REVIEW OF ACHIEVEMENTS AND CHALLENGES OF THE BEIJING + 25 IMPLEMENTATION WITH RELATION TO WOMEN'S HEALTH RIGHTS AND WOMEN'S ACCESS TO HEALTH CARE SERVICES

Network of Ethiopian Women's Association (NEWA)

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Contents

Abbreviations

AAAQ	Availability, Accessibility, Acceptability, and Quality
BPfA	Beijing Platform for Action
eCHIS	Electronic Community Health Information System
EDHS	Ethiopian Demographic and Health Survey
EFY	Ethiopian Fiscal Year
FMOH	Federal Ministry of Health
HEP	Health Extension Program
HMIS	Health Management Information System
HRBA	Human Right Based Approach to Health
HSTP	Health Sector Transformation Plan
HEW	Health Extension Workers
MDG	Millennium Development Goals
MoH	Ministry of Health
MoLSA	Ministry of Labour and Social Affairs
MoWCYA	Ministry of Women, Children and Youth Affairs
NEWA	Network of Ethiopian Women's Association
SDGs	Sustainable Development Goals
VAWC	Violence against Women and Children
WAD	Women Development Army

Introduction

Network of Ethiopian Women's Association (NEWA) is among the national civil society association working with the major objective of promoting gender equality and empowerment of women in the country. It has been working to ensure women's participation and benefit from social, economic, political, and cultural endeavors including women's right to health and access to health services. Thus, this assessment was prepared by NEWA, to produce an evidence-based analytical report that shows the achievements and gaps in women's health rights and women's access to health care services, and forward recommendations accordingly.

The approach used was the Human Right Based Approach to Health (HRBA) and the Available, Accessible and Acceptable and of Good Quality (AAAQ) of health services, goods, and facilities. The method applied to produce this report was solely desk review. The analysis was carried out in two levels i.e. at policy, legal, and program/plan level and implementation level to identify the major achievements and gaps/challenges with regard to the strategic objectives and actions stipulated under BPfA over the last five years (2014/15-2019/20). It should be noted that the Government of Ethiopia presented a report to the international treaty body to show the achievements made and challenges encountered on Beijing +25, and this report is prepared to complement in this regard.

The report, therefore, presented hereunder in three sections: (1) Overview of the International and Regional Policy and Legal Frameworks, and the National Legal, Policy, Programmes and Plans that were formulated during the reporting period, (2) Implementation of these frameworks in terms of improving women's health throughout the life cycle to appropriate, affordable and quality health care, information and services and (3) Conclusion and recommendations.

Section One
International and National Policy and Legislation Frameworks

1.1. International Legal and Policy Frameworks

- Among the international instruments, the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), Convention on Economic, Social and Cultural Rights (CESCR), Beijing Platform for Action (BPfA), the 2030 Agenda for Sustainable Development Goals (SDG), International Conference on Population and Development (ICPD), and Protocol to the African Charter on Human and Peoples' Rights on the Rights of women in Africa (the Maputo Protocol), have specific provisions that deal with women's rights to health and their access to health care services.

- **CEDAW** obliges the State to eliminate discrimination against women in health care and ensure women's access to health care services on the same basis as men. It also demands the State to take action regarding pre-and post-natal maternal health and the provision of adequate nutrition during pregnancy and lactation.

- **CESCR** is another important legal instrument that obliges the State to apply principles of non-discrimination and equal treatment of all people to access health care services. It also recommends integrating a gender perspective in the health-related policies, planning, programming, and research to promote better health for both women and men.

- Furthermore, CESCR recommends developing and implementing a comprehensive national strategy for promoting women's right to health throughout their life span. It emphasized setting a goal to reduce women's health risks, particularly lowering the rate of maternal mortality and protecting women from domestic violence. It further incorporates focusing on removing all barriers interfering with access to health services, education, and information on sexual and reproductive health, and shield women from the impact of harmful traditional cultural practices and norms that deny them their full reproductive rights.

- The Convention indicates the areas of improvement for the achievement of women's right to health, which includes: (1) improve maternal health, sexual and reproductive health services, including access to family planning, pre-and post-natal care; (2) enhance all aspect of environmental and industrial hygiene; (3) control and treat diseases such as sexually transmitted diseases, in particular, HIV/AIDS and other infectious (communicable and non-communicable) diseases including women-specific

health problems such as cervical cancer; (4) improve the quality of health facilities, goods, and services, that enhance both physical and mental health to all people including adolescents, older persons and persons with disabilities to ensure the health rights.

