental health professional
- 1 part time web developer
- 1 volunteer Chairman of the Board
- 2 volunteer Founders/advisors
- 10 volunteer mentors
- 10 volunteer support staff

January 2019 - 2020

- 1 Full time paid Founder and CEO
- 1 Full time logistics/project manager
- 1 Full time paid mental health professional
- 1 part time web developer
- 1 volunteer Chairman of the Board
- 2 volunteer Founders/advisors
- 10 volunteer mentors
- 10 volunteer support staff
- A volunteer board of directors and advisory board

Founders, Board of Directors and Officers**

The Founders of Women's Community Leadership Program are:

- Yosef Desta
- Georgia Van Cuylenburg

The Board of Directors currently consists of:

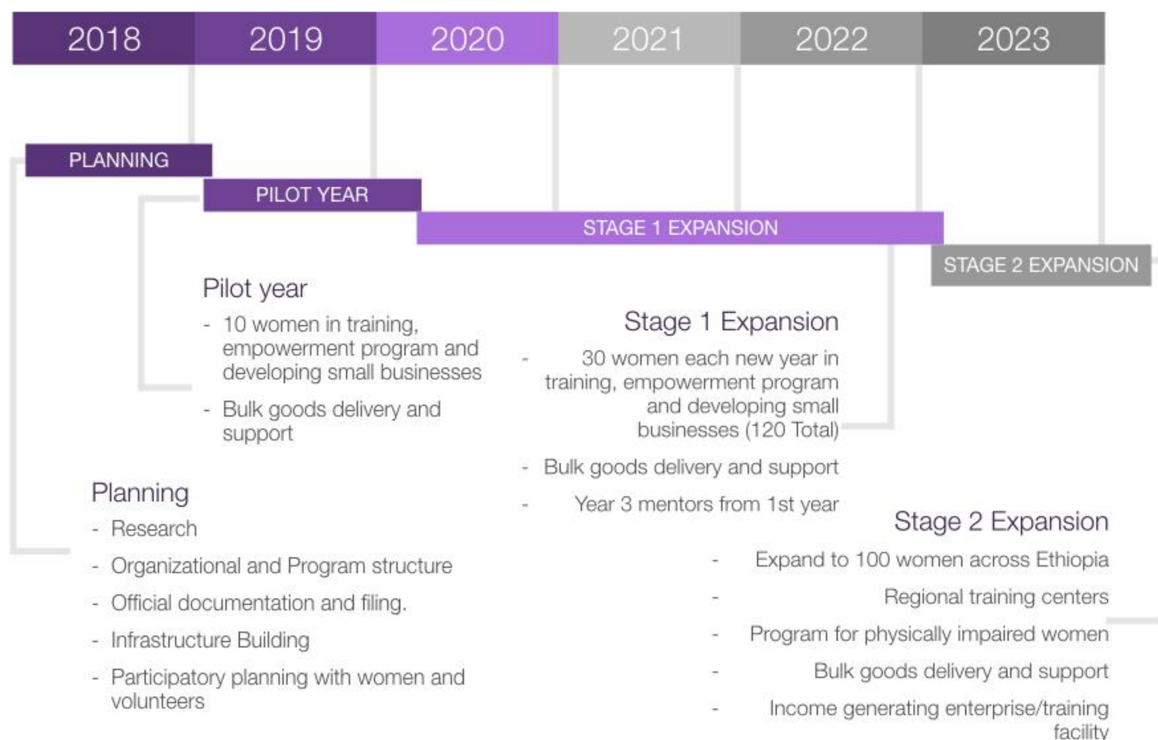
- Georgia Van Cuylenburg - Chair
- Melate Bekele
- Lulit Solomon
- Steven Ross

** Appendix contains the biography and Cv of the Founders and currently identified Directors and officers. This included the International advisory board not mentioned above.

We have chosen to create an all-inclusive team approach to the organization with our participant and 'on the ground' team as the focus of the structure:

Timeline - 5 Year Plan

Below is the direction we currently believe The Women' Community Leadership Program should take - however we understand the findings of our pilot program may shift this plan. (further detail provided below)



<u>Planning year 2018</u>

January - Research Trip 1

- Identified Pilot structure.
- Identified major needs and focus areas.
- Identified core challenges and strengths.
- Enlisted volunteers and two (potentially three) program participants.
- Two of four founders engaged.

February

- Drafted initial Proposal.
- Extended Program framework.

March - Research trip 2

- Identify additional program participants.
- Deliver proposal for feedback and changes.
- Further enlisting of volunteers and identification of potential mentors.
- Engage two additional founders.

April
- Build organizational structure including identifying paid staff, volunteers and mentors.
- Build advisory board and identify board of directors.
- Begin legal documentation and official applications for business status.
- Complete Business plan and final Program Proposal.

May - July
- Continue processing of paper work and official documentation.
- Begin outreach and discussions with funders and foundations.
- Secure funding for the 2018 paid positions as well as a vehicle.

August - December
- Work with participants and mentors to develop each individual training program.
- Identify household needs and define support program structure.
- Develop training curriculum and accreditation framework.
- Continue securing funding for office space and infrastructure needed for the pilot program year.
- Secure relationships and contracts with suppliers.
- Secure office space with computers and necessary resources.
- Collect training videos in library of content on the organization's website.

Year 1 - Pilot Program - January 2019- January 2020

Commence trainings with the Ten program Participants which will include:

January-June
- Two days per week learning from videos and resources.
- Weekly visits with mentors.
- Weekly session with mental health worker.
- Daily check-in with volunteers, either in person or on the phone.
- Extra-curricular activities.

June-December
- Addition of specific small business training.
- In the field work with volunteers observing and supporting with food delivery etc.
- Initiation of own small business with support of staff and volunteers.
- Weekly check-in with mentors and volunteers on business challenges and concerns.

