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# The 2005 revised abortion law of Ethiopia: Policy and practice

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**Abstract**

*Ethiopia has made significant strides in changing an outdated abortion law. It has taken considerable steps in increasing access to safe abortion, including developing and disseminating guidelines for abortion care, broadening eligibility criteria to allow more facilities to provide services, facilitating abortion training for more skilled providers, and addressing many other matters concerning women's rights and well-being. These have collectively resulted in an increased contraceptive prevalence rate. This will attest to the government's responsibility in respecting, protecting and fulfilling the sexual and reproductive health and rights of all. In addition, increasing women's and girls' access to technology, digitalising health care and telemedicine could be one strategy option for increasing self-care and management. This approach should be coupled with less regulation of abortion as criminal and moving to considering abortion as common healthcare where people have body autonomy and the right to access quality health care. This chapter attempts to describe the historical background and provide a glance at the origins of abortion laws and policies before the recent law of 2005 in Ethiopia. It then describes the intent of the 2005 Abortion Law, its implementation, the positive impact it has, and some challenges encountered. It concludes with some actions and recommendations for moving the agenda forward.*

## 1 Introduction

Ethiopia is Africa's second-most populated country and its oldest independent nation. The country has a history of the predominance of three of the oldest religions: Judaism, Christianity and Islam, with pre-

existing traditional and cultural practices entrenched and embedded in complex repressive political systems and gender norms. The current system of government is a federal republic with a parliamentary system of government. Its Constitution was ratified in 1994 and establishes ethnically based regions and other mechanisms intended to ensure equal representation of the country of more than 80 distinct ethnic groups. It is now divided into eleven regions and two administrative city governments, with some matters under the legislative and judicial jurisdiction of the regions, others falling to the federal government, and some subject to joint jurisdiction.

In the last three decades, Ethiopia achieved significant gains in advancing gender equality and women's empowerment on various fronts. Significant achievement has also been made in promoting women's political participation – women occupy 50 per cent[1] of the cabinet of ministers and 38,8 per cent[2] of seats of the House of Peoples' Representatives. However, significant gender inequalities persist in Ethiopia depriving women of rights and opportunities and restricting their participation in development endeavours. For example, Ethiopia achieved six out of eight Millennium Development Goals (MDGs) while the goal of promoting gender equality and women's empowerment was not met.[3][4] Human Development Index (HDI) puts the country's gender inequality index (GII) at 0.521, ranking 129 out of 170 countries in 2021. Enrolment of girls in schools has been recorded with substantial achievement with high gross and net enrolment ratios. There is some progress in terms of women's participation slightly moving the needle upward. The Global Gender Gap Report of 2022[5] ranks Ethiopia 74 among 146 countries with a gender gap index of 0.710. In reproductive

1 S Ebatamehi 'Ethiopia Prime Minister, Abiy Ahmed, has 50% women ministers in his cabinet' *The African Exponent* 16 October 2018, https://www.africanexponent.com/post/9263-defense-minister-and-50-of-ethiopias-ministers-are-women (accessed 25 October 2022).

2 See United Nations Women 'It will take 22 years to close SDG gender data gaps' 6 September 2022, https://www.unwomen.org/en/news-stories/feature-story/2022/09/it-will-take-22-years-to-close-sdg-gender-data-gaps (accessed 19 December 2022).

3 UNDP 'Ethiopia MDG Report (2014)' 22 October 2015, https://www.undp.org/ethiopia/publications/ethiopia-mdg-report-2014 (accessed 19 December 2022).

4 As above.

5 World Economic Forum 'Global Gender Gap Report 2022' 13 July 2022, https://www.weforum.org/reports/global-gender-gap-report-2022/in-full/1-

health indices, Ethiopia has recorded impressive results within the last 20 years. The total fertility rate dropped from 5.4 in 2005 to 4.4 in 2019; the contraceptive prevalence rate increased from 14 per cent in 2000 to 44 per cent in 2019; while the unmet need for family planning dropped from 34 per cent to 25 per cent in the same period.[6]

In 2004 when Ethiopia revised its prohibitive Penal Code, the maternal mortality ratio (MMR) was 673 deaths per 100 000 live births.[7] One-third of these deaths were attributed to complications of unsafe abortion.[8] There has been a marked improvement in the reduction of unsafe abortions in the last 20 years even though the data varies depending on the source. The World Health Organiation (WHO)'s estimate for Ethiopia's MMR for 2017 was 401 out of which unsafe abortion was attributed to 9 per cent.[9] Other quality of care indicators like the uptake of post-abortion contraception, use of appropriate technologies, increase in women and girls' health service-seeking behaviour, reduction in the severity of complications, and the proportion of safe abortion versus post-abortion care all show a marked improvement. The government has shown its commitment to expanding abortion care services as more health facilities are constructed and health care expanded. The most recent figure from the Ministry of Health (MOH) shows that among the 4 224 healthcare facilities currently eligible to provide safe abortion care, 2 244 (53 per cent) are providing it.[10]

There is a need to embark on further training for bodies of healthcare providers and integrating abortion in their maternal services. Additionally, more effort must be made towards fair distribution of health facilities among the regions and ensuring more proximity to disadvantaged communities. Focusing on removing barriers to health services such as

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benchmarking-gender-gaps-2022#1-1-country-coverage (accessed 1 September 2022).

6 Healthy Newborn Network 'Ethiopia: Mini Demographic and Health Survey 2019' 31 July 2019, https://www.healthynewbornnetwork.org/resource/ethiopia-mini-demographic-and-health-survey-2019/ (accessed 19 December 2022).

7 CSA & ORC Macro 'Ethiopia Demographic and Health Survey 2005' September 2006 233, https://www.dhsprogram.com/pubs/pdf/fr179/fr179%5B23june2011%5D.pdf (accessed 19 December 2022).

8 Y Berhan & A Berhan 'Causes of maternal mortality in Ethiopia: A significant decline in abortion-related death' (2014) 24 *Ethiopian Journal of Health Science* 15-18.

9 WHO and others 'Trends in maternal mortality 2000 to 2017: Estimates' (2019).

10 Federal Ministry of Health Facility Based Data (2022).

fees, stigma, and addressing the anti-abortion sentiments, which could be a global alliance initiative, is crucial. It is important to follow up and investigate the ramifications of the recent overturn of *Roe v Wade* and what the future holds in the reinstatement of the Mexico City Policy, as Ethiopia is one of the major recipients of USAID. While navigating all these, it would be crucial to make use of the 2022 WHO Technical Guidelines for Abortion.[11] It suggests the decriminalisation of abortion like any other healthcare service, alluding to the fact that it should not be a subject of law discourse, and abortion pills self-management should be strengthened as one option for women and girls. Other barriers related to providers', institutions', and communities' perceptions and practices toward sexual and reproductive health and rights should be addressed. This is to ensure that an integrated comprehensive approach is implemented as a part of the goal of attaining the right to universal health coverage.

## 2 History of Ethiopia's abortion laws: 1560s to 2004

Ethiopia was never under colonial rule, except for the five years when the Italian fascist government invaded the country (1936 to 1941). The Italians were faced with resistance from patriotic movements and, thus, had no time to work on building administrative structures or governing the country. As a result, one can hardly find any evidence or trace of their stay except for some infrastructure built and the many lives lost during the five years. The country thus has its historical discourse, which may be unique in Africa, in terms of the origins of laws and practices. This is true of the abortion law in Ethiopia. This has undergone many transformations within the last 100 years. There are historical records attesting to Christianity becoming the established religion of Ethiopian Axumite Kingdom in the fourth century.[12] There is enough evidence to confirm that orthodox Christianity was an established church, and apart from its ecclesiastical laws it projected its stance on issues concerning the laity which influenced the political domain. There is no evidence, however, on whether another religion was as established as Christianity,

11 WHO and others 'Abortion care guideline', https://srhr.org/abortioncare/ (accessed 19 December 2022).

12 T Taddesse *Church and state in Ethiopia:1270 to1527* (2009).

although there is historical evidence of the co-existence of other religions such as Judaism, Islam, and other indigenous beliefs and practices.[13] According to Wada, the existence of customary laws practised by the culturally diverse societies and communities in the country, in addition to the dominance of Christianity, may have had implications on abortion perspectives.[14]

### 2.1 The Fetha Negest (Ge'ez 'Justice of Kings')[15]

The Fetha Negest[16] is a theocratic legal code compiled around 1240 by a Coptic Egyptian Christian. It was later translated into Ge'ez in Ethiopia in the fifteenth century and expanded upon with numerous local laws. The original writer took the laws partly from the Bible and partly from former law codes of the Byzantine ruler. Its first recorded use in a constitution, provisions including penal law, family law and successions, was in the 1560s.[17] History scholars have stated that the first section (the ecclesiastical law) was already in use in Ethiopia before this time. The title *Fetha Negest*, 'Justice of the Kings', referred only to the second part meant for the laity, was a foreign concept. It was named for its secular roots, but its force was obtained from its religious sources. The numerous references to the holy scriptures and the writings of the fathers of the church permeate the work with a spiritual ambiance.[18]

As part of its second part of the Code, it describes abortion provisions as follows:[19]

> If a man makes a woman abort with poison and lies with her, he must remain outside the church for the rest of his life ... because he has committed the three greatest sins: fornication, homicide, and sorcery. As for women who commit carnal sins and kill their babies [first it was provided, regarding them that they are expelled from the community until they die, but because of the great mercy of God...] the penalty shall be for ten years, as it has been commanded.

