

**Bridging the Gaps:  
Implementation of  
Comprehensive Abortion Care in Ethiopia**

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**December 15, 2008**

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## List of Abbreviations

ANC	African National Congress
AYRH	National Adolescent and Youth Reproductive Health Strategy
CAC	Comprehensive Abortion Care
CBO	Community Based Organizations
CCG	Community Coffee Groups
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
EOT	Ethiopian Oversight Taskforce
ETS	Ethiopian Training System
FGM	Female Genital Mutilation
FMOH	Federal Democratic Republic of Ethiopia Ministry of Health
GDI	Gender-related Development Index
GEI	Girl's Education Initiative
GMP	General Medical Practitioner
HDI	Human Development Index
HEP	Health Extension Program
HEW	Health Extension Workers
HPI	Human Poverty Index
HSDP	Health Sector Development Program
HTP	Harmful Traditional Practices
ICPD	International Conference on Population and Development
LNMP	Last Normal Menstrual Period
MDG	Millennium Development Goals
MOE	Ministry of Education
MVA	Manual Vacuum Aspiration
NGO	Nongovernmental Organization
NRHS	National Reproductive Health Strategy
OB/GYN	Obstetrician/Gynecologists
WHO	World Health Organization

## **Abstract**

*Ethiopian women face major obstacles in attaining Comprehensive Abortion Care (CAC). Two of the major barriers faced by women and health care providers are a lack of awareness of the revised 2005 Criminal Code of the Federal Democratic Republic of Ethiopia (penal code), as it relates to reproductive rights and limited access to resources. Specifically, how the code is interpreted undermines women's ability to attain safe abortions. If interpreted correctly, women's ability to access safe abortion services are strengthened. This policy brief examines the negative effects that the lack of awareness and access to resources has on the quality of life in Ethiopia, highlights obstacles to these and puts forth recommendations as to how Ethiopia can bridge the gaps between policy and action. The Ethiopian government has accomplished a great deal since adopting the revised penal code. However, despite the progress, Ethiopian women continue to be confronted by obstacles to seeking CAC. An intersectoral collaboration of government, nongovernmental organizations (NGOs) and community leaders is necessary to create a foundation for effective dissemination of knowledge and increased access within Ethiopia so as to ensure the provision of sustainable safe abortion care.*

**Keywords:** unsafe abortion, comprehensive abortion care, reproductive health, women, safe abortion services, health care providers, Ethiopia, awareness, access

## **I. Introduction**

In 2008, Adina, an 18 year old Ethiopian university student became pregnant after being raped.<sup>1</sup> Fearing stigma and discrimination, Adina chose not to report the rape to the police and did not alert her family. During her freshman year, a dismembered baby was discovered in one of the toilets in Adina's dormitory. Adina, the only girl known to have been pregnant in her dormitory and sick the week of the incident, was blamed for the murder. She claimed innocence, stating that she had terminated the pregnancy months before by taking abortifacients given to her by a friend. She claimed not to know the name or dosage of these pills. Fear of being ostracized by her family had prevented her from seeking other help, but even if she had sought assistance, she lacked the knowledge of the legal, medical and support services that might have been available to her. Had Adina been aware of the revised *Criminal Code of the Democratic Republic of Ethiopia (penal code)*, her unsafe abortion and her alleged crime could have been prevented. Adina's story is only one example of the difficulties women confront. Although Ethiopia's abortion law was recently liberalized, women in Ethiopia still face major obstacles to accessing Comprehensive Abortion Care (CAC). Two of the most evident barriers impeding women from receiving CAC are a lack of awareness about reproductive rights, including safe abortion services as well as gaps in availability and accessibility of services.

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<sup>1</sup> Pathfinder International Ethiopia: Feature Stories. "Youth in Need of Services in Ethiopia: Pathfinder Working to Ensure Needs Are Met." Apr. 2008.

Ethiopia is one of the world's most culturally, geographically and economically diverse countries. The estimated population is 82,544,840, consisting of more than 100 ethnic groups who speak over 100 different languages and dialects.<sup>2 3 4</sup> There are vast disparities between urban and rural areas; with only about 15 percent of the population being urban.<sup>5</sup> Government-provided reproductive health resources are generally concentrated in urban areas. Rural Ethiopians lack awareness of reproductive health services and access to them. Ethiopia remains one of the poorest nations of the world, ranked 170 out of 177 countries in the 2006 Human Development Index (HDI)<sup>6</sup> and 92 out of 95 according to the Human Poverty Index (HPI).<sup>7</sup> The low indices reflect challenges in addressing reproductive health needs of Ethiopians. According to recent data, the government allocates 2.7 percent of GDP to the health sector.<sup>8</sup> Low socio-economic status further marginalizes the rural population thereby limiting access to resources and knowledge. Women's health and socio-economic status also remain precarious.

In 2005, Ethiopia's maternal mortality ratio was an estimated 720 deaths per 100,000 live births, compared to South Africa's estimated ratio of 400 deaths and the United States estimated ratio of 11 deaths per 100,000 live births.<sup>9</sup> The leading cause of maternal mortality and morbidity is unsafe abortion, defined by the World Health Organization (WHO) as "the termination of an unintended pregnancy either by persons lacking the necessary skills or in an environment lacking the minimal medical standards, or both."<sup>10</sup> The limited resources and knowledge of reproductive health rights hinder Ethiopian women's ability to seek safe abortion services. An estimated 1,209 of every 100,000 women, attempting to terminate a pregnancy will die as a result of abortion complications.<sup>11</sup> Hospital studies show that only tuberculosis kills more women than abortion related issues.<sup>12</sup>

Two critical aspects of improving implementation of CAC are raising awareness and increasing access to resources for both women and health care providers. Women cannot seek safe abortion care if they do not first, have knowledge of the availability of services and second, have access to resources and services. It is critical to expand access to safe abortion care by increasing awareness of the existing policies and services through

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<sup>2</sup> Ahmed, J., Angeli, A., Biru, A., Salvini, S. "Gender Issues Population and Development." Central Statistical Authority (CSA) and Institute for Population Research-National Research Council. Oct. 2001.

<sup>3</sup> CIA World Factbook. "Ethiopia." July 2008. <https://www.cia.gov/library/publications/the-world-factbook/geos/et.html>

<sup>4</sup> According to the Federal Democratic Republic of Ethiopia Ministry of Health, the population in Ethiopia is 77,127,000. This figure was estimated in 2006. The FMOH has not yet updated their statistics, therefore for purposes of this brief, the CIA World Factbook's data will be used.

<sup>5</sup> Library of Congress, Federal Research Division. "Country Profile: Ethiopia." April 2005.

<sup>6</sup> IRIN Humanitarian News and Analysis. "Federal Democratic Republic of Ethiopia: Humanitarian Country Profile." Feb. 2007.

<sup>7</sup> The Federal Democratic Republic of Ethiopia. "Report on Progress in Implementing the World Fit for Children Plan of Action in Ethiopia." Addis Ababa, June 2007.

<sup>8</sup> UNDP. "The Human Development Reports: Ethiopia Report 2007/2008." Data was calculated in 2004.

<sup>9</sup> World Health Organization. "Maternal Mortality in 2005." 2007 [http://www.who.int/reproductive-health/publications/maternal\\_mortality\\_2005/mme\\_2005.pdf](http://www.who.int/reproductive-health/publications/maternal_mortality_2005/mme_2005.pdf)

<sup>10</sup> World Health Organization. "Preventing Unsafe Abortion." [http://www.who.int/reproductive-health/unsafe\\_abortion/index.html](http://www.who.int/reproductive-health/unsafe_abortion/index.html)

<sup>11</sup> IRIN Humanitarian News and Analysis. "Ethiopia: High Death Rate from Illegal Abortion." Oct. 2002.

