



The UK All-Party Parliamentary Group on

**Population, Development  
and Reproductive Health**

**Ethiopia Study Tour:  
Family Planning, Sexual and Reproductive Health, and  
International Development**

**5<sup>th</sup> – 11<sup>th</sup> November 2017**



*UK delegation with the Ethiopian Social Affairs  
Standing Committee, Parliament of Ethiopia*

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*UK delegation in the Shire refugee camp, Tigray*

## **Executive Summary**

The UK All Party Parliamentary Group on Population, Development and Reproductive Health (APPG on PDRH) organised a study tour to Ethiopia from the 5<sup>th</sup> to 11<sup>th</sup> of November for a cross-party UK parliamentary delegation. The delegation included: Baroness Jenny Tonge, Baroness Jenkin, Baroness Blackstone, Harriet Harman MP and Karen Buck MP.

The study tour was co-hosted by Marie Stopes International (MSI) with the aim of strengthening UK parliamentarians' knowledge about family planning (FP) and sexual and reproductive health and rights (SRHR), and to enhance the membership of the UK All Party Parliamentary Group on Population, Development and Reproductive Health (APPG on PDRH).

Prior to departure, the delegation was briefed in the UK parliament by representatives from the UK Foreign and Commonwealth Office (FCO), the Department for International Development (DFID) and Marie Stopes International (MSI).

Whilst visiting Ethiopia, delegates were briefed and met with DFID in-country staff (including a security officer), Ministry of Health officials, and representatives of the United Nations Population Fund (UNFPA), the International Planned Parenthood Federation (IPPF), Marie Stopes International (MSI), Engender Health and the Family Guidance Association of Ethiopia. Delegates also met with members of the Ethiopian Social Affairs Standing Committee, government health officials and medical staff and health workers in Addis Ababa and Axum. In Tigray, the delegation travelled toward the border of Eritrea and visited the Shire refugee camp, where they met and spoke with refugee camp staff and migrants from Eritrea.

Study tour delegates were exposed to an array of family planning and SRHR services in Ethiopia, delivered by the Ethiopian government, non-governmental organisations (NGOs), the United Nations and the Independent sector. Delegates visited hospitals and clinics, safe houses for victims of gender-based violence, university and youth projects, refugee camps and the Ethiopian parliament.



*Baroness Jenny Tonge and Baroness Anne Jenkin  
meeting families in the Shire refugee camp, Tigray*

With their hosts, delegates discussed child marriage, obstetric fistula and prolapses, safe abortion services, cervical cancers, female genital mutilation (FGM), rape and gender-based violence. They also discussed services for young and vulnerable populations, including in refugee settings, as well as general maternal and child healthcare in Ethiopia.



*UK delegation visiting the Addis Ababa Fistula Hospital,  
Addis Ababa*



## **Introduction to the Ethiopia study tour and study tour delegation**

The UK All Party Parliamentary Group on Population, Development and Reproductive Health (APPG on PDRH), in collaboration with Marie Stopes International (MSI), organised a study tour to Ethiopia on family planning (FP), sexual and reproductive health and rights (SRHR) and international development, which took place from the 5<sup>th</sup> – 11<sup>th</sup> November 2017. The study tour was funded by the European Parliamentary Forum on Population and Development (EPF).

The aim of the study tour was to introduce UK parliamentarians to FP and SRHR and international development, including in refugee settings, and to increase knowledge on topics related to the International Conference on Population and Development Programme of Action (ICPD PoA).

Delegates received the study tour programme and were briefed by representatives of the UK Foreign and Commonwealth Office (FCO), the Department for International Development (DFID) and Marie Stopes International (MSI) on the 1<sup>st</sup> of November 2017 in the UK parliament.

The final delegation included UK APPG on PDRH Chair, Baroness Jenny Tonge (non-affiliate), Baroness Jenkin (Conservative), Baroness Blackstone (Labour), Harriet Harman MP (Labour) and Karen Buck MP (Labour). Sarah Champion MP, Ruby Huq MP and Chris Elmore MP had expressed interest in participating, but sent their apologies prior to departure. Baroness Jenny Tonge led the delegation.



*Baroness Jenny Tonge (Non-affiliated)*

Baroness Jenny Tonge worked as a doctor in the National Health Service (NHS) in the UK for over 30 years before entering the House of Commons as the member of parliament for Richmond Park in Surrey, in 1997. Her speciality in the NHS was women's health. She was the Liberal Democrat (LD) Spokesperson for International Development for seven years in the House of Commons, and in 2005 was made a life peer. She has been a member of the UK APPG on PDRH since 1997 and was elected chair of the APPG on PDRH in 2010. She was the President of the European Parliamentary Forum on Population and Development (EPF) 2013 – 2015 and received an Honorary Fellowship from the Royal College of Obstetricians and Gynaecologists

(RCOG) in December 2015 for her dedication and promotion of women's health services in the NHS and in developing countries.

Prior to the study tour Baroness Jenny Tonge said:

I have been to conferences in Addis Ababa on two occasions in the last six years, but had not ventured outside Addis Ababa except to visit the fistula clinic, which is becoming a place of pilgrimage from all doctors interested in women's health. I was looking forward to seeing what progress had been made, especially in setting up health networks.



*Baroness Anne Jenkin (Conservative)*

Baroness Anne Jenkin is a member of the Conservative Party in the House of Lords. She joined the House of Lords in 2011 and is a member of the Equality Act 2010 and Disability Committee. Baroness Jenkin founded and co-Chairs Women2Win, a group that aims to get more Conservative women elected to Parliament. She is a prominent campaigner on issues of hunger and food sustainability.

Baroness Jenkin joined the UK APPG in PDRH in 2011 and has held a series of committee positions in the APPG on PDRH. She is currently the Treasurer. Baroness Jenkin is a leading supporter of international development in the Conservative Party and was Chair of the Conservative Friends of International Development. She is a Trustee for UNICEF UK and Cool Earth and a Patron for Restless Development.

Prior to the study tour Baroness Anne Jenkin said: "I am looking forward to visiting Ethiopia, a country that has experienced a lot of progress on maternal health as well as significant economic progress in recent years. I will particularly be interested to see how British ODA helps and supports the people of Ethiopia."



*Baroness Tessa Blackstone (Labour)*

Baroness Blackstone has been a member of the House of Lords since 1987. She was Minister for Education from 1997 until 2001, and sat on the House of Lords Public Service and Demographic Change Committee (2012-2013) and Long-Term Sustainability of the NHS Committee (2016- April 2017). Prior to entering the House of Lords, Baroness Blackstone worked in academia, was a policy adviser to the Cabinet Office and was Deputy Education Officer at the London Education Authority. She has chaired various boards including the Institute of Public Policy Research (IPPR) board, and is currently the chair of the Great Ormond Street Hospital board. Her interests lie in education, foreign affairs and healthcare.

Prior to the study tour Baroness Tessa Blackstone said: “I greatly looked forward to returning to Ethiopia. I had spent two weeks there with VSO five years earlier focussing mainly on gender issues in health and education.”



*Harriet Harman MP (Labour)*

Harriet Harman MP was elected as a Labour Party MP to the House of Commons for Camberwell and Peckham in 1982. Since her election, she has held various senior roles both in government and in the opposition, including Shadow Secretary of State for Health (1995-1996), Secretary of State for both Social Security and Ministry for Women (1997-1998), Solicitor General (2001-2005), Shadow Secretary of State for International Development (2010-2011) and Shadow Prime Minister (2011-2015). She is currently the chair of the Parliament’s Joint Committee on Human Rights. Prior to her election, Harriet Harman MP worked as a legal solicitor. Her interests lie in gender equality, civil liberties, justice and domestic violence.

Prior to the study tour Harriet Harman MP said:

I am looking forward to the opportunity to see first-hand the challenges facing women and girls in Ethiopia. I am particularly interested in exploring the challenging issues of child marriage and FGM and knowing how Ethiopia has achieved its remarkable progress on maternal mortality.



Karen Buck MP (Labour)

Karen Buck MP was elected as a Labour Party MP to the HoC for Regent's Park and Kensington North in 1997 (later Westminster North 2010). She was Shadow Minister for Education (2011-2013), and sat on various select committees including the Home Affairs select committee (2006-2009), Children, Schools and Families select committee (2009-2010), and has sat on the Joint Committee on Human Rights since 2015. Prior to entering Parliament she was a councillor for the City of Westminster Council and worked as a health directorate researcher for the Labour Party. Her interests lie in healthcare, welfare, children, environment and climate change.

Prior to the study tour Karen Buck MP said: "I am intrigued by what I will find on my first ever visit to Ethiopia. I know the country faces massive challenges, not least as a result of the refugee crisis and it will be fascinating to see how these are being managed."

## **Background information to the Ethiopia study tour**

Invitations were disseminated in August 2017 to UK parliamentarians to join the Ethiopia study tour on family planning, SRHR and international development, co-organised with MSI.

Several parliamentarians expressed an interest including Sarah Champion MP, Ruby Hug MP and Chris Elmore MP. The final study tour delegation comprised Baroness Jenny Tonge, Baroness Anne Jenkin, Baroness Blackstone, Harriet Harman MP and Karen Buck MP.

### **Background briefing meetings**

A roundtable briefing meetings was held prior to departure on Wednesday 1st November 2017 in the UK parliament.

In attendance were all UK study tour delegates and from the FCO was Leah Gray, Ethiopia Desk Officer and Deputy Team Leader, East Africa Desk and from DFID were Sarah Newton, Policy Manager, Africa Regional Department and Anne Philpot, Senior Health Advisor and Deputy Head Extreme Poverty, Africa Regional. Sarah Shaw, Head of Advocacy, and Thomas Lee, Policy Advisor, were in attendance from MSI.

Baroness Jenny Tonge welcomed all to the roundtable briefing meeting and Leah Gray proceeded by giving a general overview on Ethiopia, highlighting its political, economic and demographic situation, as well as travel advice. She noted that Ethiopia is one of the most populated countries in East Africa, with a population of 100 million people. Nearly two-thirds of the population are under the age of 25 years, including 65 million women. The Ethiopian government have led a series of economic reforms for job creation and skills for young people in recent years. The average life expectancy is 65 years of age, and the country has seen a sharp decline in its fertility rates in recent years, to reach 4.3 children per woman in 2015.

Ethiopia has one of the highest refugee populations in the world, the majority of whom come from Eritrea, Somalia and South Sudan. In terms of travel advice, Ethiopia is still considered a 'moderate fragility state' according to the FCO and is on amber alert.

Sarah Newton and Ann Philpot followed with a short overview on SRHR statistics in the region and DFID's Ethiopia Programme. They noted that one-third of women use a modern method of contraception, and that Ethiopia has seen a 45% drop in its maternal mortality rate (MMR) to 258 deaths per 100,000 live births (2008). Much of Ethiopia's SRHR aid from the UK comes through bilateral aid, and the UK government recently pledged £90 million in family planning and SRHR over the next four years to the country.

DFID also contributes to SRHR and maternal health through other programmes, including their nutrition programmes, and non-communicable disease and tuberculosis programmes. Ethiopia's Federal Ministry of Health also launched its Reproductive, Maternal and Neonatal Health Innovation Fund, which is funded through DFID. DFID's recently launched programme Women's Integrated Sexual Health also offer funding for Ethiopia through interested organisations.

Since 2005, abortion has been legal in Ethiopia in cases of rape, incest, fetal abnormalities, if the pregnancy endangers the life of the mother and if the mother is a minor. Socio-economic conditions may be taken into account also.

Sarah Shaw and Thomas Lee provided an overview of MSI's work in Ethiopia and outlined the study tour's schedule. MSI have been working in Ethiopia for 25 years, and have 24 clinics across the country, of which are in Addis Ababa, and they have 10 mobile outreach teams.

MSI's services include abortion services, short, long-acting and permanent methods of contraception, family planning counselling, pre- and post-natal care, child health checks, free condom provision, voluntary testing and counselling on HIV, and STI screening and treatment. They noted that general supply of contraception remains a problem in Ethiopia, with 10-22% of government hospitals and clinics experiencing stock-out.

A short question and answer session followed to ensure all delegates were prepared for the forthcoming study tour to Ethiopia.

### Ethiopia at a glance



#### *Politics*

President of Ethiopia: Malatu Teshome

Prime Minister of Ethiopia: Hailemariam Desalegn

2015 Election: Ethiopian People's Revolutionary Democratic Front (EPRDF) won 500 out of the total 547 seats

National population turnout at the 2015 Election: 89.7%

### *Population, development and health indicators*

In 2016 Ethiopia had a population of 102 million and the % by age group were: 0-14 years of age, 46%; 15-64 years of age, 50% and over 65 years of age, 4%. In 2016, life expectancy was 64 years of age.