January 2020 graduation from Pilot program

Year 2 Iteration and Expansion

January-March 2020
- Evaluation of Pilot Program and implementation of changes and adjustments.
- Continuation of volunteer and mentor support for 10 pilot program participants (decreasing financial support - if still at all).

March

- Initiation of second year of programming with 30 new program participants.
- Iterate and extend to other areas in Ethiopia.

Year 3 and 4 March 2021 and 2022

- After further evaluation and feedback enlist a further 30 participants for the program.
- Continue to mentor the 30 year 2 program participants.
- Offer an opportunity to our Pilot program participants to mentor a new program.
- Explore the feasibility of developing an enterprise to help sustain the organization and provide work training to the women. This would come into effect in year 4.

Year 5

- Extend the program to 100 women across Ethiopia with regional training centers.
- Develop a program for women who cannot travel due to physical constraints and who's work possibilities are similarly limited.
- Potentially expand to other countries within Africa.

Rapid Scaling

In order to achieve the rate of scale that we hope to, there are a number of different approaches we will explore as an organization:

- Distribute our trainings through partner's network.
- Recruit and train other organizations to deliver the trainings.
- Unpack certain key elements of the program and scale those.
- Use our videos and technology to reach a larger community.
- Pursue for profit models.
- Influence policy change.
- Alter attitudes, behaviors and norms.

MONITORING AND EVALUATION

<u>Evaluation</u>
The exact details of evaluation will not be defined or available until the end of 2018 when we have a better understanding of each of the 10 women's specific needs and program. By this time, we will also be able to structure our evaluation around the exact organizational team, their roles and the benchmarks from which we can take our evaluation measures.

That being said, we intend to take detailed measure from the initial planning period of August-Dec 2018 and begin formal evaluation, including monthly surveys with the women and volunteers as well at tracking their outcomes - both in learning and self-efficacy and mental wellness.

It is our goal to complete the pilot program and February 2020 be able to produce

- ➢ Proper Impact measurement (Impact evaluation or outcome evaluation).
- ➢ Publication documenting the process of the Pilot program Year as well as the findings from the evaluation - with recommendations for changes and adjustments.

SOURCES:

The Lancet Commission on the future of health in Sub-Saharan Africa 2017: The path to longer and healthier lives for all Africans by 2030

Lissa.Rankin 2013: Mind Over Medicine: Scientific Proof That You Can Heal Yourself

The World Economic Forum 2015: 'Why SME's are the key to growth in Africa.'

C. VAN ROOYEN, R. STEWART and T. DE WET 2012, The Impact of Microfinance in Sub-Saharan Africa: A Systematic Review of the Evidence

United Nations Institute for Statistics 2014: "Adult and Youth Literacy Fact Sheet"

United Nations Institute for Statistics 2017: Higher education

Our Africa: Women

United Nations Institute for Statistics 2017: "Literacy Rates Continue to Rise from One Generation to the Next"

JAKENN Publishing P.L.C. 2017 Addis Standard magazine, December edition

The world health report 2000 - Health systems: improving performance

Ethiopian Press Agency 2018: The Ethiopian Herald, 2015

Ethiopian Review 2017 ; Hiyawkal Gizachew; Mental illness in the Ethiopian Community

The Harvard Gazette 2017: '*Good Genes are nice but joy is better*'

United Nations Development Program 2018 - Ethiopia

Education Policy and Data center 2014 - EPDC NEP_Ethiopia

United Nation 2018: UN Sustainable Development Goals

ALNAP Groupe URD 2005: Participation Handbook for humanitarian field workers - *Involving crisis-affected people* in *a humanitarian response*

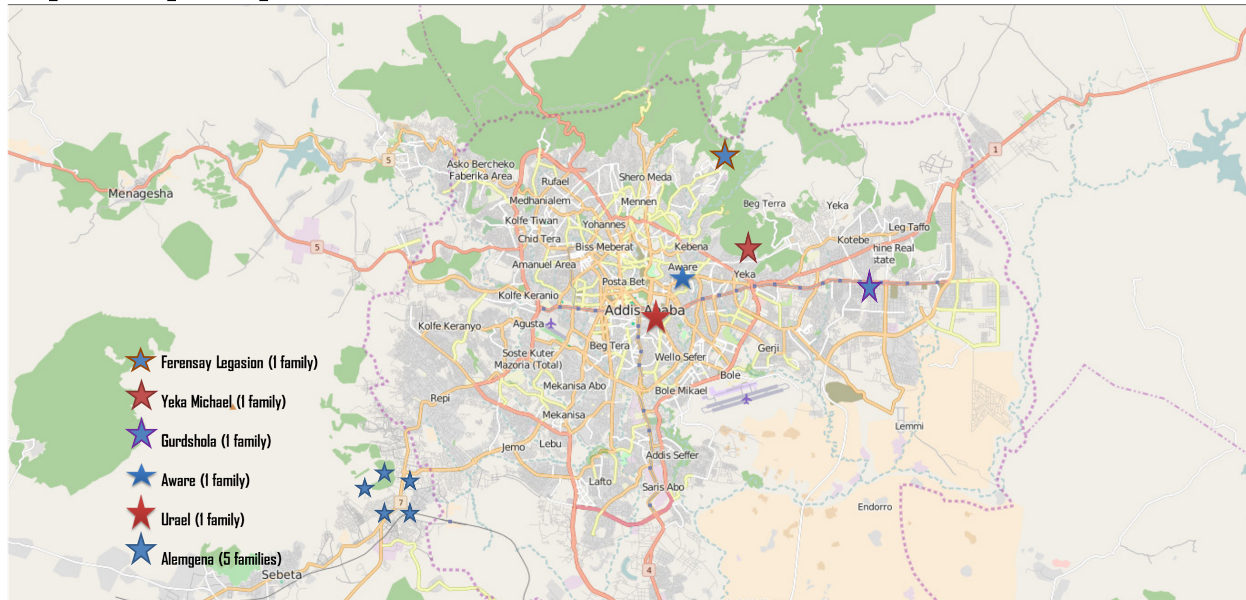
EDGlossary 2014: Growth Mindset

The Positive Psychology Center 2018:Home page

Psychologytoday www.psychologytoday.com

Appendix:

Appendix #1
Map of our participants location:



Appendix #2

Profile of Pilot Program Participants

Name: Shitu Dereje.
Age: 21 years old
Children: Five year old son - Naol Tolosa.
Current Income and Expenses: She has a small coffee business and cleans people's house, but her income is very low that now it has become very difficult to even cover her daily living expenses. On top of that, she pays 500 birr for house rent monthly.
Family Details: She does not know her son's father's whereabouts. She does not have a relationship with her parents because of what has happened to her. Her parents are divorced and do not care for her. She has brothers and sisters but does not know them.
Other Information: She is a member at 'Kidisina Leigziabher church.' Her son goes to school at the Church. She is very determined and would like to be self-sufficient. She left school after 8th grade.

Support: She wants to grow her business. Therefore she needs financial support that can increase her capital to expand and grow her business. If this can be done for her, she can live with her child in a better condition and her livelihood will improve.
Emotional State: She is very worried about life because her coffee business is so small. But she is also very full of life.

Name: Samrawit Alemayehu
Age: 27 years old
Children: Two children. Mihiret Zewude and Yabeth Zewude.
Current Income and Expenses: She does not have any work. She is now living by the support she gets from some church members. This support is not permanent. On top of all the consumption expenses she incurs, she pays 600 birr monthly for the house she lives in.
Family Details: Her husband (Zewdu Taddesse) left her recently after she gave birth to her youngest child who is only two and half months old. Her husband is addicted to different addictions.
Other information: She is a member at a local church called Mihiret Wongel. She is able and willing to work so she just needs the opportunity to be given to her.
Support:. It would be a great help to get her financial support that could cover her living expenses and give her a permanent way of providing support for her family.
Emotional State: She said that she could not sleep because of stress. She is desperate to get an opportunity to work hard and become self-sufficient.

Name: Meseret Tilahun
Age: 26 years old
Children: Three children: Daughter - Hiwot Siweya 10 years old, Daughter - Eden Siwoya 3 years old, Son - Yeroson Siweya 1 month old.
Current Income and Expenses: She used to sell coffee and tea on streets of Addis Ababa and provide for her family. But now she is not able to go out for work and provide what is needed for her family since she gave birth a month ago. Now she and her children are dependent on her aunt whose work is to sell Tella (a local Ethiopian beer). Because Mesert does not have any source of income to cover daily consumption and transportation,
Family Details: Before her husband had left her and she gave birth to her third child. Her husband is addicted to drinking, smoking and other drugs.

Other information: She is from the house of faith and she still worships God, being a member of 'Geja Kalehiwot' local church. Her first-born Hiwot Siwoya is about to drop out of school. She is unable to attend school continuously.
Support: We recommend that financial support for her and her children's basic needs and transportation costs**.** For the fact that she will be able to go out for work after five months, we recommend that if she gets financial support for restarting the work she used to work before or some other work that she is capable off.
Emotional State:

Name: Lemlem Damte
Age: 31 years old.
Children: Three sons: Barok Yohannes, 4 years old. Darik Yohannes, 1.5 years old. Third child lives with other families.
Current Income and Expenses: Before her husband Mr. Yohannes had left her, she used to have one sewing machine and work with it to cover the daily consumption of her family. Since her husband left her right after she gave birth to her second child, she was unable to go out and work. Therefore, she sold her sewing machine and the money helped for a while to provide for her family. Now she is dependent on her sister for her and her two sons' basic needs. Lemlem lives in a kebele house, which she inherited from her parents and she is still dependent on the financial support she gets from her sister, which is not enough to cover all her and her children's needs. If she could buy a sewing machine, she believes she would be independent again and work to provide what is needed for her family.
Family Details: She is still married but her husband left her alone with her two sons. Lemlem believes that her husband has a mental problem as he displays erratic behaviors. The last time she saw him was years ago, but they speak over the phone occasionally.
Other Information: Darik is not able to walk because of malnutrition.
Support: For the fact that Mrs. Lemlem believes she will be able to work and provide for her family if she gets money to buy a sewing machine, we recommend that we would buy a sewing machine for her.
Emotional State:

Name: Gelane Rebuma
Age: 22 years old
Children: Yosef Abayne 2 years
Current Income and Expenses: She lives on the money she gets by selling vegetables on the street. Since she could not afford to have a house to live in, a person let her live in his compound looking after his house without any other payment. She is serving as a guard in exchange for living in a small house.
Family Details: Her husband left her a while ago and now she is raising her child alone.
Other information: She and her child live in a very tight room that does not have either a bed or a mattress. Her child is only one and half years old. In the condition they are currently living in, they cannot sustain their livelihood**.**
Support: We recommend a mattress to be given to her since she sleeps on clothes and this will through time cause a serious effect on her and her child's health. She also needs some financial support that could sustain her livelihood.
Emotional State:

-

Name: Etenu Mohammed
Age: 25
Children: 8 years old daughter, Hirut Abreham and 4 years old son Ebenezer Abreham.
Current Income and Expenses: She tries to cover her expenses through daily labor (washing clothes, etc.), selling maize seasonally. When she is not able to cover her monthly expenses, she asks for support from family and friends. However, mostly Etenu is not able to provide the basic needs of her children.
Family Details: Her husband left her when she was pregnant with her second child. He came back briefly but after finding out that he is HIV positive he left again and she has not seen him since. She does not know where he lives. Since then she has taken all the responsibilities of taking care of her children. She is the breadwinner of the house. Etenu leaves her child Ebenezer with her neighbor when she goes for work

because he is only four years old and cannot be enrolled in school.
Other Information: She lives in Gured Shola area and can be reached at 0985456780
Support: She said that if she got the opportunity both through training and financial support, she has a plan to work on selling fruits and vegetables (Gulit). She also has interest in starting an Injera making business.
Emotional State: She displays visible signs of anxiety disorder and potentially Obsessive Compulsive Disorder. She is very open about her anxiety and how debilitating it can be for her.