13 T Wada 'Abortion law in Ethiopia: A comparative perspective' (2008) 2 *Mizan Law Review* 1.
14 As above.
15 PL Strauss (ed) *The Fetha Nagast: The law of the kings* trans AP Tzadua (1968) 15.
16 Strauss (n 15) 29.
17 Strauss (n 15) 15.
18 Strauss (n 15) 19.
19 Strauss (n 15) 29.

According to the Fetha Negest, the practice of abortion was prohibited as all other great sins. As the Ethiopian Orthodox Church exercises political dominance in the country, the provisions of the Fetha Negest were applicable to all inhabitants of the territory. The law should have applied only to Christians, for a consideration of religious freedom for other religions or traditional practices existing at the time. However, there is no other written record of any other belief or practice on abortion that is available. The Fetha Negest remained officially the supreme law in Ethiopia until 1931 when a new Penal Code was introduced by the order of the emperor. It is documented that the starting point of the new Code was still the Fetha Negest, consulted in matters of law even in the 1960s,[20]and continued as an educational resource for centuries.

## 2.2 The Penal Codes of 1930 and 1957

Emperor Haile Selassie, seeking a modern penal code to fit in with the changing times, proclaimed the 1930 Penal Code. It is not very difficult to see the influence of the Fetha Negest as it allowed no exception. The 1930 Code listed penalties for those who commit abortion or the middleman, as and/or a fine.[21] Thus, the 'modernisation' could be seen only in lesser penalties given for violations of the law as abortion continued to be a major criminal act.

The first indication of exceptions to abortion access in the Ethiopian penal codification is seen in the Penal Code of 1957. The section on abortion contains nine provisions, titled 'Offences Against Life Unborn: Abortion'. Articles 528 to 533 state the general principle of the law as a deliberate termination of a pregnancy, at whatever stage or however effected, is punishable. It describes the penalties according to whether it is procured by the pregnant woman herself or by another, and in the latter case according to whether or not the pregnant woman gives her consent. Article 533, in principle, considers abortion a crime but entitles the accused to free mitigation where 'the pregnancy has been terminated on account of exceptionally grave state of physical or mental distress, especially following rape or incest, or due to extreme poverty'.

20 NA Dominic *The Fetha Nagast and its ecclesiology: Implications in Ethiopian Catholic Church today* (2010).
21 Wada (n 13).

The most important part is article 534 with the title 'Termination of Pregnancy on Medical Grounds'. It states:[22]

> Termination of pregnancy was not punishable where it is done to save the pregnant woman from grave and permanent danger to life or health if it is performed in conformity with the stated legal requirements. These requirements were: 1) the danger [to health or life] shall be diagnosed, and certified in writing, by a registered medical practitioner, after examination of the applicant's state of health. (2) The termination of the pregnancy shall be conditional upon the findings and concurrent opinion of a second doctor, qualified as a specialist in the alleged ailment from which the pregnant woman is suffering, and empowered by the competent authority.

The title of the section is self-explanatory; this law was promulgated to protect the life of the unborn and, thus, no mention of the right of the woman carrying the foetus. On the other hand, a women's criminal charges are enumerated when an abortion is performed. The exception can be acquired with the approval of two physicians, which amounts to nothing given the country's chronic shortages of physicians and their near total absence in rural Ethiopia, where 87 per cent of the population lives. Nonetheless, the 1957 Penal Code made a significant departure from the past in recognising such exceptions. According to Wada, European liberal laws of the late 1950s may have influenced this revision of the Penal Code as it is consistent with the period.[23]

For nearly half a century after the 1957 Penal Code became operational, there seems not to be much recorded data available in terms of how the law was implemented. In 1974 there was a major political upheaval. The imperial government was toppled by a military elite group. The regime was tagged 'The Derg', which was more tilted toward the Soviets. The Soviets had an on-and-off stance on safe abortion access. This relates to the recognition of women's rights to self-determination following the 1950s re-introduction of legal terminations.[24] As an extension of this, the Ethiopian-based Balcha Hospital located in the capital city, supported by the Soviets, was the only one of its kind to provide safe abortion access in a hospital setting. It is worth noting that

22 Imperial Government of Ethiopia *The Penal Code Proclamation of 158 of 1957* (5 May 1958).

23 Wada (n 13).

24 S Talaver 'When Soviet women won the right to abortion (for the second time)' *Jacobin* 3 August 2020, https://jacobin.com/2020/03/soviet-women-abortion-ussr-history-health-care (accessed 19 December 2022).

one non-governmental organisation (NGO) had clinics in Addis Ababa and in some major towns of the regional states where life-saving services were provided amidst all these restrictions.

## 3 The 2005 Abortion Law of Ethiopia

In the 1990s, after the overthrow of The Derg, the political, economic and social systems of the country started shifting. A new government dominated by a group with a history of women's involvement in a guerrilla movement took over. It was a period of many controversies and political discourse on topics such as the equality of religion, ethnic identity, equity, democracy and human rights. According to Holcombe and Gebru, it was also a period in the discourse on abortion law revision that was led by internal forces through the coming together of many factors created to set the agenda right, within the framework of reproductive health and rights.[25]

### 3.1 The 1994 Constitution of the Federal Democratic Republic of Ethiopia and other policies

The transitional government established in 1992 issued two national policies with direct implications for reproductive health and rights. There was the 1993 National Population Policy of Ethiopia[26] which heightens the concern on the high fertility rate, unwanted pregnancy, unsafe abortion, and women's low socio-economic status. It articulates objectives such as reducing fertility, increasing contraceptive use and decreasing maternal morbidity and mortality. Later in the same year, the National Policy on Ethiopian Women was approved,[27] which affirms the government's commitment to ensuring women's rights to access to basic health care and information about family planning methods and provides a framework for the removal of discriminatory laws and regulations related to women. It also enacts a Revised Family Code (2000) which, among other measures, raises the age of legal marriage.

25 SJ Holcombe & SK Gebru 'Agenda setting and socially contentious policies: Ethiopia's 2005 reform of its law on abortion' (2022) 19 *Reproductive Health* 218.
26 Office of the Prime Minister, Transitional Government of Ethiopia 'National Population Policy of Ethiopia' (1993).
27 Office of the Prime Minister, Transitional Government of Ethiopia 'National Policy on Ethiopian Women' (September 1993).

A new Constitution was ratified in 1994 which recognises international agreements ratified by Ethiopia on the democratic rights and freedoms of citizens and residents, human rights and, most of all, the establishment of equal rights for women. The Constitution directly addresses reproductive health and rights in an article, that reads: 'To prevent harm arising from pregnancy and childbirth and to safeguard their health, women have the right to access to family planning education, information and capacity.'[28] Other provisions, such as those regarding privacy rights, marriage equality and protection from harmful traditional practices, can be interpreted to support reproductive health and rights.

Ethiopian law makers have also ratified international agreements and conventions that support reproductive health and rights, including the International Covenant on Civil and Political Rights (ICCPR); the International Covenant on Economic, Social and Cultural Rights (ICESCR); and the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW). These treaties have all issued general recommendations that clarify the meaning and content of sexual and reproductive rights. These instruments were very useful in educating policy makers in unpacking the rights to abortion access and related the human rights issues indicated in each of the agreements; that by default the country has already endorsed these rights. It is only making these rights local for explicit application to make the lives of ordinary people meaningful. The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (African Women's Protocol) was originally adopted by the parties on 11 July 2003 and went into effect in November 2005. Ethiopia signed the Protocol on 1 June 2004, but has not ratified it during the Penal Code revision.[29] There was a call by advocates that the Ethiopian government should fulfil its obligations to the African Union (AU) and its people, by playing a leading role as the founding fathers of the Organisation of African Union (OAU)

28 Constitution of the Federal Democratic Republic of Ethiopia, 1994, https://www.constituteproject.org/constitution/Ethiopia_1994.pdf (accessed 20 May 2022).

