Ipas Partners for Reproductive Justice

THE CONTRIBUTION OF IPAS ETHIOPIA IN EXPANDING CONTRACEPTIVE AND ABORTION ECOSYSTEM IN ETHIOPIA

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Addis Ababa

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EXECUTIVE SUMMARY

Background

Ethiopia made a significant progress in addressing maternal death over the last decades. The maternal mortality rate decreased from 871 per 100,000 in 2000 to 401 per 100,000 in 2017.[1],Direct obstetric complications account for 85% of the deaths.[2] Evidence indicates that unsafe abortion accounted for 10% of avoidable maternal deaths.[3] Ipas Ethiopia node is among the leading players in Ethiopia's journey towards ensuring access to quality comprehensive abortion care and contraceptive services. Over the past two decades, Ipas in collaboration with the MoH and other partners become a leader in expanding safe abortion services creating conducive environment for women and young girls to have access to SRH information and services. It has implemented wide arrays of programs including training of health workforce on comprehensive abortion care and contraceptive service provision; enhancing the capacity of health program managers on program coordination and support; expanding quality CAC and CC services at health facilities, equipping health facilities with essential supplies, and provision of support for minor renovations; advocacy and community engagement. In this document, the contribution of Ipas Ethiopia node in terms of expanding comprehensive abortion care and comprehensive contraception information and services in Ethiopia is presented.

Materials and Methods

A cross sectional mixed method performance-based, change oriented documentation process was used. Accordingly, available primary and secondary data from Ipas database as well as national programs was collected and analyzed to present trends and historical milestones. We further looked this through the lens of the WHO's strengthening health systems to improve health outcomes, knowledge generation, meaningful participation of adolescents and youth. Twenty key informants selected from Ipas, MoH, service providers, professional associations and CBOs were selected and interviewed. Document review conducted based on Ipas data and reports (e.g., donor reports, technical briefs, research reports and conference abstracts) generated from the project implementation.

Summary Findings

The Stakeholder Landscape: In Ethiopia large number of local and international organizations including NGOs and the UN system are engaged in various aspects of reproductive health programming. The major partners of the MoH to expand access for CAC and CC include Ipas, Engender Health, Pathfinder, Mariestopes and Family Guidance Association of Ethiopia. Ipas employs sustainable abortion and contraception care ecosystem strategy to ensure accessibility, availability, acceptability, and quality of CAC and CC information and services.

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[1] https://www.moh.gov.et/site/initiatives-4-col/Maternal_Health
[2] MoH (2016): National Reproductive Health Strategy 2016-2020. https://www.prb.org/wp-content/uploads/2020/06
[3] https://ethiopia.unfpa.org/en/topics/maternal-health

Major Contributions of Ipas Ethiopia

Based on document review, stakeholders' interview and validation meetings with the Ipas team, the key contributions of Ipas Ethiopia node are: supported the legal reform and implementation of reformed abortion law; health systems strengthening on CAC and CC; Introduced its flagship VCAT (values clarification and attitude transformation) intervention, contributed to standardization of in-service trainings on CAC/CC, and awareness raising and evidence generation.

Advocacy and Community Awareness

A) Advocacy on improved legal environment was achieved through the concerted effort of Ipas with coalition members. Ipas in collaboration with the Ethiopian Women Lawyers' Association (EWLA), the Ethiopian Society of Obstetrician-Gynecologists (ESOG), Consortium of Reproductive Health Associations (CORHA) and other stakeholders played significant role in terms of advocacy for the reform of abortion law as well as providing technical support in the process of development and implementation of technical and procedural guideline for safe abortion care services in Ethiopia.
B) Sustaining and defending hardly earned gains - Ipas continued to work closely with COCAC members against opposition groups. the opposition momentum took advantage of some international efforts (Global Gag Rule reinstatement by Trump Administration) or incidents (COVID-pandemic) or any other issue malleable for diversion to oppose the abortion agenda.
C) Operational support – after the reform process, Ipas supported the development of technical and procedural guidelines, initiated trainings, supported equipment, supplies and consumables and renovated various health facilities to deliver the service.
D) Collaborations with youth and women led organizations, professional associations, Civil Societies contributed to the creation of safe spaces and attitudinal transformation towards abortion.
E) Over 60 local organizations were engaged, and several community-based programs were supported that enhanced increased awareness and knowledge about CAC and CC services. Community based interventions including IEC/BCC materials helped de-stigmatization of abortion and abortion related communications among the youth. Innovative, tailored and youth friendly services and information was provided through help points, community-based interventions, reproductive health corners, m-health, and other locally driven strategies. Several community-based organizations recognized CAC and CC in their programmatic strategies.

Health Systems Strengthening to expand CAC and CC services:

A) Championing within the Ipas network - Well before Ipas International adopted sustainable abortion ecosystems approach, by design, programs in Ethiopia already mainstreamed the health systems strengthening approach. The gains made regarding abortion care services in Ethiopia are attributable to interventions addressing the whole health system. Ipas implemented a women-centered abortion care and contraception program and catalyzed AAAQ (accessibility, availability, acceptability, and quality) approaches in all interventions including training that focused on improving providers' attitude and clinical skills, orientation of health managers and experts to effectively support and sustain CAC/CC programs, integration of abortion and contraceptive

services and reorganization of service delivery in public health facilities to be more convenient for women and girls and respectful interventions tailored to unique needs of clients.

B) Health workforce training systems – Ipas's approach on training of health workforce to deliver CAC and CC information and services in Ethiopia is both in-service training of mid-level health workers with a principle of task shifting and supporting revision of pre-service training curriculum for sustainability of having trained health care providers at public health facilities. Ipas supported health facilities are serving as practical training sites for both in-service and preservice trainings of health workers. Ipas's abortion care training manuals were adopted as a National Training Manuals for in-service training. Available studies indicated that several partners including Ipas, FGAE, Engenderhealth and Mariestopes trained about 13,869 health providers since 2006.[4] Accordingly, Ipas contributed to the training of about 66% of the health workforce providing CAC and CC services in Ethiopia.

Service Delivery

A) Expanded service delivery – In less than a decade since the revised penal code, nearly 400 facilities started providing SAC, and about 90% of the providers were mid-level providers, ensuring access to SAC at primary levels.[5] A study conducted by Yirgu et al (2016), indicated increased proportion of abortion service provision by mid-level health workers increased from 48% in 2014 to 83% in 2018.[6] In 2020, there were 1,636 public and private health facilities providing safe abortion care in Ethiopia. The same year a review of Ipas programmatic report indicates that about 1,095 (67%) of the national service delivery points were supported by Ipas Ethiopia. In Ipas intervention regions, about 73% of the SAC providing health facilities were supported by Ipas.

B) Comprehensive Contraception - The national contraceptive acceptance rate is at 73%. Ipas support ranges from 50% in SNNP to 93% in Oromia regional state. Between 2008 and 2013 (EFY) nationally, there is a stable contraceptive acceptance rate plateauing around 70%, which is similar at Ipas supported health facilities (ranging between 68-73%). Accordingly, the contraceptive acceptance rate ranges from 36% in Addis Ababa to 86% in Oromia Regional State. While injectables are the most used contraceptives, there are promising results regarding long-acting contraceptives that were used by 37% of the contraceptive clients nationally.

C) Safe Abortion Care - there were about 3,268,559 expected pregnancies of which 229,149 or (7%) were ended by safe abortion (2020). The proportion is slightly higher (8%) in Ipas supported Regional States namely, Addis Ababa, Amhara, Oromia and

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[4] Ipas (2022): Assessment Report on Partners Opinions, Feedbacks, and recommendations on Ipas-Ethiopia Project Implementation (Unpublished Report)

[5] Feyssa MD, Gebru SK. Liberalizing abortion to reduce maternal mortality: expanding access to all Ethiopians. Reproductive Health. 2022 Jun;19(Suppl 1):151. DOI: 10.1186/s12978-022-01457-z. PMID: 35761348; PMCID: PMC9237962.

[6] Gebrehiwot, Yirgu, Tamara Fetters, Hailemichael Gebreselassie, Ann Moore, Mengistu Hailemariam, Yohannes Dibaba, Akinrinola Bankole, and Yonas Getachew. "Changes in morbidity and abortion care in Ethiopia after legal reform: national results from 2008 and 2014." *International perspectives on sexual and reproductive health* 42, no. 3 (2016): 121.

SNNPRS. This is about 230,000 women receiving abortion care services out of approximately 3.3 million expected pregnancies in the year.

Medical Products and Technology

A) Equipment and Supplies - Ipas is a pioneer in introducing critical inputs for CAC services in Ethiopia, including abortion technology and state of the art knowledge base for medical abortions. Since 2006, for the last two decades Ipas has been a pioneer in delivering innovative and state of the art medical technologies to increase access to safe abortion care. About 1,055,785 abortion technologies were provided across the country, especially in Ipas intervention areas, of which 56.4% (595,685) were medical abortion supplies while the rest 43.6% (460,100) were Manual Vacuum Aspiration (MVA) sets. Based on the available published evidence[7] and information from key informant interviews, over the past two decades, we estimate that over 4 million medical abortion drugs and 825,000 MVA kits were distributed in Ethiopia. A latest study conducted in 97 Ipas supported facilities found that there were about 5 MVA kits per health facility during the survey.
B) Supply chain system strengthening – in addition to partnering with organizations such as DKT, Ipas supported Ethiopian Pharmaceutical Supplies Services in terms of drugs and supplies management, including training on forecasting, procurement and distribution of essential CAC and CC commodities and supplies and strengthening systematic support of EPSS to health care facilities to mitigate stock-out and reduce wastage at health facilities.

Health information systems

A) Ipas Database - Ipas maintained a large data base of various CAC and CC data that can be utilized for programmatic, research and advocacy purpose, which can be accessed from the M&E Team.
B) Advocacy for inclusion of CAC and CC indicators in the national health management information systems – over 12 age disaggregated indicators measuring post abortion care, safe abortion care, and comprehensive abortion care users are included in DHIS.
C) Developed and disseminated various evidence on abortion and abortion care including series of periodic studies on magnitude of abortion and other studies.

Leadership and governance

A) Ipas played a significant role in terms of shaping attitude and perception towards CAC/CC in health systems leadership and governance through training of program managers and leaders. Between 2009 and 2019. A total of 2,168 program managers were trained on program coordination and support of Comprehensive Abortion Care and contraception.
B) Annual review meeting: Ipas coordinated and supported annual review meetings conducted by Regional Health Bureaus (RHBs) and Zonal health departments to

[7] Ipas and the Coalition for Comprehensive Abortion Care (2021): Expanded Access to CAC Services and the Attendant Gains in SRH Since the Abortion Law Reform in Ethiopia, A Review of the Available Evidence

ensure that abortion care is systematically integrated into their annual planning and performance review meetings.

Health care financing

A) Advocacy targeting regional governments for increased financing and budgeting of sexual and reproductive health services, including abortion care was conducted periodically.

Capacity to deliver CAC and CC services.

A) Ipas supported facilities have demonstrated strong capacity and promising system and structure to ensure continuity of CAC and CC services. Health facilities assessed by this documentation process have trained CAC and CC providers and their infrastructure is conducive for service provision. Availability of comprehensive contraception commodities and supplies is a major challenge identified by majority of the health facilities. Stock-outs are common and are increasing overtime.

Lessons Learnt

A) Gains in revision of the abortion law need to be defended and maintained. There are various organized opposition movements endangering the rights of women and girls to access safe and comprehensive abortion care. Accordingly, advocacy should and will remain a critical intervention to sustain gains.
B) The engagement of CBOs and local development associations expanded community outreaches as well as space for various community-based activities. Ipas Partners incorporated abortion care in their own strategic documents.
C) Abortion providers and access to abortion care is often threatened by “informed, trained, sometimes professional staff” which makes the service delivery environment challenging. While increasing awareness is critically important, we believe that the right information should be provided to the right target group at a right intensity.
D) Task shifting of abortion services to middle level abortion providers is a major milestone in the history of Ethiopia. Burnout, staff attrition due to various reasons, staff rotation, lack of motivation and incentives and various other factors are areas of concern for sustainable delivery of abortion services. Accordingly, Continuous technical and managerial support for health care providers and building network among providers is needed.
E) Integration of comprehensive abortion care and family planning to the routine health service program is critical for sustainability. Accessibility, availability, acceptability, and quality of abortion and contraception care is taken as essential element of ensuring women’s health and reproductive rights and justice. Accordingly, the adoption of women centered delivery model has the potential to expand the services and improve the quality of care.
F) Supply chain barriers in the centralized delivery system may affect the gains made so far negatively. ~~Out of stock for reproductive health and family planning choices,~~ Stock-out of abortion and contraception supplies such as drugs for medical abortions and some types of contraception is becoming common and it will have a potential to threaten sustainable service delivery within public health facilities.