- **ICPD-Program of Action Plan**: incorporate women's rights to health. It puts women's empowerment, gender equality, and the elimination of all forms of violence against women as guiding principles to dictate all actions taken by the States. The ICPD+5 review held in New York in June 1999 noted that "reproductive health" and "reproductive rights" had become part of the international development discourse and that an agreement was reached to focus on such pressing issues as abortion, HIV/AIDS, maternal mortality, and contraception.

- **Beijing Platform for Action**: is the focus of this report which puts women and health as a critical area of concern, where the State needs to take several actions that protect and fulfill the women's rights to health and their access to health care services. It elaborates the gaps and challenges of women's rights to health and access to health services and sets out strategic objectives with actions that need to be addressed by the State. These strategic objectives and actions include:

    - **Increase women's access throughout the life cycle** to appropriate, affordable, and quality health care, information, and related services. The actions include:
        - ✓ Provide more accessible, available, and affordable primary health-care services of high quality, including sexual and reproductive health care such as family planning information and service, and maternal and emergency obstetric care;
        - ✓ Redesign health information, services, and training to be gender-sensitive;
        - ✓ Ensure all health services and worker conform to human rights and ethical, professional, and gender-sensitive standards in the delivery of women's health services through the implementation of codes of ethics;
        - ✓ Reduce ill health and maternal mortality by strengthening and reorienting health services, particularly primary health care;
        - ✓ Recognize and deal with the health impact of unsafe abortion as a major public health concern;
        - ✓ Give particular attention to the needs of girl's access to necessary health and nutrition information;
        - ✓ Develop information, programs, and services to assist women in understanding and adapting changes associated with aging and address and treat the health needs of older women;

- ✓ Ensure girls and women of all ages with any form of disability receive supportive services;
- ✓ Take actions through special policy and program to address environmental and occupational health hazards associated with work in the home and the workplace;
- ✓ Integrate mental health services to girls and women of all ages who experienced any form of violence in particular domestic violence, sexual abuse, or other abuse resulting from armed and non-armed conflict;
- ✓ Collaborate with non-governmental organizations, particularly women focused organizations, professional groups, and other bodies working to improve the health of girls and women.

- **Strengthen preventive programs to promote women's health** is the second strategic objective that deals with various action points in relation to formulation and dissemination of information and knowledge that address discriminatory attitudes and practices that affect women's health and well-being such as FGM, early marriage, violence against, and the burden on women at a household. Adopt preventive measures to protect women, youth, and children from any abuse- sexual violence, exploitation, trafficking, and violence in the form of provision of legal protection and medical assistance.

- Undertake gender-sensitive initiatives that **address sexually transmitted diseases, HIV/AIDs, and sexual and reproductive health** issues by taking actions that involve reviewing and amending laws, strengthening multi-sectoral approaches to combat practices that make women and girls susceptible to HIV/AIDS.

- **Promote research and disseminate information on women's health** is the fourth strategic objective that focuses on promoting gender-sensitive and women-centered health research. The actions include: increasing the number of women in leadership positions in the health profession; support and fund social, economic, political, and cultural research on how gender-based inequalities affect women's health; conduct research to strengthen access and improve the quality of service delivery.

- **Increase resources and monitor and follow-up of women's health** is another strategy that incorporates actions. These actions include:

- ✓ Increase the budgetary allocation for primary health care and social services and to the reproductive and sexual health of girls and women in both rural and poor urban areas;
- ✓ Develop innovative approaches to funding health services through promoting community participation and local financing,
- ✓ Establish monitoring and evaluating programs and use qualitative and quantitative data disaggregated by sex, age, other established demographic criteria, and socioeconomic variables.

- **SDGs** have specific goals and targets on the realization of human rights to all and the achievement of gender equality and empowerment of women and girls. Goal 3 focuses on ensuring healthy lives and promoting their well-being. It incorporates targets including; reduction of maternal mortality, ending the epidemic of AIDS, and other communicable diseases. It further targets to improve universal access to sexual and reproductive health-care services, as well as family planning, information and education, and the integration of reproductive health into national strategies and programs. Goal 5 (6) targets to ensure universal access to sexual and reproductive health and reproductive rights as agreed under international action plans such as BPfA.

- **The Maputo Protocol:** also stipulates that the State shall ensure the respect and promotion of women's health rights, including the right to obtain information and resource on family planning and the right to decide on fertility, the number of children, and spacing of children. It states the right to self-protection and to be protected against sexually transmitted infections, including HIV/AIDS. The protocol also includes an obligation to provide adequate, affordable, and accessible health services to all women at all levels and maternal health services. It further puts a responsibility to authorize medical abortion in cases of sexual violence (such as sexual assault and rape) and where the continued pregnancy endangers the mental and physical health of the mother.