Ethiopia succeeded in reducing its maternal mortality rate (MMR) from 871 deaths per 100,000 live births in 2000, to 412 per 100,000 in 2016. It reduced its child mortality (CM) rate from 166 deaths per 1,000 live births to 29 per 1,000 live births over the same period. Neonatal mortality reduced from 49 deaths per 1,000 live births in 2000 to 29 per 1,000 in 2016 and contraceptive prevalence rate increased from 8 to 36%. The unmet need for family planning was 36% in 2000; by 2016 it was reduced to 22%. The proportion of births attended by skilled health personnel increased from 6% to 28% during this period. Antenatal care coverage (at least four times during pregnancy) increased from 10% to 32% and post-natal care for mothers and babies within two days of birth from 8% to 17%.

In 2016 the child marriage prevalence rate was 10%; 13% of girls between the ages of 15 and 19 years were mothers. The percentage of children fully immunised in 2016 was 39% and the percentage of children with chronic malnutrition (stunting) in 2000 was 52%, reduced to 38% in 2016. Total Health Expenditure per capita in 2014 was USD \$27.

In 2017, there were 6,000 UK citizens resident in Ethiopia. There were 15,058 Ethiopian-born individuals resident in the UK in 2011. Pphone subscriptions in 2016 in Ethiopia was 43% and 4.2% of the population now have internet access.

The UNDP ranks Ethiopia 174<sup>th</sup> out of 188 countries included in the Human Development Index. In 2016, the Primary Education Completion Rate was 54%.

### *Geography and economy*

Ethiopia has nine states: Tigray, Afar, Amhara, Oromia, Somali, Benshangul/Gumuz, Southern Nations, Nationalities and Peoples, Gambela and Harari.

The Ethiopian currency is Ethiopian Birr, Nominal GDP is 67bn and GNI Per Capita is USD \$660. Projected growth in 2016 was 9% (according to the IMF) and the inflation rate in 2017 was 10.4%.

Ethiopia's total value of exports of goods and services is £4.3bn and key exports of goods are coffee, oil seeds and gold. Sectoral % share of GDP are\_agriculture 37%; industry 17% and services 47%. The total value of imports of goods and services is £14.8bn and the key imports of goods are capital goods, consumer goods and fuel.

## **Ethiopia study tour exposure**

Study tour delegates were exposed to the following activities, institutions and concerns:

- UK Embassy and DFID programme activities that have a particular focus on family and SRHR, including in refugee settings;
- Ethiopian family planning and SRHR legislation, policies and strategic plans;
- Public health care: the Addis Ababa Gandhi Memorial Hospital, the one-stop house on GBV and the Axum referral hospital's obstetric/midwifery, gynaecological and neonatal services;
- Hamlin Fistula Ethiopia hospital in Addis Ababa;
- MSI SRHR clinic and call centre in Addis Ababa and BlueStar (MSI franchise) in Axum;
- UNFPA youth project at Addis Ababa University and the SafeHouse and GBV project in Addis Ababa;
- IPPF member association, the Family Guidance Association of Ethiopia's project and clinic activities in Axum;
- HAPCO youth project in Addis Ababa;
- Stakeholder roundtable discussion on the provision of abortion services in Ethiopia with Ministry of Health officials, MSI, UNFPA and IPPF member association, the Family Guidance Association of Ethiopia;
- A variety of clinical family planning/SRHR services including a variety of modern methods of contraception, emergency contraception, maternal healthcare services (i.e. ante-natal, intra-partum and post-partum care, emergency obstetric care, neonatal care, cervical cancer, fistula repair and abortion services both medical and surgical and Gender Based Violence including FGM and child marriage), and
- Health services in a refugee camp.

### **Stakeholders meet**

During the study tour, delegates were briefed and met with representatives from a variety of institutions and organisations, as well as individuals working in or attending health services or programmes. These included: the UK Embassy; Ministry of Health (MoH) officials; Ethiopian MPs; government and private hospital directors; doctors, midwives, nurses, health extension workers and students; UNFPA representative and the founder of the UNFPA-supported SafeHouse and its clients; representatives from NGOs MSI, IPPF and HAPCO; the Shire refugee camp manager and staff; and migrants from Eritrea.

## Study tour programme and findings

**Monday 6<sup>th</sup> November 2016**

UK Embassy Ethiopia/DFID, Addis Ababa



*Study tour delegation at the UK Embassy, Addis Ababa*

Study tour delegates were welcomed at the UK Embassy by Richard Arden, Human Development Team Leader and Senior Education Adviser, and Jo Moir, Deputy Head of Office.

Members also met Samantha Yates, Livelihoods and Humanitarian Team Leader/Senior Social development adviser; Jyoti Shankar Tewari, Senior Human Development Adviser; Martha Solomon, WaSH Adviser; Sewit Getachew, Desta/Education Advisor; and Luwam Teshome, Gari, Health Adviser.

**DFID's Security Officer started the roundtable meeting with a short security briefing.**

He noted that Ethiopia has nine administrative regions and a population of around 100 million. The UK Embassy is a very secure compound with a 4.5 km wall and perimeter and photos can only be taken with permission. Many Embassy staff reside in the secure compound. The in-house security team liaise with the local police force. The UK Embassy only recommends five large international hotels in Addis Ababa as secure compounds!

Ethiopia is in general a very safe country. It has no armed robbery, however petty crime is common, and especially by teenage gangs. Thus, he suggested no one should walk alone after dark. Traffic accidents are common and no blue and white cabs should be taken.

The telecommunications network is owned by the Government of Ethiopia and it is often monitored.

There are some terrorism concerns, however they are minimal in comparison to neighbouring countries.

**Jo May, Richard Arden and staff proceeded by giving a short summary introduction to Ethiopia and DFID's portfolio and support in country, with a particular focus on health.**

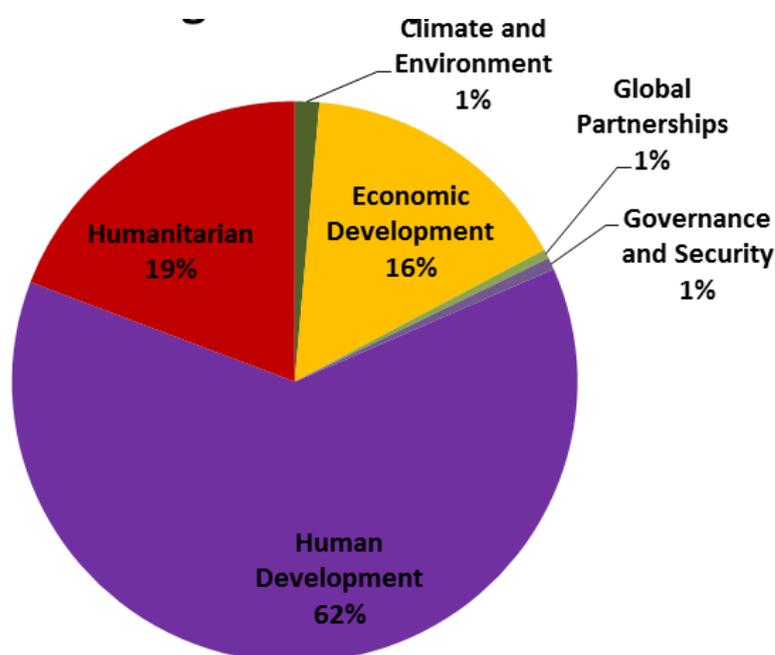
The Ethiopian government has used its own resources and international aid to boost economic development and lift millions out of poverty over the past two decades, through significant investment in public services.

Since the early 1990s, primary school net enrolment has risen from 20% to 93%, and access to clean water from 14% to 57%. Child mortality has fallen by 67% and maternal mortality by 69%. In recent years Ethiopia's economy has grown by about 8% per year. The government's push to industrialise is creating new jobs (2 million per year) for its people.

Ethiopia has delivered its remarkable development gains through a tightly controlled political system, which is increasingly being challenged by its citizens. As recent as August 2016, the government declared a state of emergency due to protests from its young people feeling disillusioned with regards to a lack of opportunities, along with land reform and ethnic tensions.

While Ethiopia has experienced progress in many areas, it remains a country with enormous development needs. It ranks 174th out of 188 countries on the UNDP Human Development Index. Contributing factors are population growth, high rates of chronic malnutrition (44%) and maternal mortality. Female genital mutilation/cutting and early marriage lead to acute gender inequalities. The absolute levels of maternal and child mortality are still extremely high: nearly 11,000 pregnant women and more than 200,000 children die in Ethiopia each year and one in five women still has an unfulfilled need for contraception.

DFID has been a longstanding development partner in Ethiopia for the past 15 years. The 2017/2018 and 2018/19 planned annual ODA budgets are £332 million per year. Sectoral distributions of planned 2017/18 bilateral ODA are illustrated as follows:



The DFID contribution to the Global Goals and other government commitments (achieved as at March 2017) is:

- 1.2 million children supported to gain a decent education
- 755,000 people with sustainable access to clean water and/or sanitation
- 5.7 million children under 5 years, women and adolescent girls reached through nutrition related interventions
- 31,000 additional women and girls using modern methods of family planning

DFID's current objectives are to support Ethiopia in its economic and industrial development. There is a wish to build social protection for the poorest, so that no one is left behind. At present, 15% of Ethiopia's population is very poor. Climate problems in certain regions often cause drought and in this situations, the population resorts to food assistance.

Ethiopia needs quality technical assistance and support to build a better tax and financial system, including private sector investment. Official Development Assistance (ODA) plays a big role in Ethiopia, including from China, which supports infrastructure development. There are currently no manufacturers in Ethiopia.

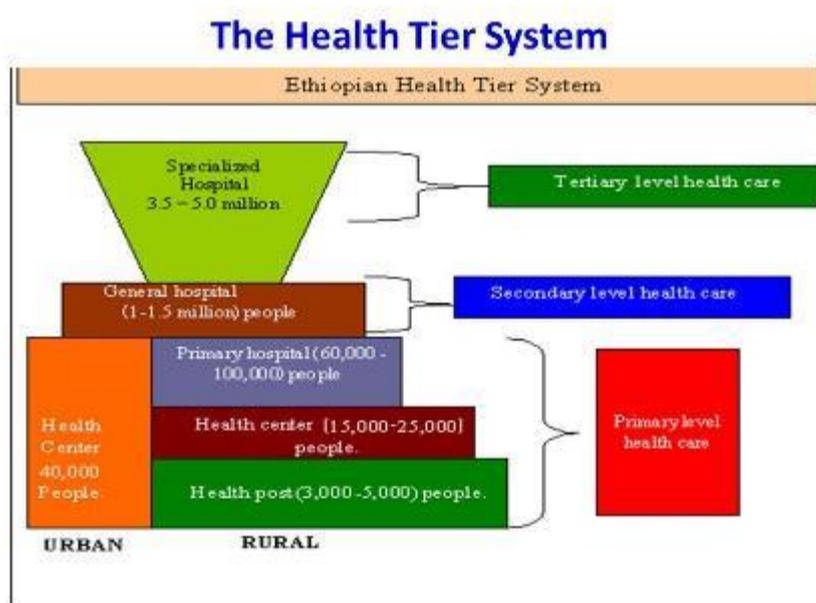
The health of women and girls are priorities in Ethiopia, with a particular focus in rural areas. DFID has been working with partners for three years on setting up health insurance. At present, the amazing reduction in MMR and CM has been achieved at low cost: USD \$30 is currently spent on health per capital, whereas the WHO recommends that countries spend

USD \$44 - \$60 per capita. Expenditure of USD \$83 per capita is regarded as a good standard to achieve good public health.

Ninety per cent of Ethiopia's health system is comprised of government services and people trust the health system. A problem remains the uneven progress: living in a rural area of Ethiopia increases mortality rate threefold.

The government has been working hard to remedy this and have trained health extension workers, mostly women, to work in rural areas to provide caring, respectful and compassionate care.

Ethiopia's health system, particularly primary, secondary and tertiary healthcare provision, is represented in the diagram below (population each facility serves):



- DFID engagement in the health sector and key achievements: Supporting eleven teaching hospitals;
- The Sustaining and Accelerating Primary Health programme (SAPHE), £250 million over five years from 2015: estimated to avert 35,000 child and maternal deaths, and provide family planning services to over 330,000 new users.
- The Reproductive, Maternal, Neo-Natal and Child Health Innovation Fund (RIF), a £25 million 'challenge fund' for civil society organisations, which aims to ensure that 67,000 babies are delivered safely between 2011 and 2018.
- Family Planning: a £90 million, four-year programme which will result in an estimated 670,000 new users of family planning services.
- Ethiopia's Ministry of Health receives around £12 million per year (centrally managed) to tackle: neglected tropical diseases (NTDs) (Elephantiasis/Lymphatic Filariasis, Trachoma, Visceral Leishmaniasis, Schistosomiasis and Guinea worm); harmful traditional practices including female genital cutting; polio; and unwanted

pregnancies through the Preventing Maternal Death from Unwanted Pregnancies (PMDUP) programme.