G) There is persistent, systematic and in some cases deep rooted ambivalence if not opposition towards abortion care among health workforces. Accordingly, the VCAT training, and its tailored versions need to be further strengthened and and incorporated into trainings of health workers.
H) Abortion stigma is rampant. Access to abortion care and the delivery of the service across health facilities is generally dependent on one critical factor which is availability of committed health workers that are impowered, well informed, and well trained.
I) The public-private partnership is a strategic engagement that enables to expand access to quality care and reduced post abortion complications and reduce pressure on referral centers for post abortion care.

1. BACKGROUND AND OBJECTIVES OF THE TASK

1.1. Background

According to the Ministry of Health, Ethiopia made a significant progress in addressing maternal death over the last decades. The maternal mortality rate (MMR) decreased from 871 per 100,000 in 2000 to 401 per 100,000 in 2017.[8] Direct obstetric complications account for 85% of the deaths. Evidence indicates that unsafe abortion accounted for 10% of avoidable maternal deaths.[9] Access to comprehensive family planning service, skilled delivery, and access to emergency obstetrics care for every complication, including those arising from unsafe abortion was attributed to the reduction. To reduce deaths and disabilities from unsafe abortion, Ethiopia liberalized its abortion law in 2005 to allow safe abortion under certain conditions. Ipas Ethiopia has been a key actor in Ethiopia's journey towards ensuring access to quality comprehensive abortion care and contraceptive services.

In Ethiopia in 2015–2019, there were a total of 4,920,000 pregnancies annually. Of these, 2,060,000 pregnancies were unintended and 632,000 ended in abortion. Abortion in Ethiopia is legal on broad medical, social or economic grounds (Guttmacher Institute, 2022).

Ipas has been implementing various promising and impactful interventions for over two decades. In this document the contribution of Ipas in terms of expanding sexual and reproductive health in Ethiopia for women and girls is presented. Over the past decades, Ipas in collaboration with the Ministry of Health and other partners has become a leader in establishing safe abortion services and creating reproductive health networks that connect women with care. It has implemented wide arrays of programs including training of health workforce on comprehensive abortion care and

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[8] MoH (2016): National Reproductive Health Strategy 2016-2020. https://www.prb.org/wp-content/uploads/2020/06

[9] MoH (2016): National Reproductive Health Strategy 2016-2020. https://www.prb.org/wp-content/uploads/2020/06

contraceptive service provision; enhancing the capacity of health program mangers on program coordination and support; improving quality of care at health facilities through periodic supportive supervisions, equipping with essential supplies, and provision of support for minor renovations; supporting youth and women led organizations to raise awareness and enhance service uptake regarding access to comprehensive contraception and safe abortion services.

1.2. Objectives

The overall objective of the documentation task is to document the contribution of Ipas Ethiopia in protecting the health and lives of women and girls from the consequences of unintended pregnancy and unsafe abortion. Specifically:

- Document the role and impacts of Ipas Ethiopia in creating an enabling environment for abortion and contraceptive information and service provisions including policy and advocacy, community education, Health System Strengthening, research, Monitoring & Evaluation and learning.
- Showcase the contribution of Ipas Ethiopia in improving the health and lives of women and young girls
- Compile experience and lessons learnt to enhance Ipas Ethiopia leadership actions and efforts at national, regional and international levels.
- Create an information pack to provide a ready source of materials for knowledge management, distribution to Ipas stakeholders and for resource mobilization and upscaling of proven interventions.

1.3. Scope of the Documentation

The documentation focused on the contribution of Ipas in protecting the lives and health of women and girls in Ethiopia over the past two decades. This includes the overall contribution of the organization irrespective of the phased programs and geographical focus. Historical archives, reports, significant milestones, and contribution of the organization were reviewed.

1.4. Limitations of the Documentation

This documentation focuses on contributions of Ipas Ethiopia as opposed to attribution for expansion of comprehensive abortion care and contraceptive information and services and the concomitant reduction in maternal death and mortality in Ethiopia. However, as data and evidence allow, we will highlight major contributions and specific attributions of Ipas Ethiopia, especially in relation to abortion and postabortion care service expansion, advocacy and systems strengthening.

2. TECHNICAL APPROACH AND METHODOLOGY

2.1. Technical Approach

To complete the task, we applied the following phased approaches.

- Phase 1 – Evidence generation to identify contribution of Ipas Ethiopia
- Phase 2 – Key stakeholders mapping and consultation.
- Phase 3 - Integrated synthesis and generation of the final report
- Phase 4: incorporating feedback and finalization.

2.2. Overall Methodology

We used cross sectional mixed method performance-based, change oriented documentation process. Accordingly, we collected all available primary and secondary data from Ipas database as well as national programs to see trends and historical milestones. We further looked this through the lens of the WHO's[10] strengthening health systems to improve health outcomes, knowledge generation, meaningful participation of adolescents and youth.

2.3. Data Collection and Synthesis

Document review conducted based on Ipas data and reports (e.g., donor reports, technical briefs, research reports and conference abstracts) generated from the project implementation. We also looked at the existing databases as well as published reports such as DHS data. In collaboration with the Ipas M&E unit, we conducted analysis of program historical data, studies and evaluations. The objective of the desk review is to summarize key milestones in the Ethiopian SRH history and identify the contribution of Ipas Ethiopia over the past decades. Best practices were documented and presented accordingly.

In addition, we collected data from selected health facilities selected from Addis Ababa, Holeta, Butajira, and Adama to document changes in terms of local capacity

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[10] WHO (2007). Everybody's business -- strengthening health systems to improve health outcomes: WHO's framework for action. World Health Organization. https://apps.who.int/iris/handle/10665/43918

to deliver CAC and contraceptives over years, using health facility capacity assessment tools.

The team standardized data collection tools to align with major studies conducted by Ipas Ethiopia over the past years to focus on key performance indicators that highlight the contribution of Ipas Ethiopia. This enabled the extraction, trend analysis and changes overtime. In addition, structured and semi structured tool was developed and used for data collection. For capacity assessment we used modified health facility capacity assessment tools.

2.4. Qualitative Methods

The qualitative data was collected concurrently with the quantitative data and used to triangulate the findings. Key informants were selected using a snowball sampling approach. We were able to identify the first list of over 17 recommended key informants after a preliminary discussion with the Ipas Team in Addis Ababa. Some of those key informants were contacted and the list was expanded later by incorporating other key informants recommended by the key informants themselves.

The number of informants were determined upon saturation of information on specified theme related to CAC and CC services. However, the evaluation team also conducted interviews from as diverse partners/stakeholders as possible to ensure representation of views and opinions. Qualitative data was collected using in-depth interview guide developed and share with the Ipas team with the inception report.

The Key Informant Guides summary

- Introduction and role
- Knowledge about Ipas work in Ethiopia and in the selected facility
- Types of reproductive health and CC services offered in the facility.
- The context of CAC in the facility
- Adequacy of resources (manpower, contraceptive choices, CAC equipment, supplies and consumables including supplies for medical abortion, infrastructure)
- Contribution of Ipas and support received over years from Ipas.
- Recommendations for Ipas

List	Role	Organization	# of Participants

1	Senior Management Staff	Ipas	3
2	Program Management Staff	Ipas	2
3	Senior Management Staff	CORHA	1
4	Program Management Staff	CORHA	1
5	Gynecologist and Obstetrician – Provider	Public Hospitals	2
6	ESOG Leadership	ESOG	1
7	Health Systems - Directors	ORHB/SNNP	2
8	CBOs Managers	Tamira, ADA	2
9	Middle Level Providers	Health Center	9

2.5. Health Facility Assessment

Health facility assessment was conducted focusing on the current status of trained health facility staff, medical equipment, Abortion Care and Comprehensive Contraceptive services at randomly selected project sites. In some of the health facilities a historical data was analyzed to depict expansion of service both quantitatively and in quality standards over the years. Furthermore, secondary data of all the service centers was accessed from Ipas head office and summarized accordingly. Six health facilities were assessed using a checklist focusing on capacity to deliver CAC and CC on sustainable basis. The checklist comprises of human resources for CAC and CC services, infrastructure, supplies and consumables, leadership and governance commitment to sustain CAC and CC services.

3. THE OPERATIONAL CONTEXT FOR IPAS PROGRAMS

3.1. Country Overview

Ethiopia is tenth largest and the second most populous country in Africa. The country is a federal democratic republic composed of 11 semi-autonomous regions, and two City administrations. Ethiopia shares borders to the north and northeast with Eritrea, to the east with Djibouti and Somalia, to the south with Kenya, to the west with Sudan and to the southwest with South Sudan.

Nearly 80% of the population of Ethiopia lives in rural areas, mainly depending on subsistence agriculture (Central statistics agency, July 2021). Agriculture accounts for 39% of the gross domestic product, and farmers depend on rainfed agriculture for their livelihoodwith 23.5% of its population living below the poverty line (US$ 1.9 per day).[11]

Figure 3-1: Map of Ethiopia

Ethiopia formulated a comprehensive health policy in 1993 to increase access to promotive, preventive, essential, curative, and rehabilitative health services for all segments of the population through decentralized, integrated health-care delivery systems. The MoH conducted a 20-year health vision exercise under the national development plan to advance towards a low- to middle income country by 2025 and an average- to middle-income country by 2035. HSTP-I (2016–2020) was prepared with this vision to serve as the health chapter of the second Growth and Transformation Plan and the first phase of the “Envisioning Ethiopia’s Path towards Universal Health

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[11] Poverty headcount ratio at national poverty lines (% of population) – Ethiopia; World Bank. 2020. https://data.worldbank.org/indicator/SI.POV.NAHC?locations=ET.

Coverage through Strengthening Primary Health Care by 2035". The second HSTP[12] is a 5-year national health strategic plan that covers the period July 2020–June 2025. HSTP II aims consolidation of gains for a resilient, sustainable, high-quality and equitable health system. The objective of HSTP-II is to improve the health status of the population by realizing four objectives: accelerate progress towards universal health coverage, protect people from health emergencies, transform woredas, and improve health system responsiveness.

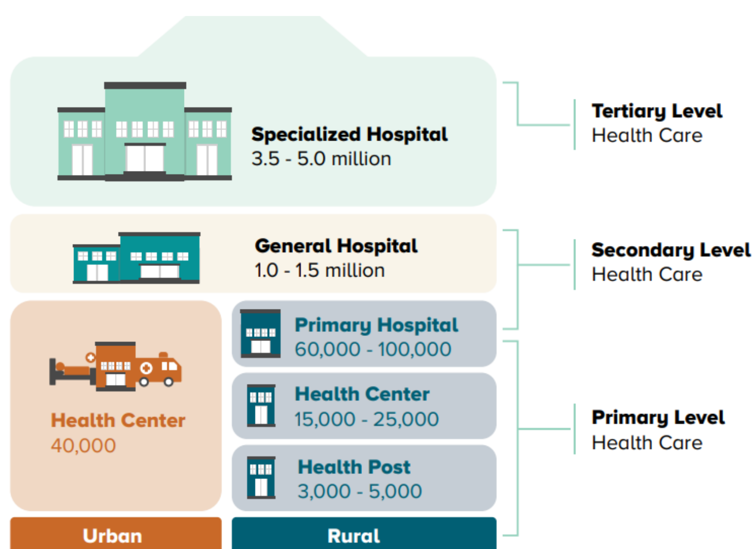

Figure 3-2: Structure of the health system in Ethiopia

The Ethiopian health system has 3 tier systems, and six components all have implications for comprehensive family planning delivery: (i) service delivery, (ii) health workforce, (iii) health information systems, (iv) access to essential medicines, (v) financing and (vi) leadership and governance. Ethiopia adopted primary health care as a national strategy in 1976 to provide fair access to health services by all people throughout the country. The health services are structured into primary, secondary and tertiary levels of care. The primary care unit comprises five satellite health posts, a health center and a primary hospital in rural areas and a health center in urban settings.