- The above-mentioned international policies and legal frameworks were ratified by Ethiopia, and most of the provisions stipulated under these instruments were further incorporated in the national policies and legal frameworks. Besides, the country took various interventions and made progress towards the realization of women's rights and their rights to health care services. However, there are challenges and gaps in protecting and fulfilling these rights.

1.2. National Policy and Legal Frameworks

- **The FDRE Constitution**, apart from adopting the above-mentioned international and regional instruments, guaranteed the equal rights of women with men in the enjoyment of rights and protections provided by the Constitution. The Constitution specifically protects the right to maternity leave, maternal health care that includes the right to have access to family planning education, information, and capacity. Furthermore, it provides an obligation on the State: to allocate ever-increasing resources to public health services, provide rehabilitation and assistance to the aged and undertake a program to improve the lives of the poor in society.

- In the last four/five (2014/15-2019/20) years, Ethiopian have issued policies, strategies, programs, and plans that help execute the overall obligations and objectives set by the FDRE Constitution, international and regional policies, and legal frameworks.

Achievements in terms of Formulating Laws, Policies, Programs, and Plans

- The **Federal Civil Servant Proclamation** (proclamation No. 1064/2017) was revised and provisions that provide protections for women and working mothers are incorporated. The proclamation increased the entitlement of maternity leave with pay from 90 days to 120 days for a pregnant employee. It also provides maternity leave for mothers who encounter miscarriage of pregnancy and paternity leave with pay for ten days at the time of wife delivery. It further guaranteed the entitlement of leave with pay to a mother, for the time spent in the follow-up of medical treatment of her child, who has not attained the age of one year. It imposes a duty upon an institution to establish a nursery where female civil servants could breast-feed and take care of their babies. Furthermore prohibits workplace sexual harassment.

- Similarly, the **Labour Proclamation** increased the maternity leave with pay from 90 days to 120 days. It prohibits the assignment of women on works that is dangerous or hazardous to their health. The Ministry of Labour and Social Affairs has listed out works that are dangerous and hazardous to women's health. It further prohibits sexual harassment and violence at the workplace.

- The **National Women Development and Change Strategy** (issued 2017) and Package (as revised in 2017) incorporated major activities such as introducing programs that reduce the workload of rural women (increase accesses to electric power, introduce technologies that reduce the workload of women, increase access to water by reducing the distance of water points, prevent and eradicate HTTPS and VAW). It also includes decreasing maternal mortality by strengthening pre-and postnatal health

care services and delivery of birth by skilled health professionals; increasing the use of family planning services, increasing accessibility and friendliness of health post at kebele levels, improving the knowledge and ethics of health professional to provide quality services, strengthening the work on reproductive health and HIV/AIDS prevention and control services. It gives focus on improving self and environmental hygiene, nutrition status, and women-specific health problems such as (Cervical and Breast Cancer) and women with disabilities to improve their health and access to health services.

- **The Seqota Declaration, National Nutrition Strategy, and National Nutrition Program (NNPII)**: are strategic frameworks that were formulated to improve the nutritional status of the citizens of the country. These frameworks apply twin-track implementing mechanisms, that are broad and specific, which focuses on improving the nutritional status of citizens and addressing malnutrition of vulnerable group of society such as pregnant and lactating mothers, adolescent girls and women of reproductive age. The National Nutrition Strategy recognizes unequal, gender-based resource distribution at the household level, harmful traditional practices such as food taboos for women and girls, early marriage, and violence against women as aggravating situations for poor nutritional status of women and girls in society. The Nutrition-Sensitive Agriculture Strategy (prepared by the Ministry of agriculture) is also another document that focuses on the empowerment of women and their role in the application of nutrition-sensitive agriculture. It incorporates provisions in terms of increasing women's access to resources and input and promotion of labor and energy-saving technologies that impact women's workload.

- **Mental Health Strategy** (2018-2025): recognizes mental health problems as a cause of suffering, loss of productivity, and death. Mental Health Legislation has been drafted and will be incorporated in the Health Care Acts Proclamation (under development).

- **Adolescent and Youth health strategy** has been prepared in line with the global strategy for Women's Children's and Adolescents' Health. The strategy focuses on access to contraceptives through strengthening adolescent and youth-friendly clinic services and introducing the school health program initiative. It lays down provisions to improve the health status of adolescents and youth aged 15-25 years by increasing modern contraceptive prevalence rates (mCPR) and reducing the unmet need for contraception. It stipulates to improve the distribution of family planning (FP) commodities and consumables from the central level to service delivery points. It gives the government responsibility of coordinating the efforts to strengthen-adolescent and youth-friendly (AFY) clinic services and referral linkages to improve

adolescent and youth access to contraceptives. It also indicates that the government will be committed to gradually increase financing to FP services.