- Multilaterals and mini-multilaterals: Ethiopia is a major recipient of the Global Fund (around £100 million per year), GAVI (£20 million per year) and other multilaterals. DFID contributes to nearly 10% of the total annual Global Fund spend and 25% of the total annual GAVI spend.

Achievements so far:

- 2 million more women are using family planning methods.
- 500,000 more women are accessing safe delivery care.
- 500,000 more children are getting vaccinated.
- 30 million more people are receiving healthcare from government facilities.
- 68,000 less children and women are dying in 2016, compared to 2011.
- Statistically, a child born in 2016 will live two years longer (~ 64 years) than a child born in 2011.

### **A question and answer session followed the roundtable briefing**

The question and answer session focused on the following topics: ongoing challenges to delivering family planning services, safe abortion care, gender-based violence (including FGM and early and forced marriage), and support to refugees.

### **1. The existing challenges on access and utilisation of family planning services in Ethiopia and policy level barriers precipitated by the Global Gag Rule of the USA.**

- Ethiopia has a very positive policy environment towards scaling up access and utilisation of comprehensive family planning services. The Government of Ethiopia is fully convinced about the health and economic benefits of family planning.
- Nearly one-in-three women (36%) are now using modern family planning methods, compared to less than one in thirty women (3%), 25 years ago.
- Despite progress, Ethiopia's population has doubled in the last 25 years, from around 50 million in 1991 to 102 million in 2016. If the current fertility trend continues, it could undermine Ethiopia's ambition to reach lower middle-income status by 2025.
- Currently, 6 million women are using modern methods of family planning in Ethiopia, and over 3.5 million more wants to use family planning (unmet need).
- DFID has initiated a new programme, in partnership with the Government of Ethiopia, to sustain the existing 6 million users and meet the unmet need of 3 million users over the next four years.
- Current family planning use varies significantly by region (less than 2% in Somali and pastoralist regions, against a national average of 36%).
- There is no extreme opposition towards family planning by the major religions of the country, Christian and Islam. Barriers are more socio-cultural, which boils down

to a belief that having more children is a sign of wealth and an insurance against children dying at an early age.

- Currently, Ethiopia spends around USD \$60 million per year on comprehensive family planning services. Nearly half of this budget (USD \$30 million) used to come from US government sources.
- A total investment of USD \$60 million on family planning supports around 6 million family planning users in Ethiopia (USD \$10 per user per year), which implies that around 3 million users will be affected if US stops funding comprehensive family planning services in Ethiopia. (This scenario seems likely at this stage).
- Assumptions: (a) three million women, who are willing to use planning, will not get access to modern family planning; (b) 75% of them will get pregnant; (c) half of the pregnant women will undergo abortion and half will deliver. These assumptions could lead to: 10,000 additional maternal deaths and 70,000 additional child deaths.

## **2. Abortion law in Ethiopia**

- Since 2005, abortion has been legal in Ethiopia in cases of rape, incest or foetal impairment. In addition, a woman can legally terminate a pregnancy if her life or physical health is in danger, if she has physical or mental disabilities, or if she is a minor who is physically or mentally unprepared for childbirth. The MMR has dropped from 32% to 6-8% since the 2005 Abortion Act.
- The Ethiopian government has evidence-based national standards and guidelines on safe abortion that permit the use of medications (misoprostol with or without mifepristone) to terminate pregnancies, in accordance with World Health Organization (WHO) clinical recommendations.
- DFID programmes support Ethiopian abortion law.

## **3. The prevalence of FGM and legal age of marriage in Ethiopia and support by DFID to tackle harmful traditional practices like FGM and child marriage?**

- FGM is very prevalent in Ethiopia, and the recent Ethiopian Demographic Health Survey (EDHS) (2016) reported that more than 60 % of women, aged 15- 49 years, have experienced FGM. Although the practice of FGM is punishable by law, it is still prevalent in pastoralist regions and rural parts of agrarian regions. The Type 3 FGM (infibulation) is associated with obstetric complications like obstructed labour and obstetric fistula.
- DFID is addressing both FGM and child marriage through its health programmes. Social development advisers are working with Ministry of Women and Children, Ministry of Health and UNFPA.
- The legal marriage age in Ethiopia is 18 years, but the prevalence of early marriage is still high, at nearly 40%. Although the country has made progress on interventions on early marriage with support from donors like DFID (e.g. the End Child Marriage programme in the Amhara region), more needs to be done.

#### 4) DFID support to refugees in Ethiopia.

- There have been refugees in Ethiopia for the past 20 years and there are currently 880,000 refugees in the country.
- Ethiopia has an open-door policy for refugees and a wish to integrate refugees in the society, including those hosted in camps.
- At the UN General Assembly last year, the UK announced a new jobs compact in Ethiopia, which will create jobs for 100,000 Ethiopians and refugees (approx. 30,000). These will be both inside and outside new industrial parks that will be created, which will support a growth in exports from Ethiopia.
- Through skills and technology, the UK is supporting Ethiopia to enhance worker productivity to drive up wages over time. Similarly, promotion opportunities and wage incentive schemes are available in the factories within the industrial parks.

The UK delegation thanked DFID representatives for their warm welcome and informative briefing, and looked forward to returning on Friday 10<sup>th</sup> November to discuss study tour findings.

#### **SRHR Stakeholder briefing meeting, Saro Maria Hotel, Addis Ababa**



*Study tour delegation at SRHR stakeholder briefing meeting, Saro Maria Hotel, Addis Ababa*

Study tour delegates were welcomed to the SRHR roundtable briefing meeting by Risha Hess, Country Director, MSI Ethiopia; Shewaye Alemu, Government Advisor, MSI Ethiopia; Fetene Gebeyehu, Public Relations Officer, Family Guidance Association Ethiopia (FGAE) (IPPF Member Association); Tinos Kebede, Programme Officer (FGAE); Dorothy Lazaro, Midwifery Specialist, UNFPA; Jemal Kassaw, Country Representative, Engender Health; Getachew Bekele, Senior Advisor, Engender Health; Liya Wondwossen, Deputy Director MCH Department, Federal MoH and Tadele Kebede, Family Planning expert from the Ethiopia Federal Ministry of Health.

**The Ministry of Health officials opened the discussion with a PowerPoint presentation outlining family planning and MCH statistics and activities in Ethiopia.**

They noted that Ethiopia has made significant progress towards achieving national and international development goals. It is also making good progress in sectoral programmes and strategies for improving maternal health, promoting gender equality and women's empowerment, and combating the HIV epidemic.

The MMR has declined from 676 to 412 per 100,000 live births in the last five years alone. The number of deliveries in health facilities have increased from 10% in 2011 to 28% in 2016. The contraceptive prevalence rate has increased to 36% and the total fertility rate has dropped to 4.1 per woman in 2016.

However, the unmet need for family planning remains high, especially for young married adolescents, 15-19 years old, who have a 33% unmet need of family planning for spacing of children. There are also emerging SRH needs that command the attention of the government and partners, such as cervical cancer.

**Fetene Gebeyehu, Public Relations Officer with the Family Guidance Association Ethiopia (FGAE) proceeded.** He noted that FGAE celebrated its 50th anniversary in 2015. It has a broad outreach in Ethiopia, with a focus on both service provisions and advocacy. FGAE activities especially target the poor and marginalised populations with a particular focus on contraception, safe abortion care, maternal and child healthcare, prevention and treatment of sexually transmitted diseases (STIs) including HIV and AIDS and associated opportunistic infection. FGAE supports eight regions and 400 facilities including 28 youth centres. Staff are backed by thousands of volunteers, hundreds of peer educators and community-based distributors (CBDs).

Access is key to FGAE's activity, and it works extensively with young people to inform, educate and provide essential SRH services. FGAE also runs special projects targeted at particularly vulnerable individuals and groups such as street children, people living with HIV and AIDS, sex workers, and young migrants in 8 of the 11 principal regions in Ethiopia.

FGAE partners with government namely the MoH, the Ministry of Women, Children and Youth, UNFPA-Ethiopia, CARE-Ethiopia, DKT-Ethiopia, Dawn of Hope, the Ethiopian Women's Lawyer Association, and a broad spectrum of NGOs and HIV and AIDS-related operations.

Private sector partners include Betezata Hospital and Janmeda/medical bio laboratories, and donors to the Member Association's work include the Royal Netherlands Embassy, the

Packard Foundation, IPPF's Japan Trust Fund, USAID/CDC and Irish Aid. Study tour delegates will have to opportunity to observe FGAE activities in its clinic in Axum.

**Dorothy Lazaro, Midwifery Specialist, UNFPA, followed Fetene, to discuss UNFPA's partnership with the Government of Ethiopia.** She noted that UNFPA have been working with the Ethiopian government since 1973 and support the Government's development strategy. Importantly the current fertility transitions in Ethiopia has the potential to create development opportunities for young people.

UNFPA's work is aligned with the Sustainable Development Goals (SDGs) and the ICPD Plan of Action. The main thrust of the current programme is to contribute to the improvement of the quality of life of the people of Ethiopia, especially women and young people, through promoting universal access to SRHR. In particular, the programme seeks to improve maternal health through provision of information and services on Emergency Maternal and Neonatal Care, skilled human resources for maternal health and redressing the unmet need for family planning; address the SRH needs of adolescents and youth; address gender inequality with a special focus on gender-based violence; and ensure better understanding of population dynamics through adopting a human rights based approach.

UNFPA's programme promotes strategic partnerships with the government, UN Agencies, donors and civil society organisations. To maximise and sustain impact, the country programme is implemented in eight selected regions covering over 90% of the Ethiopian population, with a focus on scaling up specific interventions and delivering on a small number of strategic and measurable outputs.

UNFPA Ethiopia is one of the largest country offices in the Africa Region both in terms of staff, resources and programmes with an estimated budget of USD \$120 million over four years. The delegation will visit the UNFPA supported youth project at Addis Ababa University and the UNFPA-supported SafeHouse for women and girls in Addis Ababa.

Dorothy handed over the platform to MSI Ethiopia: Risha Hess, Country Director, and Shewaye Alemu, Government Advisor. MSI noted that they have been working in Ethiopia for over 25 years. They work closely with the Government of Ethiopia and other partners to help reduce MMR and increase access to quality SRH service. MSI have more than 500 socially franchised private clinics, and outreach. Outreach teams target hard to reach clients in the three most populated regions of Ethiopia. Services are provided at over 200 sites. They are fully subsidised and offered free to clients who would not otherwise be able to afford them. Services provided include general medical consultation, short, long-acting and permanent methods of contraception, family planning counselling, pre- and post-natal care, child health checks, free condom provision, voluntary testing and counselling on HIV, and STI screening and treatment. In 2015, the MSI team delivered family planning, safe abortion and maternal health services to approximately 912,000 clients through centres, and reached the same number of clients through the social franchise network, BlueStar. The delegation will visit a BlueStar clinic in Axum.

In addition, MSI also operates a helpline that receives more than 6,000 phone calls per month, around 80% of which are young people aged 20-29 years old. They call seeking advice on

contraception, safe abortion and other topics surrounding their sexual health. The delegation will visit the Addis Ababa helpline after the roundtable briefing.

Jemal Kassaw and Getachew Bekele from Engender Health completed the presentation. Engender Health noted they have been working in Ethiopia for the past 25 years to empower women to stay healthy and decide if, when, and how many children to have. Projects span a wide range of reproductive healthcare services, from expanding contraceptive choice, to ensuring the delivery of high-quality maternal healthcare, to reducing unsafe abortions. In addition to preventing unwanted pregnancy, Engender Health also works to ensure that Ethiopian mothers have the best chance at surviving pregnancy. In partnership with the Government of Ethiopia, current projects reach five regions and two city administrations, covering a total of 175 Woredas (districts).

Engender Health introduced long-acting and permanent contraception in 1987 and its usage has increased seven-fold at the health facilities since the initiation. As a result, more than 3.5 million more Ethiopian women and men have felt the life-changing benefits of family planning and reproductive health services. Engender Health also provide training, capacity building, mentorship and technical assistance to government staff. Over the past five years they have supported the training of 5,000 midwives and 2,500 health care workers, including anaesthetists. They also support three tertiary hospitals on obstetric fistula and with equipment and commodities.

