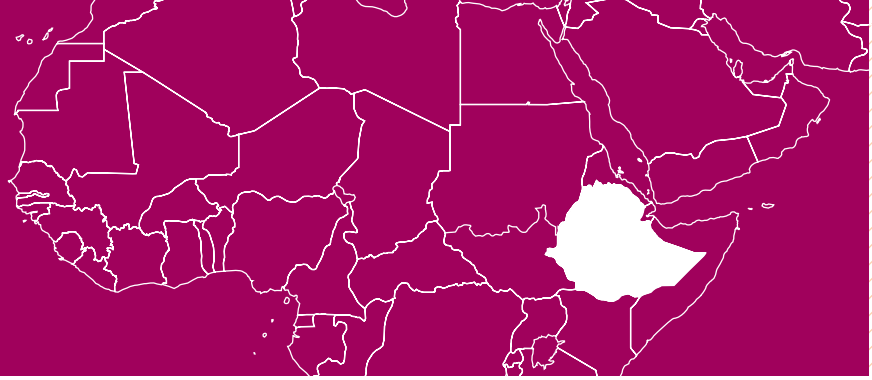
# ETHIOPIA

## PAC-FP COUNTRY BRIEF



**Postabortion care (PAC) provides a comprehensive approach to preventing morbidity and mortality caused by abortion complications (PAC Consortium, 2014). As per the U.S. Agency for International Development (USAID) PAC model, a critical component of PAC is providing access to family planning (FP) counseling and services. Providing these services helps meet the reproductive intentions of women who most clearly demonstrate an unmet need for FP, reduces unintended pregnancies, and prevents repeat abortions, thus reducing maternal deaths (Curtis, Huber, and Moss-Knight, 2010). The information below highlights the Federal Democratic Republic of Ethiopia's investment in providing PAC and FP services to women in need.**

## POLICIES, LEADERSHIP, AND GOVERNANCE

The Federal Democratic Republic of Ethiopia's national family planning (FP) and reproductive health (RH) policy is outlined in a number of documents, including the National Guidelines for Family Planning Services (2011), the Health Sector Transformation Plan 2015/16–2019/20 (2015), and the National Reproductive Health Strategy 2016–2020 (2016). The latter document aims to improve equitable access to RH services and improve the country's logistic and supply chain management. The National Reproductive Health Strategy 2016–2020 further advocates for the implementation of existing laws that protect reproductive rights, such as family health law and laws relating to traditional RH practices.

Specific guidelines related to postabortion care (PAC) include the Standard Treatment Guidelines for General Hospital (2014) and the Technical and Procedural Guideline for Safe Abortion Care in Ethiopia (2014). The Federal Ministry of Health—particularly the Maternal and Child Health Directorate—is responsible for RH and FP programming in the country.

### *Legal Status of Abortion*

In Ethiopia's Revised Penal Code (2005), abortion is illegal except in the following cases: when the pregnancy is the result of rape or incest; when the pregnancy poses a risk to health or life; when the pregnant woman, owing to a physical or mental deficiency or her being under 18 years of age, is physically and/or mentally unfit to raise a child; when the fetus has an incurable and serious deformity; or when a woman's medical conditions warrant the immediate termination of pregnancy.

## PAC TRAINING AND STANDARDS

The Technical and Procedural Guideline for Safe Abortion Care (2014) provides health workers with clinical guidelines that expand the role of mid-level providers to perform PAC, including the use of manual vacuum aspiration and misoprostol (Ipas, 2016). The National Postabortion Care Training Curriculum (2011) supports training for midwives and nurses in the provision of these services. This curriculum includes the use of misoprostol for PAC and the provision of long-active reversible contraceptive methods, as identified by national need.

## STRENGTHENING SERVICE DELIVERY

Over the past five years, Ethiopia has sought to increase the training and deployment of health cadres—notably health officers, general practitioners, and emergency surgical officers—to strengthen PAC.

PAC·FP THE POSTABORTION CARE FAMILY PLANNING PROJECT
Expanding contraceptive methods and informed choice to PAC clients

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Prior to the country's revised abortion law, facilities only provided PAC (including postabortion FP) for the management of incomplete abortions resulting from spontaneous or induced abortions (Samuel, Fetters, and Desta, 2016). Legal reforms in 2005 expanded this mandate to cover an integrated set of RH services that includes treatment of abortion complications, FP counseling, and voluntary provision of contraception and other RH services. (Samuel, Fetters, and Desta, 2016). In 2014, approximately 75% of the country's facilities provided PAC, including 2,600 public health centers, 80% of the 1,300 private or nongovernmental facilities, and 98% of the 120 public hospitals (Guttmacher Institute and Ipas, 2017).

While Ethiopia's health extension workers play an important role in community-based RH services, including through counseling clients and providing a limited selection of contraceptive methods, PAC is only available via mid-level health workers, including midwives, nurses, and health officers (Samuel, Fetters, and Desta, 2016). The provision of PAC to women in need increased from 47% in 2008 to 83% in 2014 (Guttmacher Institute and Ipas, 2017).