A health center provides both preventive and curative services. It serves as a referral center and provides practical training for health extension workers. It coordinates and supervises all health activities, including NTD programs, in the health posts in its

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[12] Health Sector Transformation Plan II (HSTP II) 2020/21-2024/25 (2013-2017 EFY), Ministry of Health-Ethiopia, February 2021.

catchment area. Primary hospitals, with 25–50 beds, offer inpatient and ambulatory services to about 100 000 people, including emergency surgery (such as caesarean sections and blood transfusions). They are referral centers for health centers in their catchment area and provide practical training for nurses and other allied health professionals. General hospitals serve as referral centers for primary hospitals (rural areas) and health centers (in urban settings) and are expected to serve about 1.5 million people. Some general hospitals also serve as training centers for health officers and nurses. Specialized tertiary referral and teaching hospitals have catchment populations of 3–5 million.

3.2 The Need for Comprehesnive Reproductive Health Services in Ethiopia

With a population of about 120 million in 2020, Ethiopia is the second most populous country of Africa and ranks 12th in the world. The country is characterized by rapid population growth (2.6%), young age structure, and a high dependency ratio, with a high rural-urban differential. Ethiopia has a high total fertility rate of 4.6 births per woman (2.3 in urban areas and 5.2 in rural areas) and a corresponding crude birth rate of 32 per 1000 in 2016. The average household size is 4.6. By 2024, the population is projected to reach 109.5 million and will reach 122.3 million by 2030[13]

Many teenage pregnancies in Ethiopia occur within marriage. Although the legal age of marriage in Ethiopia is 18 years, 14.1% of girls aged 20-24 are married by age 15, and 40.3% by age 18. There is large variation between regions, the highest being in Amhara region. Child marriage and teenage pregnancy have strong effects on the possibilities of girls to escape poverty. About 13% of women age 15-19 have already given birth. Teenage childbearing is more common in rural than in urban areas (15 vs 5%), and among women in Afar (23%) and Somali regions (19%) compared to Addis Ababa (3%). In Ethiopia, the abortion rate is 28 per 1000 women out of which 52.2% is accounted by adolescent and youth.[14],[15]

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[13] Health Sector Transformation Plan II 2020/21-2024/25 (2013-2017 EFY), MoH-Ethiopia, February 2021.
[14] Ethiopian Demographic Health Survey 2016
[15] Ministry of Health (2021): National Reproductive Health Strategic Plan (2021-2025), Addis Ababa

Over the past decades family planning services have been expanded and currently, at least one form of modern family planning services is available in almost all public health facilities in Ethiopia, ranging from 99% in health centers to more than 93% in general and referral hospitals. About 82% of private health facilities also provide family planning services. Access to modern family planning has been rapidly expanded. According to the latest Mini Demographic and Health Survey (2019), modern contraceptive use among married women increased over the last 15 years, from 8% in 2000 to 41% in 2019. According to Mini EDHS 2019, the most popular contraceptive methods used are injectable (27%) followed by implants (9%), and IUD and the pill (2% each).

According to the same survey (Mini-EDHS, 2019), the contraceptive prevalence rate (CPR) among married women increases with age, peaking at age 20-24 (52%) before declining steadily to 18% among women aged 45-49. Urban women are much more likely than their rural counterparts to use any method of contraception (50% versus 38%). Besides, CPR ranges from 3% in Somali to 50% in both the Amhara Region and Addis Ababa city administration.

According to the Guttmacher Institute (2022), in Ethiopia, the unintended pregnancy rate declined 33% between 1990–1994 and 2015–2019. During the same period, the abortion rate remained fairly level. Among all women aged 15–49 in Ethiopia, 12,000,000 want to avoid a pregnancy of which 7,500,000 (64%) whose need for modern methods is met and 4,200,000 (36%) who have an unmet need. During the same period, unintended pregnancies ending in abortion rose from 19% to 31%.[16]

Studies have also shown that there is a reduction in overall morbidity related to abortion. While maintaining the strength, still more work is needed to be done to improve the quality of comprehensive abortion care and to ensure equitable access of the service across all communities.[17]

3.3. Abortion and Post Abortion Care Providers Landscape in Ethiopia.

[16] Guttmacher Institute, undefined country profile, 2022, https://www.guttmacher.org/regions/africa/ethiopia.
[17] Ministry of Health (2021): National Reproductive Health Strategic Plan (2021-2025), Addis Ababa

In Ethiopia large number of local and international organizations including NGOs and the UN system are engaged in various aspects of reproductive health program. For example, one of the largest consortiums of organizations working on reproductive health issues, indicated its membership base reached to 78 organizations in 2022.[18] Another membership organization also indicated that it has over 70 NGOs engaged in its gender forum, which includes activities related to women, girls and children including sexual and reproductive health. However, specific to SAC and PAC the field ends up with very few international and local actors. While we are cognizant of the role of the local CSOs who have adopted progressive position regarding abortion care, for comparing apple to apple, we mainly assess the role and position of few international actors.

Table 1: Summary of major stakeholders supporting Abortion and Post Abortion Care

Stakeholder	Regional Focus	Interventions	Focus	Service Reach (2022)
Ipas	Addis Ababa, and parts of Amhara, SNNPR, Oromia, and Tigray	CAC including Family Planning Services	Public Health systems strengthening	85 Hospitals 792 Health Centers 61 Private Clinics (2019) 2 Private Hospitals (2019)
Engender	National (parts of some regions)	SAC, CAC and CFP	Public Health systems strengthening	632 public health facilities[19]
Pathfinder	National	Family Planning; PAC	Health Extension Program	Focusing on access to FP, ANC and PNC[20]
Mariestopes	National	SAC, CAC and CFP	Own Centers; Franchise with Private Sector	20 static MCH centers 10 Mobile Teams Appx. 500 Bluestar clinics/Franchise[21]
Family Guidance Association	National	SAC, CAC and CFP	Own Centers; Franchise with Private Sector	32 Health Facilities 15 Youth Centers 478 Franchised clinics

[18] https://corhaethiopia.org.et/about/history
[19] Titiyos, A. Assefa A., Mengistu W/T., Zerihun B., Kassaw, J., and O'Connell, K.A. 2021. Sustaining Comprehensive Contraception and Abortion Care Services among Transitioned Facilities in Ethiopia: Lessons Learned from EngenderHealth's Access to Better Reproductive Health Initiative (ABRI) Project. Edited by A. Agarwal. Addis Ababa: EngenderHealth/ABRI and Washington, DC: EngenderHealth.
[20] Pathfinder collaborates with governments in building the capacity of health systems to ensure quality, comprehensive abortion services that includes lifesaving postabortion care and contraception to prevent unintended pregnancies; and partner with communities to overcome the stigma and barriers that result in higher mortality and morbidity for young women from unsafe abortion
[21] https://www.mariestopes.org.et/about/our-centres/

Ipas aims at advancing reproductive health from the lens of reproductive justice by expanding access to abortion and contraception, using a comprehensive approach that addresses health, legal and social systems, including the issue of humanitarian crisis, climate change and environmental justice. Ipas works with partners to ensure that reproductive health services, including abortion and contraception, are available and accessible to all.[22]

Ipas is a key player in terms of delivering abortion care from a broader, bolder, and braver approach. Such enabling environment is partly attributable to the absence of politicized funding, such as the US government in its portfolio. Championing the cause of women requires taking harder decisions and positions, despite the funding consequences.

Ipas Ethiopia node, cognizant of the Ethiopian abortion care ecosystem has been dealing with demand and supply side barriers as well as drivers for sustainable abortion care. Such efforts include, working with the government, local and international partners as well as communities and individuals. Such approach enhances people's right for the right information at the right time; mobilizing community and political support for human rights and abortion access; and creating stronger and resilient health systems delivering abortion care; and enabling legal environment.

4. THE CONTRIBUTION OF IPAS IN EXPANDING REPRODUCTIVE HEALTH SERVICES IN ETHIOPIA

[22] https://www.ipas.org/wp-content/uploads/2022/03/annual-report-FY21-digital2.pdf

4.1. Identification of Key Contributions

Ipas began working in Ethiopia since 1999 to reduce deaths and injuries from unsafe abortion and formally opened its office in 2000. Since the abortion law was revised in 2005, Ipas Ethiopia has worked in collaboration with Ministry of Health, regional health bureaus and other partners to expand access to high-quality, safe abortion services and contraception. Community programs disseminate information on sexual and reproductive health, including a focus on informing young women where they can access safe abortion care.

In the following sections, we will highlight major contribution of the organization in terms of several parameters identified through the collection and analysis of primary and secondary data. Our major focus will be on Comprehensive Abortion Care (CAC) and Comprehensive Contraceptives (CC). In this case CAC is defined as provision of information, abortion management (including induced abortion and care related to pregnancy loss), and post-abortion care, while CC refers to provision of client centered choices of high-quality contraceptive services.[23]

Based on the evaluation criteria for the selection of best practices, and robust review of programmatic evidence, five critical contributions of Ipas Ethiopia were identified. The contributions are unanimously validated by Ipas Ethiopia team, the key informants, and stakeholders.

Figure 4-1: Thematic summary of Ipas contributions in the field of Reproductive Health in Ethiopia

[23] https://www.ipasdevelopmentfoundation.org/comprehensive-contraceptive-care

5. POLICY AND ADVOCACY: DECADES OF PROGRESS

5.1. Advocacy for Progressive Legal Environment for CAC services

Initiated in by mid-1990s, by the Family Guidance Association of Ethiopia, modern family planning expanded slowly across the country. Later, these initiatives were further scaled up by the Ministry of Health (MoH) in collaboration with UNFPA and other stakeholders.[24] Published literature in Ethiopia indicates the first guideline pertinent to family planning in Ethiopia was adopted in 1996. The revised version was developed in 2011, while the latest version is developed and adopted by the MoH in 2019.

The change of government in 1991 wide opened several opportunities for socio-economic, legal, political and policy reform in the country. Between, 1991 and 2005 several initiatives were implemented to place legal reform, mainly to align with the national constitution.

Key informant interview as well as review of existing evidence highlighted that Ipas in collaboration with the Ethiopian Women Lawyers' Association (EWLA), the Ethiopian Society of Obstetrician-Gynecologists (ESOG), Consortium of Reproductive Health Associations (CORHA) and other stakeholders played significant role in terms of advocacy for the reform as well as providing technical support in the reform process of the penal code in relation to the provisions regarding abortion and

Outcome of the advocacy Initiatives

Law Enactment: Abortion law expanded, and legal abortion is allowed in the case of save the life of the mother, rape, incest, or fetal impairment, disability, or a minor.

Conducive Environment for SAC: expanded clinical services, dedicated clinics, and training more midlevel providers.

Expanded quality care through VCAT interventions, which are later adopted by various NGOs and government trainings.

Increased number of actors and stakeholders: the liberalized law attracted several international organizations and local grassroots.

Increased networking to sustain results: active national coalition to defend Abortion Care and rights is in place.

[24] https://www.moh.gov.et/site/sites/default/files/2021-06/National%20Guideline%20final%20for%20Family%20Planning%202020%20edited-final%20version_August%2025_2020.pdf

contraception. A network of various advocacy organizations joined hands to ensure progressive policies on abortion.