**A short question and answer session followed** on the subjects of perception of UK contributions, FP2020, the Global Gag Rule (GGR) and the issue of inequity. The Ministry of Health noted that DFID is the second largest donor in the country, but concerns have arisen with regards to DFID's new NGO funding mechanism, instated in 2016/2017, and the impending decline in USA funding due to the GGR. Inequity remains a problem in Ethiopia – with some part of the country and populations not being reached at all, including by NGOs, as either unsafe or populations constantly on the move or cultural barriers.

### **Marie Stopes International Ethiopia call centre, Addis Ababa**



*Study tour delegation visiting MSI call centre, Addis Ababa*



*MSI call centre, Addis Ababa*

The study tour delegates were greeted by Jemaw Assefa, MSI call centre manager, and four call centre staff upon their arrival at the centre.

The study tour delegates were encouraged to ask questions and the following topics were discussed: opening hours, clientele and the most common topics discussed by the call centre ladies.

All telephones were manned by professionals to ensure the provision of sensitive, age appropriate and confidential advice, information and support to telephone clients. Social workers were on call for referral if needed. The majority of calls received, came from teenage girls and the majority of calls related to contraception, abortion and STIs.

The call centre was marketed via social media, the radio, TVs, magazines and clinics such as the MSI BlueStar clinics.

## **Tuesday 7<sup>th</sup> November**

### **Ethiopia Parliament and MPs**

The delegation was welcomed at the Ethiopia Parliament by the Chair of the Social Affairs Standing Committee, Abeba Yosef (EPRDF) and 7 members– one being male: Semira Sultan (EPRDF), Edosa Adugna (EPRDF), Geneat Abate (EPRDF), Tufena (EPRDF), Aselefesh Bekele (EPRDF), Almaz Mekonen (EPRDF) and Muntah Ibrahim (EPRDF).



*Study tour delegates with Ethiopia MPs, Ethiopia Parliament, Addis Ababa*



*The visit started with a short guided tour of the Ethiopia Parliament.*



*Study tour delegates inside Ethiopia Parliament with MPs from the Social Affairs Standing Committee, Ethiopia*



*Baroness Jenny Tonge in front of Ethiopia flags (Regional), Ethiopia Parliament*

After the guided tour, Abeba Yosef gave a PowerPoint presentation and overview of Ethiopia Parliament and the function of the Social Affairs Standing Committee, with a focus on population, development and reproductive health.



*Study tour delegates meeting with Ethiopia MP, Ethiopia Parliament*

The Ethiopia Parliament has 547 seats and members of the House are elected by the people for a five-year term. Thirty-two percent of Ethiopia's MPs are women – up from 2.7% in 1995. Women were first allowed to vote in 1918 in Ethiopia. The House sits from September until June (according to the Ethiopian calendar, which differs from the European calendar). Plenary sessions are held two days per week and the three other days are for committee activities.

Standing committees in Ethiopia have between 15 and 25 members. As well as scrutinising government legislation and policies, committees review and monitor all regional policies and statistics.

A roundtable discussion followed the presentation on the importance of SRHR, early forced marriage, FGM and GBV, women caucuses and getting more women into parliament, number of female ministers, improvements in maternal health, adolescent pregnancies, data collection in country, girls' education, and the constant resistance and struggle for gender equality.

Of particular interest was the strong political will presented for universal SRHR, including free contraception and access to safe abortion services, and the strong link made between balancing population growth and economic development. All parliamentarians present shared a strong commitment to making progress on women's rights, including their sexual and reproductive rights.

All women MPs were unhesitating in their belief that their role in parliament was to speak up on behalf of women in Ethiopia, who want to make progress towards gender equality. They mentioned the all-party women's caucus in the Ethiopian parliament and women's caucuses in each region. Members emphasised the importance of their regional caucuses that ensure gender issues are included in all government plans and that issues such as FGM and early forced marriage are being addressed and tackled.

Whilst at the Ethiopia Parliament, Baroness Jenny Tonge was interviewed by the Ethiopia Broadcasting Center. She outlined the linkages between family planning and SRHR and social and economic development. This was later broadcast on national television.

### **UNFPA youth and disability project, University of Addis Ababa**

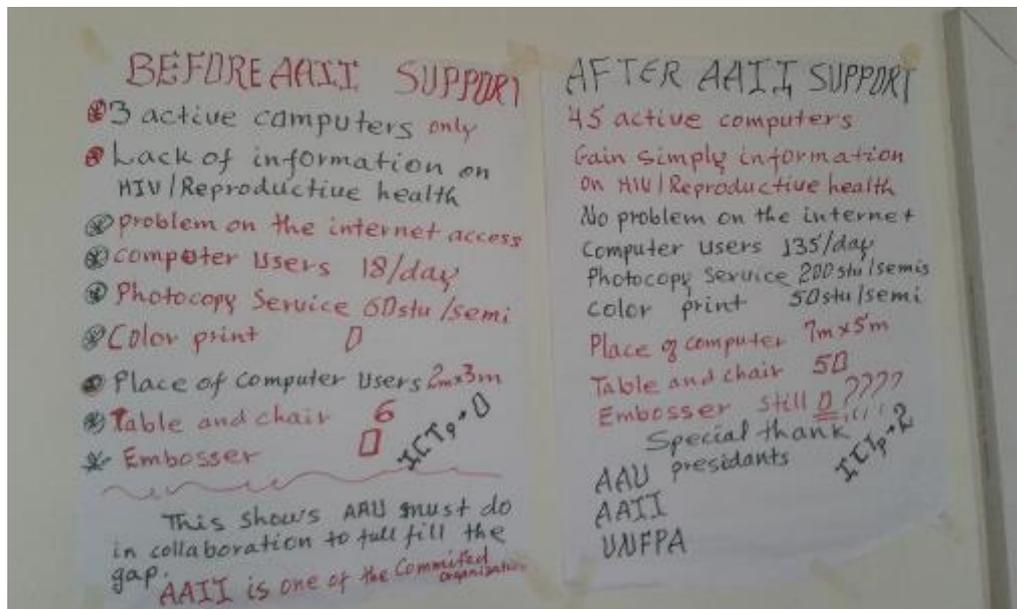
The delegation was met by Meron Negussie, Programme Specialist, HIV Prevention and Adolescent and Youth Development, UNFPA and Mekonnen Manaye, Senior Expert, Special Needs Support Centre at the Addis Ababa University and escorted to the disability project library room, next to the entrance hall.



*Mekonnen Manaye, Senior Expert, presenting the UNFPA youth and disability project, University of Addis Ababa*

Mekonnen Manaye presented the UNFPA/UNICEF and AAIL supported resource centre project for disabled students at the University, which opened in 2016. The establishment of the resource centre was a response to the particular vulnerability of students with disabilities. Students with disabilities experience quite a number of challenges related to SRH and gender-based violence.

The resource centre offers space, 42 computers (with internet connections), counselling and referrals for SRHR services. The project has, thus far, served 500 disabled students, 200 with hearing or visual impairments. Similar projects can be found in 16 higher education institutions across the country.



Student poster showing disability project achievements, University of Addis Ababa



Study tour delegation meeting with female law students, University of Addis Ababa

The delegation was then met by a group of dynamic young Ethiopian female law students, who were involved in the UNFPA-UNICEF supported Young Footprints Club. They were supported in organising gatherings to assist students at the campus, especially from rural areas, recognising that, away from their families and coming from patriarchal communities, they might find it difficult to speak up about any concerns they have.

Once every week a 'Safe Space Platform' is set up in the women's dorms for students to speak about any issue that concerns or matters to them. Issues discussed relate to gender equality, equal opportunities, SRHR, safe motherhood, violence against women and girls, and general life concerns.

They run a 'Pad Paradise' initiative, collecting donations of sanitary pads for girls in villages who, without them, would miss a week's schooling each month because of their periods. They also run a 'male engagement' club to encourage support and awareness amongst male students. The two young women who led the discussion were assertive, full of confidence and determined to play their part in transforming the role of women in their country. One wanted a future in policy making and the other wanted to be training and teaching.



*A female law student presents the Young Footprints Club, University of Addis Ababa*



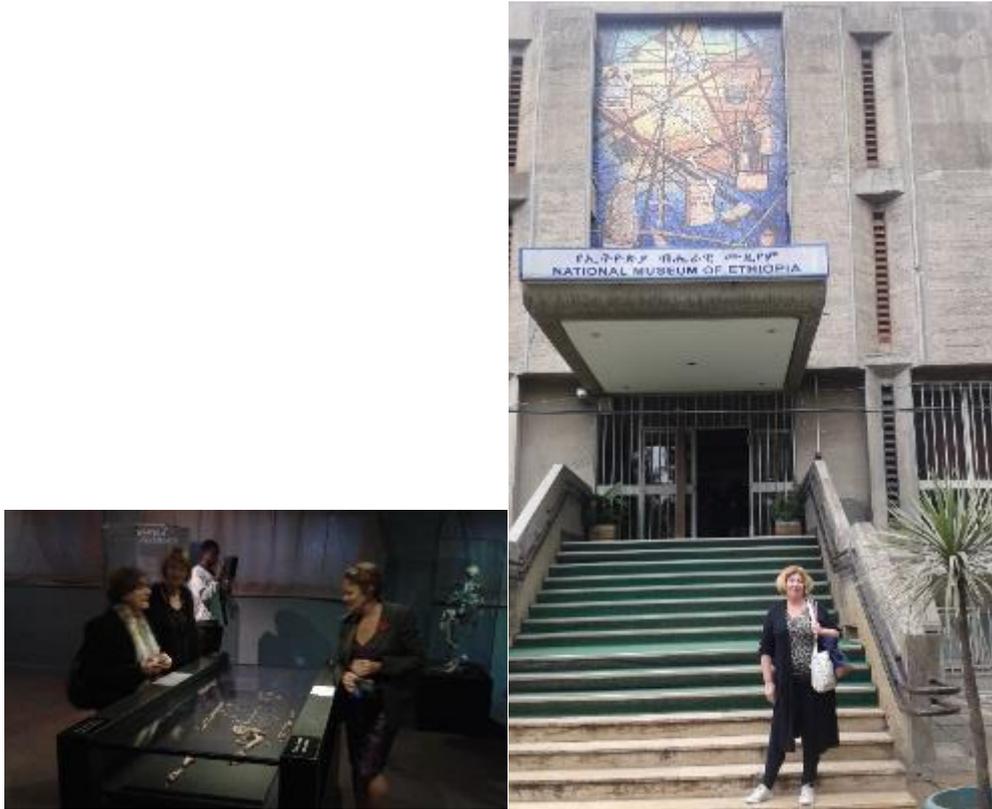
*A student studying in the female dorm library, University of Addis Ababa*

After the gathering at the campus, the delegation visited the students' dorm. The dorm now has its own library, as the female students previously were losing study time in the evening because they could not study in the university library, which is located across the campus, without risking being assaulted or raped in the dark, between the dorm and the library.

### **Addis Ababa private fistula hospital, Hamlin Fistula Ethiopia**

A luncheon was hosted on route to the Addis Ababa Fistula Hospital, immediately next door to the Ethiopia National Museum. The delegation took advantage of this and visited the nation's artistic treasures and archaeological finds such as the fossilized remains of early hominids, the most famous of which is 'Lucy', the partial skeleton of a specimen of *Australopithecus Afarensis*.





*Study tour delegates visiting the Ethiopia National Museum, Addis Ababa*

At the Addis Ababa Fistula Hospital, the delegation was met by Zenebe Mesfin, the Hospital Chaplin, and two surgeons, Dr Yeshiney Demirew and Dr Renatae Roentgen, the latter from Germany and specialising in urogynecology.





*Study tour delegates being briefed by Dr Renatae Roentgen and Dr Yeshineh Demirew, Addis Ababa Fistula Hospital*

The delegation received an introduction to the history of the hospital, its philosophy and service provisions.

Hamlin Fistula Ethiopia is dedicated to the treatment and prevention of childbirth injuries, called obstetric fistulas. The organisation, Hamlin Fistula Ethiopia, and the Addis Ababa Fistula Hospital were founded by Dr Reginal Hamlin and Dr Catherine Hamlin in 1974. They were two Australian doctors who were in Ethiopia to train midwives when they discovered the terrible plight of the fistula patients.

Hamlin Fistula Ethiopia is a world-class centre of excellence for treating obstetric fistula patients and training obstetricians to specialise in this surgery. Hamlin Fistula Ethiopia directs the work of the Addis Ababa Fistula Hospital, its five regional hospitals, the Hamlin College of Midwives and Desta Mender, a farm and training centre for long-term patients. Rehabilitation programmes assist former patients to reintegrate to village life. The organisation also has a preventative strategy that aims to eradicate obstetric fistula from Ethiopia by providing trained midwives in the rural regions of the country.