29 Africa Union 'List of countries that have signed, ratified/acceded to the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa' 16 October 2019, https://au.int/sites/default/files/treaties/37077 (accessed 2 November 2022).

had done in the ratification of the Protocol. Under Ethiopian law, such international conventions carry the force of law and become domesticated only if ratified by Parliament. A National Reproductive Health Strategy for the period 2006 to 2015 that incorporates Millennium Development Goals and seeks to mainstream reproductive health was approved.[30] All these measures show that there was an undeniably high level of political commitment by the government.

### 3.2 Emergence of civil societies and coalitions

Numerous foreign relief agencies began working in Ethiopia during the famine period in the country in the mid-1970s and 1980s; their presence spawned the development of indigenous civil society. In addition, due to the enabling environment created in the 1990s, indigenous NGOs have begun to flourish in addressing the needs of women, including reproductive health. The most prominent leaders on abortion were members of the medical community, mainly obstetricians and gynaecologists.[31] Momentum to address unsafe abortion began to build with the 1986 publication of a study by Kwast and others on abortion as a leading cause of death in Addis Ababa hospitals.[32] Ipas and ESOG compiled a review of the literature on abortion in Ethiopia in 2000, which includes about 40 articles written as at then.[33] The studies' findings are consistently compelling in documenting the magnitude and consequences of unsafe abortion. All these data were used as evidence to convince policy makers of the extent of the problem.

Some Ethiopian legal professionals were introduced to the issue of unsafe abortion by the extensive evidence of its impact on public

30 Federal Democratic Republic of Ethiopia 'Ethiopia National Reproductive Health Strategy (2016-2020)' October 2016, https://www.prb.org/wp-content/uploads/2020/06/Ethiopia-National-Reproductive-Health-Strategy-2016-2020.pdf (accessed 19 December 2022).

31 SJ Holcombe 'Medical society engagement in contentious policy reform: The Ethiopian Society for Obstetricians and Gynecologists (ESOG) and Ethiopia's 2005 reform of its Penal Code on abortion' (2018) 33 *Health Policy and Planning* 583.

32 B Kwast, R Rochat & W Kidane-Mariam 'Maternal mortality in Addis Ababa, Ethiopia' (1986) 17 *Studies in Family Planning* 288.

33 Ethiopian Society of Obstetricians and Gynaecologists 'A data base on abortion literature review' (2000) Ref 6, https://www.guttmacher.org/journals/ipsrh/2010/03/estimated-incidence-induced-abortion-ethiopia-2008 (accessed 20 May 2022).

health. They brought a different perspective to the matter, informed by knowledge of global legal experience with abortion and particularly by the emerging influence of the concept of human rights. The most concerted advocacy of abortion from a legal perspective was conducted by the Ethiopian Women Lawyers Association (EWLA). EWLA, which was founded in 1995, had led successful advocacy related to the 2000 Family Code revision and drew from its experience gained then, to take up the issue of unsafe abortion in the early 2000s.

A coordinated advocacy movement began to coalesce in March 2003, after a conference organised by Ipas, Action to Reduce Maternal Mortality in Africa: A Regional Consultation on Unsafe Abortion'.[34] It assembled government officials, youth leaders and women's health activists from 15 countries. After this international consultation, an advocacy group was formed with strategies and plans identified. The members include the Ethiopian Society of OB/GYN (ESOG), EWLA, Family Guidance Associations of Ethiopia (FGAE), the Consortium of Reproductive Health Associations (CORHA), EngenderHealth, the National Office of Population and Ipas Ethiopia. This group played a key role as a hub for providing evidence, consistent messaging and follow-up, and reinforcing achievements during the law reform process.[35] In addition, the group bridged the collaboration between organisations using the rights-based and public health-based approaches of advocacy that hitherto were working separately. According to Bridgman-Packer and Kidanemariam, the use of evidence-based public health and human rights arguments in messaging helped in getting buy-ins from decision makers.[36] Within a few years, the agenda of several others were conducive to incorporating attention to unsafe abortion to at least some degree.

34 Organisers were Ipas; the African Partnership for Sexual and Reproductive Health and Rights of Women and Girls; the Centre for Gender and Development of the Economic Commission of Africa; the Commonwealth Regional Health Community Secretariat (CRHCS); the Regional Prevention of Maternal Mortality Network (RPMMN); the Ethiopian Ministry for Women's Affairs; the Ethiopian Office of Population, FGAE and ESOG.

35 Ipas.Abortionlawstudy2022E/Tools for ProgressivePolicyChange.pdf Ipas's document, https://globaldoctorsforchoice.org/resource/tools-for-progressive-policy-change-lessons-learned-from-ethiopias-abortion-law-reform/..

36 D Bridgman-Packer & S Kidanemariam 'The implementation of safe abortion services in Ethiopia' (2018) 143 *International Journal of Gynaecology and Obstetrics* 19.

### 3.3 Alignment of the Penal Code with the Constitution of 1994

Demand for the revision of the Penal Code intensified in the decade after the ratification of the 1994 Constitution, and it became increasingly apparent that alignment was needed. The preface to the new Code notes that its revision was necessary because of 'radical political, economic, and social changes' in Ethiopia since the previous Code had entered into operation. As the revision was for the whole Penal Code, it took the participation of a couple of offices for the drafting process and Parliament for review as all other legal revision processes are done in the country. Abortion was among the most controversial subjects, but the evidence presented was overwhelming. Public forums were conducted to some degree and the final draft was presented for approval in Parliament when an appeal was made by an anti-abortion group. No public opinion polling or other such measures were ever undertaken. In the contentious climate of the revision of the law, the abortion law was retained within the Penal Code, signalling to the public that abortion remains a crime, while a few exceptions were allowed making safe abortion services accessible. Operating within this tension between the religious communities' concerns and public health aims, the government enacted the most permissive abortion law in Eastern Africa.

Articles 545 to 552 outline the factors to be considered for imposition of punishment, and most significantly the situations in which pregnancy termination is not punishable.[37] In addition to 'in the case of grave and imminent danger which can be averted only by an immediate intervention', these include when

(a) the pregnancy is the result of rape or incest; or
(b) the continuance of the pregnancy endangers the life of the mother or the child or the health of the mother or where the birth of the child is a risk to the life or health of the mother; or
(c) where the child has an incurable and serious deformity; or
(d) where the pregnant woman, owing to a physical or mental deficiency she suffers from or her minority is physically as well as mentally unfit to bring up the child.

Significantly, the new Criminal Code sanctions the MOH to issue a directive and asserts that 'the mere statement by the woman is adequate

37 Art 551 Penal Code of the Federal Democratic Republic of Ethiopia (FDRE), 2005.

to prove that her pregnancy is the result of rape or incest'.[38] In addition to abortion, the revised Criminal Code includes numerous other important changes relevant to reproductive health and rights, including criminalising domestic violence and early marriage, and imposing harsher penalties for rape and female genital mutilation. The Code was scheduled to go into effect on 9 May 2005, with its publication in the government gazette.

## 4 Incidence of unsafe abortion-related mortality and morbidity in Ethiopia

Evidence-based arguments that a high maternal mortality rate is attributed to complications of unsafe abortion seem to be acceptable to most Ethiopian decision makers when framing conversations on abortion legal reform, rather than a woman's rights framework. It could be due to the public health argument associated with the accepted and respected medical practice itself. Globally, maternal mortality is the most sensitive indicator of the health disparities between poorer and richer nations, for overall developmental initiatives. Locally, the effect of maternal mortality has impacts on children and remaining families and the whole society in general. The incidence of unsafe abortion is a credible index in maternal mortality, with its limitations with the data variations as various sources use different methodologies.

The WHO estimates that in 2000 abortion contributed to 32 per cent of the 871 deaths to 100 000 live births in Ethiopia.[39] According to the facility-based report of MOH (2003), abortion was the leading cause of maternal mortality in Ethiopia accounting for 32 per cent. In a systematic review of the meta-analysis by Mekonnen in 2016, unsafe abortion accounts for 8.6 per cent of maternal deaths in Ethiopia.[40] The Ethiopian Demographic Health Survey (EDHS) 2005, shows that MMR was 710 in 2005, and EDHS 2016 was 412 per 100 000 live births. EDHS does not report causes of maternal deaths but points to

38 As above.

39 GA Tessema and others 'Trends and causes of maternal mortality in Ethiopia during 1990-2013: Findings from the Global Burden of Diseases Study 2013' (2017) 17 *BMC Public Health* 1.