> *"Ipas,[…] played a central role. In 2003, these and other organizations joined to coordinate their work through the Advocacy Working Group (AWG), a core set of NGOs committed to liberalizing the country's laws on abortion."*[25]

> *"[….of] the NGOs, Ipas was the most engaged and played a special boundary-spanning role. Although an international organization, Ipas hired a local director experienced in aligning organizational with national objectives, and added training, work on contraception, and increased engagement with policy. During reform, Ipas supported policy-related research, backstopped the Advocacy Working Group, and shared relevant resources and experience from other settings"*[6]

Generally, Ipas's advocacy in Ethiopia significantly contributed towards availability of abortion under broad indications through the reform of the penal code and creating conducive legal environment, addressing barriers related to policy and practice across the health system through trainings, workshops and mentorship, reduction of abortion stigma (an area that requires further and extensive investment), and expansion of access to abortion and comprehensive contraceptive services through direct implementation (model centers), policy and advocacy, engagement of local and international NGOs as well as the government of Ethiopia.

5.2. Operational Support to Deliver CAC: Piloting and Scaling up

Over the past two decades, through a series of concerted policies, programs, and commitments, Ethiopia has made notable advances in improving the reproductive health of its population, including expanding comprehensive abortion care information and services to larger segments of the population.[26] Ipas played a

[25] Holcombe SJ, Kidanemariam Gebru S. Agenda setting and socially contentious policies: Ethiopia's 2005 reform of its law on abortion. Reprod Health. 2022 Jun 13;19(Suppl 1):218. doi: 10.1186/s12978-021-01255-z. PMID: 35698196; PMCID: PMC9195348.

[26] DeMaria, L.M., Smith, K.V. & Berhane, Y. Sexual and reproductive health in Ethiopia: gains and reflections over the past two decades. *Reprod Health* **19** (Suppl 1), 175 (2022). https://doi.org/10.1186/s12978-022-01464-0

significant role in terms of shaping the policies and leading the implementation efforts of those policies over the past two decades through piloting and scaling up of various models and approaches.[27],[28] Furthermore, Ipas played a significant role in terms of the development, dissemination and cascaded training related to the introduction and implementation of technical and procedural guide for CAC service delivery in Ethiopia.

Ipas provided significant, technical, financial, and backstopping role in the reproductive health and family planning strategy development of the country. The latest National Reproductive Health Strategy (2016-2020) states that the goal of Family Planning is to reduce unintended pregnancies and enable individuals achieve their desired family size. Within Ipas, Ipas Ethiopia being the first country office to advocate for integration of comprehensive family planning (mainly learning from other peer organizations), the role of Ipas in terms of generating lessons learnt for the Ipas network to expand CC is found to be exemplary.

> *Without the technical assistance from Ipas and some other partners, the government may expand the service…may be, but not with the current pace, quality, and reach. Ipas was a key player in training health workers and expanding abortion care service in various parts of the country.*
> *Key Informant, MoH*

5.3. Keeping the Momentum: Advocacy Against Opposition Movements

Abortion is one of the rare health conditions legislated and often exposed for contentious views due to several social and religious factors. The most ardent supporters of individual right, often fail to embody abortion and the right of a women

[27] Otsea, K., Benson, J., Alemayehu, T., Pearson, E., & Healy, J. (2011). Testing the Safe Abortion Care model in Ethiopia to monitor service availability, use, and quality. *International Journal of Gynecology & Obstetrics*, *115*(3), 316-321.
[28] Samuel, M., Fetters, T., & Desta, D. (2016). Strengthening postabortion family planning services in Ethiopia: expanding contraceptive choice and improving access to long-acting reversible contraception. *Global Health: Science and Practice*, *4*(Supplement 2), S60-S72.

regarding her body and health. The determination of Ipas, on the right to contraceptive and abortion care and be able to determine their own future is central to sustain abortion care services in Ethiopia.

Over the past decades, the abortion law has been facing several deep-rooted and emerging regressive movements. Abortion rights are often under attack, from the left and right and are vulnerable for attack anytime in the future[29]. Recently, the opposition momentum took advantage of some international efforts (Global Gag Rule reinstatement by Trump Administration) or incidents (COVID-pandemic) or any other issue malleable for diversion to oppose the abortion agenda. In addition, the U.S. Supreme Court decision on overturning of constitutional protection of abortion (Roe v. Wade) has also embolden the antichoice groups. As one of the key informants indicated:

> *"In 2020, during the national prayers in Ethiopia, as part of the COVID-19 awareness creation initiative, various religious leaders attributed [our sin], such as liberalized abortion law for the pandemic."*

Ipas contribution in leading efforts against anti-choice movements has been well documented since advocating for the enactment of the law to date. Currently, Ipas leads various initiatives and coalitions of organizations (Coalition for Comprehensive Abortion Care) advocating for access to abortion care and working against opposition movements (those opposing abortion care). The approach taken by Ipas, which builds on local capacities of service providers and professional associations to influence policy and practice, exemplified a country led initiative for change. Accordingly, the Ipas approach which built on the interest of Ethiopian women and girls, women organization and leaders challenged misconceptions that consider abortion as a pro-western ideology laden agenda, often promoted at the behest of liberal, western donors and NGOs and other international organizations. This

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[29] Globally, there are various movements opposing women's right to access abortion care. In some countries, existing progressive laws were challenged by courts. In Ethiopia national prayers during the earlier days of the COVID-19 pandemic indicated that some of the difficulties the country is facing are attributed to "sin", including the stance of the government regarding abortion services.

mystified the myth – challenged abortion is not an agenda, rather is a critical element of women's health care and human right.

5.4. Genertaion of informed advocates and stakeholders:Youth voice

Despite the liberalized abortion law and expansion of safe legal abortion services, after two decades of work, yet significant proportion of Ethiopian practitioners experience moral dilemmas in connection with abortion.[30] Ewnetu et al (2020) highlighted the presence of concerning difficulties in reconciling tensions between religious convictions and moral norms and values, and professional duties among health service providers in Ethiopia.[31] Furthermore, despite the decriminalization abortion related stigma is pervasive across the community as well as the health systems.

Investment on Youth Voice Include partnership and support for:

- Younger Generations of Medical Students and their association
- Youth Led Organizations
- Local NGOs and Community Based Organizations

Accordingly, the role of Ipas in terms of creating safe space for abortion and attitudinal transformation towards abortion is critical. As one key informant from Ipas indicated:

> *"The current generation of health service providers are not very much aware of the gains we made over the years; they do not know what the septic ward looked like; they might not have seen women dying in the corridors bleeding due to unsafe abortion…our role is keeping the momentum and consolidating the gains we made through training, attitudinal transformation, prioritizing clients aspiration,…we believe we delivered it, though there are several areas to be addressed yet" (Key Informant, Ipas).*

[30] https://bmcmedethics.biomedcentral.com/articles/10.1186/s12910-021-00735-y

[31] Ewnetu, Demelash Bezabih, Viva Combs Thorsen, Jan Helge Solbakk, and Morten Magelssen. "Still a moral dilemma: how Ethiopian professionals providing abortion come to terms with conflicting norms and demands." BMC Medical Ethics 21, no. 1 (2020): 1-7.

“Youth bear a disproportionate burden of unintended pregnancy, unsafe abortion, and complications. The paradox is many youths do not have positive attitude towards abortion care, including university students coming to this sight for practice.” (Female Health Service Provider, Health Center)

The collaboration with Youth and Women led organizations, CBOs and NGOs helped Ipas to raise awareness of the younger generation regarding CAC and CC. This includes Technical and financial support to Ethiopian Medical Students Association, training to youth focused organizations, the media and advocacy organizations.

6. COMMUNITY AWARENESS RAISING AND DEMAND CREATION

Availability and accesibility of safe, legal abortion doesn't gurantee reproductive health, espeiclaly abortion care utilization among women and girls. In a highly stigmatized environment awareness creation for policy makers, providers and users is critically important. Rampant abortion stigma—along with social and religious barriers persists in denying many women access to safe abortion. As identified in Ipas advocacy framework for program design, action, and evaluation (2020), in a sustainable abortion ecosystem, social norms are free of abortion stigma and discrimination and are supportive of people's ability to exercise their sexual and reproductive health and rights. This demands for empowered communities, community organizations and civil society organizations. In a sustainable abortion ecosystem, women and girls seeking care have access to social support from a diverse range of community members. The effectiveness of Ipas supported community-based interventions is documented in Bekalu et al (2022).

Over the past two decades, Ipas supported over 60 Ethiopian local civil society organization through small grants initiative. The small grants initiative played a significant role in creating awareness, but also helped various CSOs to integrate various SRH and abortion care activities into their plan and program. Some of the local CSOs

STUDENT – CENTERED UNIVERSITY BASED SRH "HELP POINTS"

As per a study conducted by Ipas, young people especially college students are vulnerable groups to HIV and unintended reproductive health outcomes.

Ipas Ethiopia partnered with youth focused CBOs and 10 universities and established a youth friendly SRH "Help Points" to reach students with SRH information and referral services.

The university partnership increased the knowledge and attitude of university leadership towards importance of SRH well-being on academic performance.

Through this partnership, 400 peer educators were trained to provide fellow students with SRH information on safer reproductive health practices and options. Between 2009 and 2015, close to 200,000 university students were reached with SRH information and 3,402 fellow students received referral for SRH services including contraception and comprehensive abortion care.

Studies indicated improved knowledge about contraception, safe abortion, abortion law and availability of SRH services. It also facilitated open discussion and dialogue in relation to SRH among the university students.

supported by Ipas, which incorporated abortion related services in their strategy include:

- Amhara Developmnet Association
- Oromia Developmnet Association
- Action for Sustainable Developmnet
- Tamira for Social Developmnet Organization
- Mahibere Hiwot for Social Development
- Tiret – Youth Association, Gurage
- WYDA – Community Intervention
- AwiDa – Awi Developmnet Association

Cognizant of this fact, Ipas Ethiopia initiatied various awarenss raising initaives targeted various population groups. Some of the initiatives are summarized below.

Table 2: Major Ipas led initiatives to address demand creation and awareness.

Intervention	Target Group	Setting	Approach	Implementing partners
Help Points	University Students	Campus. 10 universities	Connects students with peer educators and sexual and reproductive health services	Implemented by Amhara Development Association and Mahibere Hiwot Reproductive and Health Social Development Organization, YMCA and TAYA
Community based interventions	Health Extension Workers, and Women's Development Army and volunteers.	Communities	Interventions to improve abortion knowledge and reduce stigma	Oromia Development Association Action for Sustainable Development Totally about 40 CBOs supported
Reproductive Health Corners	Youth (Out of school and in-school Youth)	Communities Youth Centers:	Educators raising issues and drama to initiate conversations (including abortion)	Batu town, Oromia region, implemented by Tamira Reproductive Health

		Shimbit (Amhara); Batu (Oromia); Hagereselam (Tigray); and Butajira		and Development Organization And other partners in Tigray and Amhara
MHealth	Four Universities	Campus based	Education and remote support (FP, CAC)	

Through the Community Partnerhsips with Youth Focused interventions and local sub-granting Ipas supported students and young people; especially with university partnership and integrating reproductive health training in pre-service curriculums. As indicated above, the university partnership supporetd over 10 universities to establish Sexual and Reproductive Health Service points and several youth cenetrs to establish youth SRHR corners.

Earlier studies indicated that community and youth engagement have been proven to be an effective approach for increasing contraceptive choice and uptake for young women seeking abortion care in Ethiopia.[32] Ipas was able to achieve the results by adopting youth-focused and targeted training, in addition to the standard general trainings.

7. HEALTH SYSTEMS STRENGTHENING FOR FP AND CAC

The health system refers to all organizations, people and actions whose primary intent is to promote, restore or maintain health. The health system consists of the six core building blocks including service delivery, health workforces, information, medical products, vaccine and technologies, financing, and leadership/governance.[33] A well-functioning health system, with all the blocks working in harmony, depends upon having trained and motivated health workers, a well maintained infrastructure

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[32] Alemayehu, T., Biru, D., Brahmi, D., & Fetters, T. (2016). An evaluation of postabortion contraceptive uptake following a youth-friendly services intervention in Ethiopia.
[33] Everybody's business: strengthening health systems to improve health outcomes: WHO's framework for action. Geneva: World Health Organization; 2007 (https://apps.who.int/iris/handle/10665/43918).

and a reliable supply of medicines and technologies, backed by adequate financing, strong health plans and evidence-based policies.[34]

The gains made regarding abortion care services in Ethiopia are attributable to interventions addressing the whole health system. This includes training that focused on improving providers' interpersonal and clinical skills, stronger integration of abortion and contraceptive services and reorganization of service delivery in public health facilities to be more convenient for women and girls and respectful interventions tailored to unique needs of clients. In the following section we will present the contribution of Ipas in Ethiopia regarding the expansion of abortion care in Ethiopia in a sustainable way, addressing the health system approach.