Name: Fikrte Ashenafi
Age: 30 years old
Children: Five year old son - Anania Tesfaye and 2 year old son Zowi Tesfaye.
Current Income and Expenses: She is attempting to support her family through being a messenger/post women at a private bank. However, she is not currently able to cover house rent, her child's school fee and other expenses at home.
Family details: Her husband died two years ago. Since then she has taken on all the responsibilities of the household and her children. She is the breadwinner of the house.
Other Information: She lives in Urael area and can be reached at 0913658058.
Support: Fikrte has had experience working in laundry service before the death of her husband. After her husband passed away, her business stopped. She said that if she gets the opportunity both on training and financial support, she has a plan to work on her own laundry shop and a children's clothing and toy shop.
Emotional State: No information is available.

Name: Gete Mussie
Age: 40 years old
Children: 22 years old daughter-Hanna Belay
Current Income and Expenses: She works as a janitor on a part time basis and also sells Injera. When she is not able to cover her monthly expenses, she asks for other family and friend's support. Most months she has covering her expenses.
Family details: Her husband left when she was three months pregnant. She has never seen him for almost 22 years. In addition, she does not know where he is living. Starting from that time, she took all the responsibilities to take care of her child. She is the breadwinner of the house.

Other Information: She lives in Yeka Abado condominium and can be reached with her cell phone at 0910519701.
Support: She said that if she got the opportunity through training and financial support, she has a plan to work on baking and distributing Injera and opening a shiro bet or shiro house.
Emotional State: Her daughter Hanna has suffered serious nerve problems for two years and she was forced to drop out from school. She was a second year Civil Engineering student at Welkite University, which is far from Addis. In order to get regular medical treatment, the university board gave permission to transfer her from Welkite University to Addis Ababa University where her mother resides. Now she has started her education at Addis Ababa University and has regular medical follow-ups.

Name: Mistre Haile
Age: 28 years old
Children: 13 years old daughter: Rahel Kasahun, grade 7 student
Current Income and Expenses: She works part time as a janitor. She also provides door-to-door beauty salon services, especially hair braiding. However, she is seriously in a problem to cover house rent, her child's school fee and other expenses at home.
Family details: Her husband died twelve years ago. Since then, she has taken all of the responsibilities to take care of her child. She is the breadwinner of the house.
Other information: She lives in Abuare area in Addis and can be reached at 0922331974
Support: She has the experience in women beauty salon service. She is trained and certified. She was employed in a beauty salon until the shop was closed due to construction. She said that if she gets the opportunity both on training and financial support, she has a plan to work in a women beauty salon and selling chips and fast foods.
Emotional state: No information is available.

Appendix #3
Staff/volunteers Profile

Paid Staff roles and profiles:

CEO/President - Yosef Desalegn Desta

Role Description
The President and CEO's responsibilities:

- Provide leadership and management of WCLP, including all the financial, administrative, HR and programming activities both for field office and for the international HQ.
- Lead the management team in order to ensure coordination across regions.
- Supervise, coordinate and finally report project activities.
- Ensure that the technical, financial, and administrative activities are carried out according to WCLP policies.
- Coach and develop team members for effective projects and program management.
- Oversee and participate in collection and analysis of statistics pertaining to all activities.
- Provide supervisory responsibilities; develop and coach staff including but not limited to; interview/selection, performance review and development; ensure excellent communication from the field and HQ.
- Always lead WCLP's effort in providing grass root empowerment and education to women living in extreme poverty in order to empower them and make them self-sustainable.
- Travel frequently for all responsibilities within each region or to WCLP HQ office.

Biography of CEO
Yosef was born and raised in Ethiopia, where he personally witnessed human suffering caused by extreme poverty. He also had opportunities to work and visit several areas in Ethiopia where children and families struggle to survive their daily life facing the complex problem of poverty. He is very passionate about the work of transforming the lives of women by providing grass root empowerment and education to women living in extreme poverty. He personally knows the complex problem of extreme poverty and is passionate about the vision of WCLP to see one million women thriving and free of poverty by 2040. He graduated from a university in Ethiopia and assumed several responsibilities in government offices before he moved to the US for his Masters degree.

Relevant Experience
Currently, he is in charge of overseeing the work of the Children's Hunger Fund in nine African countries that focuses on the complex problem of poverty. This responsibility includes providing food security for emergency needs and self-sustainability projects for long term solutions. He has the privilege of collaborating with local NGOs, government offices and churches to manage and coordinate several projects in Africa. He works with others to tackle these problems by implementing several programs including shipping fortified food from US, empowering the poor and the displaced through training and equipping, by implementing self-sustainability projects and so many other programs.

All of this has given him firsthand experience in living and doing relevant work in Africa as well as here in the US. Because he has also been exposed to the needs of extremely poor people in Ethiopia while working for Ministry of Agriculture of Ethiopia and has had an opportunity to propose a viable solution that addresses those challenges.