40 W Mekonnen & A Gebremariam 'Causes of maternal death in Ethiopia between 1990 and 2016: A systematic review with meta-analysis' (2018) 32 *Ethiopian Journal of Health Development* 225.

high rates of maternal deaths in the age groups of 20 to 24 and 25 to 29 years. The higher rate of young adolescents dying, as per the study, could be associated with unmet needs for family planning services. This suggests that programmes that aim to reduce pregnancy among young adolescents could reduce the risk of maternal mortality arising from childbirth complications.[41]

As part of the Health Sector Transformation Plan (HSTP), Ethiopia aspired to reduce MMR to 177 deaths per 100 000 live births in 2020, which was not achieved. According to the MOH, the rate of decline in the MMR in the country is 4.9 per cent per year.[42] Moreover, for the Sustainable Development Goal (SDG) an ambitious target of achieving an MMR of 70 per 100 000 live births in 2030 is indicated.[43] One needs to assess what is being done differently to achieve this target.

The first of its kind in terms of estimates of the magnitudes of abortion was conducted in two studies in 2008[44] and 2014, led by Guttmacher. According to these studies, between 2008 and 2014, the share of abortions performed in healthcare facilities nearly doubled,[45] and the proportion of abortion care provided in the public sector increased from 36 per cent to 56 per cent nationally. The same study also shows that 13.7 per cent of women were treated for complications of such abortions. In a 2008 study, health professionals estimate that 58 per cent of all women who have abortions experience serious complications.[46] The proportion of all women requiring hospitalisation for severe complications in 2008 and 2014 were 23.1 per cent and 19.1 per cent respectively, while the

41 Central Statistics Office of Ethiopia (CSO) & ICF International 'Ethiopia Demographic and Health Survey 2016: Key indicators report' (2016).

42 Ministry of Health 'Technical and Procedural Guidelines for Safe Abortion Services in Ethiopia' (2014), https://abortion-policies.srhr.org/documents/countries/03-Ethiopia-Technical-and-procedural-guidelines-for-safe-abortion-services-2014 (accessed 19 December 2022).

43 United Nations Department of Economic and Social Affairs 'Sustainable development: The 17 goals', https://sdgs.un.org/goals (accessed 19 December 2022).

44 A Abdella and others 'Meeting the need for safe abortion care in Ethiopia: Results of a national assessment in 2008' (2013) 8 *Global Public Health* 417

45 AM Moore and others 'The estimated incidence of induced abortion in Ethiopia, 2014: Changes in the provision of services since 2008' (2016) 42 *International Perspectives on Sexual and Reproductive Health* 111.

46 S Singh 'The estimated incidence of induced abortion in Ethiopia, 2008' (2010) 36 *International Perspectives on Sexual and Reproductive Health* 16.

proportion of women presenting for care who died from complications of unsafe abortion was less than 1 per cent in both years.[47]

The Ethiopian Emergency Obstetric and New-Born Care (EmONC) assessment conducted in 2016 shows that 25 per cent of the obstetric complications reported were due to non-severe complications of abortion, while close to 2 per cent of women had severe abortion complications of whom nine died.[48] Another relatively large data series about hospital admissions due to abortion comes from a report in Tigray where the total number of women who received abortion services in four tertiary hospitals, increased three-fold from 2008 to 2012, while the proportion of patient procedures declined from 28 per cent to 24 per cent.[49] The relative decline in the percentage of admissions in the background of an increasing number of users is indicative of the transition to safe abortion services and the eventual decline in the burden on health facilities. Yet, Ethiopian women continue to experience abortion-related injuries and death despite the existence of legal safe abortion.

## 5 Factors that enable access to abortion services

### 5.1 Technical and procedural guidelines for safe abortion services in Ethiopia

The key to the broader interpretation of the abortion law was the law makers' procedural decision that the MOH is responsible for the development of a 'directive' rather than the Ministry of Justice as it is customary for all other judicial issues. This action also sends a message that abortion requires medical rather than purely legal interpretation. Accordingly, the MOH established a technical team of experts to work

47 Y Gebrehiwot and others 'Changes in morbidity and abortion care in Ethiopia after legal reform: National results from 2008 and 2014' (2016) 42 *International Perspectives on Sexual and Reproductive Health* 121.

48 Ethiopian Public Health Institute & Ethiopia Federal Ministry of Health 'Emergency Obstetric and New-born Care (EmONC) Assessment 2016: Final Report' September 2017, https://www.ephi.gov.et/images/pictures/download2010/FINAL-EmONC-Final-Report-Oct25-2017.pdf (accessed 19 December 2022).

49 N Prata, S Bell & A Gessessew 'Comprehensive abortion care: Evidence of improvements in hospital-level indicators in Tigray, Ethiopia' (2013) 3 *BMJ Open* 1.

on the development of the directive. Since, the WHO had already issued its first Safe Abortion: Policy and Technical Guidelines in 2003, which made it easy for the team to domesticate its contents to Ethiopian reality. The 'directive' named the 'Technical and Procedural Guidelines for Safe Abortion Services in Ethiopia' was issued in June 2006.[50]

According to the 'women-centred care' concept underlying the guideline, eligible women have the right to access abortion services within three days of contact with the health services. The Abortion Law of 2005 is particularly exceptional since adolescents' reproductive health needs are acknowledged. Thus, minors (as per the Constitution, less than 18 years of age) should not be required to seek parental/guardian consent to obtain an abortion. In addition, a minor is not obliged to show proof of age nor is any other woman. For all legally allowable conditions, a woman can access a health provision centre and present her case without any second or third party requirements. In cases of rape, the law is clear that there is no requirement for proof of criminal charges or evidence as a woman's word is enough.

Another important feature is the sanctioning of mid-level health providers which include healthcare officers, midwives and clinical and public healthcare nurses to perform an abortion in addition to those already authorised. This inclusion is a major game changer as it opens the gate for most of the professional work force that can provide services in primary-level health centres. Appropriate technologies recommended by WHO for abortion, manual vacuum aspirator (MVA) and medical abortion drugs (MA), are included with the appropriate dosages and routes for usage. The requirements for the second trimester are also indicated with a list of equipment and supplies.

The guideline is very clear that all the mandated healthcare providers need to have hands-on training with the use of the technologies described as appropriate. A values clarification and attitudinal transformation training (VCAT) that helps providers to distinguish between their values and clients' rights to safe reproductive services is also included as an essential component of all training programmes.[51] Other than

50 MOH 'Technical and procedural guidelines for safe abortion services in Ethiopia' (June 2006).

51 MOH 'First-trimester comprehensive abortion care training manual' Second Edition (April 2018), https://www.arsiun.edu.et/images/health/CAC Participant's Manual_ (accessed 20 December 2022).

training, there is no other requirement for special certification or need that could potentially be an administrative barrier to providers, as noted in experiences of other countries. Any trained provider can provide safe abortion care without requiring consultation with any other body unless for medical reasons if deemed necessary. Conscientious objecting either by a provider or a facility is not allowed as all service provision centres and providers, with the recommended methods and appropriate training must provide abortion service that matches the law requirements. This is further reinforced by an additional law that explicitly states that one may not reject service provision on grounds of religion or belief.[52]

The updated version of the technical guidelines was issued in 2013.[53] The most prominent inclusion is the elaboration on medical abortion drug use due to the availability of more evidence. The second factor is that due attention is given to second-trimester abortion as it was not sufficiently addressed in the first edition. The third area is the issue of task shifting and task sharing, particularly the role of the health extension workers and integrated emergency surgical officers (IESOs), which have now been included with their existing respective job descriptions. Besides, private institutions that were not providing abortion care are included. The guideline also requires all healthcare facilities and clinical providers to maintain data on abortion services in a regular system of recording and provide guidance for programme monitoring and evaluation. Thus, the abortion law is restrictive, but the law text backed by detailed clinical guidelines arguably makes abortion rather liberal and permissive.

### 5.2 Healthcare providers' training, preparation and attitude

The MOH and local and international partners working in support of abortion provisions continue to train and equip providers as per the guidelines. Hence, thousands were trained using the nationally approved competency-based comprehensive women-centred abortion care training manuals. For lack of national data on the number of trained providers

52 Food, Medicine and Healthcare Administration and Control Authority (FMHACA), Federal Negarit Gazette of Ethiopia, Regulation 299/2013, 20th Year No 11, Addis Ababa, 24 January 2014.