- **Ethiopian Growth and Transformation Plan II**: had strategic health interventions that improve women's health rights and their access to health care services. These interventions include the provision of equitable, accessible, and quality basic health services; strengthening implementation of primary health care at all levels of the health tier system; and ensuring the good governance of health facilities to realize excellence in health service delivery. It states that the implementation of a health extension program is a core strategy to organize the participation of the community in basic health care activities (preventive, curative, rehabilitative, and emergency health services).

  It also provides to ensure the quality of service delivery in hospitals, the improvement in pharmaceutical supply service, strengthen the institutional capacity in terms of human resource and equipment, and putting in place an effective monitoring and regulating system to promote the role of the private sector in the health sector. Among the GTP II targets: reach health service coverage from 98% (in 2014/15) to 100 % (in 2019/20), decrease maternal mortality from 420/100000 live birth to……, contraceptive prevalence rate from 42% to 55%, deliveries attended by skilled health personnel form 60.7% to 90% and HIV/AIDS incidence rate from 0.03% to 0.01%. It also includes targets on family planning service coverage, treatment of people living with HIV/AIDS, and transmission of HIV from mother to child.

- **Women, Children, and Youth Transformation Plan II (2014/15-2019/20)**: also include intervention on ensuring women's participation and benefit from development through a strong development army, and set a goal to building women's overall capacity to enjoy their political, economic, and social rights. The plan also focuses on raising the awareness of the people regarding the rights of women to improve the participation and benefits of women in the country.

- In conclusion, putting in place policies and programs, such as National Nutrition Strategy, Women Development Strategy, Adolescent and Youth Health Strategy, Growth and Transformation Plan II, Health Sector Transformation Plan, and National Nutrition Program, that mainstreams women health rights and their access to health care services, are some of the achievements that were registered in the reporting years. These frameworks, more or less, were gender-sensitive as they try to achieve gender equity and equality as well as empowerment of women through women-specific interventions.

- Guaranteeing the rights of working mothers to better maternity leave during pregnancy and after delivery as well as for mothers who encounter miscarriage is another achievement in terms of legislation. Additionally, stating an obligation on an institution to set up a daycare for mothers, prohibiting assigning women to a disadvantage or hazardous work, and sexual harassment in the workplace can be considered as achievements to ensure the women's rights to work in healthy, safe, and conducive environment which intern increase their productivity.

Gaps in National Policy and Legal Frameworks

- Lack of a comprehensive strategy/program on women's health right and their access to health care services is a major gap for the protection and fulfillment of these rights throughout their life cycle. For instance, actions in relation to preventing, diagnosing and treating osteoporosis (that predominantly affects women), health needs of older women, and services to survivors of domestic violence were left out or not addressed comprehensively in any of the above-mentioned national frameworks.

- The Labour Proclamation has gaps in terms of creating a conducive and safe environment for women and mothers. The proclamation has a gap in ensuring daycare services, within an organization, for mothers who have infants or young children. The definition regarding sexual harassment is too general and is not as per the international definition given by the ILO Convention 111. It also lacks provisions or guiding principles of survivor-centered grievance redress mechanisms to victims of sexual harassment in the workplace. The Federal Civil Servant Proclamation also has gaps with regard to prohibiting works that are disadvantageous and hazardous to women's health.

- There is a gap in adopting preventive measures to protect women, youth, and children from any abuse (sexual and physical abuse) including medical and other services. Also, gaps in terms of addressing the root cause of unwanted pregnancy and providing comprehensive services for women who have unwanted pregnancy including access to reliable information and compassionate counseling, and post-abortion counseling.

Section Two
Implementation of Policy, Legal, and Policy Frameworks

Achievements

2.1. Access, Availability, Affordability of Health Care Services to Women

- Gender equality is a fundamental human right and a necessary foundation for a peaceful, prosperous and sustainable world and central to interventions to achieve the 2030 Agenda and the Sustainable Development Goals (SDGs) as well as other commitments agreed by the UN Member States. Women and girls in Ethiopia are strongly disadvantaged compared to boys and men in several areas, including literacy, health, livelihoods, and fundamental human rights. They also suffer from low status in their society and lack social support networks. Manifestations of discrimination against women are numerous and acute. Ethiopia suffers from some of the lowest gender equality performance indicators in sub-Saharan Africa. The same report indicates that Ethiopia's Gender Inequality Index (GNI)[1] score is among the lowest. Ethiopia is ranked 121st out of 160 countries on GNI scoring.