<sup>12</sup> Ibid.

community-level educational initiatives. Improving access also includes increasing the number of health care providers skilled in CAC. When services are easily attainable and affordable, a woman's ability to access safe abortion services is increased. In order to increase women's access to services, providers must be sensitive and understanding of women's needs and use appropriate technology.<sup>13</sup> In an effort to create sustainable safe abortion care it is important to identify the gaps in awareness and access in order to break down the barriers faced by women and health care providers.

## II. National and International Law and Policy

Over the past two decades, the international community has increasingly recognized the need to improve maternal health and protect reproductive rights. However, the Ethiopian government has historically played a limited role in providing adequate reproductive health services, educational initiatives and access to resources for its population. The *Penal Code of Ethiopia 1957* permitted abortion only to save the life or health of a woman. In order for a woman to have an abortion, visible signs of suffering were required. In addition, termination of pregnancy had to be diagnosed and certified in writing by a health care provider and two doctors had to authorize the procedure. Health care providers were subject to prosecution if they terminated a pregnancy based on false information provided by a woman.<sup>14</sup> The restrictive penal code, coupled with lack of access to reproductive health services, contributed to a higher use of unsafe abortion services.

In 1981, Ethiopia ratified the *UN Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)*.<sup>15</sup> Article 12(2), emphasizes that as a precondition to uphold women's human rights, it is the state's responsibility to "...ensure to women appropriate services in connection with pregnancy, confinement, and the post-natal period..."<sup>16</sup> As such, improving access to safe abortion services is an essential component of ensuring women's human rights. In 1993, the *National Policy on Ethiopian Women* addressed the affairs of women, in particular, disparities relating to health, harmful customs and practices and education.<sup>17</sup> Despite Ethiopia's official acknowledgement of its responsibility to uphold the rights of women, women still continue to be denied basic human rights.

In 1993, Ethiopia developed a decentralized health policy, creating the *Health Sector Development Program (HSDP)*, which incorporated a 20-year health development strategy launched in 1997 and now in its third phase (HSDPIII). In addition, the *Health Extension Program (HEP)* increased distribution of services and resources to rural Ethiopia. Both the health policy and the HSDP call for a democratization and

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<sup>13</sup> Hyman, A., Kumar, A. "What is woman-centered comprehensive abortion care?" *Ipas*. Sept. 2003.

<sup>14</sup> Federal Democratic Republic of Ethiopia. "The Penal Code of Ethiopia 1957." July 1957.

<sup>15</sup> Division for the Advancement of Women: Department of Economic and Social Affairs. "United Nations Convention on the Elimination of All Forms of Discrimination Against Women." 1979.

<sup>16</sup> *Ibid.*

<sup>17</sup> Ahmed, J., Angeli, A., Biru, A., Salvini, S. "Gender Issues Population and Development." Central Statistical Authority (CSA) and Institute for Population Research-National Research Council. Oct. 2001.

decentralization of health services, preventive health care, capacity building, self-reliance, promotion of inter-sectoral activities and participation of the private sector and NGOs.<sup>18</sup>

In 1994, Ethiopia adopted its current Constitution and the Federal Democratic Republic of Ethiopia was established in 1995. In 1999, WHO issued an *Assessment of Reproductive Health Needs in Ethiopia* identifying quality of available services as a major limitation to the access of safe abortion services. Poor quality was marked by inadequate provider knowledge and skills, inconsistent training, inadequate monitoring and supervision and lack of appropriate technical guidelines or manuals.<sup>19</sup> Since then, the government has taken a more progressive and proactive stance on abortion care. Today, international human rights organizations and Ethiopia's constitutional and national policies provide a basis for government efforts to improve abortion care and reduce the high rate of maternal mortality and morbidity.

As one of 147 countries present at the Millennium Summit in 2000, Ethiopia made a commitment to implement and enforce policies meant to improve the quality of life for all Ethiopians by 2015. The MDGs reflect a commitment to improving access and education relating to reproductive health through promoting gender equality and empowering women, improving maternal health and achieving universal primary education by 2015.<sup>20</sup> Ethiopia, as a party, is devoted to developing and implementing strategies that will comply with and enforce the *Millennium Development Goals* (MDGs). Other notable international initiatives focused on improving the status of women are *The Tehran Proclamation*, Fourth World Congress on Women and the International Conference on Population and Development (ICPD).<sup>21</sup>

Seeking to build on the MDG momentum, in 2006, the Ethiopian government launched the *National Reproductive Health Strategy 2006-2015* (NRHS) to meet reproductive health needs of Ethiopia's culturally diverse population. NRHS is focused on three priorities; the first is a commitment to achieving promotion of gender equality and improvement of maternal health. The second priority addresses socioeconomic and demographic inequities, such as the urban-rural disparity. The third is to build on strides established in the past decade to improve the reproductive health of Ethiopians. Another government advancement is the *National Adolescent and Youth Reproductive Health Strategy 2007-2015* (AYRH), launched in 2007. The AYRH goal is to improve the well-being and reproductive health of young people ages 10-24 in Ethiopia, so they may utilize fully, reproductive health information and services and be empowered to make informed decisions about their lives.<sup>22</sup> The recent policies demonstrate Ethiopia's

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<sup>18</sup> Lakew, Zufan Dr., Hiwot G., Yirgu Dr., Abdella, A. Dr. "Assessment of Policy and Operational Gaps Limited the Use of Long Acting and Permanent Methods of Contraception in Ethiopia." June 2008.

<sup>19</sup> World Health Organization. "An Assessment of Reproductive Health Needs in Ethiopia." 1999.

<sup>20</sup> Development Planning and Research Department Ministry of Finance and Economic Development. "Ethiopia: The Millennium Development Goals (MDGs) Needs Assessment Synthesis Report." Addis Ababa. 2005.

<sup>21</sup> Federal Democratic Republic of Ethiopia Ministry of Health. "Technical and Procedural Guidelines for Safe Abortion Services in Ethiopia." June 2006.

<sup>22</sup> Federal Democratic Republic of Ethiopia Ministry of Health. "National Adolescent and Youth Reproductive Health Strategy." 2007.

commitment to enhancing and expanding health services and awareness through educational initiatives.

On May 9, 2005, the Ethiopian parliament revised the country's antiquated penal code, paving the way for major reform of the law related to abortion. According to the new law a woman can legally terminate a pregnancy under the following circumstances:

- When pregnancy results from rape or incest
- When the health or life of the woman and the fetus are in danger
- In cases of fetal abnormalities
- For women with physical or mental disabilities and for minors who are physically or psychologically unprepared to raise a child

The revised law also notes that poverty may be grounds for reducing the criminal penalty for abortion.<sup>23</sup> Although abortion is legal under certain circumstances, it may be still punishable by up to three years in prison.<sup>24</sup>

In June 2006, a group of concerned international and national nongovernmental organizations and the Federal Democratic Republic of Ethiopia Ministry of Health (FMOH) issued the *Technical and Procedural Guidelines for Safe Abortion Services in Ethiopia*.<sup>25</sup> These guidelines are an official interpretation of the law on safe abortion services<sup>26</sup> and use two approaches: women-centered care and post-abortion care. Women-centered care accounts for “the various factors that influence a woman’s individual mental and physical health needs, her personal circumstances and her ability to access services.”<sup>27</sup> Post-abortion care is “a service-delivery strategy that includes: emergency health services (treatment of complications of spontaneous or unsafely induced abortion); post-abortion counseling and family planning services; and links to other reproductive health care services.”<sup>28</sup> These safe abortion services are in place to guide women in taking full advantage of their reproductive rights. The guidelines provide the “timing and place” for terminating pregnancy, which should be performed within three days of a woman’s request, during which counseling and diagnostic measures necessary for the procedure are done. The guidelines also give specific implementation guides for each revised penal code article such as: a woman seeking an abortion on the grounds of rape or incest is not required to submit evidence of act, nor identify the offender; a woman does not have to show signs of ill health to request a termination of pregnancy; a woman seeking an abortion on the grounds that she is a minor and unable to care for the child, is

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<sup>23</sup> Federal Democratic Republic of Ethiopia. “The Criminal Code of the Federal Democratic Republic of Ethiopia.” May 2005.