Yosef has experience providing oversight to projects and tasks, which requires timely execution and reports. Furthermore, he was blessed with the opportunity of caring for, developing, mentoring and supervising team members for projects and tasks in Africa. Before joining Children's Hunger Fund, he had extensive experience in providing overall vision, leadership, and management for a Not-for-Profit Ministry that operates in Africa, focusing on alleviating poverty from the poorest of the poor areas. He has also been assisting African immigrants in the US in skill training, job training and empowering them to integrate into and create sustainable careers within the new culture.

Salary
Salary for the president and CEO of WCLP:
2018: TBD - funds raised for early planning in Ethiopia
2019: $86,000
2020: $96,000
2021: $105,000

Hours of Work
The president/CEO is expected to work more than 40 hours a week with the expectation that work may need to be completed on weekends or outside of regular business hours.

Other Paid Staff Positions

2018 onwards
- Web development Team - Beki Square
BEKI Square is a professional website and graphic design company in Addis Ababa, Ethiopia. It specializes in providing high quality graphic design services and web development solutions for companies or individuals interested in outsourcing their web design and web application development needs. Operating since 2008, the company has created and developed smart and professional graphic design in addition to web based solutions for small & large enterprises. The services rendered have also been extended to other web design companies, with a competitive edge which has enabled them to focus on their core activities.

Team Lead - *Bereket Tadesse*

A passionate web designer, front-end developer, and illustrator specializing in CSS driven web design with an emphasis on usability and search engine optimization. Having acquired a Bachelor of Science degree in Computer Engineering, his design experience began with a programming background that laid the groundwork for a comprehensive design skill set. He is truly passionate about his work and lives and breathes the lifestyle of a die hard designer and front-end developer.

2019 onwards
- Mental Health professional Details TBC
- Logistics Manager Details TBC

Volunteer staff roles and profiles:

Mentors
Logistics support & Participant support

- **Ruth Getachew**
  Work experience:
  Team coordinator - VSO
  Credit officer - Joshua multipurpose co-operative
  Education:
  Bachelor of Arts in Economics, Addis Ababa university
  Entrepreneurship training workshop
  Training on Peach-tree Accounting
- **Muna Gebrehiwot**
  Work experience:
  20 years teaching experience
  Education:
  Diploma in Applied Chemistry Kotebe University
- **Dagim Tilahum**

Work Experience:
Customer service officer - Debo Microfinance S.C
Education:
Bachelor of Arts in Accounting and Finance - Addis Ababa university
Entrepreneurship training workshop
Training on International Financial- Reporting Standards (IFRS)

- **Anemut Minda**
  Work Experience:
  Salesperson - GET-A
  Education:
  Bachelor of Arts Management - Addis Ababa university
  Entrepreneurship training workshop
- **Awgichew Gerawork Yihune**
  Work experience:
  Development Facilitators at World Vision Ethiopia
  Project Coordinator at Pro Pride
  Rehabilitation and Support Officer at Social and Labor Affair Bureau
  Market Research Expert Teddy plc
  Education:
  BA degree in Sociology and Social Anthropology - Addis Ababa University
  Integrating programming model and project and program redesign
  Certificate in Domestic Violence training
  TOT on Gender
  Child Right Convention (CRC) trainings
  Situation analysis of orphans and vulnerable children (OVC) in Amhara Region Commissioned by ANRS Bureau of Social and Labor Affair and Save the children Norway _ Supervisor

Other volunteer roles:

- **Medical doctor Details TBC**
- **Mental health professionals TBC**

Board of Directors - roles and relevant experience

The Board will support the work of WCLP and provide mission-based leadership and strategic governance from the US and around the world. While WCLP's president leads the day-to-day operations, the board-president relationship is crucial in accomplishing the mission. Specifically, the working partnership between the current president and the current Board chair is the core foundation of the organization.

Roles

Board member responsibilities include:

- Leadership, governance and oversight.
- Serve the president and leadership team in developing and implementing WCLP's mission.
- Vision, mission and plans.
- Approving WCLP's annual budget, audit reports, and material business decision; being informed of, and meeting all legal and fiduciary responsibilities.
- Reviewing outcomes and evaluate WCLP's impact around the world.
- Review agendas and supporting materials prior to board and committee meetings.
- Making board and committee meetings a priority.
- Partnering with the president and other board members to ensure that board resolutions are carried out.
- Providing encouragement, love, and assistance to the leadership team.
- Serving on committees and task forces and taking on special assignments.
- Representing WCLP to stakeholders.
- Promote WCLP in every opportunity possible.
- WCLP board members will consider WCLP a philanthropic priority and make annual financial or in kind gifts reflecting that priority, so that WCLP can credibly seek additional funding showing full board support.
- Solicit contributions from foundations, organizations, and individuals.
- WCLP expects to have 100% of board members make an annual contribution that is commensurate with their capacity. For some, this may be a very modest amount.
- WCLP board members shall also use their talents and abilities in fundraising efforts.

Term Limits and Meeting Schedules

- WCLP board members will serve three years term and be eligible for re-appointment.
- Board meetings will be held 3-4 times per year and committee meetings will be held in coordination with full board meetings.
- Board members are expected to attend at least 75% of the board meetings annually.

Qualification

It is expected that all board members will be passionate about WCLP's mission and have track records in leadership. Selected board members will have achieved leadership

stature in their community, business, government, philanthropy, or the nonprofit sector. Ideal candidates will have the following qualifications:

- Strong non-profit experience.
- Savvy diplomatic skills and natural affinity for cultivating relationships and persuading, convening, facilitating, and building consensus among diverse individuals.
- Personal qualities of integrity, credibility, and passion for improving the lives of WCLP's beneficiaries.

Service on WCLP's board is without remuneration, except for administrative support. If required, travel and accommodation costs in relation to board member duties can be subsidized.