- Irrespective of the low performance in some of the gender equality indicators, Ethiopia has achieved tremendous progress toward the empowerment of women and gender equality. Women, to some extent, have benefited from the implementation of gender-sensitive health services, health right based approach (HRBA) visa vis quality, accessibility, and affordability of services. Hereunder is the outcome of the implementation of these policies, strategies, programs/plans that brought positive impact on women's health in various areas such as access and affordability of services; maternal health, reproductive health services, and others.

- **Accessibility, affordability, and quality of services:** a fee waiver is a right offered to a household or an individual, who is economically disadvantaged, to enable them to access health care services without direct charge. Thus, a large number of people including women benefited from this right. For instance, in 2018/19 (EFY 2010), a total of 1,416,342 beneficiaries received the necessary health services through the fee waiver system. To this end, the government allocated ETB 61,951,860 and utilized ETB 23,389,066 in the fiscal year. Exempted health services are those services that have been provided to all citizens free of charge regardless of the level of income. In line with exempted service provision, health facilities were implementing exempted services such as immunization, antenatal care, postnatal care, delivery, treatment of tuberculosis, HIV and malaria, epidemic prevention and control, and other public health services in the fiscal year.

- Improve access to services, the government deploys 38,000(98% female) health extension workers in rural and urban areas. The Health Extension Program (HEP) is created in response to the rural community's need for basic health services. They provide door-to-door services in order to facilitate access to quality and affordable health care. The program gives special attention to mothers and children in rural areas focusing on maternal, neonatal, and child health interventions to the community to reduce maternal and child mortality. The development army, composed of households at a community level, is established to promote community participation and engagement to ensure the continuation and sustainability of health programs. They provide door-to-door services to facilitate access to quality and affordable health care. The program gives special attention to mothers and children in rural areas.

- **To improve the service quality:** The Clean and Safe Hospitals (CASH) initiative is being implemented to maintain the comfort and satisfaction of customers and health service providers through cleanliness and safety measures applied in hospitals. To improve the quality of services, the government from time to time has improved the ratio of population to health professionals. Accordingly, the total number of health professionals where 72,039 Male and 52,241 female joined the health sector in 2019/20 (EFY 2012)[1]. Trainings on quality improvement was provided to health professionals and staff. Besides National Quality Improvement Training Guide was prepared to improve training provision in this regard. However, the guide has not considered the effect of quality service on gender/women-specific services.

- **Maternal and reproductive health[2]:** Ethiopia achieved most of the MDG targets, a 69% decrease in maternal mortality from the 1990s estimated 14000 maternal deaths per 100,000 live births. Maternal mortality has been reduced by 39% from 676 in 2011 to 412 per 100,000 live births in 2016. The coverage rate provided by trained midwives and delivery-care coverage rate increased from 60% in 2014/15 to 72.7% in 2015/16. Reduction of maternal mortality may be attributed to the society becoming increasingly aware of the benefits of maternal care; awareness-creation services provided by the Government and NGOs; and the increased accessibility of ambulance and health services. An improved Manual for Health Sector Gender issues has been prepared using some study outputs.[3]

[1] MoH reports -2015-2019
[2] Ibid
[3] Ethiopia 2017 Voluntary National Review on SDGs, Report. National Planning Commission, June 2017

- In addition to decreasing the maternal mortality rate, the Government has tried to increase several women-specific services that contribute to the improvement of women's health such as Cervical Cancer screening and treatment programs. Currently, 207 health facilities are providing VIA screening and cryotherapy treatment and more than 65,000 women were screened in 2018/19 (EFY 2010). In addition, LEEP service was scaled up from five to fifteen hospitals and working to scale up VIA screening and cryotherapy treatment into all the 890 districts, and to this effect, PFSA is procuring 1,500 Cryotherapy machines. Loop Elecro Excision Procedure (LEEP) service for the cervical cancer program is functional in 10 referral hospitals, additional 30 LEEP machines and accessories are under procurement. Currently, there is only one Radiotherapy center in Ethiopia. Ministry of Health working with Teaching Hospitals to increase the number of sites to 7 in selected geographic locations. Chemotherapy services for cancer were limited to 3 or 4 centers in the country with a lot of service interruptions. To ameliorate this, the Ministry of Health has started decentralizing Cancer Chemotherapy services by training cancer care teams (48 HCWs were trained) in 12 Hospitals from major regional towns in collaboration with Tikur Anbessa Hospital Oncology Center Chemotherapy medicines are expensive, hence many of the patients cannot afford to buy them in private pharmacies. And the Ministry of health has been procuring a selected group of chemotherapy drugs for cancer treatment and supplying them through Tikur Anbessa Hospital at subsidized prices.