The Ethiopian staff are the backbone of Hamlin Fistula Ethiopia. There are over 500 staff across various sites: the main hospital in Addis Ababa, the five regional hospitals and the Hamlin College of Midwives.

Hamlin Fistula Ethiopia employs gardeners, drivers, cooks, cleaners, seamstresses, teachers and guards as well as administration and office personnel and medical staff. Medical staff include pathologists, physiotherapists, nurses, nurse aids (many of which are former fistula patients) and of course fistula surgeons.



*Study tour delegates being shown around the Addis Ababa Fistula Hospital*

The hospital has treated over 50,000 women/girls since it was established and treats approximately 250 to 300 women/girls per year. Most clients stay for two to three weeks and only some go back to their villages or homes. There are usually around 100 patients in the hospital at a time. Some of the 70 nurse aids are previous patients and as there are 80 different languages spoken in Ethiopia, there is usually a translator available.

The delegation was shown around the hospital and managed to speak with a couple of the women patients on the wards who had recently undergone surgery.





*Study tour delegates speaking with girls in the Addis Ababa Fistula Hospital*

It transpired that several of the women had waited for years for the fistula repair and some would return to the hospital after the initial repair, in need of repeated surgery. Some women, despite the best surgery, were in need of permanent urostoma. Our hosts informed us that all women had seen great improvements in their lives and the majority could lead 'normal lives' again. Many clients also returned to the hospital to have babies by caesarian section.

The wards were peaceful and clean and nurse aids were seen caring for the women.



*A Hamlin Fistula Hospital ward, Addis Ababa*

The network of health extension workers now trained in Ethiopia to identify problematic deliveries, the increase in obstetric emergency referral centres and caesarian sections and fewer child marriages, had reduced the incidence of obstetric fistula. However, there are an estimated 39,000 women still waiting for fistula repair surgery across the country.

## UNFPA-supported SafeHouse project, Addis Ababa



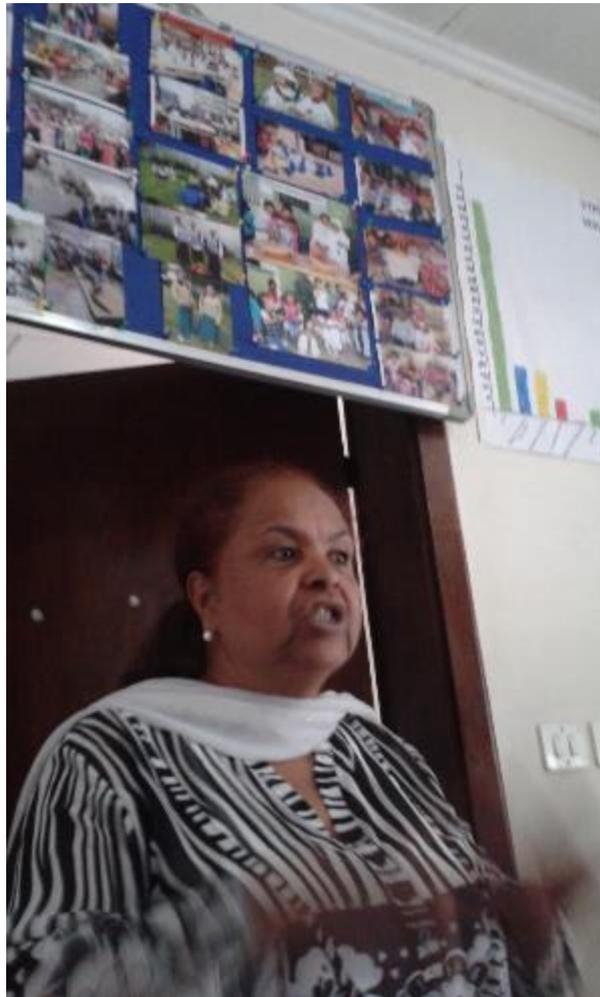
*SafeHouse poster, Addis Ababa*

The delegation was met by a UNFPA representative close to the safe house for victims of gender-based violence. They were then escorted to the safe house, which is discretely located behind tall, grey walls in a nondescript neighbourhood and is known only by the police who refer and bring women and girls, and their supporters, to the house. It is run by Tsotawi Tekat Tekelakay Mahiber (TTM), which translates to 'the Organisation Against Gender-based Violence', and it is supported by UNFPA, UN Women, Comic Relief, Womenkind Worldwide and MSI.



*Study tour delegation arriving at the SafeHouse, Addis Ababa*

Upon entering the safe house, delegates were met by its founder and Executive Director, Maria Munir Yusuf.



*Maria Munir Yusuf, founder of the safe house, briefing delegates on the women, girls and children residing in the safe house, its history and remit*

The safe house is based on the premise that effective work against gender-based violence cannot be achieved without providing support and protection for survivors/victims of violence.

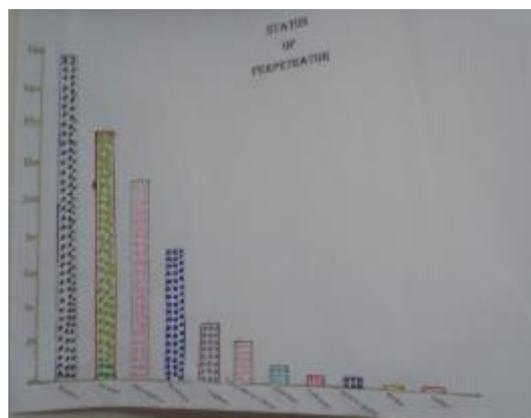
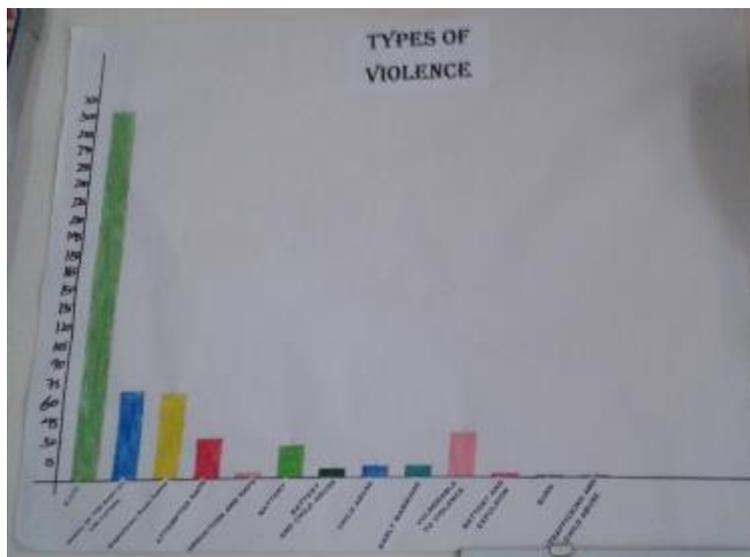
According to Maria Munir, the demand for the shelter far outstrips available capacity, due to the pervasive nature of gender-based violence in the country. Ethiopia has one of the highest prevalence rates of both sexual and physical violence by an intimate partner. Societal abuse of young girls continues to be a problem. Besides rape and battery, the most widespread manifestations of violence against women in Ethiopia are harmful traditional practices, including FGM/cutting and child marriage. Other harmful traditional practices are abduction, for the purpose of forcefully contracting marriage, and wife inheritance: in some places a woman is considered the property of the family into which she marries, so if her partner dies she is expected to wed a male relative.

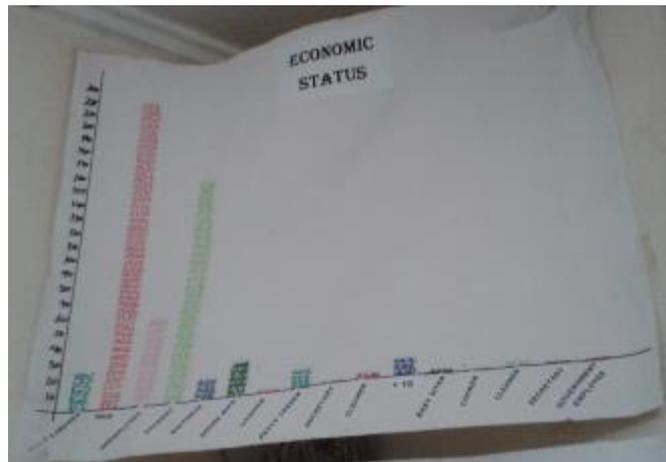
Among the key measures that the Ethiopian government has established to combat such practices is Article 35 of the Federal Constitution, which prohibits laws, cultures and practices that oppress or cause bodily or mental harm to women.

While women have recourse to the police and the courts, societal norms and limited infrastructure inhibit many women from seeking legal redress, especially in rural areas. Social practices obstruct investigations into rape and the prosecution of the rapist. Many women are not even aware of their rights under the law.

The safe house is a mitigation measure, aimed at cushioning the effects of violence on some of its most vulnerable victims. As such, the organisation offers a holistic approach that includes shelter, healthcare, food and clothes for survivors and their children; individual and group counselling; self-defense and life skills; and professional skills training. It also supports lawsuits against perpetrators and assistance with their reintegration into society. Many of the survivors bear children that are born whilst at the safe house.

Ms Munir pointed to several graphs on the wall during the introductory meeting with the delegation, that quantified the numbers of women and girls seen in the safe house and the reasons for their admission.





*SafeHouse statistics and graphs, Addis Ababa*

Ms Munir shared some harrowing stories. One of these was about a young girl brought in by a police officer one evening. Initially Ms Munir turned her away due to a lack of capacity, however the police officer insisted she stay and he brought her a mattress and paid for her stay! It was a young teenage girl who had, against all odds, excelled in running. Two local boys had taken it upon themselves to destroy her success by hanging her upside down, gang raping her and breaking her legs! She survived and stayed at the safe house for a very long time, but with life-long mental and physical disabilities.

Other stories included girl students being raped when they refused advances and sexual offences by relatives, including a 13-year-old girl raped by her dad. Her mother had passed away. Few survivors return to their previous lives and the safe house has recently supported a couple of girls with their further studies and shared accommodation outside the safe house. All arrivals at the safe house are recorded and followed up.

Ms Munir followed by saying:

Our ultimate salvation will come only when gender-based violence is totally stamped out in Ethiopia. For us to address the problem properly, we need to understand the magnitude of the problem; its manifestations and justification; and consequences on the individual, community and nation... As a result, in addition to running the safe house, TTTM has embarked on community outreach education, networking and research.

The community outreach education component of the project targets law enforcement bodies (police and prosecutors), women's affairs officials, health professionals, community and religious leaders and students. It focuses on creating awareness in the community about women's rights, gender issues and traditional practices that harm women and girls.



*Study tour delegation visiting the SafeHouse compound, Addis Ababa*

Ms Munir invited the delegation to walk around the safe house and note the various activities and living conditions. Women were seen busy minding the newly born babies in the shelter. The complex also had offices, a health clinic, a counselling room, kitchen and dining facilities, dormitories and workshops. The 50-bed facility appeared very welcoming for women and their children, who often arrive battered and with nothing but the clothes on their backs.



*Study tour delegates visiting the SafeHouse dorms, Addis Ababa*



*Baby sleeping in SafeHouse dorm bed, Addis Ababa*



*SafeHouse nursery, Addis Ababa*

## **Wednesday 8th November**



*Simian mountains seen from aeroplane between Addis Ababa and Axum*

The delegation was on a very early flight to Axum this morning. Flying across the beautiful Simian Mountains and seeing the terrain reaffirmed reports the delegates had heard about the difficulties experienced by many populations in accessing health and other essential services in remote areas.

### **Refugee camp, Shire, Tigray**

Upon arrival to Axum, the delegation was met by Asmelash Adhamom, Regional Manager, MSI. The luggage was dropped at the hotel and the delegation set off with a packed lunch toward the Eritrean border to visit the Shire refugee camp. Over the course of the approximate two-hour drive, delegates experienced a drop in altitude and large rise in temperature from a comfortable 23 C to 30 C. The landscape changed from mountains and lakes into a plateau and desert.



*Landscape between Axum and Shire refugee camp, Tigray*

Upon arrival at the Shire refugee camp, the delegation were met by Haftom Tekle-Michael, Camp Coordinator and Administrator for Refugee and Returnee Affairs (ARRA).



*Haftom Tekle-Michael, Camp Coordinator briefing delegates in Shire camp office, Tigray*

The Government of Ethiopia maintains a strong commitment to the 1951 Convention Relating to the Status of Refugees and a favourable protection environment. For many years, Ethiopia has maintained an open-door policy toward refugees. For example, when refugees arrive at the borders they will enter a reception centre and receive an ID card that registers their entry. Many refugees are then transported in buses to the designated camp.

