**Presentation of Ms. Saba Kidanemariam, Country Director Ipas Ethiopia**

**UN Human Rights Council Side Event: Criminal Laws & Women's Health**

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Madame Chair person, distinguished delegates, ladies and gentlemen, I am very pleased to have been invited to speak today at this important session which takes about criminal laws and other legal restrictions related to SRH and right to health.

I have been working for the past 12 years in Ethiopia as Country Director for Ipas, an international NGO that works around the world to reduce deaths and injuries from unsafe abortion and protect women's sexual and reproductive rights. This provided me with the opportunity to have a first -hand experience on what it takes in reforming an abortion law and starting the implementation process.

I wanted to thank and acknowledge to the sponsors of this panel, and especially Action Canada for Population and Development for providing me with the opportunity to speak to this august gathering. It is very great to see the attention that the Human Rights Council has given to maternal mortality and unsafe abortion. These discussions, and the international agreements and documents that come out of them, are very important because they establish principles and set standards for countries to follow.

I understand that there are other experts in the room on the international agreements and guidelines. I will therefore be talking about the experience of Ethiopia in revising the abortion law and in providing safe abortion services following the WHO protocol as is recommended by Mr. Grover's report. I hope that it will reinforce the discussions that are ongoing regionally and globally in terms of reaffirming that:

1. States have the obligations to reform laws and regulations that restrict access to sexual and reproductive health services, including safe abortion,
2. Legalizing abortion is necessary but not sufficient condition as States have to ensure that services are available and accessible as per the law.

In 2004, the Ethiopian parliament revised the 50 years old Penal Code further criminalizing actions against women such as abduction, rape, trafficking, female genital mutilation and domestic violence. On the other hand, though still criminal, it revised the section on abortion where women can access safe abortion services with broader conditions. I will spend the next few minutes talking about the process of law reform and how the law is being implemented.

Hospital based studies conducted in the 80's and 90's showed that unsafe abortion was a major public health problem in Ethiopia. Some studies show the contribution of unsafe abortion to maternal mortality being as high as 32%-40%. MMR of Ethiopia being on of the highest when compared with sub-Saharan counties (870-1200/100,000). Though the toll that unsafe abortion was taking on Ethiopian women's health was documented no measure was taken to avert this preventable cause. The law on abortion was very restrictive only allowed to safe women's life

from death or life threatening situations. As a result, abortion was highly stigmatized forcing women to seek services in clandestine and unsafe conditions. A few organizations like the Ethiopian Society of GYN, Ipas and others, then starting calling for policy actions while working on measures to save women's lives and treat complications.

On the other hand, there was an effort to align all laws with the Constitution of Ethiopia which was promulgated in 1994 after the change of government in 1992. The new Constitution refers to the rights to life, liberty and security of the person. Article 35 on the rights of women also stipulates that the state should protect women from laws and practices that violate their rights. The subsequent placement of various national policies such as the national health policy, population policy, women's policy and youth policies in Ethiopia all recognized the right of women. The existence of all these policy instruments created a conducive environment in the country whereby arguments for revision or elimination of old laws which violate women's rights were grounded. Thus the revision of the abortion law was not addressed in isolation but as part of reforms widely recognized as essential to actualizing rights enshrined in the Constitution.

Using both the human rights and the public health approach in indicating the magnitude and consequences of unsafe abortion, interested organizations and activists started advocating for broader support base. Ipas, Ethiopian Society of Gyn/obs, EWLA, FGAE and others joined hands with public organizations and committed individuals to create a form of coalition with defined goals and conducted:

- Studies of morbidity and mortality associated with unsafe abortion ( including estimates of the heavy costs to public health system incurred by treating women with severe abortion-related complications were compiled and disseminated to decision and opinion makers;
- Developed an advocacy strategy with clear and evidence based messages;
- Mobilized key stakeholders through advocacy campaigns;
- Used mass communications to mobilize public opinion;
- Worked with the review committee of the parliament in fine tuning the language of the law.