53 MOH 'Technical and procedural guidelines for safe abortion services 2014', https://abortion-policies.srhr.org/documents/countries/03-Ethiopia-Technical-and-procedural-guidelines-for-safe-abortion-services-2014 (accessed 19 December 2022)

from 2006 to 2019, data from an unpublished report compiled by the Consortium of Comprehensive Abortion Care (COCAC)[54] from its four member organisations are used. The total number of providers trained is close to 13 800 with the number gradually increasing since 2006. Among the total, only 1 per cent is OB-GYN and general practitioners, while the rest, 99 per cent, are mid-level providers proving that sanctioning the professional bodies did indeed make a difference. This is also an indicator that women are also accessing services at the primary healthcare level where mid-level providers are posted and that task shifting to mid-level providers is vital because of severe doctor shortages. A fact sheet jointly issued by Ipas and the Guttmacher Institute state that the proportion of abortions provided by mid-level healthcare workers has increased from 48 per cent in 2008 to 83 per cent in 2014.[55]

Research conducted by Holcombe and others, exploring the willingness of midwives to provide abortion services, and the factors associated with it shows that those with greater training and experience with abortion provision are more willing to provide services.[56] Another study conducted by Balcha and others in Eastern Ethiopia finds that approximately three out of five of the healthcare providers working at public health facilities have a favourable attitude towards safe abortion care. It also states that training on safe abortion care supported by familiarisation with the country's abortion laws is crucial to improve health care providers' attitudes toward safe abortion services in Ethiopia.[57] One study conducted by Abdi and others indicates that the majority of health providers (96.4 per cent) recognise that unsafe abortion is a serious health problem and providers who have safe abortion practices are three times more likely to have a favourable attitude towards

54 Ipas & the Coalition for Comprehensive Abortion Care (COCAC) 'Expanded access to CAC services and the attendant gains in SRH since the abortion law reform in Ethiopia: A review of the available evidence' (3 July 2021).

55 Guttmacher Institute 'Induced abortion and post-abortion care in Ethiopia: Fact sheet' (January 2017) 1-4, https://www.guttmacher.org/fact-sheet/induced-abortion-ethiopia (accessed 20 December 2022).

56 SJ Holcombe 'Medical society engagement in contentious policy reform: The Ethiopian Society for Obstetricians and Gynecologists (ESOG) and Ethiopia's 2005 reform of its Penal Code on abortion' (2018) 33 *Health Policy and Planning* 583.

57 T Balcha and others 'Attitudes toward safe abortion care and its associated factors among health care providers working in public health facilities in eastern Ethiopia' (2022) 10 *SAGE Open Medicine* 10.

safe abortion than those without it. Similarly, providers who know the law governing abortion are two times more likely to have favourable attitudes than those who lack this knowledge.[58] All these studies confirm that competency-based training of health providers on safe abortion and reproductive rights is essential to reduce maternal mortality.

### 5.3 Expansion of the number of healthcare facilities providing abortion care

Ethiopia's healthcare system has expanded significantly following the political reforms of 1991. Healthcare policy is directed at the federal level by the MOH, with government services administrated at a regional level and supplemented by non-governmental and private providers. A series of five-year programmes has been implemented to increase access to the healthcare system through the expansion of primary care and task sharing with new bodies of healthcare workers as per the technical guidelines.[59]

According to a report on a comprehensive review of the expansion of comprehensive abortion care (CAC) services in public facilities which compares progress between 2008 and 2014, the number of health facilities offering first-trimester abortion care has increased from 149 to 823, and those that offer their services at or after 13 weeks more than doubled from 29 to 66. In 2014, almost three-fourths of facilities that could potentially provide abortions or post-abortion care did so, including 67 per cent of the 2 600 public health centres; 80 per cent of the 1 300 private health centres or NGOs; and 98 per cent of the 120 public hospitals.[60]According to the 2022 facility-based report of the MOH, the estimated percentage of health facilities providing safe abortion services is 53 per cent.

Another comparable data is an unpublished national assessment compiled in 2019 by the Consortium of Comprehensive Abortion Care (COCAC) organisations from four of its members – Ipas,

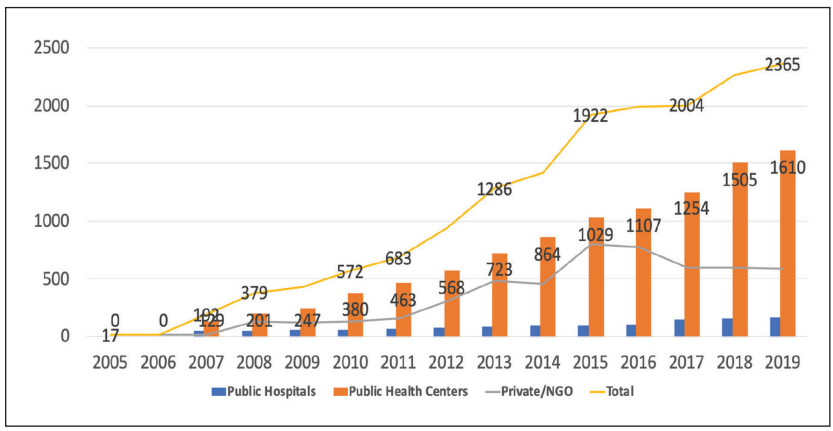
58 J Abdi & MB Gebremariam 'Health providers' perception towards safe abortion service at selected health facilities in Addis Ababa' (2011) 15 *African Journal of Reproductive Health* 31.

59 MOH 'Health Sector Transformation Plan HSTP 2015/16 – 2019/20 (2008-2012 EFY)' (2015).

60 Moore and others (n 45).

EngenderHealth, MSIE and FGAE[61] – with disaggregated data between the public and private sectors. These organisations work with the MOH in the provision of CAC services, thus indicating the data shown is a subset of the national data. Table 1 shows that the provision of safe abortion services has expanded from 143 in 2007 to thousands of public and private health facilities as of 2019.

***Table 1: Number and type of health facilities providing CAC Services, 2005-2019***




Although there is almost a 100 per cent increment in the number of facilities within the first five years since the law changed, the second seven-year period 2014 to 2022 shows a slight change in numbers. The proportion of abortion provision centres with the total number of available healthcare centres seems to remain constant. The impacts of the advent of COVID-19, the ongoing conflict, and the resulting economic and social crisis on the availability and accessibility of abortion care should be a subject of investigation for researchers.

## 5.4 Availability of effective and safe methods of abortion services

Since liberalisation, efforts by the Ethiopian government and its partners have led to significant improvements in the availability and utilisation of facility-based abortion services in the country. Data on the number

61 Ipas and COCAC (n 54) 63.

of women who received abortion services in both public and private facilities varies depending on the source. Two studies have attempted to assess the extent to which women are utilising the expanded services. The first estimate reported in 2008 puts the total number of abortions in the country at 382 000, with an abortion rate of 23 per 1 000 women aged 15 to 44 years. There were an estimated 103 000 legal procedures (27 per cent of all abortions) in healthcare facilities.[62] A second study conducted in 2014, repeating the same methodology, estimates 620 300 induced abortions, of which 53 per cent were conducted at healthcare facilities. The annual abortion rate was 28 per 1 000 women aged 15 to 49, while it was 23 in 2008. The proportion of pregnancies that ended up in abortion increased from one out of eight to one out of six between 2008 and 2014.[63]

MOH's reports show the number of women who received abortion services had steadily increased from below 100 000 per year in 2011 to close to 264 374 by 2019.[64] However, the data was not disaggregated between safe abortion care (SAC) and post-abortion care (PAC), or between trimesters. To show the trend in both number, type and other quality indices, the COCAC report is used here, again. It is important to note that there are data inconsistencies between the two sources. Table 2 below shows that the number of women receiving abortion care in healthcare facilities grew by five-fold in 2019. It also shows the trend in the proportion of SAC versus PAC over the years since 2007. SAC consists of less than two out of ten abortion service provided in 2007. The proportion of safe abortions grew to more than half in only two to three years and reaches 80 per cent by 2011 and remains the same until 2019.[65] There is enough evidence to show that not only does the PAC decrease in proportion but so too do the severity of complications.