### *Infrastructure*

As part of the Health Sector Development Plan IV for 2010/11–2014/15, the government undertook an infrastructure renovation that included designating rooms for PAC. The plan aims to ensure that communities have access to health facilities that are well equipped, supplied, and maintained, as well as supported by information and communications technology adhering to national standards (Federal Democratic Republic of Ethiopia Ministry of Health, 2010).

## BARRIERS TO PAC

Women in Ethiopia face multiple barriers to accessing PAC and FP services. Lack of information on services and stigma are reportedly the biggest barriers to PAC (Gebrehiwot et al., 2015). Other barriers include service costs, distance to the facility, inadequate transportation options, and hostile and unfriendly provider attitudes (Gebrehiwot et al., 2015).

Inadequate service provider knowledge on PAC and FP services is an additional challenge. In a 2008 study conducted in facilities in the Southern Nations, Nationalities, and Peoples' Region, only half of providers demonstrated the knowledge and training required to provide long-acting reversible contraceptives or permanent methods (Samuel, Fetters, and Desta, 2016). Shortages of contraceptive commodities, equipment, and supplies compounds this issue.

A lack of designated service delivery space for PAC and FP is another obstacle: without confidential space for service provision, providers direct clients to seek FP support elsewhere in the facility, give clients referrals to other facilities, or instruct clients to return later.

## FINANCING MECHANISMS

Through Ethiopia's national health insurance plan, the government provides FP methods (condoms, implants, injectables, intrauterine devices, and oral contraceptives) and PAC (FP, misoprostol, manual vacuum aspiration, and emergency care) for free under the maternal and child health services umbrella.

The government directly manages the purchase and distribution of FP commodities to public health facilities across the country. For 2007–2008, the national health accounts of Ethiopia estimated a total expenditure of $150.9 million in RH costs (Vlassof et al., 2012). In 2008, the total national expenditure on PAC was approximately $7.6 million (Vlassof et al., 2012).

| ETHIOPIA | | Year | Source |
|---|---|---|---|
| **Demographic/background indicators** | | | |
| Country population | 105,000,000 | 2017 | World Bank1 |
| Total fertility rate | 4.6 | 2016 | Demographic and Health Survey, 2016 |
| Age at first birth | 19.2 | | |
| Maternal mortality per 100,000 live births | 412 | | |
| Newborn mortality per 1,000 live births | 30 | | |
| Infant mortality per 1,000 live births | 48 | | |
| Under-five child mortality per 1,000 live births | 67 | | |
| Facility-based deliveries | 26% | | |
| Proportion of women received antenatal care | 62% | | |
| Proportion of women who received a postnatal check within two days of live delivery | 17% | | |
| **Abortion and FP-related indicators** | | | |
| Number of abortions | 620,300 | 2014 | Guttmacher Institute, 2017 |
| Abortions per 1,000 women | 28 | | |
| Number of women receiving treatment from abortion complications | 103,600 | | |
| Proportion of women seeking abortion-related services that receive postabortion FP | 75% | | |
| Number of unintended pregnancies | 1,449,000 | 2017–2018 | FP2020 Core Indicator 2017–18 Summary Sheet |
| Number of unintended pregnancies averted due to use of modern contraceptive methods | 2,750,000 | | |
| Number of unsafe abortions averted due to use of modern contraceptive methods | 606,000 | | |
| Number of maternal deaths averted due to use of modern contraceptive methods | 7,300 | | |
| Modern method contraceptive prevalence rate, all women of reproductive age (WRA) | 26.9% | | |
| Knowledge of FP, currently married women | 99% | 2016 | Demographic and Health Survey, 2016 |
| ***Contraceptive use by type*** | | 2017–2018 | FP2020 Core Indicator 2017–18 Summary Sheet |
| **Long-acting and permanent methods** | | | |
| Sterilization (female) | 0.8% | | |
| Sterilization (male) | 0.0% | | |
| Intrauterine device | 2.2% | | |
| Implant | 24.1% | | |
| **Short-acting methods** | | | |
| Injection (intramuscular and subcutaneous) | 63.5% | | |
| Pill | 7.2% | | |
| Condom (male) | 1.4% | | |
| Condom (female) | 0.0% | | |
| Other modern methods (e.g., cycle beads, and lactational amenorrhea method) | 0.9% | | |
| *Unmet need for FP*[2] (2018) | 22.0% | 2017–18 | Demographic and Health Survey, 2016 |
| Unmet need for spacing | 13.0% | | |
| Unmet need for limiting | 9.0% | | |
| Percentage of all women who received FP information during their last visit with a health service provider | 26.1% | 2017 | PMA2020, R5 |

[1] https://data.worldbank.org/indicator/SP.DYN.TFRT.IN

[2] Women with unmet need are those who are fecund and sexually active but are not using any method of contraception, and report not wanting any more children or wanting to delay the next child. The concept of unmet need points to the gap between women's reproductive intentions and their contraceptive behavior.

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