- **Physical and mental problems and disability services:** Among communicable diseases, leprosy is the leading cause of permanent physical disability. Notable achievements observed in reducing the prevalence of the disease are achieved, especially after the introduction of Multiple Drug Therapy (MDT). Although the leprosy elimination target of less than 1 case per 10,000 population has been reached at the national level since 1999, the new case notification remains the same for the past ten years; the proportions of multibacillary (MB) cases, childhood leprosy, and new cases with grade-2 disabilities (G2D) have remained static However, the annual national case-detection remains constant between 3000 - 4000 cases.4 The proportion of Grade II Disability among New Leprosy Cases for 2017/18 (EFY 2010) is 13%, which has a slight decrement from last year's performance. However, the data is not disaggregated by sex.[5] Plus, disability caused by other than leprosy is not captured in the MoH report.

- **Mental health services:** The FMOH is implementing a program scale-up for the past four years by integrating the service at the Health Center level in all regions and city

[4] MoH reports
[5] Ibid

administrations in the country. However, implementation was not uniform across the country. To make up for that, legislation has been drafted and will be included in the Health Care Acts Proclamation. The mental and HIV Integration manual is under development to address the huge burden of mental illnesses in HIV-infected individuals. To facilitate the provision of health services by creating a corner for peoples with a disability at four Federal hospitals. Currently, the corner is being functional at St. Peter's and St. Paulo's hospitals, but it is not yet functional in Alert and Emmanuel hospitals. The report does not show how it is affecting women and men differently.

- Regarding the implementation of the WASH program, mentorship programs were conducted in the regions and 210 public water facilities for the community, 266 improved latrines at Health facilities, 17 public latrines, and 25 communal latrines were constructed. Also, 88 health facilities were identified for water line installation and 23 of them have access to water.[6]

2.2. Family Planning Information and Materials and Sexual and Reproductive Health Services

- The trend in total fertility rate (TFR) is declining, from 4.6 children per woman in 2016 to 4.1 children in 2019, a decrement of 0.5 over the past three years. The TFR among women in rural areas declined from 5.2 children in 2016 to 4.5 children in 2019. In urban areas, however, the TFR rose from 2.3 in 2016 to 3.2 in 2019.[7]

- The survey[8] showed, 41% of currently married women are using modern methods of family planning, and only 1% are using traditional methods. The most popular contraceptive methods are injectable (27%) followed by implants (9%), IUD, and the pill (2% each). The contraceptive prevalence rate (CPR) among married women increases with age, peaking at age 20-24 (52%) before declining steadily to 18% among women age 45-49. Urban women are much more likely than their rural counterparts to use any methods of contraception (50% versus 39%).[9]

- Smart Start and Willow Box activities have been integrated into the health extension program aimed at newly married adolescents and youth adolescents[10]

[6] *MoH reports*
[7] *Ethiopia Mini-Demographic and Health Survey 2019 –Key Indicators Report – EPHI, FMoH, July 2019*
[8] *Ibid*
[9] *Ibid*
[10] *The Motion Tracker, Prepared by Consortium of Reproductive health Associations- developed by the contribution of the local non-governmental organization, international NGOs, and Government, 2019*

- Comprehensive life skills education training curriculum is integrated and implemented both in and outside of school settings. Civil society organizations are actively advocating for the integration of comprehensive sexuality education (CSE). Some organizations are implementing CSE as an extracurricular intervention and life skills education targeting both in-school and out-of-school youth adolescents.[11]

- Family health guidelines were developed and widely distributed to support families in better understanding and implementing healthy practices and skills to keep their families healthy. Examples of community-level structures being leveraged include HEPs involving health extension workers (HEWs)and health development armies, faith-based organizations, religious institutions, Sunday schools, and other traditional community platforms.[12]

- Several awareness-raising and training programs on FP, SRH, and youth responsive service delivery and other related issues were provided to different target groups (youth, community and religious leaders, members of the House of Representatives and HEW, etc) by different governmental and non-governmental organizations.[13]

- FP commodities and consumables were procured and distributed according to the quantified needs which include IUDs, injectables, combined oral contraceptives, and condoms.[14]

2.3. Nutritional Status of Women

- Hunger and malnutrition are devastating problems, particularly for the poor and unprivileged. Women in the reproductive age group and children are most vulnerable to malnutrition due to low dietary intakes, inequitable distribution of food within the household, improper food storage and preparation, dietary taboos, infectious diseases, and care. Particularly for women the high nutritional costs of pregnancy and lactation also significantly contribute to their poor nutritional status. Various factors such as economic and educational status, access to clean water and sanitation, and many others affect women's nutritional status. Recognizing this the government of Ethiopia has introduced programs and interventions to improve the nutritional status of women and children.