A study conducted by Sully and others, which examined whether the law allows pregnant minors to access safe services if they choose, finds evidence that Ethiopian adolescents are more likely to access legal services, and among women presenting with abortion complications,

62 Y Dibaba and others 'A decade of progress providing safe abortion services in Ethiopia: Results of national assessments in 2008 and 2014' (2017) 17 *BMC Pregnancy and Childbirth* 76.
63 Moore and others (n 45)
64 FMOH 'Health and health related indicators' (2019).
65 Ipas and COCAC (n 55) 66.

adolescents complications are no more or less severe than those of older women. This indicates that adolescents are benefiting from the abortion law that grants them the right to request safe abortion services. The study also shows that one-third of adolescent abortions are still clandestine and, thus, potentially unsafe, and those presenting with complications are more likely to be married, have less education, and present at later gestational ages.[66]

***Table 2: Trends in the percentage of safe abortion and postabortion care services, 2006-2019***

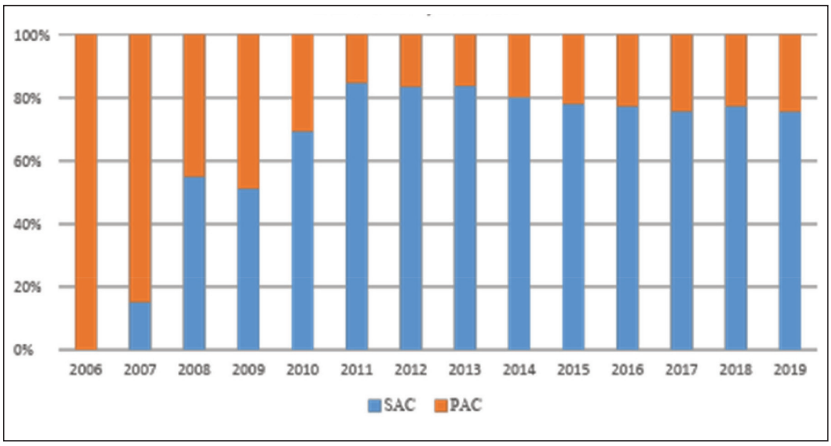
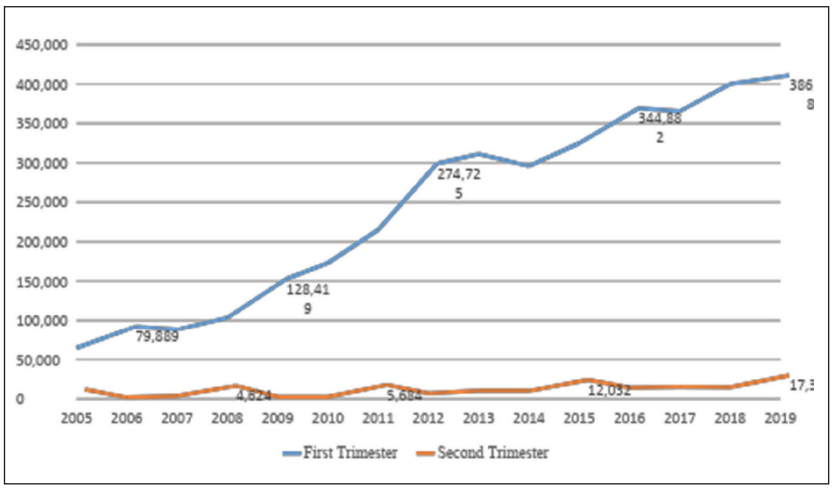



Table 3[67] shows the number of women presenting early for first-trimester abortion grew at an increasing rate while those coming for the second trimester increased at a very low rate. This is also one indicator to show that women are using safe services and that complication rates are decreasing benefiting women and saving the health system additional costs for treatment.

66 E Sully and others 'Playing it safe: Legal and clandestine abortions among adolescents in Ethiopia' (2016) 62 *Journal of Adolescent Health* 729.
67 Ipas and COCAC (n 55) 67.

*Table 3: Trimester distribution for abortion care*




### *5.4.1 Use of post-abortion contraception*

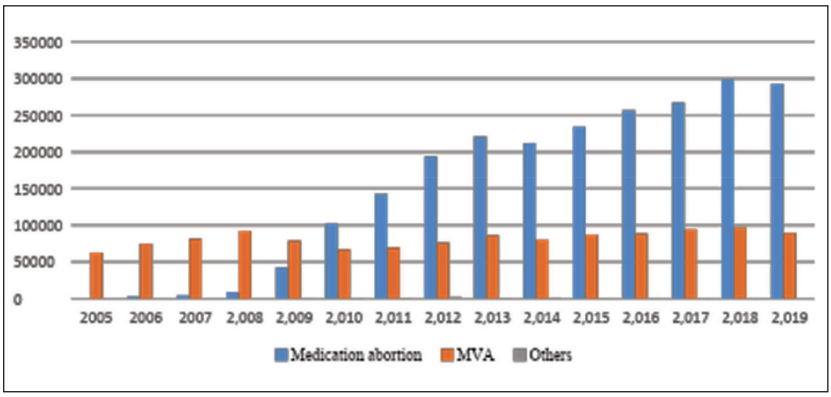
Progress in the expansion of safe abortion services in Ethiopia also shows that the availability and provision of contraception increased in hospitals and healthcare centres between 2006 and 2019. In 2008, one-quarter of women getting abortion services received contraception, while in 2019 this increased to more than 80 per cent. One study states that while the number of public health centres providing post-abortion contraception increased from 447 to almost 2 000 facilities in 2014, making contraception much more broadly accessible, the percentage of health centres providing the service only increased from 76 per cent in 2008 to 77 per cent in 2014.[68] This shows the need for more effort in terms of expanding prevention methods for unwanted pregnancies and women have more options in undertaking decisions on their reproductive health and rights.

68 Dibaba and others (n 62).

### *5.4.2 Use of appropriate technology*

According to the data shown in Table 4[69] below, MVA was the predominant technology in the years immediately after 2006. The share of all abortion procedures accounted for by MA increased from 0 per cent to over three-fourths of all procedures since 2016. The use of medication offers women a non-surgical method and has been proven to be highly acceptable to both clients and providers. Particularly in low-resource settings, with limited healthcare access and few trained surgical abortion providers, MA can increase safe abortion access, and decrease maternal morbidity and mortality associated with unsafe abortion by providing a safe and effective non-surgical option.

*Table 5: Trend in the use of appropriate technologies for abortion procedures, 2005-2019*




This trend is corroborated by a study conducted by Yergu and others, that the use of medical abortion was below 1 per cent in 2008 and increased to 41 per cent by 2014.[70] Medical abortion drugs become the most favoured by women due to their less invasive nature and by providers for the relative ease of administration. It is worth noting that the proportion of abortion procedures performed with methods not recommended by WHO has always remained below 1 per cent through the years.

69 Ipas and COCAC (n 55) 76.
70 Gebrehiwot and others (n 47).

### 5.5 Provider values clarification and attitude transformation training

The comprehensive abortion care training curriculum endorsed by the MOH not only provides competency-based training to providers but also includes values clarification and attitude transformation (VCAT) training. The goal of the VCAT training is for participants to explore, clarify and affirm their values and beliefs about abortion and related sexual and reproductive health, such that their awareness and comfort with the provision of abortion care increased.[71] Holcombe conducted a study to find out whether abortion VCAT workshops improve participants' knowledge and attitudes among midwives attending an annual Ethiopian Midwives Association Conference in 2018. The study applied the stigmatising attitudes, beliefs and actions scale (SABAS) to participants' levels of stigma and found it low compared to those reported elsewhere. It also highlighted that, although negative stereotyping was prevalent, the willingness to provide abortion care among midwives was high.[72] This shows that the training indeed is contributing to reducing stigma.

### 5.6 Administrative support to SAC-offering centres

Expansion in the number of health provisions is a necessary but not sufficient condition as the availability of convenient infrastructure and other administrative and managerial support in each facility such as having a private counselling/procedure room, water supply, electricity, availability of essential supplies and commodities for infection prevention are equally important. All regional health bureaus responsible for managerial support to health offering centres have included SAC in their annual plans, monitoring, supportive supervision and follow-ups. One important policy milestone taken by the MOH in terms of health system support is making safe abortion services accessible to women and girls free of charge in public health centres as all other maternal health

71 KL Turner and others 'Values clarification workshops to improve abortion knowledge, attitudes, and intentions: A pre-post assessment in 12 countries' (2018) 15 *Reproductive Health* 40.

72 SJ Holcombe, A Berhe & A Cherie 'Personal beliefs and professional responsibilities: Ethiopian midwives' attitudes toward providing abortion services after legal reform' (2015) 46 *Studies in Family Planning* 73.

care is in the country. This can reduce cost barriers to women in addition to the availability of SAC services. It would also contribute to the notion of normalisation of abortion as any other care as we continue to see more integration with other reproductive and maternal health care.

## 6 Factors that disable/discourage access to services

### 6.1 Medical and non-medical barriers to access services at health facilities

The availability of a trained provider is a precursor to services in a healthcare facility. A study among randomly selected mid-level providers conducted in Addis Ababa shows that only 20.5 per cent were trained on safe abortion. Almost half of the respondents have positive attitudes toward safe abortion, and those with adequate knowledge of abortion are 3.4 times more likely to practise safe abortion care.[73] When there are no more than two CAC-trained providers in a particular site, the likelihood of services being interrupted at any time is high due to absenteeism. In addition, there is a high turnover of providers due to several factors that needs studying and documenting.