Some refugees have been in the Shire camp since its inception, but many men travel to Sudan illegally and then into Libya, and across the Mediterranean Sea into Europe. Once arriving there, they contact their wives and/or children and arrange for them to follow if possible. Some people have been living in neighbouring refugee camps, not far from Shire, for 14 years.

Haftom Tekle-Michael explained that this particular camp was the newest in the area. It was three years old and housed around 13,000 Eritrean refugees. Today, an additional 80 or 90 refugees had arrived. The majority were young men, but the camp also hosts families and between 1500 – 2000 unaccompanied minors. The camp receives support from UNHCR and other UN agencies as well as seven or eight NGOs, including Médecins Sans Frontières. The camp is divided into different areas and a variety of buildings exist in the different areas that host schools, occupation skills rooms, leisure facilities and health clinics. Refugees in the camp can move freely and some have jobs in the nearest town.

Accommodation and buildings are built – often by skilled refugees – in concrete blocks with corrugated aluminium roofs. An allowance is provided to the refugees for their work, usually USD \$50 per month. Some house around 10 people and some house families, pending circumstances. Toilets are located a few metres behind living accommodation. The

unaccompanied minors live in a designated area together. All refugees are given 10 kg of food rations, but the food is very monotonous and does not include enough vegetables and fruit according to staff. Unaccompanied minors receive cooked food.

The camp has community security police, which minimize violence in the camp. According to Haftom Tekle-Michael, gender-based violence is not a problem in the camp! However, many challenges exist including boredom – due to a lack of recreational activities – and the refugees have difficulties in finding jobs, in part due to language barriers. The onsite healthcare is good, but stretched, with one doctor and 19 nurses, who all live onsite. The camp has no electricity or running water, which is a challenge for the clinics especially.

After the on-site briefing meeting, the delegation was escorted around the camp by Seifedin Kasim, Programme Officer, ARRA.



*Baroness Jenkin and Karen Buck MP in the Shire refugee camp, Tigray*



*Study tour delegation visiting the Shire camp, Tigray*

The camp appeared very peaceful and livened up in the afternoon. Children were seen playing football in a field, some men were playing snooker in a covered area, others were seen bathing in a waterhole and some on their mobile phones. Donkeys were carrying large water containers on their backs around the camps and water pipes were seen over ground.

A staff residential area/compound was visible in the distance surrounded by a small fence. The delegation visited a health clinic, which had a long queue of people waiting to be seen. We saw women of all ages, young men and children outside the consultation rooms.



*Eritrean refugees awaiting consultation, Shire camp health clinic, Tigray*



*Baroness Jenny Tongge meeting Eritrean refugees, Shire camp, Tigray*



*Clients being called in for consultations by the nurse, Shire camp, Tigray*

The delegation visited one of the consultation rooms and a delivery room. The consultation room had some empty boxes of injectable contraceptives on the table and the delivery room had basic beds, buckets, drip stands and dressing tables.

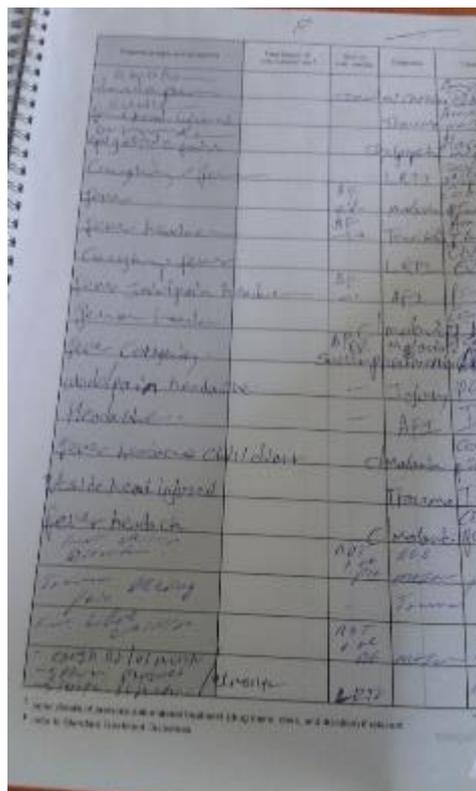


*Karen Buck MP in delivery room, Shire camp, Tigray*

A couple of registration booklets was noted on the table to have a list of names, ages, HIV/AIDS status/test and family planning method provided.



*Dressing trolley in Shire camp clinic, Tigray*



*Health clinic registration booklet, Shire refugee camp, Tigray*

A delivery had taken place this morning and waste material and blood were noted in the bin, as were used dressings and syringes. According to Seifedin Kasim, 30 babies had been delivered in the camp over the past year and there had been no maternal deaths. Women with obstetric complications were transferred to the referral hospital in town.

The clinic in the camp provided a variety of contraceptives, abortion services, delivery and post-natal care and appeared very rudimentary. The accommodation appeared very tidy, clean and organised.



*A family house, Shire camp, Tigray*

People were of all ages and appeared up to date with the latest global trends!



*Young guy in the Shire refugee camp combing his new haircut, Tigray*



*Elderly lady in the Shire camp, Tigray*

Through an interpreter, delegates visited and spoke to some women who were looking after their children.



*Mother with her child, Shire camp, Tigray*

Harriet Harman MP spoke to two women in a spotlessly clean hut with a swept earth floor sprinkled with freshly picked leaves. There were two beds and five people living in it. In the centre was a small open stove burning charcoal next to a low table holding a tray and a neatly laid out set of coffee cups.

One of the women was eight months pregnant. She had been in the camp for two years and her husband is now in the Sudan, which is the route used by refugees who then go via Libya to Europe. The other woman had been in the camp for three years. She had left Eritrea to escape violence and poverty, travelling on foot at night to avoid attack. She wanted to go to Europe. She was carrying a boy of 18 months. His father was elsewhere in the camp, but his mother had died of a snakebite a month previously.



*Harriet Harman MP meeting Eritrean refugee family, Shire camp, Tigray*



*Row of latrines at the back of houses, Shire refugee camp, Tigray*



*Outskirt of Shire refugee camp, Tigray*

## **Thursday 9th November**

At sunrise, study tour delegates took an early morning walk around the centre of Axum, where they found the tall, carved obelisks, relics of the ancient Kingdom of Aksum. They also visited the centuries-old St. Mary of Zion, the Christian church and pilgrimage site, believed to house the biblical Ark of the Covenant.



*Study tour delegates in front of the Obelisks, Axum*

The town was already busy at sunrise with elderly women chatting, young boys herding goats and street sellers.



*A young guy herding goats, Axum*



*A group of elderly ladies chatting outside St. Mary of Zion, Axum*

## **MSI franchise BlueStar clinic, Axum**

Beyene Tewele, Blue Star Clinic Owner, met the delegates at the MSI franchise, the BlueStar clinic in Axum.



*Study tour delegates outside MSI franchise BlueStar clinic, Axum*

Prior to entering the clinic, Asmelash Adhamom, Regional Manager, MSI, explained that BlueStar Ethiopia is a social franchise operated by MSI Ethiopia. BlueStar aims to expand and standardise SRH services in the private sector, thereby contributing to improved access to quality healthcare.

BlueStar Ethiopia currently supports family planning and safe abortion services as well as HIV counselling and testing and STI management services. There are over 200 BlueStar private clinics in Ethiopia. As part of membership benefits, BlueStar franchisees receive training, on-site technical assistance, free or subsidised equipment, and at-cost or subsidised commodities with a free delivery service. In exchange, they accept routine monitoring visits, report monthly service statistics and adhere to clinical protocols and other terms laid out in the BlueStar agreement.

In the Tigray region there are 30 franchise clinics and the one visited by the delegation was in Axum town centre.

Beyene Tewele showed the delegation around his clinic. The building was painted in the blue and white MSI colours. It was tranquil and clean with an enclosed walled garden.

The clinic hosted a couple of consultation rooms and a small operating room. A girl was noted resting on a soft bed after a procedure. Beyene Tewele explained that 95% of his clientele were women and he was supported by one nurse and one laboratory technician onsite. He

provides a variety of family planning methods and abortion services, but does not offer sterilisation. He collaborates with a social worker to provide outreach services.

A registration booklet was noted with names, ages and the service provided. The majority of clients were young girls who had registered for abortion services under the banner 'rape'. After some discussion with staff, delegates came to understand that as rape is one of the best-known criteria for obtaining abortion services, this is often the reason cited by young girls, whereas the actual reasons are often a lack of education and an unmet need for contraception.

**IPPF member association, the Family Guidance Association of Ethiopia clinic, Axum**



*Desta Kidanu, Northern Area Office Programme Coordinator presenting FGAE activities, Axum*

The next visit was to the Family Guidance Association of Ethiopia (FGAE) where Desta Kidanu, Northern Area Office Programme Coordinator and Asfaw Belay, Axum Clinic Coordinator presented FGA activities. FGAE provide a range of SRH services to the local population and has a focus on youth and vulnerable populations. They serve a population of 767,070 and 50% of services at present are contraceptive services and 5% are abortion services. The rest are maternal and child health and STI services.

FGAE are also involved in media and advocacy activities and has an outreach programme. A discussion followed the presentation on the GGR, demand for SRH services and the involvement of men.

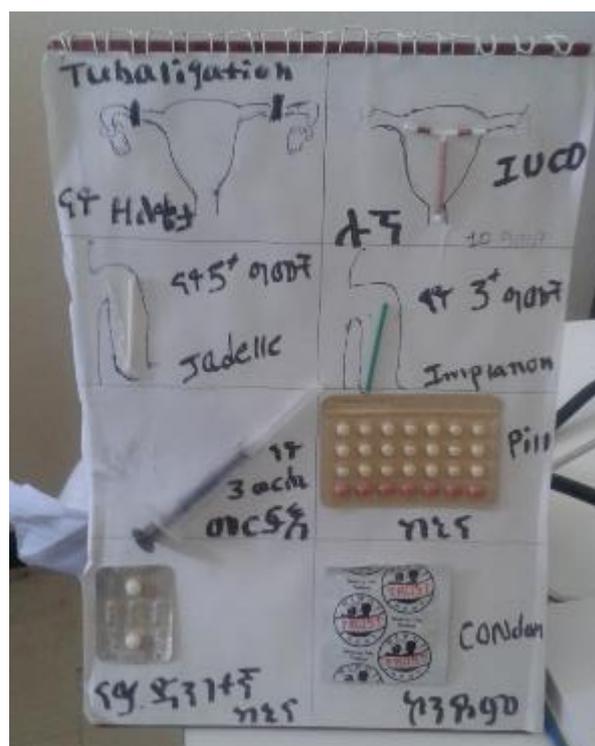
Desta Kidanu and Asfaw Belay noted that the GGR had already had an impact in country, in that 10 of FGAs clinics had closed despite the growing demand for services in part due to population growth. FGA would usually have been expanding its services and clinic outreach activities.

Men in rural areas of Ethiopia often want large families, so the involvement of men is crucial when it comes to family planning. FGA work with religious and other leaders in communities to combat male dominance and create a demand for family planning services.

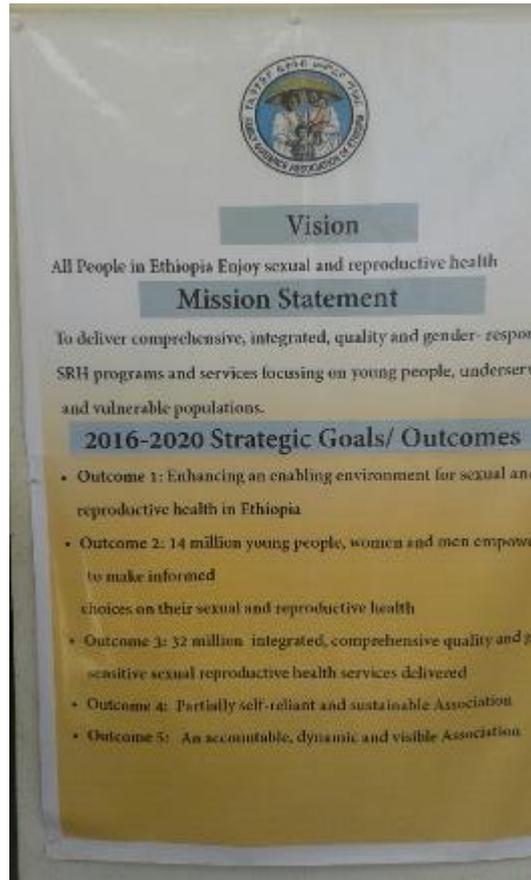


*Baroness Jenny Tonge and Harriet Harman MP speaking to health worker, FGAE clinic, Axum*

The delegation was escorted around the compound, which was tranquil, clean and had several consultation rooms, and a functioning laboratory with equipment. Available contraceptive methods were displayed on the tables and a poster was noted with the FGAE mission statement.