> *"Currently, in addition to provision of abortion care and comprehensive contraceptive, we serve as training sites for Ambo University, Addis Ababa University and St Paul Millennium Medical College. Every year we accept over 100 students for practical training. Majority of the students complete their training after practically demonstrating their capability to provide choices of family planning services.*
>
> *Key Informant, Holeta Health Center*

7.1. Health workforce

In the following section two key contributions of Ipas Ethiopia are documented. These include building the health workforce capacity to deliver comprehensive abortion care and comprehensive contraceptives and supporting a training ecosystem through strengthening systems and availing resources for training provision. Ipas approach contributed towards meeting short, intermediate, and long term needs of health workforce of the country through in-service task shifting and pre-service training with standardized curriculum. In addition to the universities, that incorporated abortion care and comprehensive contraceptive service in their training curriculum, Ipas supported health centers are also serving as practicum or internship sites.

[34] https://www.who.int/publications/i/item/9789240039483

7.2.1 Trained Manpower and addressing the needs for expedited expansion.

Existing evidence indicate that since 2006, Ipas continued training health care providers to provide quality and safe abortion care and contraceptive services in collaboration with the Ministry of Health and regional health bureaus. This effort strengthened the health system capacity to deliver comprehensive abortion and contraception and range of reproductive health services as part of the regular health service provision in large number of health facilities in Ethiopia. The major success of Ipas and other partners in this regard is task shifting and task sharing innovations across the country. In addition to Gynecologists and Obstetricians, Ipas and other partners trained large number of middle level health service providers including midwives, nurses and health officers on SAC and CC. As early as June 2012, in a less than a decade since the revised penal code, nearly 400 facilities started providing SAC, and about 90% of the providers were mid-level providers, ensuring access to SAC at primary levels.[35] Furthermore, this transition has been confirmed by a study conducted by Yirgu et al (2016), which indicated increased proportion of abortion service provision by mid-level health workers, from 48% in 2014 t0 83% in 2018.[36]

After legal reform, Ipas started to provide comprehensive abortion care training. Ipas played significant role in shifting practice from sharp metallic curettage to safest and WHO recommended methods of Manual Vacuum Aspiration and medical abortion. Since the early phases, the Ethiopian Ministry of Health adapted the Ipas training manual and curriculum, which was adapted as the national training manual.

The task sifting of abortion care and contraception services towards mid-level providers helped to expand comprehensive abortion and contraception services to vulnerable groups. A review of a publication[37] indicates that by 2014, a greater

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[35] Feyssa MD, Gebru SK. Liberalizing abortion to reduce maternal mortality: expanding access to all Ethiopians. Reproductive Health. 2022 Jun;19(Suppl 1):151. DOI: 10.1186/s12978-022-01457-z. PMID: 35761348; PMCID: PMC9237962.

[36] Gebrehiwot, Yirgu, Tamara Fetters, Hailemichael Gebreselassie, Ann Moore, Mengistu Hailemariam, Yohannes Dibaba, Akinrinola Bankole, and Yonas Getachew. "Changes in morbidity and abortion care in Ethiopia after legal reform: national results from 2008 and 2014." *International perspectives on sexual and reproductive health* 42, no. 3 (2016): 121.

[37] https://www.ipas.org/wp-content/uploads/2020/07/PMDEXPE16-ExpandingRolesofProvidersinSAC.pdf

number of less educated, younger, and unmarried women received abortion care services in Ethiopia from mid-level health care workers compared to physicians.

7.2.2 Establishing High Impact Training Systems

The contribution of Ipas in terms of strengthening the training systems in Ethiopia has been a critical element of the health systems strengthening. Two key contributions are notable: establishment of training centers (e.g., Yekatit 12 and Gondar) hospitals with increased presence of Ipas trained master trainers in the centers and development of evidence-based state-of-the art training materials/manual. Based on the key informant interviews, currently, majority of the CAC and CC related training materials and resources used in Ethiopia on abortion are mostly adapted from Ipas resource materials (Table 9 below).

In addition to the training materials, Ipas further supported over 15 universities and hospital based training institutions (example Yekatit 12) and integrated abortion care into the curriculums of Ethiopian higher learning institutions. Training materials are tailored to address the needs of the health workforce in terms of improving their knowledge and skills as well as transforming attitudes and practices towards abortion care services.

Table 3: Summary of Ipas initiatives in strengthening sustainable supply of health workforce for Abortion Care

Manual	Purpose	Level of adoption
Woman-Centered, Comprehensive Abortion Care Reference Manual	The Manual reflects Ipas's comprehensive abortion care service delivery model, which encompasses induced abortion as well as treatment for incomplete abortion and complications of unsafely induced abortion and postabortion contraception. This manual provides in-depth clinical information on uterine evacuation with both MVA and pills.	Fully adopted standard training material by MoH and Partners in Ethiopia
Dilatation & Evacuation (D&E) Reference Guide: Induced Abortion and Postabortion care at or after 13 weeks gestation	This reference guide provides information and recommendations based on evidence for dilatation and evacuation (D&E), a form of abortion that utilizes a combination of specialized forceps and vacuum aspiration to evacuate the uterus at or after 13 weeks gestation, for women who need either induced abortion, treatment of incomplete abortion or postabortion care.	Standard training manual used by several NGOs

Misoprostol for use in postabortion care: A service delivery toolkit	The toolkit provides information and tools to help district or national-level clinicians, facility managers or program managers to (1) initiate the use of misoprostol as a medical treatment for incomplete abortion or (2) integrate misoprostol into existing postabortion care (PAC) services that already use manual vacuum aspiration (MVA).	Standard training manual used by several NGOs
Abortion Attitude Transformation: A Values Clarification Toolkit for Global Audiences	This toolkit is a resource for trainers, program managers and technical advisors who organize or facilitate training events and advocacy workshops in the field of sexual and reproductive health and, specifically, for increased access to safe abortion care. It is designed to provide experienced facilitators with the background information, materials, instructions, and tips necessary to effectively facilitate abortion values clarification and attitude transformation (VCAT) interventions. There are also activities and materials to conduct a workshop to help experienced trainers increase their skills in facilitating abortion VCAT training events.	Fully adopted standard training material by MoH and Partners in Ethiopia
Pre-service Training Curriculum[38]	Developing and standardization of Comprehensive Abortion Care Training among Ethiopian universities Continuous supporting of the pre-service training – for Modular training organizing workshops Strengthening practical attachments and skill lab – including supplies	National; 15 higher learning institutions/universities

In 2014, Ipas International in collaboration with the International Federation of Medical Students' Associations developed a training module named youth act for safe abortion.[39] This manual has been used to train young and future healthcare workers. Accordingly, engaging younger generation of medical service providers through training and advocacy has been instrumental in sustaining abortion services in Ethiopia. This training has been critically important in positioning various health workers as potential abortion care providers. As a key informant indicated:

> *"This [Young Providers Training] is partly training to develop their knowledge and skill towards abortion care, ….it is an essential effort towards de-*

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[38] Interview with the SMT of Ipas Ethiopia (December 2022)

[39] Ipas Ethiopia used Woman Centered Comprehensive Abortion Care (WCCAC) training manual it developed to train abortion care providers. Later this manual was adapted by MoH, and the National Abortion care training manuals (trainers guide and trainee manual) was developed. Currently, Ipas is using the National manual to train new health professionals on comprehensive abortion care. Ipas also trains comprehensive family planning providers using the National training manual.

stigmatization of abortion services among the future health workforces. Without this groundwork, task shifting would have been very challenging, if not impossible."

Key informant, Ipas.

A study conducted to assess Partners Opinions, Feedbacks, and recommendations on Ipas-Ethiopia Project Implementation (Ipas, 2022) concluded that the contribution of Ipas in training and infrastructure support to expand CAC and CC was tremendous, especially in terms of expanding the pool of master trainers through TOT who cascaded trainings to service providers. The training, especially VCAT reached a larger audience beyond health service providers, and expanded to various community groups, including police officers, community, and religious leaders.[40] The conclusion is in line with the programmatic/periodic data of Ipas collected for over a decade. As per the dataset, since 2006, about 9096 health professional received training on comprehensive abortion care (CAC) by Ipas programs.[41]

The contribution of Ipas Ethiopia node regarding the training of reproductive health and abortion care service providers was significant.[42] Accordingly, Ipas contributed to the training of about 66% of the health workforce providing CAC and CC services in Ethiopia. The professional disaggregation is summarized in the following table. Majority (94%) of the health workforce was trained in the last 10 years including the

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[40] Ipas (2022): Assessment Report on Partners Opinions, Feedbacks, and recommendations on Ipas-Ethiopia Project Implementation (Unpublished Report)
[41] Ipas database 2006 – November 2022
[42] Ipas (2022): Assessment Report on Partners Opinions, Feedbacks, and recommendations on Ipas-Ethiopia Project Implementation (Unpublished Report)

year 2022, signaling accelerated expansion of CAC services in Ethiopia and its accessibility to large parts of Ipas supported Regional States.

> *"Seemingly simple interventions may bring significant change in terms of rational use of drugs, supplies, instruments, and equipment. For example, if not well-informed people might dispose MVA aspirator and cannula by simply reading the package and the expiry date. The expiry date is not about the instruments, rather it is for the packaging (sterile shelf life). Medical abortion drugs come in a package. Health service providers may use them separately to meet urgent needs using separate drugs. However, this might lead to great cost inefficiency, especially if they use the Misoprostol for PAC and leave the Mifepristone. Accordingly, simply providing the right information, if not training, makes difference. These are examples of what Ipas has done. This knowledge and logic is transferable to other products to, enhancing rational use of supplies"*
>
> *Key Informant, Addis Ababa.*

Table 4: Summary of health workforce trained by Ipas to deliver CAC and FP

Trained Health workforce by profession	Total (2006-2022)	FY12 – FY22
Obstetricians and Gynecologists	15	15
General Medical Practitioners	53	53
Health Officers	829	829
Midwives	4038	3991
Nurses	2042	1926
Program managers/coordinators	2168	1924
Others	195	40

Generally, other studies relying on primary data collected from 97 facilities in 2020 confirmed that there are adequate health workforces to provide abortion care and comprehensive contraception in the visited health facilities. The mean number of active abortion care providers available was 2.6 for both MVA and MA and the average number of trained providers per facility was 3.4 during the survey conducted in 2020.[43] If we combine a team of a health officer and midwife/nurse trained over

[43] Ipas (2020): Women-centered abortion care in public health facilities in four regions of Ethiopia: An assessment of service quality from women's and provider's perspectives

years by Ipas program, the expected number service providers per health facility supported is about 4.4 providers per facility, which is consistent with the sample survey results.

7.2. Service delivery

Ipas and partners in Ethiopia changed the abortion landscape in significantly, with speed, quality, and reach over the past two decades. In 2002, Gebreselassie (2002) highlighted that out of 120 health facilities studied, only 54% were able to deliver post abortion care, by performing a uterine evacuation with either sharp curettage or manual vacuum aspiration (MVA). During the same period, only three (13%) of all the public sector health facilities in Addis Ababa were providing PAC services. Only half of the 120 facilities were able to clinically manage an incomplete abortion, mostly hospitals (Gebreselassie, 2002). The sad reality of providers experience in relation to the effects of unsafe abortion is summarized in a note at a DKT website.[44], [45]

> "*The septic room. The ward at Black Lion.*"
>
> "*A trail of blood on the clinic floor. A beautiful woman dying shortly after arrival at care.*"

In Ethiopia access to safe abortion care significantly expanded over the past 15 years. In 2019, the latest year data is available for service delivery points for safe abortion care services (MoH, 2020), there were 1,636 public and private health facilities providing safe abortion care in Ethiopia. The same year a review of Ipas programmatic report indicates that about 1,095 (67%) of the national service delivery points were supported by Ipas Ethiopia. Regarding region specific contribution, we conducted a separate analysis of regional disaggregation was conducted based on Ipas focus regions, namely Addis Ababa (private health facilities), Amhara, Oromia, SNNP and Tigray. Within the Ipas targeted regions, about 73% of the SAC providing health facilities were supported by Ipas. Ipas support ranges from 50% in SNNP to 93% in Oromia regional state. Between 2008 and 2013 (EFY) nationally, there is a

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[44] https://dktethiopia.org/en/safe-abortion-what-does-it-mean-in-the-ethiopian-context/
[45] During our interview, nearly all key informants mentioned about their experience of the septic room in different facilities in Addis Ababa, irrespective of their professional background.

stable contraceptive acceptance rate plateauing around 70%, which is similar at Ipas supported regions (ranging between 68-73%).