<sup>24</sup> Basu, R. “Ethiopia Part 4: Africa’s Abortion Law Offer Lessons of Hardship.” The Des Moines Register. Oct. 2006.

<sup>25</sup> The group included representatives from Ipas, the Ethiopian Society of Obstetricians & Gynecologists (ESOG), the Ethiopian Nurse Midwives Association, the Family Guidance Association of Ethiopia, the Ethiopian Public Health Association and representatives from the Ministry of Health’s Family Health Department.

Ipas. “Moving Forward: Ethiopia Develops New Safe Abortion Guidelines.” Aug. 2006.

<sup>26</sup> Federal Democratic Republic of Ethiopia Ministry of Health. “Technical and Procedural Guidelines for Safe Abortion Services in Ethiopia.” June 2006.

<sup>27</sup> UNFPA Global Population Policy Update. “Ethiopian Health Ministry Adopts Technical and Procedural Guidelines for Safe Abortion Services.” Jan 2008. [www.unfpa.org/parliamentarians/news/newsletters/issue77.htm](http://www.unfpa.org/parliamentarians/news/newsletters/issue77.htm)

<sup>28</sup> Population Council. “Reproductive Health, Postabortion Care.” Mar. 2008.

not required to prove she is under 18 (the provider will use the stated age on the medical record).<sup>29</sup> The guidelines also state that a provider will not be held accountable if a woman provides incorrect information.<sup>30 31</sup> This is important because it is likely that most providers are not aware of this provision and withhold services out of fear of prosecution. Furthermore, the guidelines state that a highly developed referral system is essential to providing safe abortion services. Health care providers have an ethical obligation to direct women to a health facility that will provide suitable services.<sup>32</sup> The health provider in charge should make the referral.

The history of policy and action in Ethiopia emphasizes the restrictions of lack of awareness and access, which contribute to the high rates of unsafe abortion and thus high rates of maternal mortality and morbidity. Although the revised penal code is a tremendous reform, there are significant gaps in its implementation. In particular, dissemination of information about the new abortion law has been weak, and many within the health care system as well as the general population have limited knowledge about the issue. For example, many women and health care providers are not aware that poverty is an extenuating circumstance under which to have an abortion.<sup>33</sup> For the future success and implementation of the penal code, it is imperative to clarify to women and providers the circumstances under which abortion is legal and how the law is interpreted.

The recently developed policies, strategies and implementation guidelines reflect the government's commitment to raise awareness and increase access to safe and comprehensive reproductive health services. However, despite progress there remain major gaps between policy and action.

## **A. Comparative Studies**

### **1. Policy**

For the purposes of this study and to better understand the history and current situation of abortion care in Ethiopia it is beneficial to study other countries where abortion reform has been attempted and/or implemented. A case in point is South Africa, where lessons learned provide insight on abortion law. It is helpful to study the liberalization of South Africa's abortion law because South Africa's history of restrictive laws on reproductive health under apartheid negatively affected women's rights similarly to Ethiopia's history of restrictive laws. Women's low social status in Ethiopia and South Africa has contributed to limited access to safe abortion services, which has been and continues to be a major contributing factor to high rates of mortality and morbidity in both countries. Even though Ethiopia is at a different stage of economic and social development than South Africa, important comparisons may still be drawn.

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<sup>29</sup> Federal Democratic Republic of Ethiopia Ministry of Health. "Technical and Procedural Guidelines for Safe Abortion Services in Ethiopia." June 2006.

<sup>30</sup> Ibid.

<sup>31</sup> Family Health Department, Federal Ministry of Health. "Strategic Scheme to Roll Out Comprehensive Abortion Care in the Ethiopian Health System 2008-2010." 2008.

<sup>32</sup> Federal Democratic Republic of Ethiopia Ministry of Health. "Technical and Procedural Guidelines for Safe Abortion Services in Ethiopia." June 2006.

<sup>33</sup> Interview with Dr. Muhidin Banko, EngenderHealth. Nov. 2008

Historically, South Africa's high number of unsafe abortions stemmed from discrimination of women's reproductive rights under apartheid. Further, a lack of health care facilities and resources hindered the ability of women to have a safe abortion. In 1975, the South African government passed the *Abortion and Sterilization Act*, which provided that abortions could be carried out under certain circumstances. These include "...when a pregnancy could seriously threaten a woman's life or her physical or mental health; could cause severe handicap to the child; or was the result of rape (which had to be proved), incest or other unlawful intercourse, such as with a woman with a permanent mental handicap."<sup>34</sup> However, the *Abortion and Sterilization Act* required two doctors' permission for the abortion to occur. Due to stigma, this was almost impossible. Thus, the act ultimately had little effect on reducing unsafe abortions. The number of women who visited hospitals due to incomplete abortions continued to grow and strain the health care system. The South African government recognized further reform of the 1975 act was needed. African National Congress (ANC) leaders proposed improvement of reproductive health policies, calling for expanded access to abortion and for legalized abortion. The proposed reform passed—a monumental step towards protecting women's reproductive rights.

In 1997, South Africa became the first country in the world to legislate access to abortion services.<sup>35</sup> After years of debate, the government of South Africa passed the *Choice on Termination of Pregnancy Act* which grants a woman the legal right to terminate a pregnancy. A woman need not consult with anyone, even her husband. Further, the act "encouraged the development and integration of abortion as part of reproductive health services at the primary health care level."<sup>36</sup> According to the new law, abortion is permitted if a woman is less than 12 weeks pregnant. Women who are between 13 and 20 weeks of gestation can seek abortion services if a health care provider believes that the pregnancy may threaten the mental or physical health of the woman or fetus, if the pregnancy resulted from rape or incest, or if it negatively affects the woman's socio-economic situation. A woman may terminate a pregnancy after the 20<sup>th</sup> week, only if a doctor or trained midwife finds that continuing the pregnancy would threaten the woman's health or result in severe handicap to the fetus.<sup>37</sup> In South Africa it is most often only medical doctors who may perform abortions, though it is permissible for properly-trained nurses to do so, but only up to the 12<sup>th</sup> week of pregnancy. Health care providers are given the option, if specially trained, to perform an abortion. The government has ruled, however, that trained health care providers are obligated to perform an abortion if the woman's life is in danger. The government also ruled that it is the duty of all doctors, nurses and health care providers to inform the woman that she has the right to abort the fetus. In South Africa, abortion is free at almost all government run health facilities. By law, all health care facilities must provide abortion and reproductive

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<sup>34</sup> Guttmacher, S., Kapadia, F., Naude, J., de Pinho, H. "Abortion Reform in South Africa: A Case Study of the 1996 Choice on Termination of Pregnancy Act." Guttmacher Institute. *International Family Planning Perspectives*. 24(4) Dec. 1998.

<sup>35</sup> National Abortion Federation. "South Africa." Feb. 2006.