Board Member Profiles

Chairman - Georgia Van Cuylenburg
She has dedicated her life to creating solutions for those born into an unjust experience of our world and is honored and excited to spend every day combining her passion for humans, technology and philanthropy to create a thriving future for everyone.
She is founder and executive director of the non-profit organization Arts Bridging the Gap that bring artists, educators and community organizations together to create arts education for children in underserved areas in order to improve their self-efficacy and academic results.

Georgia is heavily involved with many children's non-profit organizations as well as her own and is constantly infusing VR into their work to enhance donor and cause engagement.
She is a public ambassador for Alopecia Awareness, poverty & homelessness issues and education for children. She volunteers weekly with the LA Mission, Children's Hospital of LA and the Gabriella Foundation and volunteers regularly with a number of other amazing changemaking organizations.
She is owner of the production company, I am Spartacus Entertainment, which creates socially conscious positive content. She just completed a journey to India and Lebanon where two parts of a three part VR documentary, *Human by Any Other Name*, were filmed in 360. She is a founding member of Girls Make VR – which, through her non-profit, provide classes for underserved teen girls to learn VR content.

She is also a chairperson trustee of Community Impact Uganda and serves as a junior executive board member for C5LA.
She has a Bachelor's degree in Art-Public Relations and a Master's degree in Leadership in Global Sustainable Development.

Treasurer - Steven Ross
Former Coordinator of Multicultural Advancement at The Master's University, where he mobilized students for ongoing community outreach, Steven facilitated an annual semester course on the introduction to urban ministry and developed an education program that enhanced the cross-cultural competence of students, staff and faculty of

the institution. He currently serves as the Executive Director of Mission at Seed of Mercy, a faith based non-profit organization in Ventura, CA. He also coordinates ministry development at Children's Hunger Fund, equipping global leaders in the complexities of urban poverty, compassion, and humanitarian aid.

Secretary - Melate Bekale
Melate is an experienced relationship management, communication and international development professional. She has over 13 years in private and public sector experience consisting of strategic planning, community relations, project management, stakeholder engagement and development.
Melate was born in Addis Ababa, Ethiopia. Philanthropy has always been a passion of hers, since she was young, she volunteered at nonprofits and stayed active member in the Ethiopian community. Melate studied Communications and Ethnic studies at California State Fullerton. After finishing her undergrad she traveled back to Ethiopia for year contract working on the Millennium Goals and basic services working throughout the country.
She returned to the US where she got a Masters in Communication Studies at San Jose State University. Her research focused on international Development and the effectiveness of international organizations in developing countries. Following her masters, Melate spent 4 years in DC consulting nonprofits with stakeholder engagement and project management.
Melate later founded Habesha Networks in 2016. A platform and nonprofit created to connect community members and supporting community development. Their work is providing local and abroad impact. Melate works for United Way of Greater Los Angeles partnering with donors by connecting and engaging them in poverty issues.
She spends her time mentoring, advocating for the community and finding resources. Melate's life purpose is creating connections, providing access and helping others.

Director - Lulit Solomon
Lulit Solomon is a first generation Ethiopian-American with a deep passion for creative marketing, philanthropy, and international strategy. Solomon has extensive experience in creating sales and dynamic marketing solutions in both the entertainment and technology industries. Currently, she is focusing her sights on the immersive media industry as an integrated Marketing Manager at Jaunt, the global partner of choice for producing and distributing immersive content. Her experience has extended to a global level, with a proven track record of success activating events and executing marketing strategies across Europe and Asia. Above all things, however, Lulit is an Ethiopian-American devoted to her culture and heritage. She is an eager world traveler and student of life, whose deep appreciation for art, diversity, and creativity are pillars of who she is.

Local and Global Advisory Board

Role of Advisory Board

Profile of Advisory Board members

Founding Advisor:
Alemayu Ayalew Tegegn (Alex)

Life Principle: Change starts with a sense of purpose and a feeling of hopefulness. Hopefulness can be created where ever there is passion and dedication. When all of this exists, commitment goes beyond words and translates into action to bring the change that we want.

Formal Education

- **Master of Arts in Children and Youth Studies**, Completed in December, 2011
  International Institute for Social Studies, Erasmus University, the Netherlands.
- **Bachelor of Arts in Management**, Completed in July, 2009
  ST. Mary's University Challenge, Addis Ababa, Ethiopia.
- **Advanced Diploma in Computer Science,** Completed in July, 2003
  Micro link IT College, Addis Ababa, Ethiopia.
- **English as a second language,** September, 2003 –June, 2004 June
  Sandford School Addis Ababa.
- **12th Grade Graduate,** Completed, 1994
  Ayer Tena Senior Secondary School, Addis Ababa, Ethiopia.

Career Related Work Experience:
Per time consultant to developing different working documents and provide social training to different companies (Horn of Africa under AA University, Melca Ethiopia, Endurance Youth Association etc and one private company)
Institute for Sustainable Development (ISD)

- 2014 to Present – Youth Development Program Department Head and Operational Unit Advisor.
- From 2012 to Present - high level social and attitude training facilitator.
- January, 2012 –December, 2013 - Youth Capacity Development team leader.
- 2008-2010 - Youth development (YD) program officer and Member of the technical management and recruitment committee in ISD.
- 2007 to present - Consultant on setting self organization groups, including youth and women, how they become formal and effective organizations.
- 2005- 2007 - Assistant Team Leader, social and attitude trainer of youth Association Leaders.
- 2003-2005 - Junior Youth Project Officer, Institute for Sustainable Development (ISD);

- 1995-2002 Founder of Mekrez Reading Association and created the first 24 hour Community Library in Ethiopia by mobilizing the youth and community to promote reading habits and environmental protection.