Table 5: Contribution of Ipas in expanding access to abortion care in private and public health facilities.

Region	Total # of health facilities providing SAC	Total # of Ipas supported HFs providing SAC	Ipas contribution
Addis Ababa[46]	101	63	62%
Amhara	377	262	69%
Oromia	520	483	93%
SNNP	301	150	50%
Tigray	199	137	69%
Total	1498	1095	73%

At an intermediate results level, the overall effect of the service expansion over the decades has been translated into women's benefit in terms of accessing comprehensive abortion care and comprehensive contraception. In this period, Ipas contributed for over a million women and girls accessing comprehensive abortion care services, of which about 40% is achieved between 2018 and 2022. This claim has been supported by evidence generated by Ipas (2020), where an independently commissioned consultant found that among 97 facilities visited, CAC was available in 100% of the health facilities supported by Ipas.[47]

Ipas contribution regarding larger geographical coverage is often noted by partners. As an informant from Oromia Regional Health Bureau indicated:

> *"Majority of the CAC, SAC and PAC partners are based in urban parts of Oromia. However, Ipas has been serving remote health facilities, often challenging to be reached by our own capacity."*[48]

Table 6: Contribution of Ipas in terms of delivering comprehensive abortion care in Ethiopia.

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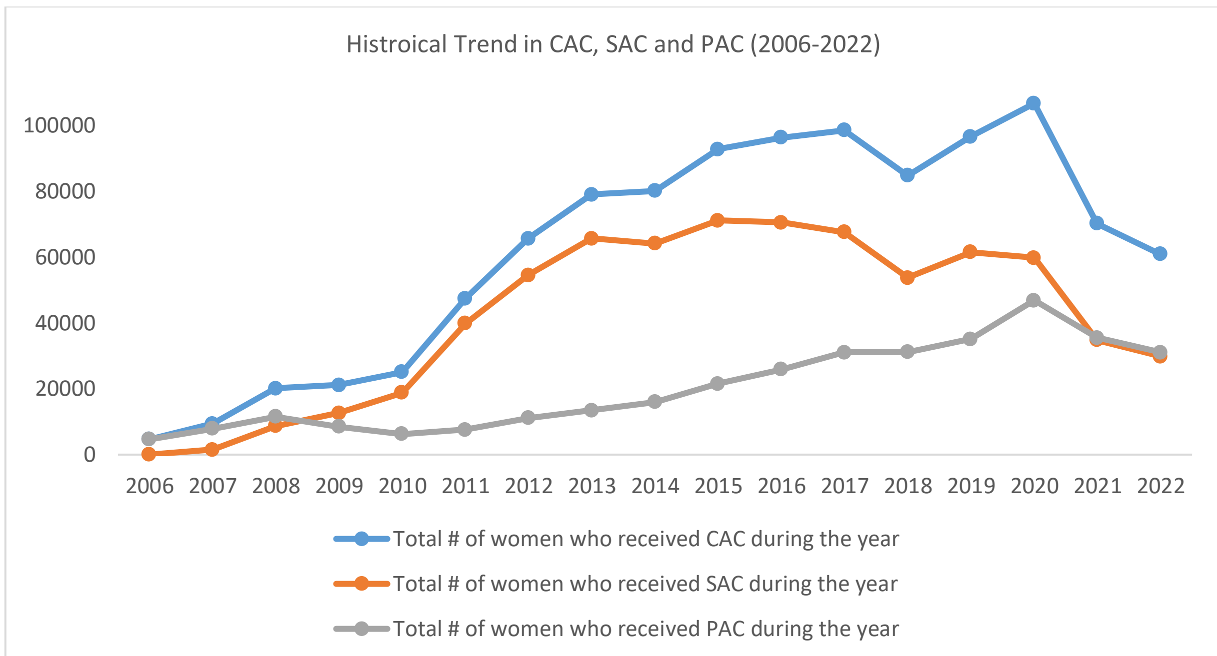
[46] It should be noted that Ipas support in Addis Ababa is mainly focusing on private health facilities and limited public health facilities.
[47] Ipas (2020): Women-centered abortion care in public health facilities in four regions of Ethiopia: An assessment of service quality from women's and provider's perspectives
[48] Key informant from Oromia Regional Health Bureau

Comprehensive abortion care provided	2009- 2022	2018- 2022
Total # of women who received CAC during the year	1,058,946	418,992
First trimester abortions	924,407	359,628
Second trimester abortions	133,706	58,701
Total # of women who received SAC during the year	714,259	239,519
First trimester abortions	480,443	224,475
Second trimester abortions	31,546	14,886
Total # of women who received PAC during the year	344,687	179,473
First trimester abortions	205,742	135,153
Second trimester abortions	67,956	43,815

The following graph highlights that a successful transitioning has been achieved from a predominantly PAC related service to SAC services, since 2009 and successfully maintained until 2021.

Table 7: Historical contribution of Ipas in reaching women and girls receiving CAC and PAC services



Contraceptive prevalence rate has steadily increased from 8% in 2000 to 41.4 as per the mini-DHS. Unmet need has declined from 37% in 2000 to 22% in 2016. There is still a huge disparity across regions and among various socio demographic indicators. The CPR is 3.4% in Somali compared to 50% in Addis Ababa. The ministry of health believes that access to family planning service is one of the reproductive rights of a woman and it is one of the tools used to prevent unintended pregnancy and to reduce maternal mortality in Ethiopia.[49] Based on the latest heath and health related indicators (MoH2020/21), the national contraceptive acceptance rate is at 73%. Contraceptive acceptance rate is the proportion of women of reproductive age (15-49 years) who are not pregnant who are accepting a modern contraceptive method (new and repeat acceptors). Each acceptor is counting only once, the first time she/he receive contraceptive services in the calendar year. Accordingly, the contraceptive acceptance rate ranges from 36% in Addis Ababa to 86% in Oromia Regional State.

Table 8: Contraceptive acceptance in Ipas supported Regional States (2020) [50], [51]

Region	Contraceptive Acceptance	Contraceptive Acceptance Rate (CAR)
Addis Ababa[52]	328,706	36%
Amhara	3,766,619	83%
Oromia	6,253,769	86%
SNNP	2,418,270	74%
National	14,008,577	73%

In the following section the role of Ipas in terms of service expansion, ensuring access, acceptability, quality, and equity of comprehensive family planning service in Ethiopia is presented. Based on the health and health related indicators (MoH,

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[49] Ministry of Health (2020): National Guideline for Family Planning Services In Ethiopia https://www.moh.gov.et/site/sites/default/files/202106/National%20Guideline%20final%20for%20Family%20Planning%202020%20edited-final%20version_August%2025_2020.pdf

[50] Note that this is an overall contraceptive coverage in the Ipas supported Regional States. This is not an attribution of the results to Ipas support. However, as a key player in the region and sometimes as an only actor, we have a reasonable confidence that significant role has been played by Ipas in the Regional states.

[51] MoH (2020/21), Health and Health Related Indicators, Addis Ababa

[52] Ipas support in Addis Ababa is limited to public health facilities..

2020/21), by 2019, there were about 3,268,559 expected pregnancies of which 229, 149 or (7%) were ended by safe abortion. The proportion is slightly higher (8%) in Addis Ababa, Amhara, Oromia and SNNPRS. This is about 230,000 women receiving abortion care services out of approximately 3.3 million expected pregnancies in the year.

Table 9: Abortion Care coverage in Ipas supported Regional States (2020)[53]

Region	Total # of expected pregnancy (n)	Abortion (a)	% of women received abortion care (a/n)
Addis Ababa	87,854	34,869	40%
Amhara	759,483	46,923	6%
Oromia	1,355,898	101,265	7%
SNNP	572,700	25,285	4%
Total	2,775,935	208,342	8%

The contribution of Ipas Ethiopia node in expanding access to comprehensive family planning is notable. A robust service delivery data is available at Ipas database since the year 2009. In terms of ensuring access to comprehensive contraceptive services, Ipas played a substantial role in delivering range of services and choices. A clear indicator of success of the program is that about three forth of the services, except for condoms, were delivered over the past five years (between FY 2018-2022).

Table 10: Contribution of Ipas in delivering comprehensive family planning service in Ethiopia.[54]

Comprehensive Contraceptive Services	2009- 2022	Percent
Injectables	5,151,641	49.9%
Implants	3,382,107	32.8%
Oral Contraceptives	1,117,925	10.8%
IUCD	406,298	3.9%
Condoms	195,916	1.9%
Other	35,522	0.3%
Emergency Contraception	19,795	0.2%
Tubal Ligation	5,208	0.1%
Vasectomy	249	0.0%

[53] MoH (2020/21), Health and Health Related Indicators, Addis Ababa
[54] Ipas Data base

Total	10,314,661	100.0%

As indicated above, against the debate that increased access to abortion care may increase abortion seeking behavior, majority of the women and girls in Ethiopia maximize prevention of unintended pregnancy by using choices of contraceptives. It is very encouraging that nearly 37% of the Ipas supported modern family planning service users rely on long-acting contraceptives such as implants and IUCD.

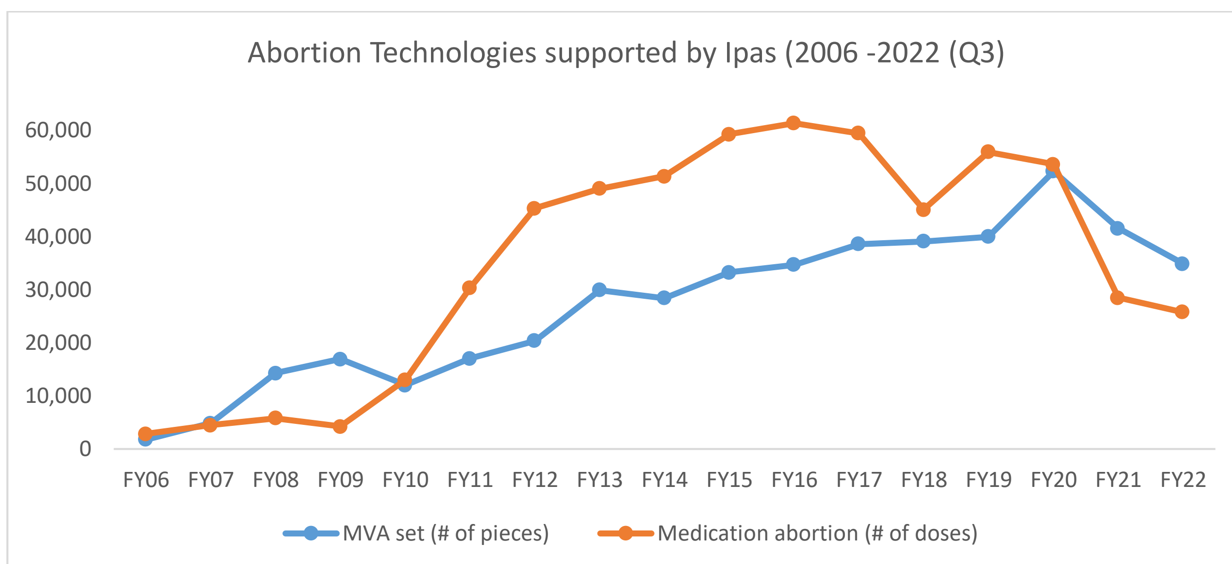
7.3. Medical products and technologies

Ipas Ethiopia node significantly contributed in introducing majority of the critical inputs for SAC and PAC in Ethiopia, this included both the technology and knowledge base. Ipas introduced Ipas MVA Plus® aspirator and easy grip cannula in Ethiopia and elsewhere. While there are few other stakeholders directly or indirectly engaged in the introduction and distribution of technologies, based on key informant interviews and available data, we found that Ipas has been playing a significant role in this attribute.