<sup>36</sup> *Ibid.*

<sup>37</sup> Guttmacher, S., Kapadia, F., Naude, J., de Pinho, H. "Abortion Reform in South Africa: A Case Study of the 1996 Choice on Termination of Pregnancy Act." Guttmacher Institute. *International Family Planning Perspectives*. 24(4) Dec. 1998.

health counseling. Unfortunately, studies show that some health care providers do not counsel the woman if she does not request it. Medical abortion is the most common method used in South Africa.<sup>38</sup> A medical abortion refers to “pregnancy termination with abortion-inducing medications in lieu of surgical intervention. The most common regimen includes two medications: mifepristone, followed by 1-2 days by misoprostol.”<sup>39</sup>

As per the *Technical and Procedural Guidelines for Safe Abortion Services in Ethiopia*, skilled health care providers at all health facilities equipped with the appropriate supplies and equipment can perform an abortion if the gestation period is less than 12 weeks. Between 13 and 28 weeks, abortions must be performed at secondary or tertiary level health facilities by general medical practitioners (GMPs) or obstetrician-gynecologists (OB/GYNs). Legal abortions in Ethiopia are not free. Medical abortions are administered up to nine completed weeks since the last normal menstrual period (LNMP) and for pregnancies within 12 weeks of gestation from the first day of the LNMP. The preferred method of termination is manual or electric vacuum aspiration. According to the guidelines, dilation and sharp metallic curettage should be used only when medical methods are not available.<sup>40</sup>

Ethiopia’s 1957 penal code resembled South Africa’s 1975 *Abortion and Sterilization Act* in that both restricted women’s right to legal abortion, resulting in an increased number of women seeking unsafe abortions. The South African government recognized the 1975 act’s detrimental effects and passed the *Choice on Termination of Pregnancy Act* in 1996.<sup>41</sup> The ANC procured passage of the abortion legislation and began to implement the law on all levels including primary care. South Africa’s new law provides for increased access to abortion services and resources as well as expanded educational initiatives. The purpose of these initiatives is to inform women of their reproductive rights and providers of their responsibility to counsel women and perform abortion services. Ethiopia took similar steps by passing the revised penal code in 2005. In 2006, the *Technical and Procedural Guidelines for Safe Abortion Services in Ethiopia* provided an official interpretation of the law. Although Ethiopia has made strides, further action is necessary to bridge the gap between policy and action. Ethiopia can draw from the actions of South Africa to institute methods of expanding and enhancing safe abortion care. In order to do this, it is imperative that governmental, nongovernmental organizations and community leaders take collective action towards raising awareness and increasing access to safe abortion services.

## 2. Women’s Groups

Although political, economic and social conditions vary from one country to another, the negative effects of conditions such as poverty, inequity and persistent denial of basic

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<sup>38</sup> National Abortion Federation. “South Africa.” Feb 2006.

<sup>39</sup> Ibid.

<sup>40</sup> Federal Democratic Republic of Ethiopia Ministry of Health. “Technical and Procedural Guidelines for Safe Abortion Services in Ethiopia.” June 2006.

<sup>41</sup> Guttmacher, S., Kapadia, F., Naude, J., de Pinho, H. “Abortion Reform in South Africa: A Case Study of the 1996 Choice on Termination of Pregnancy Act.” Guttmacher Institute. *International Family Planning Perspectives*. 24(4) Dec. 1998.

human rights often transcend national borders. It is to this effect that we may and should compare the experiences of other nations and people, in an attempt to apply lessons learned for the betterment of those affected by similar conditions. In Ethiopia, as in many countries around the world, women's social status is subordinate to that of men. Despite this inequity, examples abound of women coming together to take brave steps to break stereotypes and deeply rooted barriers thus creating meaningful change and improving their own well-being and that of others. One example can be drawn from a group of empowered Azerbaijani women displaced as a result of political conflict between Armenia and Azerbaijan, who live in poverty stricken and unsanitary refugee camps. Started by a woman who herself was displaced, the Women Initiative Group aims to help women who are trying to reintegrate into rural communities and cities. The group works to improve educational opportunities for girls by tackling traditions such as early marriage that inhibit and discourage girls' education. The group also aims to enhance women's self-determination and empower them to make decisions relating to their reproductive health. For example, through organized seminars on family planning, women are encouraged to use contraception rather than abortion as a means of birth control. As a result of the Women Initiative Group's hard work, a local hospital made a commitment to provide free care to women enduring various reproductive health issues.<sup>42</sup>

The Women Initiative Group is one example of the positive change women can create through collective effort, raising awareness through education and empowerment. It is also an example of how political, economic and social conditions impact reproductive health. In Ethiopia, many young girls and women are unaware of their rights to a legal and safe abortion. They also lack self-determination to access information and services relating to CAC. South Africa and the Women Initiative Group are two examples that illuminate the need for expanding women's ability to potentially improve reproductive health.

### **III. Obstacles to Awareness and Access**

In Ethiopia, unsafe abortion is closely related to poverty, social inequity and a persistent systematic denial of women's human rights. Women often lack access to the most basic preventive reproductive health care information and services. Based on available research, it is evident that awareness and access are the two foremost areas where improvement in CAC is necessary and possible. These two aspects have significant influence on abortion care, both individually and collectively. It is important to understand the ways in which they reinforce one another. In order to increase access to CAC it is imperative to raise awareness for both women and health care providers on the recently revised Ethiopian penal code, the stigma associated with abortion, the availability of abortion services and women's reproductive rights. With increased knowledge and awareness, women may be empowered to seek safe abortion care. Educating providers on their responsibility to uphold and implement the laws of the penal code will increase women's access to safe abortion services. An environment where

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<sup>42</sup> Global Fund for Women. "Women's Initiative Group: Success Stories." 2008.  
<http://www.globalfundforwomen.org/cms/success-stories/initiative-group-azerbaijan.html>

women and health care providers are knowledgeable of the prevailing law and how to access resources and services will help reduce the rate of maternal mortality and morbidity.

Although important factors such as high fertility rates, low contraceptive use, harmful traditional practices (HTP) such as early marriage, female genital mutilation (FGM), domestic violence and low female literacy contribute to the significant gap between law and implementation of CAC, it is important to have a pragmatic, targeted approach when considering possible interventions. The two areas where reform is necessary and possible are awareness and access. In order to improve women's reproductive health, women must be aware of the services that exist and how to access them.

### **A. Obstacles to Raising Awareness**

Awareness is knowledge gained through means of information. When a population is aware of its rights, people are more inclined to demand that their basic human needs are met. Education is one of the tools to raise awareness and is critical to the successful development of a country. Education can also have a formidable impact on issues such as reproductive health. When knowledge of reproductive health rights is disseminated to women they become empowered to seek health services. Importantly, Ethiopia's educational and community-based initiatives lack a curriculum geared towards educating Ethiopians about reproductive health issues, particularly in rural areas. Until recently, there has been low importance placed on increasing awareness through educational initiatives. In view of the gravity of the current reproductive health problems, and as the Ministry of Education (MOE) is the sole responsible body for reproductive health educational initiatives in schools,<sup>43</sup> it is imperative to raise awareness on a community level.

The FMOH has been working in collaboration with governmental and nongovernmental organizations in an effort to emphasize education and its direct correlation to women having better control over their reproductive rights. The link between the status of women and education is implicit in that education demands literacy and knowledge and exposure to new ideas including the right to have a legal abortion. When women have more power over their lives and obtain more rights and autonomy in a social, political and economic sense, they are more likely to control their own fertility and reproductive health.<sup>44</sup>

### **1. Youth and Women**

Young people aged 10-24 make up 30 percent of the total population.<sup>45</sup> As adolescents enter adulthood, they form the backbone of Ethiopian society. The vision of the FMOH, MOE and NGOs is to create a sustainable environment for youth where they can develop

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<sup>43</sup> Federal Democratic Republic of Ethiopia Ministry of Health. "National Adolescent and Youth Reproductive Health Strategy 2006-2015." 2007.