*Contraceptive methods available and displayed in FGAE clinic, Axum*



*FGAE mission statement, Axum SRHR clinic*

The delegation met and spoke to a group of women sitting in the compound. This was a self-help group of women living with HIV/AIDS. They meet regularly to share their concerns and discuss related difficulties and solutions. The women revealed their appreciation for the meetings and compound facilities. The majority in attendance knew about the self-help group via the community outreach staff and friends and all received anti-retroviral therapy. The issue of partner VCT was discussed, and all said their partners were notified of their status.



*Baroness Jenny Tonge and the self-help group, FGAE, Axum*

In another corner of the compound, the delegates met with two health extension/outreach workers and discussed the difficulties they had in reaching the most vulnerable and poorest segments of their communities. The low level of education remained an obstacle to the health seeking behaviour. The health extension workers were working closely with community leaders, including religious leaders, to change this to the better. Family planning uptake had increased dramatically from 27% to 36 % over the past years due to the outreach work.



*Baroness Blackstone speaking to staff, FGAE clinic, Axum*



*Baroness Jenkin entering FGAE consultation room, Axum*

Delegates visited a laboratory and two consultation rooms. The rooms looked clean and welcoming, with contraceptive displayed to show clients. The facility had a large variety of contraceptives in stock to disseminate to clients.

### **Axum Government Specialised Referral Hospital, Axum**

The delegation visited the Axum Specialised Referral Hospital on the outskirts of town, where they met by Dr Tewelde Berhe, Medical Director, and colleagues.



*Study tour delegation with Dr Tewelde Berhe, Medical Director and colleagues, Axum referral hospital, Axum*

This referral hospital has 200 beds and accepts obstetric and gynecological referrals from surrounding areas. Delegates were shown around the two-year-old hospital. It was not up to full capacity according to the medical director, as its location – a distance from town – deterred the local population.





*Dr Tewelde Berhe, Medical Director, Axum Specialized Referral Hospital escorting study tour delegates around the hospital ground and wards, Axum*

The hospital was calm, clean and busy with medical, midwifery and nurse student. Areas visited included the paediatric outpatient, maternity and gynaecology wards, as well as the neonatal unit.



*Medical students, Axum specialized referral hospital, Axum*

All mothers and children received treatment and care free of charge at the hospital, as per government policy. The main concerns raised were a lack of specialised clinicians and specialised equipment in the hospital. The 'intensive care' beds were staffed by generalists.



*Baroness Jenkin visiting the labour ward, Axum specialised referral hospital, Axum*

The majority of women admitted to the specialised unit were women with pregnancy-induced hypertension. They would receive care in line with the WHO guidelines.

The issue of abortion and cervical cancer services at the hospital were discussed. All staff spoken to appeared content with the new 2005 abortion law and conscientious objection by staff was rare.

Treatment for cervical abnormalities was not available at the hospital, so women would have to travel to Addis Ababa at their own cost. Many were unable to afford the cost!



*Beautiful paper animals were seen hanging from the ceiling in the paediatric unit, Axum specialised referral hospital, Axum*

The neonatal unit was caring successfully for some premature babies from 26-28 weeks gestation.

## **MSI senior management team dinner, Addis Ababa**

The delegation was on a late afternoon flight back to Addis Ababa from Axum. Delegates met the MSI senior management team for dinner at the 2000 Habesha Cultural Restaurant. Private conversations were held with Risha Hess, Country Director; Dr Nega Tesfaw, Director of Quality of Clinical Services; Nils Gade, Regional Director; Hailemariam Amare, HR Director and Ayalew Fikru, Director of USAID-SIFPO.

## **Friday 10th November**

### **Gandhi Government Memorial Hospital, Addis Ababa**



*Study tour delegates with Dr Lulseged Tessema, Clinical Medical Director at the Gandhi Memorial Hospital, Addis Ababa*



*Study tour delegates outside the Gandhi Memorial Hospital, Addis Ababa*

Delegates received a briefing by Dr Ashebir Getachew, Director of Obstetrics and Gynaecology and Dr Lulseged Tessema, Clinical Medical Director at the Gandhi Memorial Hospital.



*Dr Ashebir Getachew, Director of Obstetrics and Gynaecology introducing study tour delegates to the history and work at the Gandhi Memorial Hospital, Addis Ababa*

The Gandhi Memorial Hospital was founded in 1951 as a regional maternity referral hospital and the biggest in the country. It has 120 beds and 427 staff, of whom 127 are male. Patient admissions have been increasing over the years, whilst occupancy has remained steady at around 86%. As well as offering regular maternity and gynaecological services, the hospital has specialised in intensive maternity and neonatal services and a one-stop sexual violence clinic, which has seen a steady increase in clients. This unit works closely with the police and prosecutors.

Deliveries have now increased to 8,833 per year and the caesarean section rate is around 52%. This is high, but mainly due to it being a referral hospital. The maternity HIV prevalence rate is around 2%. The mortality rate has steadily declined. The hospital has experienced between 28 maternal deaths each year over recent years. The hospital has recently opened a clinic for cervical cancer and is hoping to deliver infertility treatment in the near future.

The main challenges are the lack of specialised trained staff, medical equipment and IT. A discussion followed on quality of care, family planning and abortion services.

Dr Ashebir Getachew, Director of Obstetrics and Gynaecology noted that the Gandhi Hospital is committed to quality of care and the provision of abortion services is integral to women's healthcare. Around 1,000 women seek abortions per year in this hospital.



*Study tour delegates in hospital corridor, the Gandhi Memorial Hospital, Addis Ababa*

The delegation was escorted around the hospital and visits included the post-natal ward. All beds were occupied and partners/husbands were noted beside the beds and the babies either being breastfed or in a cot next to the beds. Despite it being busy, it was a calm and quiet environment and many women were resting.



*Husband caring for his new family, the Gandhi Memorial Hospital, Addis Ababa*

Baroness Blackstone visited the neonatal unit, which was very busy with babies from around 26 weeks upwards, some were twins.



*Baroness Blackstone, Neonatal Unit, the Gandhi Memorial Hospital, Addis Ababa*



*Premature twins in the Gandhi Memorial Hospital, Addis Ababa*

All babies were in clean incubators with clean, new nappies, nasogastric tubes, drips, etc. There were no ventilators, nor CPAP (continuous positive airway pressure), noted in the unit. The unit looked well-staffed and all babies looked comfortable, warm and content. Some were having blood taken during the visit.



*Neonate having blood taken by staff, the Gandhi Memorial Hospital neonatal unit, Addis Ababa*

### **HAPCO HIV/AIDS youth project, Addis Ababa**

The delegation visited a HAPCO HIV/AIDS youth project in Addis Ababa. This is a government-supported project for young people living with HIV/AIDS. Around 108 similar centres can be found in Addis Ababa and all other regions. They are established to prevent and control the HIV/AIDS epidemic and mitigate its impacts by creating universal access to HIV prevention, treatment, and care and support services.

This particular centre was located in a deprived area of Addis Ababa, in a large building. On the ground floors table tennis tables and a gym were noted, on the first floor youth were seen chatting over a drink in the canteen, on the second floor there was a library with books, tables and computers, as well as a study room, some consultation rooms and a large room for workshops and meetings.



*Baroness Jenny Tonge in entrance hall, HAPCO youth project, Addis Ababa*



*Young boy exercising in the hallway, HAPCO youth centre, Addis Ababa*



*Study tour delegation in the HAPCO youth centre gym, Addis Ababa*

Eyob Eshete, General Manager, HAPCO youth centre met and showed the delegation around. He explained that the youth centre host daily life skills session and indeed this morning a session had taken place and notes with hand-writing were noted on the seats in the workshop room.



*Study tour delegates with Eyob Eshete, General Manager, HAPCO youth centre, Addis Ababa*

The consultation rooms seen had tables, chairs, a locked cupboard and open shelves, where boxes of the morning after pill were displayed. In the corridors numerous boxes were noted with condoms available for pick up. Many education posters were also noted on the walls.



*Emergency contraception on shelves in HAPCO youth centre, Addis Ababa*



*Condoms available in corridors, HAPCO youth centre, Addis Ababa*

At present the national statistics show that approximately 665 million people are living with HIV/AIDS in Ethiopia. The majority being youth and young adults.

Eyob Eshete said that the Ethiopian government support the youth centres and funding comes from a variety of countries and organisations including UNFPA, UNAIDS, the World Bank and NGOs.

This particular club has 200 members and many volunteers. The male-to-female ratio at the youth centre is 11:9. The cafeteria employs 21 youth. The centre is open to all youth and young people between 15 and 35 years of age and holds regular sports competitions. Many trophies were on display in the centre.

## UK Embassy debriefing meeting



*Jo Moir, Deputy Head of Office and Richard Arden, Human Development Team Leader, DFID, UK Embassy, Addis Ababa*

The study tour delegation returned to the UK Embassy this afternoon for a debriefing meeting with the DFID team.

Jo Moir, Deputy Head of Office, and Richard Arden, Human Development Team Leader and Senior Education Adviser, welcomed the delegation back. Jo Moir opened the discussion with the news that Priti Patel MP, Secretary of State for International Development, had resigned this morning, and Jeremy Lefroy MP was in Addis Ababa as the UK Trade Envoy to the country.

A roundtable discussion followed, where study tour delegates gave a short synopsis of their impressions and findings during their week in Ethiopia.

Baroness Jenny Tonge said that the progress in Ethiopia was extraordinary rapid and the expansion of its public health services were admirable considering the low expenditure. The work carried out by the health extension workers was applaudable. However, questions remained surrounding the economics of the country, with particular reference to proportion of health expenditure arising from taxes versus ODA.

Water, sanitation and sewage in Addis Ababa appeared impressive, but remained a problem in the peripheries. For example, sinks were available in the Shire refugee camp, but donkeys were seen carrying large water bottles.

The Ethiopia Abortion law was progressive and a great in-country achievement for women's health.

Baroness Anne Jenkin followed by noting the value for money was amazing in Ethiopia and the passion and care noted by staff in all facilities were impressive. The health service appeared better organised than many others she had visited. She made a reference to obesity and the importance of Ethiopia not following the Western world.

Baroness Blackstone visited Ethiopia five years ago with VSO and noted a stark difference between then and now. She was impressed with the fertility decline achieved and the subsequent reduction in MMR. She was also extremely impressed with the UNFPA-supported youth project at Addis Ababa University and in particular one of the girls who presented her vision for women of Ethiopia to the group. If scholarships were still available via FCO, these young girls should be considered. The lack of specialised doctors and staff were of concern, as was the lack of modern technology available in tertiary hospitals, including diagnostics such as Ultra Sound Scans and ventilators in neonatal units.

Harriet Harman MP felt energised after the study tour. What she knew in theory had been seen in practice. The US Trump administration and its defunding of FP/SRHR services in country were of great concern, but she was happy to see the uprising and energy instigated by the youth and especially young women at the Addis Ababa Universities – it was brilliant!

Ann Mette Kjaerby made a reference to cervical cancer and the fact that many women/girls were tested for cervical abnormalities, but only one treatment site available in Addis Ababa. This might be an area DFID could look into supporting as too many young girls were needlessly left to suffer and die in silence in hospitals.

Jo Moir responded to delegate's summary findings by noting that Ethiopia is one of the fastest growing economies in Africa, but is still a low-income country and remains a major recipient of ODA, which is around 14% of GNI, but dropping. Around one-third of health service provisions come from taxes, one-third from user fees and one-third from ODA.

Ethiopia has managed with little financing to get healthcare accessible in many peripheries. Certain regions and areas however remain a challenging for a variety of reasons including nomadic lifestyles, security and environmental issues.

Private investment is needed in Ethiopia. DFID is investing in and supporting Ethiopia to improve its tax system and private sector investment including via the Commonwealth Development Corporation.

Martha Solomon, WaSH Advisor referred to the DFID WaSH programme on water and sanitation. She noted that this sector in Ethiopian started from a very low base. However, much progress has been made in increasing access to drinking-water and sanitation services. Access to water supply improved from 14% (1990) to 57% (2015). Access to improved sanitation increased from 8% (2012) to 28% (2015). The country has achieved its MDG water target but is off track with regards to its sanitation target.

Over the last three years (2014/15 – 2016/17) the sector has constructed about 51,000 new water supply schemes; Out of these, about 30%, (14,700) are supported by the One WaSH pooled fund, the Consolidated WaSH Account (CWA) where DFID is the main contributor (30%). These facilities have created access to clean water to 3.3 million beneficiaries over the last three years (2014/15 – 16/17) hugely benefitting women and girls.