The system level influence of Ipas, specially, efforts towards transitioning from an NGO funded procurement system to the public sector system is a critical milestone for sustainability of the program. Currently, majority of the family planning and abortion care supplies, instruments and equipment are part of the essential supplies, planned, procured, and delivered through the central procurement system. Ipas also supported regional hubs of Ethiopian Pharmaceutical Supplies Services in terms of drugs and supplies management, including training on forecasting, procurement and distribution of essential CAC and CC commodities and supplies and strengthening systematic support of EPSS to health care facilities to mitigate stock-out at service delivery points.

Since 2006, about 1,055,785 abortion technologies were provided across the country, especially Ipas targeted areas, of which 56.4% (595,685) are doses of drugs for medical abortion supplies while the rest 43.6% (460,100) are Manual Vacuum Aspiration (MVA) sets.

Figure 7-1: Abortion technologies supported by Ipas Ethiopia



As it can be seen from the graph above, the proportion of medical abortion drugs has significantly increased since 2010 overtaking the supply of MVA kits almost for a decade. There is also a noted decline in supply of both technologies since the year 2020. Based on the available published evidence[55] and information from key informant interviews, over the past two decades, we estimate that over 4 million doses of drugs for medical abortion and 825,000 MVA kits were distributed in Ethiopia. As indicated above, we estimate that between 15-20% of the medical abortion drugs and 72% of the MVA kits are supported in collaboration with DKT Ethiopia. A latest study conducted in 97 Ipas supported facilities found that there were about 5 MVA kits per health facility during the survey.

To facilitate the drug logistics and supply systems, Ipas worked with the Ethiopian Pharmaceutical Supplies Agency and Food and Drug Administration Agency over the years. The trainings are technical assistance range from basic trainings on supplies and consumables handling and rationale drug use to systematic issues of quantification, planning and forecasting.

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[55] Ipas and the Coalition for Comprehensive Abortion Care (2021): Expanded Access to CAC Services and the Attendant Gains in SRH Since the Abortion Law Reform in Ethiopia, A Review of the Available Evidence

7.4. Health information systems

The contribution of Ipas in terms of health information systems partly arises from service driven data. For several years, the health and health related indicators annual report captured various family planning and abortion care statistic. MOH has incorporated abortion service statistics into its health information system and requires health facilities providing CAC services submit reports on selected indicators. Through concerted advocacy, technical assistance and various consultative workshops organized by Ipas and other coalition, over 12 age disaggregated indicators are currently incorporated into the DHIS2 system. The indicators include number of post abortion car, safe abortion care, and comprehensive abortion care users. The latest version of the DHIS incorporated age disaggregated data by trimester for age below/above 18 years.

One of the notable contributions of Ipas Ethiopia is the maintenance of a large database of various indicators regarding the abortion care ecosystem in Ethiopia. The data base without doubt will continue to inform the organization, ministry, and researchers now and in the future. Over the last decades Ipas collects and analyses data from all partner facilities. Core indicators include a detail information on comprehensive abortion care provided, abortion technologies used over years, trainings, and number of trained individuals (both health professionals and community), Ipas supported health facilities, comprehensive contraceptive services and various meetings held to promote comprehensive contraceptive service and abortion care. The information is available for several indicators since 2006 in excel sheet and Ipas Portal.[56]

7.5. Leadership and governance

[56] We have analyzed some of the data indicated in this document from the Microsoft Excel data base. But we didn't access the Ipas portal.

Realization of human rights, including sexual and reproductive health rights are enshrined in various international, national, and local conventions, statutes, and legal frameworks. Accordingly, the role of both political and administrative leadership at all levels of government and health systems is critically important. Ensuring meaningful access to reproductive health services including abortion care services requires integration of the services into the regular health care system and public sector budgets. Abortion care providers should maximize the window of opportunity which is in place due to the leadership positions being held by professionals with Gynecology and Obstetrics, which makes some of the advocacy efforts easier.[57]

Ipas played a significant role in terms of shaping some of the structural issues in health systems leadership and governance. Ipas supported various review meetings conducted by MOH, Regional Health Bureau (RHB) and Zonal health departments to ensure that abortion care is systematically integrated into their annual planning and performance review meetings. Furthermore, Ipas provided various technical assistance at all levels.

7.6. Health system financing

While Ipas programs may not have a direct contribution towards the health system financing, currently, all maternal and child health interventions are supported by the government (free of charge for the user) or are entitled for health insurance coverage. At this juncture, it is worth mentioning the advocacy activities targeting regional governments for increased financing and budgeting of sexual and reproductive health services, including abortion care.

Between 2009 and 2019 Ipas trained about 197 health care program managers on annual basis. A total of 2,168 program managers were trained on Comprehensive Abortion Care. Source: Ipas database

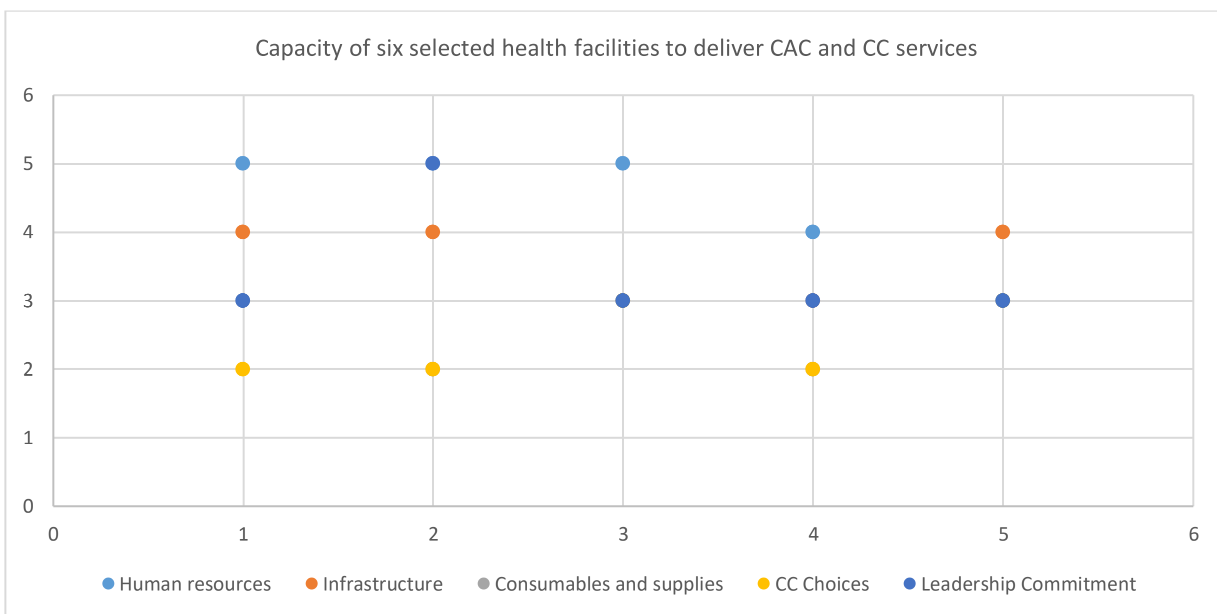
Ipas programs closed critical gaps for delivering and expanding CAC, SAC and FP services in large part of the

[57] Since 2019 most of the ministerial (at least 2 Minsters and 2 State Minsters) positions include state minsters has been occupied by Gynecologists and Obstetricians.

country through donor funded programs for decades. It should be noted that Ipas programs have supported both the government and communities for decades through various grants. Accordingly, this is a massive contribution for the health system in terms of financing. The government of Ethiopia has a resource mobilization mapping strategy, as part of the One Plan, One Budget and One Report initiative, and Ipas has been part of the initiative for years as a channel three partner. Generally, it can be concluded that the advocacy efforts might have direct or indirect impact on prioritization of women's health in Ethiopia.

7.7. Capacity to deliver CAC and CC

Based on the findings of the six-health facility assessment, generally there is a promising system and structure to ensure continuity of the CAC and CC services. In all the facilities, family planning services as well as abortion care were often part of the MNCH program, which is a priority program area of the MoH. As it can be seen from the following chart, the availability of comprehensive contraception commodities and supplies is a major challenge identified by majority of the health facilities. Stock-outs are common and are increasing overtime.



8. PARTNERSHIPS AND COLLABORATION

The history of Ipas leadership in coalition and partnership building for reproductive health rights in general and abortion care services in Ethiopia dates back to 2002. In 2003 Ipas led a partnership named Advocacy Working Group (AWG), a core set of NGOs committed to liberalizing the country's laws on abortion.[58] The partnerships enabled Ipas to build strong network of like-minded organizations for advocacy, service expansion and joint resource mobilization (for example consortium projects with MSIE funded by the former UK Department for International Development). Moreover, various collaboratively developed training materials and manuals were in place to support the health system,

In Ethiopia, Ipas closely works with Ethiopian professional societies such as Ethiopian Society of Obstetrics and Gynecology, Ethiopian Midwives Association, Ethiopian Public Health Officers Association and various other entities as needed. This partnership was reinforced by the establishment of a collective voice of advocates and establishment of CoCAC, a Coalition for Comprehensive Abortion Care. A recent study conducted by Ipas regarding partners opinion and recommendations on Ipas-Ethiopia Project Implementation clearly spelt out that there

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[58] Holcombe, S. J., & Kidanemariam Gebru, S. (2022). Agenda setting and socially contentious policies: Ethiopia's 2005 reform of its law on abortion. *Reproductive Health*, *19*(1), 1-18.

is a valued partnership between Ipas and various governmental and NGO partners working to promote reproductive health in Ethiopia.[59]

[59] A study report submitted to Ipas by Alephtav Consultancy (2022).

9. EVIDENCE GENERATION FOR POLICY AND PRACTICE

Over the past decade several studies have been conducted in Ethiopia, in reproductive health and family planning. While the research portfolio related to comprehensive abortion care, safe abortion and post abortion care is still limited, existing evidence indicates that the role of Ipas in generating and disseminating research findings in the topics was enormous. Based on our review of published materials and key informant interviews, we found that 38 studies are publicly available. Generally, the contribution of Ipas was vivid during:

- Prior to the Legal Reform – major positioning papers, advocacy briefs and technical reports were developed. Over 9 articles and legal critiques were published.
- Since 2005 – Several research works mainly focusing on efficiency, effectiveness, and quality of abortion care in Ethiopia were published.
- 2021 onwards – major shift in terms of studies has been observed from service focused studies to quality assurance and preparation towards a network organization has been observed. Accordingly, partners feedback, overall review of evidence regarding abortion care, Quality of Care in public facilities and transitioning elements were addressed over the past two years. In this period Ipas expanded the evidence generation themes into climate change and sexual and gender-based violence.

> "Literally, there is no study that never mentioned Ipas as a key actor or not citing Ipas generated literature in their study."
> Key Informant, Addis Ababa University

- Among all evidence generation contributions, the two magnitude studies conducted in 2008 and 2014 have had significant impact in broadening the knowledge base in relation to abortion care and contraceptive services in Ethiopia cited over 173 times based on google scholar search.[60] Later analysis by Yohannes et al cited more than 34 times.[61] Generally, it is very uncommon

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[60] Singh S, Fetters T, Gebreselassie H, Abdella A, Gebrehiwot Y, Kumbi S, Audam S. The estimated incidence of induced abortion in Ethiopia, 2008. International perspectives on sexual and reproductive health. 2010 Mar 1:16-25.

[61] Dibaba Y, Dijkerman S, Fetters T, Moore A, Gebreselassie H, Gebrehiwot Y, Benson J. A decade of progress providing safe abortion services in Ethiopia: results of national assessments in 2008 and 2014. BMC pregnancy and childbirth. 2017 Dec;17(1):1-2.

to see any study related to abortion care in Ethiopia without referencing the aforementioned studies.