<sup>44</sup> Ahmed, J., Angeli, A., Biru, A., Salvini, S. "Gender Issues Population and Development." Central Statistical Authority and Institute for Population Research-National Research Council. Oct. 2001.

<sup>45</sup> Federal Democratic Republic of Ethiopia Ministry of Health. "National Adolescent and Youth Reproductive Health Strategy 2006-2015." 2007.

mentally and physically. The goals include: enhancing reproductive and basic health services, increasing access to social services, expanding and enhancing the education system and developing educational and social initiatives. According to one expert on youth programming, ensuring girls access to information and services is dependent upon collaboration between decision makers at the national policy level, health care advocates, local NGOs and community and religious leaders.<sup>46</sup> In working towards achieving the aforementioned goals, it is necessary to promote the education of girls and improve women's awareness of their reproductive rights, as well as recognize their diverse religious, ethnic and socioeconomic needs. Thus far, several initiatives have been developed. Since 2002, the Ethiopian Youth Forum has worked to lobby the government to strengthen, enhance and expand the education system to include as many Ethiopian children as possible. Also, UNICEF, the World Bank and other partners are working to strengthen basic education with the *School Fee Abolition Initiative* in order to increase attendance.<sup>47</sup> The 2006 *National Adolescent and Youth Reproductive Health Strategy* (AYRH) is an attempt to reach out to adolescents, one of Ethiopia's most vulnerable populations. The Ethiopian government recognized the vast and diverse needs of this group, and launched AYRH in an attempt to improve access to quality reproductive health information and services.<sup>48</sup>

The MOE's *Basic Education Programme* supports the government's third *Education Sector Development Program* through a collection of initiatives that include the *Girl's Education Initiative* (GEI), options for additional basic education and the endorsement of the cluster school model (a basic unit of local management of primary education).<sup>49</sup> The *Girls' Education Initiative* addresses the gender gap in net enrollment ratios. The purpose of this is to: make schools more child and girl friendly, encourage community dialogue on the importance of girls' education and address harmful traditional practices. Further, rural and marginalized youth can have the option to attend alternative basic education centers.<sup>50</sup> These strategies and initiatives are crucial because in order to improve women's health and ultimately reduce unwanted pregnancy and unsafe abortion, girls must be educated from an early age about their reproductive rights and their rights as women.

The Ethiopian FMOH notes that only 18.5 percent of women are literate.<sup>51</sup> Not only are higher levels of education associated with better maternal health and reduced maternal mortality, but such low literacy rates further alienate women from gaining access to the knowledge and awareness of existing and available services. Illiterate women are harder to reach by advocacy campaigns, due to lack of access to media resources. Despite education reform and NGO efforts, girls still lack adequate education opportunities and

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<sup>46</sup> Interview with Jen Cantino, Senior Technical Advisor to the President and Youth Programming, EngenderHealth. Nov. 2008.

<sup>47</sup> UNICEF. "Ethiopian Education Statistics." <http://www.unicef.org/ethiopia/education.html>

<sup>48</sup> Federal Democratic Republic of Ethiopia Ministry of Health. "National Adolescent and Youth Reproductive Health Strategy 2006-2015." 2007.

<sup>49</sup> UNICEF. "Ethiopian Education Statistics." <http://www.unicef.org/ethiopia/education.html>

<sup>50</sup> Ibid.

<sup>51</sup> Ibid.

awareness of education resources.<sup>52</sup> An estimated 50 percent of girls do not have access to primary schools,<sup>53</sup> and those girls with access often drop out or repeat grades for economic or cultural reasons. The schools are entirely dependent on federal funding and private donors, making them extremely vulnerable. There is a lack of educational facilities and in the existing facilities, infrastructure is inadequate. Rural educational facilities are the most deficient with most resources and funding provided to schools in the capital, Addis Ababa. One study found that education directly influences access to safe abortion services, in that it is "...likely to enhance female autonomy so that women develop greater confidence and capabilities to make decisions regarding their own health. It is also likely that educated women [will] seek out higher-quality services and have greater ability to use healthcare inputs to produce better care."<sup>54</sup>

Despite, recent attempts to raise awareness about reproductive health rights, women continue to lack adequate access and resources to increase knowledge of their rights and available options. Thus, grassroots initiatives are necessary for supplementing the lack of information disseminated through educational programming in schools and communities. Although limited programs exist, an example is the work done by ACORD in Ethiopia, an organization that works with poor and marginalized people. ACORD strengthens capacity of Community Based Organizations (CBOs) and enables them to address needs of local communities. CBOs and grassroots initiatives encourage women to participate in decision-making within their communities. These initiatives bring women together and provide a space where women can learn, exchange information about health care and social services. In the process women gain confidence, receive reproductive health education and develop new skills. To build on the aforementioned community initiatives it is important to develop further community programs which target youth, in particular girls, in an effort to increase awareness of reproductive health rights and services.

## **2. Revised Criminal Code of Federal Democratic Republic of Ethiopia, 2005**

In Ethiopia, as in most developing countries, access to safe abortion continues to depend on women's awareness of the law. Despite the relatively liberal nature of the law, knowledge of legal rights remains extremely low amongst most women. Due to major misconceptions about details of the law, women often resort to utilizing unsafe services. Women, health care providers and the general population are often unaware that health care providers are obligated by law to refer women to an appropriate health facility or to a provider who will perform the abortion. As a result, most women do not seek safe abortion services although they have the right to do so under the revised penal code. Stigma is also a major factor. Shame and fear of disapproval and rejection by a husband, family and society hinder women's ability to seek adequate care.<sup>55</sup> Education of the law

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<sup>52</sup> Hare, H. "ICT in Education in Ethiopia." Survey of ICT and Education in Africa: Ethiopia Country Report. June 2007.

<sup>53</sup> Assegedetch, Haile Mariam. "Today's Children, Tomorrow's Leaders: Are We Neglecting the Agents of Change?" Northeast African Studies. Vol. 8(1) 2001.

<sup>54</sup> Mekonnen Y., Mekonnen A. "Factors Influencing the Use of Maternal Healthcare Services in Ethiopia." Journal of Health, Population and Nutrition 2003.

<sup>55</sup> World Health Organization. "Unsafe Abortion: The Preventable Pandemic." The Lancet: Sexual and Reproductive Health 4. Oct. 2006.

and women's reproductive rights will also lessen the harsh effects of stigma on women's ability to access safe abortion services.

### **3. Health Care Providers**

Health care providers must be educated on the revised penal code and its legal obligations, which they are required to fulfill. Ethiopia has a limited number of gynecologists. Midwives, health officers and nurses are allowed to perform an abortion (up to the 12<sup>th</sup> week of gestation)<sup>56</sup> but are often not properly trained. In addition, they are often unaware of the newly revised abortion laws. A study conducted by the Ethiopian Society of Obstetricians and Gynecology found that only 29 percent of health workers knew the correct provision of the penal code for termination of pregnancy.<sup>57</sup> According to an abortion care expert who is familiar with abortion in legally transitioning countries, including abortion skills as part of the training of mid-level providers, nurses and physicians, is crucial to increasing availability of safe abortion services.<sup>58</sup> Furthermore, the negative attitudes of health care providers create barriers for women in seeking safe abortion services. Providers must be educated on their ethical obligations to perform abortion services for women whose circumstances fall under the revised penal code or refer them to a physician who will. Additionally, health care providers may not be aware that according to the *Technical and Procedural Guidelines for Safe Abortion Services in Ethiopia* they will not be prosecuted if they terminate a pregnancy based on erroneous information provided by the woman.<sup>59</sup> As such, it is important for health care providers to be made as comfortable as possible in providing compassionate care in order to increase women's ease at accessing safe abortion services.<sup>60</sup> As a long-term solution to creating sustainable CAC, increasing awareness of health care providers is recommended.