Key Achievements

- Founder, First 24 x 7 Community libraries in Ethiopia.
- Author, Leadership Training Manual for Social Programs (published in Amharic).
- Engaged and lead three strategic and Administration Manual Development processes.
- Contributed to many organization strategies and program development processes.
- Founder and served as board member for the following three youth focused local NGOs:
  - **Endurance Youth Association**
  - **Youth Network for Sustainable Development**
  - **Beza in Dessie**
- Founder and board member for following two environmental focused National NGOs:
  - **Forum for Environment**
  - **Melca Ethiopia**

International advisors:

Robert Moodie

The Professor of Global Health at the Nossal Institute of Global Health at the University of Melbourne and was named Victorian Father of the Year in 2005. He is married and has two children.

He graduated in medicine at the University of Melbourne in 1976, and has also studied Tropical Medicine at Paris University and Public Health at Harvard University. He has worked for the Save the Children Fund, Médecins Sans Frontières, the Burnet Institute, the World Health Organisation and UNAIDS. He was CEO of the Victorian Health Promotion Foundation (VicHealth) from 1998 to 2007.

Roy Dittman

Roy Dittmann, OMD, MH has dedicated his professional life to evolving an integral organic approach to prevent birth defects and optimize fetal brain development during the perinatal period – the most powerful time to impact human development.
Since earning his doctorate in Oriental Medicine and his masters in Herbology, Dr. Dittmann served as Official Team Doctor in the Olympics, and was featured in a “Doctor to the Stars” article in Vogue magazine in 1997.

Starting in the late 1990s, he founded two biotech companies, which licensed technologies from the University of Illinois and University of Texas, capable of delivering stable, non-refrigerated, non-injectable drugs to prevent AIDS and other

infectious diseases in remote villages. The research was featured at the United Nation's World Summit on Sustainable Development in 2002.

Fatuma Namutosi

After graduating from college in Uganda, Fatuma Namutosi focused on self-employment and entrepreneurship. She considered several agribusiness ideas, and decided on a product she believed would be profitable and nutritious—pumpkin.

Namutosi's business acumen has caught the eyes of world leaders who have invited her to share experiences as an entrepreneur at the Global Youth Economic Oportunities Summit in Washington in September.

In 2015, Namutosi established Byeffe Foods Ltd. and began selling a variety of pumpkin-based products: pumpkin millet, pumpkin seeds, pumpkin leaves, and combination soy and rice flours that include pumpkin

Appendix #4
Profile of Existing Organizations with a similar focus:

Association for Women's Sanctuary and Development (AWSAD)

- Ethiopia
- Africa

AWSAD supports women to rebuild their lives after experiencing violence. They have a safe house with counseling, training, legal aid and medical care.
AWSAD was established in 2003 and is committed to creating a safe and inclusive environment for all members of society, particularly women and girls.

AWSAD operates the first women-only shelters for survivors of violence in Ethiopia, supporting hundreds of women, girls and their children every year. In the care of the organization, the women and girls gain the confidence and skills needed to rebuild and improve their lives once they leave the shelter. They also raise awareness of women's issues and provide training sessions on violence against women and girls to community leaders and government representatives. They also raise awareness of women's issues to community leaders and government representatives by providing training sessions on violence against women and girls. This will improve responses to violence and make sure women can seek justice.

AWSAD offers various skills training to its residents and supports their initiatives to be economically self-reliant. AWSAD also runs capacity-building programs for stakeholders including police, prosecutors, community members, media professionals and school children toward the prevention of violence against women and girls.
As a pioneer organization with a wealth of experience in addressing and responding to violence against women and girls, AWSAD possesses expert knowledge on the topic and makes inputs to government, women's organizations and others in key processes in the sector.

Center for Accelerated Women's Economic Empowerment (CAWEE)

- Ethiopia
- Africa

The vision of CAWEE is to create a class of globally competitive women entrepreneurs in Ethiopia.

Center for Accelerated Women's Economic Empowerment (CAWEE) was established in 2004 as a membership organization, licensed under the Ethiopian Ministry of Trade.

CAWEE promotes women in business, with a special focus of working on value-chains through the provision of technical and marketable skills that can help women get involved in income generating activities.

The vision of CAWEE is to create a class of globally competitive women entrepreneurs in Ethiopia, with a focus on export markets operating at different levels, through the provision of different kinds of support services.

Addis Continental Institute of Public Health (AC-IPH)

- Africa
- Ethiopia

Addis Continental Institute of Public Health (ACIPH) is an independent centre of excellence for public health research and training located in Addis Ababa, Ethiopia.

Since 2006, ACIPH has been providing technical services and training in major public health issues in Africa. ACIPH provides graduate level education, short-term trainings, and assists in generating strategic information through research, monitoring and evaluation. ACIPH works in diverse areas such as communicable diseases, non-

communicable diseases and on issues of gender empowerment.

Womankind's partnership with AC-IPH will focus on strengthening and supporting a diverse range of organizations working on women’s empowerment in Ethiopia.

Siiqqee Women’s Development Association (Siiqqee)

- Ethiopia
- Africa

Siiqqee brings together marginalized women to train them in practical work skills and provide them with information on their rights.

Siiqqee was established in 1997 and is a not-for-profit organization that works with women and children to enable them to control their own livelihoods and contribute to the development of their families and communities.

Organizing women in self-help groups enables them to feel less isolated by poverty and HIV and AIDS. They can build their social networks and take action both individually and collectively against violence. Siiqqee is committed to ensuring that women are able to live their lives with dignity and security, and are able to improve their social and economic well-being. They encourage women to be active, productive and respected members in their communities.

Setaweet

- Ethiopia
- Africa

Setaweet is a home-grown Ethiopian movement that aims to explore and articulate what feminism means for Ethiopian women.

Setaweet is the first feminist movement and business in contemporary Ethiopia. Setaweet means ‘of woman’ in Amharic.