- FMOH has mobilized more than 52 m ETB for the implementation of the Sequota declaration and conduct a baseline survey and feasibility assessment for the Unified

[11] Ibid
[12] Ibid
[13] Ibid
[14]

Nutrition Information System for Ethiopia (UNISE). Different training manuals, guidelines, and case management booklets on Nutrition were developed, revised, and distributed. Capacity building training provided on SAM (severe acute malnutrition) Management for 42 on IYCF-E for 28 health workers. Awareness & Demand Creation Activities conducted on the first 1000 days and different IEC materials distributed. Supplies & Commodities Distributed for 83 hospitals and 1555 Stabilizing centers. A 97 million Eth Birr Budget support for the transition of VAS, Deworming, and Nutrition screening (EOS to CHD, CHD to Routine) for all regions.

- One of the initiatives of the MOH is the School Health and Nutrition Program that has been launched in Ethiopia to improve the health and learning of school children. The program is implemented in collaboration with the Ministry of Education. A strategic document named School Health and Nutrition Framework is prepared to direct the overall implementation of the program. As a result, ten core packages of school-related health services have been identified for implementation at all school levels. In 2018/19 (2010 EFY), 88 schools in Amhara Region and 100 schools in Tigray Region were selected to start the program as a first phase. The program is led by the Health Extension Professionals based on the training modality manual developed for them. In addition, the National School Health and Nutrition Program (SHNP) implementation manual has been developed and distributed to the Health Bureaus of Amhara, Tigray, SNNP Regions as well as Addis Ababa City Administration. High-level advocacy and sensitization of the program were held with the management members of the Regional Education and Health Bureaus in Amhara, Tigray, and SNNPR.

2.4. HIV/AIDS and HTP/VAW Prevention and Response

- The health status of the population is an important factor that determines the productivity of the population, educational attainment, and achieving other socio-economic indicators of development. The MoLSA recently reported a sharp increase in HIV risk factors associated with trafficking women due to poverty and unemployment. Such women are particularly vulnerable to various forms of abuse and exploitation, and usually have little or no access to preventive information or health services. Harmful Traditional Practices (HTPs) and Violence against Women (VAW) (female circumcision, child marriage, rape, child sexual abuse, kidnapping, and domestic violence) also cause and/or contributing factors to the transmission of HIV/AIDS in Ethiopia. The trend among African commercial sex workers to enter into prostitution at an earlier age also reported from Ethiopia, increases the risk of HIV infection due to the biological and socioeconomic vulnerability of adolescents (Helmut et al. 2007). The empirical data revealed that in Ethiopia health is one of the

major areas that reflect gender disparity. Low economic empowerment due to unemployment and poverty together with culture, harmful traditional practices, and other constraints make women highly vulnerable to health risks than men. Recognizing these interrelated problems the government of Ethiopia has been taking several measures to decrease the impact of HIV/AIDS on men and women.

- Various interventions were carried out to prevent and control HIV/AIDS. According to the MoH report, a total of 14,154 (60.5%) mothers received ART to prevent HIV transmission from mother to child in 2017/18 (in 2010 EFY). Of the total mothers, 69% were known as HIV positive and linked to PMTCT and the remaining 31% of them were newly diagnosed in the fiscal year. Measures including capacity building, awareness-creation, mainstreaming of HIV/AIDS agendas in the plans and programs by various sectors, and monitoring and evaluation of the programs in coordination took place.[15]

- The number of patients newly contracting HIV has fallen considerably. To eliminate HIV incidence, the Government has arranged for up to 10 million people to get tested for HIV and for those who test positive to receive antiretroviral drug treatment. Those tested negatives are consulted about the essential preventive care they should adopt.[16]

- Awareness creation programs on GBV/VAW prevention and response were provided to the public in general and stakeholders at different levels. These programs were organized by governmental, non-governmental, and community-based organizations. Additionally, trainings on GBV/VAW prevention and response to law-enforcing bodies and medical professionals were provided with the aim of improving the quality of services to survivors of GBV and HTPs.

- Twenty-six one-stop care and support centers have been established in different parts of the country to provide medical, legal, and psycho-social services to survivors of rape and sexual violence. To improve the quality of services, the Standard Operating Procedure (SoP) for the Response and Prevention of Sexual Violence in Ethiopia was prepared and disseminated to the one-stop centers in the country. Trainings on the SoP were also provided to health professionals working in health facilities throughout the country.[17]

2.4. Research to Improve Women's Health and Access to Health Care Services

[15] *Ethiopia 2017 Voluntary National Review on SDGs, Report. National Planning Commission, June 2017*

[16] *Ibd*

[17] *MoH reports and EWLA , a study on law and enforcement gaps on DV, SH and AA 2021*