#### **B. Obstacles to Access**

Increasing access to CAC requires careful consideration and understanding of the multilayered physical, legal, political, economic and cultural context of women's daily lives. Social status, level of education, community norms, standards, expectations and limited health services are all factors that determine the choices women have and their ability to exercise their right to make decisions relating to reproductive health.

#### **1. Policy Implementation and Enforcement**

Historically, the Ethiopian government and public service organizations have provided limited access to reproductive health services. Safe abortion services were largely unavailable to women for most of Ethiopia's modern history. The restrictive penal code of 1957, coupled with narrow access to family planning services, limited women's

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<sup>56</sup> Federal Democratic Republic of Ethiopia Ministry of Health. "Technical and Procedural Guidelines for Safe Abortion Services in Ethiopia." June 2006.

<sup>57</sup> Ethiopian Society of Obstetricians and Gynecologists. "KAP Study on Abortion among Ethiopian Health Workers." Nov. 2005.

<sup>58</sup> Interview with Ms. Betty Farrell, Senior Medical Associate, Integration, EngenderHealth. Nov. 2008.

<sup>59</sup> Federal Democratic Republic of Ethiopia Ministry of Health. "Technical and Procedural Guidelines for Safe Abortion Services in Ethiopia." June 2006.

<sup>60</sup> Interview with Ms. Betty Farrell, Senior Medical Associate, Integration, EngenderHealth. Nov. 2008.

options, thereby forcing them to seek unsafe abortions. The impact of restrictive laws and lack of services was far-reaching. According to CEDAW, access to services during pregnancy as well as access to safe abortion services is a critical area in need of government intervention. WHO guidelines identify essential components for the transition from unsafe to safe abortion services as: changing national policies, training providers on abortion procedures, ensuring provision of services at accessible delivery points and guaranteeing that women are accessing these services.<sup>61</sup> The revised penal code significantly liberalized abortion law and the *Technical and Procedural Guidelines for Safe Abortion Services in Ethiopia*, which followed in 2006, demonstrated a sign of significant reform in addressing women's reproductive health needs. Although the aforementioned policies, strategies and programs demonstrate significant efforts to address the population's dire and complicated reproductive health needs, the implementation of laws and policies remains limited and inefficient. Lack of enforcement mechanisms and delays in updating and disseminating pertinent regulations constrain the public's access to the much needed services.

## 2. Socio-economic Status of Women

Early marriage is a deeply ingrained cultural practice with major social and health implications. The significant age difference between a girl and her husband serves as an additional barrier to women's and girls' ability to exercise their reproductive rights. On average, girls in Ethiopia are married at the age of 16, and boys are encouraged to marry around the age of 23. Such disparity creates unfavorable power dynamics. Once married, girls tend to move in with their husband's family where they fall under the influence and control of the husband and in-laws. A Population Council study in the Amhara region found that 86 percent of girls aged 10-19, 73 percent of women aged 20-29, 66 percent of women aged 30-39 and 55 percent aged 40-45 all required permission before leaving the house.<sup>62</sup> These numbers demonstrate the extreme restrictions women face. Within a family, young married women hold the lowest social status, and are thus the most disadvantaged. Scarce household resources are first invested in the health care of husbands and children, often at the expense of women's social and health-related needs.<sup>63</sup> Basic indicators outlined in the NRHS reflect the low status of women in Ethiopian society. According to the Gender-related Development Index (GDI), which determines women's social and economic opportunities, Ethiopia ranks seventh lowest of 144 developed and developing countries.<sup>64</sup> Ethiopian women are also over 50 percent less likely to be literate than men and 30 percent less likely to be employed and generally tend to marry seven years earlier.<sup>65</sup> High dependence on husbands severely restricts women's autonomy, thereby further perpetuating their already low reproductive health and social status and limiting their ability to seek CAC services.

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<sup>61</sup> Berer, M. "Making Abortions Safe: A Matter of Good Public Health Policy and Practice." Bulletin World Health Organization. 78(5) 2000.

<sup>62</sup> UNFPA. "Leave No Woman Behind Ethiopia. Baseline Report." Population Council. 2007.

<sup>63</sup> Federal Democratic Republic of Ethiopia Ministry of Health. "National Adolescent and Youth Reproductive Health Strategy 2006-2015." 2007.

<sup>64</sup> Ibid.

<sup>65</sup> Ibid.

As Ethiopia remains one of the world's poorest countries, poverty continues to serve as a major inhibiting factor of accessing safe abortion services. It is estimated that 47 percent of the population live below the poverty line.<sup>66</sup> According to Dr. Banko, a practicing OB/GYN in Ethiopia, poverty is the number one reason behind women seeking an abortion; however, he notes that poverty is rarely used as a specific condition for having an abortion.<sup>67</sup> The average Ethiopian's income is not enough to afford medication, contraceptives or health services. According to Dr. Banko, a surgical abortion can vary from 50 Ethiopian Birr (US\$5) in a public health facility to 500 Ethiopian Birr (US\$50) in a private health facility.<sup>68</sup> Ethiopian women are able to easily obtain unsafe abortions at a minimum expense, whereas safe abortion services are costly and difficult to find.

### 3. Health Care Providers and Facilities

In rural Ethiopia, where an overwhelming majority of the population resides, adequate health facilities are scarce and those that do exist often have limited human resources and medical supplies. Acknowledging this problem, the FMOH initiated training of 30,000 new health extension workers (HEW), as part of the HSDP to work at local health posts and provide accessible services to the local population. In addition to focusing on the human resource development, the HSDP also identified the need for construction of new facilities and rehabilitation of existing ones.<sup>69</sup> Table 1 below demonstrates 2006 FMOH statistical data of the total number of selected categories of health care providers in Ethiopia.

**Table 1: Number of Available Human Resources during HSDP II and Second Year of HSDP III**

Human Resources	HSDP II (2002/03-04/05)		2 <sup>nd</sup> year of HSDP III (2006/07)	
	Total Number	Ratio to population	Total number	Ratio to population
<b>All physicians</b>	2,453	1: 29,777	1,806	1:42,706
<b>Specialists</b>	1,067	1: 68,457	974	1:79,055
<b>General Practitioners (GPs)</b>	1,386	1:52,70	832	1:92,548
<b>Health Officers (HOs)</b>	776	1:94,128	792	1:97,222
<b>Nurses, BSc* and Diploma</b>	17,300	1:4,222	18,146	1:4,250
<b>Midwives (seniors)</b>	1,509	1:48,405	1,012	1:76,086
<b>Pharmacists</b>	191	1:382,427	178	1:432,584
<b>Pharmacy technicians</b>	1,428	1:51,151	1,023	1:75,286
<b>Environmental health workers</b>	1,312	1:55,673	1,109	1:69,546
<b>Lab technicians and technologists</b>	2,837	1:25,747	1,816	1:42,400
<b>Health extension workers (HEWs)</b>			24,571	1:3,134

\*BSc refers to the Graduate Diploma in Nursing

Source: WHO. "Ethiopia's Human Resources for Health Programme." Global Health Workforce Alliance. 2006.

<sup>66</sup> Federal Democratic Republic of Ethiopia Ministry of Health. "National Adolescent and Youth Reproductive Health Strategy 2006-2015." 2007.