The uninterrupted supply of MVA or medical drugs and other supplies is also very crucial as it often happens in all facilities. According to the technical guidelines,[74] healthcare facilities providing safe abortion services should be supplied with basic minimum equipment, and supplies that must be regularly replenished. The medical supplies and equipment purchase, and distribution system is highly centralised and tends to focus on the most known supplies rather than those such as abortion which requires more push and pull due to several factors, including stigma. The government should also ensure that falsified drugs are not entering the country and causing more harm to women. The uneven distribution of resources within the regions should also be addressed to avoid disparities in the availability of services.

73 KA O'Connell and others 'Signs of a turning tide in social norms and attitudes toward abortion in Ethiopia: Findings from a qualitative study in four regions' (2022) 19 *Reproductive Health* 198.

74 FMOH 'Technical guidelines for safe abortion' (2013) 29.

## 6.2 Lack of knowledge of the law among women

The silence around the abortion law and safe abortion services has made it possible to avoid public confrontation and fuss around the law, but simultaneously limited the possibilities for dissemination and awareness creation on abortion. Information on abortion for women is not public, although they can get some information through word of mouth. Knowledge of safe abortion eligibility is low as there is no formal forum where women can learn except through occasional facility outreach programmes, or community-based organisations that work on sensitisation and educating communities. Health service-seeking behaviour is generally low in Ethiopia, and when fear of ill-treatment due to abortion stigma and lack of confidence in the privacy and confidentiality of service provisions is added, many women may not access services despite availability free of charge. Many women may not have information on the free availability of services either or may still shun services for fear of non-affordability.

A study that shows the persistent unsafe abortion rate among adolescent women in Ethiopia points out that educational attainment and marital status are likely associated with a range of factors that could influence access to and use of legal abortion, including autonomy in abortion decision making, abortion stigma, and ability to navigate the abortion care system.[75] Other factors related to women's beliefs, and religious, cultural and social influences would also be determining factors for not accessing services.

## 6.3 Abortion stigma

In a less restrictive legal environment such as that of Ethiopia, one reason why unsafe abortion persists is the stigma surrounding abortion which prevents women from accessing services, and potential abortion providers from offering services, and prevents other decision makers such as policy makers or community leaders from supporting abortion service provisions. Due to stigma, women across countries and socio-cultural contexts report undergoing social isolation, fear of social judgment and

75 Sully and others (n 66).

psychological distress as part of their abortion experience.[76] Stigma occurs not only on the individual or interpersonal levels, but is manifested at all levels of society, including institutional, structural and community levels. Kumar and others conceptualise abortion stigma as a compound stigma 'which builds on other forms of discrimination and structural injustices', such as gender roles and inequalities.[77]

Kebede and others find that young women who have an unsafe abortion consider social safety to be more important than medical safety.[78] A 2014 community survey conducted in three regional states of Ethiopia by Wado and others found that many women agree that abortion among married and unmarried women is sinful or bad.[79] A similar study conducted by O'Connell and others in four regional states shows that women seeking abortions are still heavily stigmatised as abortion is deemed unacceptable, concluding that abortion stigma may be a barrier to comprehensive abortion care for women.[80]

A study conducted by Assefa, examining knowledge, attitude and practice among mid-level providers, reports that nearly three-fourths of participants are not comfortable working in a site where termination of pregnancy is performed given their religious values, lack training on the method, and/or consider abortion to be outside of the scope of their practice. Only one-fourth of the participants agree on the provision of legal abortion under any circumstances.[81] Daba and Gebru also state that abortion providers often experience disapproval and isolation from their peers, which discourages them from continuing to provide the service.[82] Moreover, many healthcare workers face stigma from colleagues not performing abortions and therefore keep their job a secret from family and friends. This seems a common phenomenon as other

76 A Kumar, L Hessini & EM Mitchell 'Conceptualising abortion stigma' (2009) 11 *Culture, Health & Sexuality* 625.
77 Kumar and others (n 76) 634.
78 MT Kebede, PK Hilden & A-L Middelthon 'The tale of the hearts: Deciding on abortion in Ethiopia' (2012) 14 *Culture, Health and Sexuality* 393.
79 YD Wado and others 'The effects of a community-based intervention on women's knowledge and attitudes about safe abortion in intervention and comparison towns in Oromia, Ethiopia' (2018) 58 *Women & Health* 967.
80 O'Connell and others (n 73).
81 EM Assefa 'Knowledge, attitude, and practice (KAP) of health providers towards safe abortion provision in Addis Ababa health centres' (2019) 19 *BMC Women's Health* 138.
82 MD Feyssa & SK Gebru 'Liberalising abortion to reduce maternal mortality: Expanding access to all Ethiopians' (2022) 19 *Reproductive Health* 151.

research suggests that abortion care providers in sub-Saharan Africa and Southeast Asia face personal conflicts, stigmatisation and victimisation regarding the delivery of abortion care because of negative attitudes belonging to family, the community and policy makers as well as their colleagues.[83]

## 6.4 Conscientious objection and provider attitudes and perspectives

The technical guidelines on abortion in Ethiopia do not explicitly recognise providers' right to refuse (conscientious objection) services for religious reasons as abortion service is one of their duties to provide. This stance is reinforced by law as proclaimed by *Negarit Gazatte* Regulation 299/2013[84], whereby it states that a healthcare professional may not refuse to provide services such as contraception and legal abortion on grounds of belief. As stated by Wicclair, limiting patient choice may be less detrimental to patients who have access to many options, but it can disproportionately impact the poor, those living in rural areas, which most women in Ethiopia are.[85] In reality, conscientious objection appears to constitute a barrier to care, especially for certain sub-groups such as adolescents. When researchers talk to healthcare providers working in public facilities, they find that they create unnecessary arbitrary and unfair requirements and impose their judgments upon teens trying to make a personal decision.

A national survey mapping conducted by Ewnetu and others on moral dilemmas experienced by physicians in public hospitals points out that they feel that the law depends on providers' discernment in the application of the abortion law.[86] For women, it means that access to abortion is dependent on the views and practices of the practitioner encountered. In another study, healthcare providers with previous experience with induced abortion are 2.5 times more favourable towards

83 Turner and others (n 71).
84 FMHACA (n 52).
85 M Wicclair 'Conscientious objection, moral integrity, and professional obligations' (2019) 62 *Perspectives in Biology and Medicine* 543.
86 DB Ewnetu and others 'Still a moral dilemma: How Ethiopian professionals providing abortion come to terms with conflicting norms and demands' (2020) 21 *BMC Medical Ethics* 16.

it than those without the practice.[87] In general, providers from the private/NGO sector report fewer moral dilemmas than those working in the public sector. Implementing healthcare workers' training on the legal, technical and attitudinal aspects focus on ensuring the provision of quality and respectful sexual and reproductive health services would help enhance health outcomes for women of all ages in Ethiopia.

## 6.5 The global gag rule and its impact

As sexual and reproductive healthcare services and advocacy in Ethiopia are by and large supported by NGOs, safe abortion access is denied in some areas. Since some of these NGOs are financed by USAID, which requires foreign NGOs providing sexual and reproductive health (SRH) services to agree not to perform or promote abortion with the so-called Mexico City Policy otherwise known as Global Gag Rule (GGR) whenever a Republican president is elected. Marie Stopes International (MSI) and the Family Guidance Association of Ethiopia (FGAE) were once obligated to close some clinics in Ethiopia due to their refusal to compromise their clients' rights to full access to SRH services. This adds to the women's burden, particularly adolescents and youths, who have traditionally relied on the private sector for sexual and reproductive healthcare services.[88] Now that the GGR has again been reversed, it will take some time for SRH services to scale back up to their previous footprint. However, it is likely that the GGR will be implemented again in the future, threatening the provision of safe abortion services unless a major positive change happens in the US.

## 6.6 Anti-choice movement towards abortion

Like advocates for the liberalisation of abortion, opponents have authored opinion pieces in the national media. There are some organisations registered to work as opponents in Ethiopia. They have heralded their objective since the parliamentarians' discussion on abortion in 2004.

87 E McLean and others 'When the law makes doors slightly open: Ethical dilemmas among abortion service providers in Addis Ababa, Ethiopia' (2019) 20 *BMC Medical Ethics* 60.

88 JM Vernaelde 'The US global gag rule in Ethiopia: A foreign policy challenging domestic sexual and reproductive health and rights gains' (2022) 19 *Reproductive Health* 56.

A decision that should have been a private one for a woman is taken out of proportion at all levels with many discourses based on religion and moral grounds arguing for the right to life of the unborn child. This is a highly resourceful global movement and works at a community level as well as overturns laws. It has formed allegiance in high government offices and institutions including support within the medical community in Ethiopia. This group may be supported by global organisations that relate to the conservative Christian movement in the USA and, thus, is highly funded. Now that the *Roe v Wade* case in the USA has been overturned, the opposition is emboldened and may intensify its effort to create a similar situation in Ethiopia.