Founded in 2014, Setaweet is a home-grown Ethiopian movement that aims to explore and articulate what feminism means for Ethiopian women. They do this through consciousness-raising efforts such as the Setaweet Circle, a woman-only group that meets monthly, and Open Sessions which focuses on women’s equality through contemporary Ethiopian issues of culture, media and language.

As a business, Setaweet PLC provides a range of feminist services for private companies, NGOs and schools seeking to create a better working environment for women and men alike.

Through feminist engagement in both voluntary and private sectors, Setaweet enables women to come together to solve the problems of inequality and empowers women to take charge on feminist issues such as gender-based violence, equal pay, economic empowerment, and equality in care work.

Womankind’s partnership with Setaweet focuses on the economic empowerment of women.

Mujejegwa Loka Women Development Association (MLWDA)

Mujejeguwa Loka Women Development Association (MLWDA) was established in 1996 when it started working on community health related issues of Gumuz Women and advocacy to enable women to deliver in their homes, challenging a harmful practice of giving birth in forests. The association strives to empower the Gumuz people socially, economically, and politically and the protection of rights of children.

It’s mission is to promote gender equality for the protection of the rights of women and children and advocate for the protection and rehabilitation of the environment.

Good Samaritan Association (GSA)

GSA is a local non-governmental, non-profit making and non-religious volunteer organization established in December 1996 with its headquarters at Addis Ababa. The organization works to address the Ethiopian women and marginalized sections of the population to become free from poverty and their attainment of acceptable standard heath and education services. It exists to work toward achieving an improved quality of life of the most marginalized and discriminated segment of the community through participatory, integrated development initiatives, health education, basic skill training and other developmental schemes.

Appendix #5
Further Background on child hood physical trauma.

The CRC came into force in 1990, after it was ratified by the required number of nations. Currently, 194 countries are party to it, including every member of the United Nations, except Somalia, South Sudan, and the United States. The CRC states that all parties must “take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence.” In General Comment 8 in 2006, the Committee on the Rights of the Child stated there was an “obligation of all state parties to move quickly to prohibit and eliminate all corporal punishment and all other cruel or degrading forms of punishment of children.”

Such work has led to *over 100 countries prohibiting physical punishment in schools and 44 countries banning physical punishment in all settings*, including the home. Of these 44 countries, 28 are in Europe, seven in Africa, and several in South and Central America. These include Sweden, Finland, Spain, Austria, Germany, Israel, Kenya, Tunisia, Venezuela, Argentina, and Brazil. The laws and consequences tend to be more educative (about development) than punitive.
Physical punishment elicits precisely the negative affects one does not want in parent-child relationships and socializing children: distress, anger, fear, shame, and disgust. Socializing and discipline can be accomplished through the positive affects of interest and enjoyment and the early use of language and cognition with infants and young children.

Pioneering research has been conducted in this area over the past decade by Gershoff, Bitensky, Straus, Holden, Durrant, and others.

Gershoff (2008, 2002) examined hundreds of studies and presented the results of meta-analyses of the association between parental physical punishment and child and adult outcomes. She found that in childhood physical punishment was positively associated with aggression, delinquent and antisocial behavior, and being the victim of physical

abuse; it was negatively associated with the quality of the parent-child relationship, mental health, and more internalization (child's internalizing of socially acceptable behavior); and associations with immediate compliance were mixed. When measured in adulthood, physical punishment was positively associated with aggression, criminal and antisocial behavior, and adult abuse of one's own child or spouse; physical punishment was negatively associated with mental health.

Gershoff (2008, 2002) also summarized the various demographic and risk factors which are more likely to be associated with use of physical punishment: being single, separated, or divorces; excessive stress from negative life events; maternal depression; lower income, education, and job status; southern part of the United States; and conservative religious beliefs and affiliation.

Bitensky (2006) presented a detailed summary of the international findings regarding physical punishment. She also described the various efforts made by the United Nations to prevent physical punishment.

Durrant and Ensom (2012) have provided an eloquent historical review and summary of recent research. In addition, they outlined the steps necessary to continue the progress toward eliminating physical punishment. More recently, Straus et al. have done a remarkable job summarizing the research on associations between physical punishment and various psychopathology and sociopathy(2014). They found 15 major trends associated with physical punishment:

1. Increased antisocial behavior and delinquency as a child and as a young adult;
2. Greater approval of other forms of violence, such as the belief that torture is sometimes justified to obtain information critical for national defense, or that there are occasions when it is justified to slap a wife or husband;
3. Greater impulsiveness and less self-control;
4. Poorer parent-child relationships;
5. More risky sexual behavior as a teenager;
6. Greater juvenile delinquency;
7. More crime perpetrated as an adult;
8. Poorer national average mental ability;
9. Lower probability of graduating from college;
10. Higher probability of depression;
11. More violence against marital, cohabitating, and dating partners;
12. More violence against non-family members;

13. More physical abuse of children;

14. More drug abuse; and

15. More sexual coercion and physically-forced sex.

This growing body of research strongly suggests that a variety of poor outcomes are associated with physical punishment. There are more than 40 countries which have prohibited physical punishment in all settings, including the home.

Are there studies of outcomes in countries which have prohibited physical punishment? One such investigation was conducted in Finland by Karin Österman et al. and published in 2014. This was 28 years after the complete ban on physical punishment of children in Finland. Two findings stand out from this study of over 4,500 people. First, greater amounts of physical punishment were associated with greater alcohol abuse, depression, mental health problems, divorce, and suicide attempts. Second, and perhaps most strikingly, the decline in physical punishment was associated with a similar decline in the number of murdered children. Additional studies of countries banning physical punishment have shown a significant decrease in adult approval of physical punishment.[54]

[54] https://www.psychologytoday.com/au/blog/great-kids-great-parents/201508/physical-punishment-and-violence