<sup>67</sup> Interview with Dr. Muhidin Banko, EngenderHealth. Nov. 2008.

<sup>68</sup> Ibid.

<sup>69</sup> World Health Organization. "Ethiopia's Human Resources for Health Programme." Global Health Workforce Alliance. 2006.

Despite Ethiopia's recently increased efforts to broaden the number of trained health care providers and build more health facilities the inadequate state of the health system continues to limit access to safe abortion services.<sup>70</sup> It is estimated that only one physician is available for every 35,000 people, and one midwife for every 3,756 expected deliveries.<sup>71</sup> Access to health care services is restricted due to insufficient distribution of medical supplies and a high disparity between urban and rural areas.<sup>72</sup> One study shows that in urban areas 53 percent of deliveries are attended by health care providers as compared with seven percent in rural areas.<sup>73</sup> At present, there are only 635 health centers and WHO estimates that 3,200 health centers are needed (1 for every 25,000 people).<sup>74</sup> At the hospital level there is an estimate of 0.2 beds per 1,000 people whereas a developed nation such as the United States has an estimate of 2.7 beds per 1,000 people.<sup>75</sup> The health sector is severely under-funded, with total spending of less than US\$5.6 per capita per year.<sup>76</sup> Geographical constraints remain one of the most significant barriers with over 50 percent of the population living more than 10km from the nearest health facility.<sup>77</sup> Additionally, transportation is limited and unreliable. The gravity of this situation is supported by Dr. Banko, who states that "some of the challenges in the training of OB/GYNs and other professionals are [the] shortage of supplies utilized for the service provision, poor referral linkages, lack of transportation and poorly equipped infrastructures."<sup>78</sup> As such, it is imperative to strengthen, expand and enhance training initiatives to ensure availability of safe abortion services. According to Dr. Tibebu Alemayehu, Program Manager at Ipas, mobile clinics are a form of rural outreach which may be a way of addressing the severe lack of access to health care services.<sup>79</sup>

WHO suggests the use of Manual Vacuum Aspiration (MVA) as a preferred method to provide abortions due to the fact that it is cost efficient, relatively simple and safe. MVA can be performed by mid-level medical providers. As such, this method would allow for women to have expanded access to safe abortion services at an increased number of service delivery sites.<sup>80</sup> Essential components of increasing implementation of safe abortion services are increasing service delivery points, training mid-level providers and building community awareness of where services are available.<sup>81</sup> There are numerous advantages of utilizing MVA as a preferred method of abortion. MVA allows for a wider range of providers to make available safe abortion services as well as decrease the need for a great deal of pain relief medication due to its simplicity.<sup>82</sup>

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<sup>70</sup> World Health Organization. "Health Action in Crises." Sept. 2007. [http://www.who.int/hac/crises/eth/background/Ethiopia\\_Sept07.pdf](http://www.who.int/hac/crises/eth/background/Ethiopia_Sept07.pdf)

<sup>71</sup> Federal Democratic Republic of Ethiopia. "Report on Progress in Implementing the World Fit for Children Plan of Action in Ethiopia." June 2007.

<sup>72</sup> World Health Organization. "Health Action in Crises." Sept. 2007.

<sup>73</sup> Federal Democratic Republic of Ethiopia. "Report on Progress in Implementing the World Fit for Children Plan of Action in Ethiopia." June 2007.

<sup>74</sup> World Health Organization. "Health Action in Crises." Sept. 2007.

<sup>75</sup> Kaiser Family Foundation. "State Health Facts." Aug. 2008. <http://www.statehealthfacts.org/index.jsp>

<sup>76</sup> World Health Organization. "Health Action in Crises." Sept. 2007.

<sup>77</sup> Ibid.

<sup>78</sup> Interview with Dr. Muhidin Banko, EngenderHealth. Nov. 2008.

<sup>79</sup> Interview with Dr. Tibetu Alemayehu, Program Manager, Ipas. Nov. 2008.

<sup>80</sup> World Health Organization, "Unsafe Abortion and Post Abortion Care."

<sup>81</sup> Interview with Ms. Betty Farrell, Senior Medical Associate, Integration, EngenderHealth. Nov. 2008.

<sup>82</sup> Ibid.

## **V. Recommendations**

After much research and careful consideration of knowledge and access as they relate to reproductive health in Ethiopia, we have developed four recommendations we feel may assist Ethiopia in reducing maternal mortality and morbidity by raising awareness and expanding and enhancing access to health services. The recommendations include:

- Ethiopian Oversight Taskforce (EOT)
- Ethiopian Training System (ETS)
- Community Coffee Groups (CCGs)
- Rural Mobile Clinics

### **A. Ethiopian Oversight Taskforce (EOT)**

Ensuring CAC for all Ethiopian women starts with a collaboration between the FMOH, community leaders and NGOs. Programs can be more effective when these groups work together. This collaboration should be in the form of an Ethiopian Oversight Taskforce (EOT) appointed by the FMOH, whose members should include health care providers, government officials and community and religious leaders who have a vested interest in the improvement of abortion services. The goal of this taskforce should be to create effective projects to ensure Ethiopians are educated on their reproductive rights and have access to safe health facilities and trained providers. The EOT should create and oversee projects regarding CAC such as a training system, community coffee groups and mobile clinics throughout Ethiopia.

The first objective of the EOT shall be to create training curriculums for implementation by the aforementioned projects. The curriculum for the Ethiopian Training System (ETS) shall educate providers about the revised penal code and sensitize them on ethical issues of providing abortion services. The curriculum will also include pre-service and in-service clinical training as well as how to use appropriate medical technology. The EOT should develop a curriculum specifically addressing the diverse needs of youth as highlighted in the AYRH. This curriculum will also pertain to the health providers who work in the mobile clinics.

The curriculum for the community coffee groups should educate community leaders on how to facilitate an open discussion and a safe space for women to feel comfortable discussing issues relating to reproductive health. The curriculum will also educate community leaders on how to increase women's awareness of the revised penal code and their reproductive rights.

The second objective shall be to appoint a team of health care providers known as the training committee within the ETS, community leaders who will facilitate the coffee groups and health care providers who will work in the mobile clinics and facilitate the various projects throughout the program.

The third objective of the taskforce shall be to address the issue of access by designing and creating a system of mobile clinics. The taskforce should determine a route bearing in mind the rainy season. The vehicles should be all terrain buses with space for two single beds and an adequate bathroom. Furthermore, the taskforce must follow the *Technical and Procedural Guidelines for Safe Abortion Services in Ethiopia* in determining supplies and resources to be stocked in each mobile clinic. The taskforce should oversee the process so all women can have full access to the mobile clinics and its resources.

The fourth objective shall be to appoint a monitoring and evaluation team to monitor all projects of the program. In order to achieve this, it is recommended that the EOT develop a method to assess the ETS throughout the program. A checklist of health care, reproductive health and family planning issues should be created. The monitoring and evaluation team must be led by FMOH officials, as that office's involvement is critical to long-term success. In addition to their FMOH jobs, the team will travel to the health care facilities once every six months beginning at the start of the second year. They will evaluate if health care providers are delivering the safe abortion services they are responsible for by law and if more women are seeking CAC at the health care facilities in order to determine if the ETS is successful. The monitoring and evaluation team will use the *Technical and Procedural Guidelines for Safe Abortion Services in Ethiopia* as a guide. At the end of each year the team will convene at the FMOH headquarters to draft a report of their findings to be distributed to the EOT and presented at the following seminar.

The proposed government-led EOT will be different from pre-existing efforts, which have been primarily NGO-based. For effective implementation of the aforementioned recommendations, it is important that the EOT is established in the first six months. It is essential for the taskforce to meet biannually to assess the improvement and the quality of abortion care throughout Ethiopia.