The Parliament passed the law in 2004, with the new law becoming official in 2005. Liberalization of the abortion law in Ethiopia is, therefore, attributable to a convergence of factors, including the historical moment, political will of the government and actions by advocates.

Madame Chair Person,

The following conditions were stipulated as allowable for safe abortion services in the revised Penal Code of 2004: a) when the pregnancy is the result of rape or incest; or b) continuing the pregnancy would endanger the life of the mother or the fetus or the health of the mother or where the birth of the fetus is a risk to the life or health of the mother; or c) where the fetus

has an incurable and serious deformity; or d) where the pregnant woman, because of a physical or mental deficiency or her age (under 18yrs) is physically as well as mentally unprepared to bring up the child. In addition, the Penal Code contains no language limiting gestational age, and in cases of rape or incest, no proof is required beyond the woman's statement that it has occurred.

Subsequent to the passage of the law, the Ministry of Health issued protocols to be observed in the safe practice of pregnancy termination. A working group was created to advise the Ministry in the formulation of these guidelines, which are largely based on the WHO technical document issued in 2003 but made specifically applicable and relevant to the legal and reproductive health situation in Ethiopia.

In summary, the provisions in the guidelines:

1. Address such issues as standards for providers' skills and performance, when, how and where services should be provided. In addition, the guidelines explicitly allow mid-level providers, such as nurses and midwives, to provide comprehensive abortion services, using appropriate technologies including medical abortion.
2. A woman seeking abortion on the grounds that she is a minor and unable to care for the child, is not required to prove she is under 18.
3. Health care providers have an ethical obligation to direct women to a health facility that will provide suitable services.

The intent of these guidelines were to broadly interpret the law, remove medical, procedural and other barriers which could hinder women from accessing services.

Since 2006, the Government of Ethiopia, with development partners including Ipas, has continued training health care providers to provide safe services. In addition efforts are being exerted to make safe and legal abortion services a normal and acceptable part of the existing range of reproductive health services offered by public and private health systems. There were also some effort to ensure that the provisions of the new law and its regulations are clearly described, well understood by health professionals and the public at large.

Information on the availability of services and referral is being provided in integration with the front line health extension workers which are deployed at the lowest administration level providing door to door services to families and individuals. There were CBOs engaged in educating men and women, girls and boys on their sexuality and provide information on the availability of services.

Health service data compiled at the end of 2011 from 400 public health facilities supported by Ipas shows that:

- Almost 90% of the health facilities allowed to provide services have started providing safe abortion care

- 90% of the providers are mid level providers and therefore services are mostly available at primary health care level
- The most preferred method of care by women is medical abortion
- Strengthened counseling (pre and post procedure) the post abortion family planning intervention.
- Post abortion family planning uptake is 75%, which is 3 times higher than the national contraceptive prevalence
- Around 70% of those women coming to facilities received safe abortion care while 30% had post abortion care indicating the direction of change in health seeking behavior.

**The most important outcome is that revision of the law has affected the safety of procedures obtained.**

Two assessments done in 2008, [Magnitude Study on Abortion and EMOC assessment] indicated that maternal mortality attributed by unsafe abortion has declined to 6-13%. However, Ipas and its development partners are now preparing to conduct a national magnitude study in 2013 to see the impact.

Even without studies, we know that more needs to be done:

- Women still need better access to contraception to prevent unwanted pregnancies in the first place. The contraceptive prevalence rate is still currently 28.6%. Fortunately, the government and others are doing more to address this need and the use of contraception, especially long term methods like IUD is now increasing.
- Women who are young, poor, or in rural areas of Ethiopia still lack access to both contraception and safe abortion services, and much work remains to be done.
- Abortion is still considered as a taboo by some indicating that more needs to be done to de-stigmatize it.
- Provision of comprehensive education and information on sexual & reproductive health

Still, despite many challenges, we are seeing that even in a low-resource country like Ethiopia, women's lives can be saved and their human rights protected. I hope that other countries can benefit from the lessons learned in Ethiopia.

Would be glad to answer questions

Thank you