## 7 Recommendations

Despite all the progress in the last 15 years, Ethiopian women still face barriers to contraceptive services, which is one of the fundamental tenets of sexual and reproductive autonomy. Abortion is largely a product of unintended pregnancy, which can be prevented using modern contraceptive methods. The EDHS 2016 shows that only 39 per cent of women aged 15 to 49 in Ethiopia are using a modern method, indicating that their vulnerability to unintended pregnancy is high. Policy and programme efforts are required to help prevent unintended pregnancies, close to half of which end in abortion.

Women and girls in all regions should access relevant, accurate and evidence-based healthcare information and counselling when they desire. Their capacity for decision-making skills and self-autonomy should be enhanced with a focus on knowledge bridging the gap in self-awareness and self-empowerment. Not only do they need to understand their right to bodily autonomy but also hold governments and decision makers accountable. Widely disseminating the contents of the law among women, men, providers and decision and policy makers will further increase understanding of the intent of the law as well as support in destigmatising abortion. Advocates should utilise the regional alignment factor in anchoring the Ethiopian Abortion Law with article 14(2)(c) of the African Women's Protocol since the country ratified the Protocol on 18 July 2018.[89] Training judges, lawyers and law enforcement officials

89 African Union (n 29).

is crucial so that they understand the legal framework to reference provisions of the African Women's Protocol in cases designed for the treaty's intervention.

In the previous part, the indicated list of factors that are enablers for abortion access should be further reinforced to expand access and ensure that quality care is provided to women and girls in need of such services. Likewise, factors creating barriers to abortion care should be critically analysed and overcome with direct involvement and meaningful community engagement. Additional research on barriers may help explain how these factors may relate to abortion access, which is critical to addressing the persistence of unsafe abortion and inequities among women and girls in Ethiopia. Intervention activities should draw on local institutions, such as Health Extension Workers (HEWs) and Worda Development Armies (WDAs), and traditional interpersonal communication activities. Areas that need improvement include an increased focus on adolescent women and their specific needs; more involvement of local health facilities in community engagement and linkages with health care; and increased involvement of community leaders and members in becoming gatekeepers of health services. Advocates should critically examine the practice of administrative and judicial mechanisms for enforcing individual rights and state duties. In addition, women, healthcare professionals, advocates and community leaders must continue to work together to hold the government accountable for normalising abortion care and support its full integration into the country's existing maternal health programme and essential healthcare services to achieve universal health care.[90] The justification should be linked with the evidence in hand that a woman's life is worth saving and that more action is needed to guarantee women and girls the full enjoyment of their human rights.

Below are some of the strategies on which Ethiopia can focus to expand access to safe abortion.

90 Feyissa and Gebru (n 82) 151.

### 7.1 Expansion of pre-service training in professional schools

Almost all healthcare professionals providing services are trained on competency-based and rights-based comprehensive abortion care in service, while they should have been given courses while they were attending schools before their deployment. The fact that pre-service institutions are not uniformly providing CAC training is one area that needs reinforcing. The current trend in focusing on in-service training, which is expensive, may also be reinforcing the silo approach rather than integration and linkages in the healthcare system. While ensuring that all currently deployed providers undergo in-service training, pre-service training should adequately include a curriculum on safe abortion as in the case of all other healthcare services. This can also contribute to the normalisation of abortion, thus reducing stigma. In addition, training of providers and all other capacity-building activities related to sexual and reproductive health, including abortion, have been largely supported and financed by external sources through partnership agreements. Although this is commendable, domestic resources must be allocated for inculcating ownership, sustaining the services, and integrating with universal primary and tertiary care.

### 7.2 Comprehensive sex education is crucial

Strengthening the quality of adolescent and youth-centred healthcare services and school-based programmes, especially for more marginalised groups, such as adolescents and persons with disabilities and those with less education or lower socio-economic status, is very important. Awareness of bodily autonomy and rights as well as gender equality to ensure enduring changes for women's reproductive choices are critical in the country. The WHO guidelines on safe abortion care of 2022 sums this up well: State parties must reduce maternal mortality and morbidity; states must ensure the provision of comprehensive, non-discriminatory, scientifically accurate and age-appropriate education on sexuality and reproduction, including information on abortion, both in and out of

schools; and must ensure that comprehensive sexuality education (CSE) is available to minors without the consent of their parents or guardians.[91]

## 7.3 Digital health

The broad scope of digital health includes categories such as mobile health, health information technology (IT), telehealth and telemedicine, and personalised medicine. These technologies can empower consumers to make better-informed decisions about their health and provide new options for facilitating prevention, early diagnosis, and management outside of traditional healthcare settings. The use of technologies, such as smartphones, social networks and internet applications, is changing the way in which we communicate and providing innovative ways to monitor our health and well-being through greater access to information. There are already initiatives by some organisations in Ethiopia, using call-in radio programmes and the use of cell phones to disseminate information on abortion access and clinical follow-ups but also to listen to concerns adolescents and young girls might have. These technologies might not work for everyone as the digital divide has created discrimination against disadvantaged groups. These could be complemented by existing localised information networks such as the use of the healthcare extension workers' door-to-door approach that is working. In addition, grassroots organisations with outreach systems should enhance their activities in reaching out to marginalised groups which most likely will be affected by unsafe abortion.

## 7.4 Self-care and management

According to WHO, not many countries in the world have a healthcare system that is staffed with enough trained and motivated health workers, supported by a well-maintained infrastructure and a reliable supply of commodities, equipment and technologies, and guided by strong health plans and evidence-based policies. Even in places with a well-functioning health system, vulnerable and marginalised populations are often underserved and lack quality health care. Countries, therefore,

91 World Health Organisation, https://srhr.org/abortioncare/chapter-1/availability-and-accessibility-of-information/ para 2(2022).

need to find innovative strategies, such as self-care, that go beyond the conventional health sector and respond as urgently as possible.[92]

The increasing adoption of digital health and digital therapeutics in the self-care space offers new opportunities to generate real-world in real-time. However, significant legal barriers and stigma remain. Ethiopia can expand its self-managed care guidance to sufficiently include abortion, with quality abortion drugs available at pharmacies and drug stores sold over the counter. This should be supported by information, education and guidance for women so that they can avoid unnecessary risks associated with the determination of the gestational age of pregnancies. The existence of referral services where women can receive needed services will complement a continuum of care beyond the provider settings and empower women more in informed decision-making. The WHO guidelines sum this up as self-management to be recognised by states as a potentially empowering and active extension of the health system and task-sharing approaches.[93]

## 7.5 Vigilance in protecting the law

To protect the law from reversals or overturns, advocates need to ensure that the intent of the law is well understood by the public and especially women's rights advocates. As Ethiopia has now ratified and acceded to the African Women's Protocol, the government must ensure that article 14(2)(c) is respected and continues to be implemented. Advocates should educate Ethiopian policy and decision makers to understand the value of regional, national, and local community ownership and guardianship of its rights and privileges and be open to encouraging voices to talk about abortion and other reproductive rights. Advocates should also look for champions from all walks of life to voice their support and encourage their constituencies to take informed decisions and stay vigilant to protect their rights. Complacency should be avoided as the anti-choice group in Ethiopia could be emboldened by the event in the US to increase its campaign to reverse or erode the existing opportunities for women in exercising their human rights.

92 As above.
93 As above.

### 7.6 Decriminalisation or de-legalisation of abortion

Despite the huge public health significance of unwanted pregnancy and abortion, it is a paradox that abortion service perhaps is the only health care that must be legalised. It is not only that it is full of controversies, but also it is highly politicised in some contexts, which requires re-examination. Most of all, abortion should not be regulated by criminal laws/criminal codes as it is a common healthcare issue and should never have been considered an exception. Though this is easier said than done, it needs actions by rights activists in mobilising efforts toward this goal. Further work is required in working on its de-stigmatisation, decriminalisation, and taking out of the legal regulation except to protect women from harm.

## 8 Conclusion

The revised abortion law has paved the way for reducing maternal morbidity and mortality from unsafe abortion by creating a favourable environment for women to exercise their reproductive rights in Ethiopia. This national law is reinforced by a regional treaty instrument, the African Women's Protocol, to realise the protection and implementation of this right. The state actors have a responsibility to enrich the enabling environment in which women's rights and needs are at the centre of their policies and programmes and all human rights of individuals are respected, protected, and fulfilled. One ultimate mechanism is by normalising abortion care, like all other healthcare services, and supporting its fullest integration into the country's existing maternal health programmes and essential healthcare services to achieve universal healthcare coverage. This will uphold the rights of people to access services and respect the rule of law of the land and all the international, regional and rights instruments the country has ratified and domesticated.

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