## **B. Ethiopian Training System (ETS)**

We highly recommend that an expanded and improved training system be developed within the first year of the program. The training committee chosen by the EOT should develop and hold initial training seminars pertaining to CAC. The committee should consist of 10 health care providers chosen and trained by the EOT within the first six months of the project. The committee will then select one OB/GYN and one mid-level provider from each region. The selected health care providers will be trained at their respective regional health facilities during the second half of the first year. The goal of this recommendation is to educate health care providers on the recently revised abortion law and the technical guidelines relating to safe abortion services. Additionally, providers must be trained in appropriate medical procedures to implement safe abortion services. These trainings are meant to build on the *Technical and Procedural Guidelines for Safe Abortion Services in Ethiopia*. In order to increase the skills and performance of providers, pre-service and in-service trainings are critical. Trained health care providers who are knowledgeable of the law and the legal obligations, which they are required to

fulfill, are a crucial component of revamping the Ethiopian health care system and reducing the number of unsafe abortions.

The first objective of this goal is to increase knowledge of abortion services among Ethiopian health care providers by training them on key abortion related issues, providing refresher seminars for providers, addressing stigma related to performing abortion procedures, disseminating information about the penal code and the responsibility of health care providers in delivering safe abortion services. The training committee should implement the intensive training curriculum designed by the EOT for health care providers. This will include a facilitator's manual to be used by health care providers to deliver safe services in health care facilities throughout Ethiopia.

Next, the committee should design and implement the seminars which health care providers will be required to attend. The seminars should be run in collaboration with a local public or private hospital. The facilitators, selected by the EOT from a combination of regional hospitals and community health care facilities throughout Ethiopia, should lead the seminars and teach health care providers. A quarterly seminar outlining key abortion related issues, stigma related to performing abortion procedures, information about the penal code and the responsibility of health care providers in delivering abortion services should be provided initially within the first year of the program at each health facility. In subsequent years, the seminars will be held once every six months at regional hospitals. The seminars should train mid-level providers in safe abortion services at all health care facilities. Ultimately, there should be an increased number of trained providers. The seminars should attempt to dispel common misconceptions that fuel stigma and discrimination, address erroneous knowledge of the existing abortion law and address traditional beliefs that inhibit provision of safe and adequate abortion services. The seminars should build the capacity of local health providers' to be able to provide safe abortion services. The seminars given during the first year will educate health providers on how to perform MVA. These skills will also be taught during subsequent years but an emphasis will be placed on training during the first year. Furthermore, it is imperative to sensitize providers to the needs of youth. It is recommended that the aforementioned curriculum include a youth component. The curriculum will be presented during the seminars.

The second objective of the ETS is to build sustainable support networks, which will encourage providers to feel protected when performing abortion services. This follows the aforementioned *Technical and Procedural Guidelines for Safe Abortion Services in Ethiopia*. With increased support, providers are more likely to provide sustainable safe abortion services. In order to achieve this objective it is recommended that a refresher session be designed by the EOT and conducted by members of the training committee who will act as facilitators. The sessions will be community-based, run and attended by health care providers. The purpose is to discuss successes and find solutions to the challenges facilitators may be facing, and to offer health care providers up-to-date information on abortion care. It will also conduct teach-back sessions where facilitators will demonstrate small sessions of the curriculum and receive feedback and have open discussions. The sessions should be conducted every six months after the initial year of

the program. However, it is the discretion of the facilitators and providers if they should choose to hold sessions more often. It is recommended that a portion of the session be open to the public. Community members, hopefully women, will provide feedback to the health care providers at the specific health care facility.

### **C. Community Coffee Groups (CCGs)**

Coffee ceremonies are a deeply valued tradition within Ethiopian society. Traditionally, Ethiopian women play a central role in the ceremonies. Since coffee is an integral part of Ethiopian society, we propose establishment of coffee groups as safe and casual spaces where women can discuss sensitive issues relating to their reproductive health and serve as spaces for dissemination of information and education of reproductive rights. The goal of this recommendation is to encourage self-determination and empower women to make healthy and safe decisions pertaining to their reproductive health, thereby elevating women's social and health status within their communities.

Acknowledging the complex social and health needs of Ethiopian girls and women, it is necessary to scale up the number of outreach programs and enhance community support. The objective of the community coffee groups is to serve as safe spaces for women of all ages where they can build support networks as well as gain and share information relating to their overall health and reproductive rights. For this purpose it may be effective to use the idea of existing traditional practices such as coffee ceremonies as a means to disseminate knowledge of the revised penal code and raise awareness of where and how to access CAC. In these groups women can learn the specifics of the law as it pertains to abortion, share common experiences, exchange thoughts and feelings, as well as raise questions and concerns relating to their reproductive health. It is important to stress that the purpose of these groups is not to advocate abortion, but create spaces for open, public dialogue and discussion on the existing law.

The community coffee groups, established by the EOT, should be conducted at the beginning of the second year of the program and subsequently held monthly. These groups will be facilitated by community-based leaders who have been trained by the aforementioned training committee and implement a curriculum created by the oversight taskforce. The facilitators will deliver information in a clear and culturally sensitive manner, teaching women about their reproductive health rights as stated in the revised penal code and where and how to access safe abortion services. During these groups issues of stigma, discrimination, gender inequalities and a host of traditional practices will be addressed as well. Community-based leaders on the EOT should be encouraged to inform women on the newly established coffee groups throughout the community by spreading information where women gather such as markets, community wells and health facilities. The facilitators should distribute educational materials, such as pamphlets with words and pictures of safe abortion services, disseminate knowledge of how to access safe abortion services in their region and provide schedules of upcoming mobile clinics.

#### **D. Rural Mobile Clinics (RMCs)**

We propose a system of rural mobile clinics (RMCs), designed by the EOT, to travel throughout rural communities and provide safe comprehensive abortion services to women who have no means of reaching existing health facilities. Due to the sparsely located existing health facilities in rural Ethiopia, it is important to make it as easy as possible for women to seek and access safe abortion services. Women can recognize RMCs as potential service delivery points where they can be treated without bias. The goal of this recommendation is to expand women's access to safe reproductive health and abortion services.

The objective of this recommendation is to provide abortion services to those who have no access to health facilities. The mobile clinics should provide abortion services performed by trained health care providers such as MVA and counseling. The clinics will also provide informational material and resources. Ultimately, the RMCs should create a highly dispersed and effective network of reproductive health care for rural Ethiopians who do not have knowledge of and access to safe abortion services. The government, under the supervision of the EOT, should allocate a stipend to fund the RMC system. Although existing health facilities could always use more funding, these mobile clinics are meant to target a segment of the rural population who cannot access the already existing health facilities. The mobile clinics should serve as an extension of regional hospitals to ensure quality of services and for emergency purposes. The route determined by the EOT should target as many rural communities as possible.

#### **VI. Final Remarks**

These recommendations are designed with the purpose of targeting gaps in the Ethiopian health care system and in effectively and efficiently implementing the policies set forth by the government of Ethiopia. The Ethiopian Oversight Taskforce, the Ethiopian Training System, Community Coffee Groups and the Rural Mobile Clinics are four ways to raise awareness and improve and increase access to Comprehensive Abortion Care. The findings of our research form a platform for our recommendations. Although the suggested projects constitute a program, they may be used individually and expanded upon to create separate programs based on the discretion of the Ethiopian Government or relevant stakeholders. It is our sincere hope that these recommendations will encourage and support Ethiopia in modifying its safe abortion services and ultimately creating a higher quality of life for all Ethiopians.

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