The school WaSH support include: provision of separate latrines for girls and access to clean water; supplies for effective menstrual hygiene management, including sanitary pads; linking up the sanitary pad production centre and safe spaces in coordination with the school administration. These supports have improved girls' school attendance. Previously, many girls used to miss, on average, five school days every month.

Mieraf Mergia, Social Development Advisor, noted that Ethiopia's total fertility rate (TFR) had declined from 5.5 children per woman in 2000 to 4.6 children. However, in rural areas the TFR remains high at 7.2 children per woman. Family planning usage has increased from 8% to 30% over recent years mainly due to access. Demand, however, remains low, in part due to male dominance, which is being addressed along with harmful practices, such as FGM and child marriage. The government, NGOs and religious leaders are engaged in activities to change behaviour and attitudes.

On the point of demand, Baroness Jenny Tonge raised the issue of raising demand for family planning by linking it to vaccination coverage and food distributions. It was noted that as well as husbands making family decisions, in-laws also have a role in Ethiopia as do religious institutions.

Louisa Medhurst, Humanitarian Advisor, proceeded to outline the refugee situation in Ethiopia and the stakeholders new strategy. The majority of refugees in Ethiopia can be found in three border areas. Camps are usually in sparsely populated areas, so access by road is difficult, especially towards the Somali boarder. Governance also remains problematic in some areas. Near Somali, there are pastoral communities and clans. This year is the third year with droughts, which has increased the need for humanitarian assistance.

Gender-based violence is common in camps, in part due to the lack of lit up areas at night. Light is desperately needed.

DFID has spearheaded the latest strategy for responding to refugees in Ethiopia, which has shifted from shock supply in refugee camps to expanding the existing services. This is a more sustainable strategy that will ultimately support Ethiopia in the long term. So, for example, instead of saying refugees need water and therefore sending water trucks, the approach is to increase mains water and sewerage in the area. That supports development and helps the local population as well as the refugees. UNICEF has a five-year plan with a budget of USD \$40 million to support water, health services and child nutrition and healthcare through the government health system.

Baroness Jenkin noted that the refugees she had spoken to in the Shire camp indicated their wish to go to Europe via Sudan, Yemen, Libya and across the Mediterranean sea. She hoped that the change in strategy will support migrants in-country better than previously, in order to combat the atrocities witnessed in the Mediterranean Sea.

The delegated thanked the DFID team for their time and briefings, which had been very informative. Delegates hoped to raise some of the issue back in parliament upon their return.

### **SRHR Stakeholder meeting on Abortion, MSI Head Office, Addis Ababa**

A roundtable discussion on abortion in Ethiopia was held at MSI's head office in Addis Ababa.

Around the table were: Sister Aster Teshome, SRH adolescent specialist, MoH, Ethiopia; Sam Ntelamo, Resident Representative, IPPF; Getachew Bekele, Senior Advisor and Jemal Kassaw, Country Representative, Engender Health; and Dr Nega Tesfaw, Director of Quality of Clinical Services, Marie Stopes International Ethiopia.

Sister Aster Teshome started the meeting with a PowerPoint presentation on abortion in Ethiopia.



*Sister Aster Teshome, SRH adolescent specialist, MoH, Ethiopia introduction study tour delegates to the 2005 Ethiopia Abortion Law*

The abortion law was liberalised in 2005 to allow abortion in cases of rape/incest, if the woman has physical or mental disabilities; it is needed to preserve the woman's life or physical health; she is a minor who is physically or mentally unprepared for childbirth.

In 2006 and again in 2014 guidelines and training manuals were developed on safe abortion services to assist practitioners in bringing down the incidence of maternal deaths due to unsafe abortions.

Now 60% of abortion are safe in the country, down from 6% prior to 2005 and the MMR has reduced from 32% to 6-9%.

All health professionals are trained in the provision of abortion services up to 12 weeks gestation. Specialised training is needed at later gestation. The Government is also rolling out family planning education programmes along with information on abortion services. There is a new adolescent health strategy, 2016 – 2020.

A question and answer sessions followed on the topics of late abortions, stigma surrounding abortion, religion and abortion, medical vs surgical abortions, quality of care and how the abortion law came about in Ethiopia.



*A roundtable discussion on abortion services in Ethiopia, MSI head office, Addis Ababa*

Later abortions require extra skills so they are usually performed in referral hospitals by specialised personal. Religious beliefs and stigma surrounding abortion is apparent in certain communities, but the majority of health professionals support abortion services with few having conscientious objections. The ratio of medical to surgical abortions is about 4:1, so the vast majority are provided in the community in small clinic facilities.

Due to increased awareness about high mortality due to unsafe abortion, professional organisations and the public supported the liberalisation of the abortion law in 2005.



*Study tour delegates receiving an Ethiopia souvenir/memorabilia MSI Head Office, Addis Ababa*

## MSI SRHR clinic, Addis Ababa



*Baroness Jenny Tonge at MSI SRH Clinic, Head Office, Addis Ababa*

The study tour delegation ended their Ethiopia study tour with a walk around the MSI SRH Clinic, Head Office, Addis Ababa. Sister Rahel Yitbarek, Technical Head, MSI Ethiopia showed the delegation around the very clean and well-equipped clinic. The clinic provided SRHR services to surrounding population and looked similar to UK health clinics.

## Summary highlights and comments

All study tour delegates agreed that the hospitality and welcoming at the UK Embassy, Ethiopian parliament, government and private hospitals, UN and NGO clinics and premises visited and places stayed, were very warm, kind and generous.

The aim of the study tour – to introduce, broaden and deepen delegates’ understandings about core family planning, SRHR, refugee and international development issues – had been accomplished.

Ethiopia had been of particular interest to delegates due to its long-standing support from the UK government and diaspora populations in the UK. Delegates had also been impressed and intrigued by Ethiopia’s its successful reduction in MMR and morbidity, in part due to an increase in contraceptive uptake and changes in abortion legislation. The country’s high refugee population and integration policy was also of particular interest.

The delegation visited government, private, NGO and UNFPA supported projects and clinics in and around Addis Ababa and Axum and the Shire refugee camps towards the border of Eritrea. Study tour delegates met and spoke with DFID staff, government and private hospital directors, medical staff and clients; UNFPA and NGO representatives and staff, members of the Ethiopian parliament and managers, staff and refugees.

The delegation commended the Ethiopian government and the UK Government, the UN and NGOs for their support to the Ethiopian government’s efforts to leave no one behind, with specific reference to the efforts made to improve women’s and girls’ SRHR in the country.

The rapid expansion of family planning provisions, including through NGO facilities and the health extension workers to many peripheries, and through the mechanism of the 2005 abortion law, were applaudable. The value for money, and the attitude and energy of staff in government and private institutions were impressive, as was the knowledge and confidence demonstrated by youth at the Addis Ababa University. The Addis Ababa Fistula Hospital was exemplary with regards to its specialised quality services for fistula patients. Delegates were equally appreciative of the sustainable strategy to expand services in refugee areas/regions, spearheaded by DFID, as opposed to shock supply.

The lack of specialised doctors and staff, as well as specialised equipment to treat preventable reproductive health problems remains of concern. The effect of the US Trump administration on women’s and girls’ SRH in Ethiopia was deeply concerning.

Gender-based violence, including FGM and child marriage, remains a concern. This is particularly the case in refugee settings due to basic infrastructure, such as well-lit areas, but also underlying cultural and social norms and gender inequalities. The SafeHouse in Addis Ababa was a model to be followed with its holistic approach.

Upon their return, individual parliamentarians reflected on their experiences:

Baroness Jenny Tonge said:

Although the government of Ethiopia is regarded as repressive and undemocratic by our standards it is relatively incorrupt and the advances Ethiopia is making are quite dramatic. The capital is still a huge building site and roads have sprouted all over the

countryside, thanks mainly to Chinese investment. This has enabled much more efficient delivery of public services, such as health and education.

We visited many health facilities and talked to government and NGO representatives, as well as our own people in the British Embassy.

The Government of Ethiopia is building hospitals and health centres countrywide to form an impressive network manned by health workers. Doctors and nurses are in short supply, especially in specialties, but efforts to improve education countrywide will surely feed through and trained people will be available in time. This is something our teaching hospitals could contribute to.

Family planning is widely promoted and the fertility rate is down from 6.7 in 2000 to 4.3 in 2015. Maternal health rate has been reduced dramatically from 897/100.000 in 2000 to 353/100.000 in 2015.

Despite efforts to make family planning universally available, and one in three women now use some form of birth control, there is still an unmet need for 3.5 million women.

It is good however to come back from a developing country with spirits high and wishing Ethiopia every success as it continues to improve the lives of its people.

Baroness Jenkin:

The value for money on health spend was impressive in Ethiopia, as was the passion and care noted by staff in facilities we visited. The health service appeared better organised than many others I have visited. However, I came back home with a concern surrounding increasing obesity. This is already becoming a visible problem in the capital Addis Ababa. The governments of all developing country need to ensure that they learn from the Western world's mistakes. If they do not, it will cripple their health service before it has had a chance to become fully developed.

Baroness Blackstone:

The visit was well organised and provided an excellent opportunity to learn about the progress being made on population issues and women's health. There is still a long way to go especially in the poorest and most remote regions, but there has been progress since I last visited Ethiopia. The combination of visits to hospitals, birth control clinics and a refugee camp, as well as the chance to talk to NGOs, Members of Parliament, students and DFID staff made for a rich and valuable experience.

Harriet Harman MP:

Ethiopia has worked hard to improve the lives of women and girls with support from many partners including DFID and UK SRHR NGOs, such as Marie Stopes International and the International Planned Parenthood Federation. The fertility rate is declining and maternal mortality and morbidity are decreasing due to the government's determination to improve women's lives and leave no one behind.

During my visit to Ethiopia, I met some very dynamic young Ethiopian women students from the University of Addis Ababa. They support other women and play their part in transforming the role of women in their country. I also met Eritrean refugees in the Shire camp in Tigray, who had left their country to escape violence and poverty, travelling at night to avoid attack. They want to go to Europe for a better life.

I was particularly interested to note the new approach that instead of saying refugees need water and therefore sending water trucks, they should approach it on the basis that an increase in population in the region necessitates more mains water and sewerage. That supports development and helps the local population as well as the refugees.

I am very concerned about the US President, Donald Trump's expanded 'Global Gag Rule' as it undermines the work of Marie Stopes International and other NGOs in Ethiopia. Of particular concern is the fact that the USA family planning funds will instead go to organisations such as evangelical organisations, which advocate abstinence and other measures which don't work and set back women's development.

The eight members of the Social Affairs Committee that we met all shared a strong commitment to making progress on sexual and reproductive health and the women MPs were unhesitating in their belief that their role in parliament was to speak up on behalf of the progress women in Ethiopia want to make towards equality.

I am so pleased that Ethiopia is improving the lives of their women and girls.

Karen Buck MP:

I came away feeling both optimistic and disturbed by different aspects of what we saw. Positives included real progress on improving access to reproductive health, especially in more urban areas. Negatives included the continuing challenges presented by child marriage and conditions in the refugee camps we saw.

## **Conclusion and acknowledgment**

Participants felt the Ethiopia APPG on PDRH study tour was informative, educational and successful in stimulating plans to engage in family planning/SRHR parliamentary advocacy to further the International Conference on Population and Development Programme of Action and its integration in the Sustainable Development Goals.

Delegates will promote and encourage continued ODA to Ethiopia through questions and debates in the UK Parliament, as UK AID appears necessary to further improve women and girl's health situation in the country.

Delegates expressed their gratitude to the European Parliamentary Forum on Population and Development (EPF) for its financial support to the study tour and MSI for agreeing to co-host the study tour. Delegates also thanked DFID and FCO staff in the UK and UK Embassy, Ethiopia; the Gandhi Memorial Hospital medical director and obstetrician and gynaecologist in Addis Ababa; the Axum referral hospital medical director and staff; the UNFPA Ethiopia representative; the IPPF member association, the Family Guidance Association of Ethiopia, staff; the Addis Ababa Fistula Hospital medical and other staff; the SafeHouse founder and staff; the Shire refugee manager and staff; the MSI BlueStar manager in Axum; the HAPCO general manager in Addis Ababa; Ethiopian government officials and members of the Social Affairs and Standing Committee for briefing and informing them during the study tour.

A particular thank you to Heran Demissie, Communication and External Relations Manager at Marie Stopes International Ethiopia, for all her hard work, which resulted in a successful study tour. Thank you also to Ann Mette Kjaerby, Parliamentary and Policy Advisor APPG on PDRH, for her advice and organisational skills.

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