10. REPRODUCTIVE HEALTH OUTCOMES IN ETHIOPIA:

10.1. Progress Made: Resilient Abortion Care Ecosystem

In conclusion, decades of investment by Ipas in the health system created opportunities to create opportunities to strengthen abortion care and contraception ecosystem in Ethiopia. Highlights are presented in the text box.[62]

Significant change was registered in terms of abortion service delivery and experience in Ethiopia following the expansion of access to comprehensive abortion care services. The traumatic experience of providers and women often expressed by key informants from Ipas and hospitals as well as in publications known as "*The septic room*. *The ward at Black Lion*" is no more in a recent memory of the health sector actors.[63]

According to a physician practicing emergency obstetrics surgery, the abortion care ecosystem in Ethiopia made a significant progress in terms of not only saving lives but also dignifying women's reproductive right and decision.

Generally, there is strong evidence that a resilient abortion care ecosystems are created in Ethiopia over the years as evidenced by:

Increased proportion of public health facilities with the capability to provide safe abortion care rose from 67% to 83%, as more facilities were able to provide medication abortion

The number of safe abortions provided in health facilities increased by almost 10%.

Postabortion care cases decreased by 7%, possibly indicating that fewer women needed care for complications of unsafe abortion.

> *"The traumatic experience of the providers and clients in those wards, humiliated faces of women stigmatized due to unsafe abortion in those departments was heart breaking. I never wished to be an obstetrician due to*

[62] Sully EA, Shiferaw S, Assefa S, Bell SO and Giorgio M, Impact of the Trump administration's expanded global gag rule policy on family planning service provision in Ethiopia, *Studies in Family Planning,* 2022, 53(2):339–359, https://doi.org/10.1111/sifp.12196

[63] Key informant interview with senior leaders at Ipas Ethiopia and Addis based hospitals; https://dktethiopia.org/en/safe-abortion-what-does-it-mean-in-the-ethiopian-context/

the same experience. The right to safe abortion is liberating experience not only for the women and girls, but also for the providers."

Key Informant at Yekatit 12 Hospital.

10.2 Reproductive Health: Progress Made over the past two decades

significant progress has been made in averting maternal mortality in Ethiopia over the past two decades. Evidence indicates that the contribution of unsafe abortion to maternal mortality has declined from about 32% in the 1990s[64] to between 6% and 10% in 2014[65]. Latest evidence from the Countdown 2030, reported that Ethiopia made a striding change in maternal death over the last decades, the MMR decreased from 871 per 100,000 in 2000 to 401 per 100,000 in 2017[66], which is consistent with the findings of the latest Demographic and Health Survey as well as data from the World Bank which showed that the MMR in Ethiopia is closer to this figure.

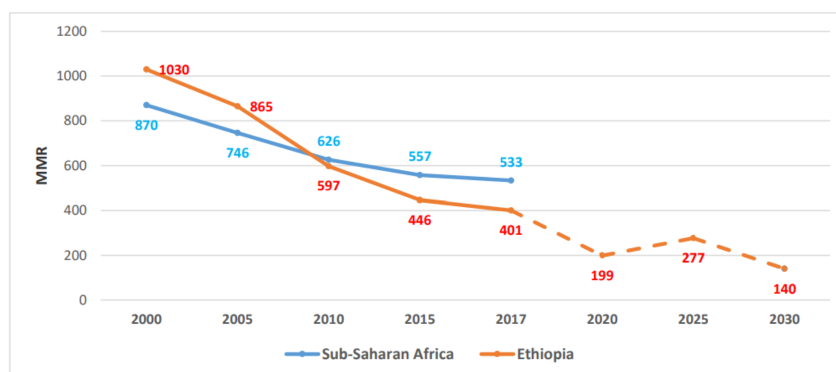

Figure 10-1: Trends of Maternal Mortality in the past two decades

- A significant increase in modern contraceptive use in Ethiopia—27.3% in 2011 to 35.3% in 2016.
- Abortion had been contributing to over 20 to 50 % of maternal deaths before 2003, but over time it has become a much less common cause of maternal death. Recently, the contribution of abortion to maternal death was as low as 4% compared to 32% in 1990s.[67], [68]In Ethiopia in 2015–2019, there were a total of 4,920,000 pregnancies annually. Of these, 2,060,000 pregnancies

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[64] Federal Ministry of Health [Ethiopia]. Technical and Procedural Guidelines for Safe Abortion Services in Ethiopia. 2006.

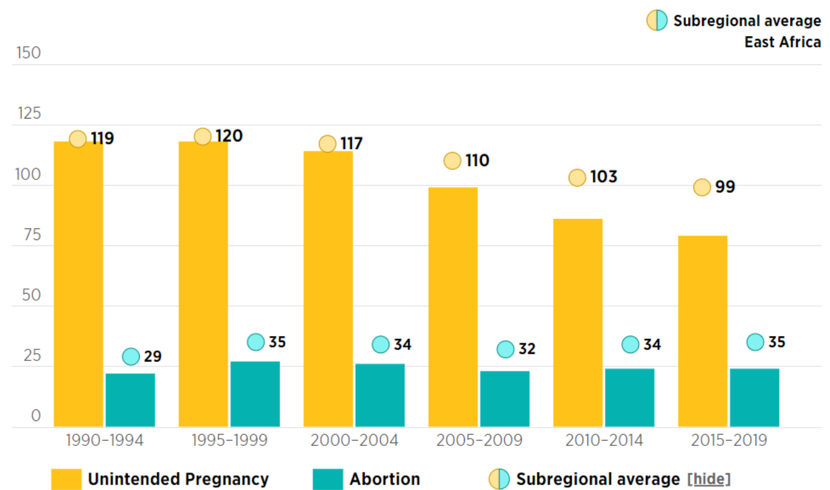
[65] Federal Ministry of Health [Ethiopia]. Technical and Procedural Guidelines for Safe Abortion Services in Ethiopia Second Edition.; 2014

[66] https://www.moh.gov.et/site/initiatives-4-col/Maternal_Health

[67] Ministry of Health (2021): National Reproductive Health Strategic Plan (2021-2025)

[68] Federal Ministry of Health [Ethiopia]. Technical and Procedural Guidelines for Safe Abortion Services in Ethiopia. 2006.

were unintended (accounting for 42% of all pregnancies) and 632,000 ended in abortion (31% of unintended pregnancies).



In conclusion, significant progress has been made over the past two decades regarding ensuring access to comprehensive family planning and abortion. However, as it can be seen from the figures above, much work is needed to maintain and scale up the gains. Ipas will continue to be an irreplaceable partner in the field of abortion care in Ethiopia.

11. LESSON LEARNT

Gains in revision of the abortion law are not warranted forever. There are various organized regressive movements endangering the rights of women and girls to access safe and comprehensive abortion care. Accordingly, advocacy should and will remain a critical intervention to sustain gains.

Abortion providers and access to abortion care is often threatened by “informed, trained, sometimes professional staff” which makes the service delivery environment challenging. Accordingly, while increasing awareness is critically important, we believe that the right information should be provided to the right target group at a right intensity. Social and behavior change communication element of abortion education and training should be stressed.

Task shifting of abortion services to middle level abortion providers is a major milestone in the history of Ipas Ethiopia. Burnout, staff attrition due to various reasons, staff rotation from clinic to clinic, lack of motivation and incentives and various other factors are areas of concern for sustainable delivery of abortion services. Accordingly, training and re-training of health workforce, strengthening pre-service training programs and in-service support are needed.

Integration of comprehensive abortion care and family planning to the routine health service program is critical for sustainability. Access to abortion care is a critical element of women’s health. Accordingly, the adoption of women centered delivery model has the potential to expand the services and improve the quality of care.

Increase in the number of PAC is misinterpreted as a “failure” of the abortion law by abortion critics. However, it should be noted that this can be also attributed to service availability due to the enabling legal environment (health seeking behavior) at one hand and prevailing barriers to family planning services. Accordingly, strengthening family planning services is critically important. Moreover, over the counter administration of medical abortion drugs in private facilities should also be monitored to minimize PAC. It should be majority of complicated cases requiring PAC end up in the public health facilities.

While transitioning the service to the health care system including logistics and supplies management is a notable success, we further recommend continued support of the supply chain system. Supply chain barriers in the centralized delivery system may affect the gains made so far negatively. Out of stock for reproductive health and family planning choices, such as drugs for medical abortions are common, and have a potential to threaten sustainable service delivery within public health facilities.

There is persistent, systematic and in some cases deep rooted ambivalence if not opposition towards abortion care among health workforces. Accordingly, the VCAT training, and its tailored versions need to be further strengthened and should be frame a people/women centered care approach.

Abortion stigma is rampant. Access to abortion care and the delivery of the service across health facilities is generally dependent on one critical factor: committed and gallant manpower. This is true for Ipas staff, health workers, advocates, and various actors in the network. And the presence of Ipas is highly justified to sustain the gains and ensure walking the talk despite the challenging context.

In Ethiopia the private sector through its own effort and franchising with other CC partners provide care significant proportion of family planning users, including abortion care services. The public-private partnership and strategic engagements expanded access to quality care and reduced post abortion complications, that often-put pressure on referral centers for post abortion care.

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APPENDIX

Appendix II: Selected Research Products

Chekol, B. M., Dijkerman, S., Muluye, S., & Wondimu, D. (2022). Community-based intervention improves abortion knowledge and reduces abortion stigma among women in Oromia, Ethiopia: a quasi-experimental mixed methods evaluation. BMC Women's Health, 22(1), 1-15.

Holcombe, S. J., & Kidanemariam Gebru, S. (2022). Agenda setting and socially contentious policies: Ethiopia's 2005 reform of its law on abortion. *Reproductive Health*, *19*(1), 1-18.

Acre, V. N., Dijkerman, S., Calhoun, L. M., Speizer, I. S., Poss, C., & Nyamato, E. (2022). The association of quality contraceptive counseling measures with postabortion contraceptive method acceptance and choice: results from client exit interviews across eight countries. *BMC Health Services Research*, *22*(1), 1-15.

Oda, T., Sento, M., & Negera, A. (2022). Level of Satisfaction on Abortion Service and Associated Factors Among Client Who Received Service in Public Health Facility of Mojo Town, Ethiopia.

Tufa, T. H., Feyissa, M. D., Desta, D., Bekele, G., & Gebrehiwot, Y. (2022). An article critique on a publication about Ethiopia's safe abortion law and maternal mortality. *Ethiopian Medical Journal*, *60*(4).

Cherie, N., Gebrie, N., & Yasin, T. (2022). Post Abortion Contraceptive Use and Determinant Factors in Ethiopia: A Systematic Review and Meta-analysis. *Current Women's Health Reviews*, *18*(2), 27-37.

Jacobson, L. E., Ramirez, A. M., Bercu, C., Katz, A., Gerdts, C., & Baum, S. E. (2022). Understanding the abortion experiences of young people to inform quality care in Argentina, Bangladesh, Ethiopia, and Nigeria. *Youth & Society*, *54*(6), 957-981.

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Samuel, M., Fetters, T., & Desta, D. (2016). Strengthening postabortion family planning services in Ethiopia: expanding contraceptive choice and improving access to long-acting reversible contraception. *Global Health: Science and Practice*, *4*(Supplement 2), S60-S72.

Alemayehu, T., Biru, D., Brahmi, D., & Fetters, T. (2016). An evaluation of postabortion contraceptive uptake following a youth-friendly services intervention in Ethiopia.

Samuel, M., Muluye, S., Tolossa, T., & Alemayehu, A. (2019). Expanding contraceptive choice in Ethiopia: a comparative analysis of method mixes in post-abortion contraception versus routine family planning. *Gates Open Research*, *3*(1518), 1518.

Demeke, D., T. Alemayehu, and M. Gelaso. "Integration of abortion care and family planning services: family planning acceptance, trend and method preference among abortion care clients in ipas-supported facilities." *Contraception* 88, no. 3 (2013): 447.

Wada, Tsehai. "Abortion law in Ethiopia: a comparative perspective." *Mizan Law Review* 2, no. 1 (2008): 1-32.

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