- Different researches, surveys, and assessments were carried out by different organizations in the reporting year. The EDHS (2016), Min-Demographic Survey(2019), Top ten causes of morbidity of female (2008 -2012EFY), National Review on SDGs performance of the Government of Ethiopia (2017), among the research that was carried in the reporting period. Operational research was conducted to document cases of SRH issues as well as demand in selected higher educational institutions and aim to inform the advocacy plan for sexual and reproductive health and rights activities in higher educational institutions

2.5. Partnership and Resource Mobilization/Allocation

- ***Partnership and collaboration***

  A Community Based Health Insurance scheme was introduced during the previous reporting period 2017-2019/20 (EFY2011/2012) to ensure universal health coverage. The scheme has shown an increase in implementation and expansion during the reporting period. The program is designed to benefit women who have limited access to quality health care due to economic, cultural, and mobility-related constraints. In 2017, the total number of woredas with CBHI reached 377 and out of which 248 are providing the necessary health services to their members as a result of which women benefited and their access to health services improved. [18]This increases accessible and affordable health services without having to pay any fee at the time of services. Many women and children could now go to healthcare centers without requesting financial support from the male head of the household. Their CBHI card gives them the agency to simply walk into a health care center and demand health care assistance

- The WDAs, are volunteers who are not institutionalized in the health system. As a result, there is a move towards institutionalizing the WDA platform in consultation with the Ministry of Women and Children Affairs.

- There were collaborations with government, local non-government, international government, and UN agencies on various health-related issues to improve women's rights to health and their access to health services. This includes consultations and activities involving the Regional Health Bureaus (RHB), the various Directorates of the Federal Ministry of Health (FMOH), agencies accountable to the FMOH, and Development Partners (DP). The overall coordination and technical support were provided by a Committee led by the Policy, Planning, Monitoring, and Evaluation Directorate (PPMED) and a write-up team organized by FMOH and Development Partners.

[18] MoH Reports

- Moreover, MOH has participated in a national-level task force that works on prevention and response to VAWC. The task force is led by the Federal Attorney general and in alignment with the objective of the taskforce, follow-up and support were provided at regional and federal hospitals on the provision of services provided by one-stop centers.

- **Budget allocation/Fund mobilization:** Even though the Government did not achieve the 2011 Abuja Declaration urging the Africa Union States to allocate at least 15% of national budgets to the health sector, which remained at 11.5% in 2017/18 (2010EFY), have made progress in allocating budgets and use SDG pool fund. The fund is mainly spent on the expansion of health infrastructure and the workforce to achieve universal primary health coverage, improve maternal health services, sexual and reproductive health services, and the nutritional status of citizens including women and girls. For instance, the increment in the number of health posts, health centers, and hospitals rose from 16,048 to 18,816, 3100 to 3956, and 127 to 402 between 2012/13 -2017/18 respectively.

2.7. M & E /HIS

- Routine administrative reporting offered large numbers of indicators, but these did not allow for monitoring of gender equity and health. Therefore, health organizations need to assess their adequacy to monitor key issues related to gender, equity, and health. A comprehensive health information framework is important to capture gender data for analysis and identification of gender-related gaps. Despite some data unavailability in some women's health issues, currently; the MOH of Ethiopia has made progress in collecting, compiling, and disseminating gender-responsive data as well as putting in place a gender-responsive M&E mechanism.

- FMOH prepared a comprehensive HMIS recording and reporting, information use, and data quality in-service training manuals that will be used in the upcoming year for cascading the Information Revolution to the lower level. Along with the training manuals, Integrated Supportive Supervision guideline and checklist comprising all the four Transformation Agendas is drafted in collaboration with various FMOH Directorates and implementing partners.

- Monthly, quarterly, and annual institution-based reports, with some exceptions of data for certain program areas such as administrative reports and surveys undertaken by different institutions were captured each year. Population figures are used based on the projection estimates for the fiscal year provided by the Central Statistical Agency (CSA) and conversion factors from the same source. Besides, simple measures of

inequality ratio are applied for comparisons of equity stratifies such as geography (regional) and age (adult/child) to show relative inequality (reflecting proportional differences) in health among subgroups.

- Different training and biweekly meetings have been provided to the WDAs to strengthen their skills and capacities. It helped in promoting community ownership of health programs and provides an unprecedented platform to engage the community in the planning, implementation, monitoring, and evaluation of health interventions at the community level and beyond. The development of the Electronic Community Health Information System (eCHIS) has made significant progress over the past year. In the 2010 EFY, the development of the digital family folder and the RMNCH mobile apps was finalized. FMOH has been documenting various iterations of requirements for the eCHIS, including overall system design and deployment architecture. Based on the new requirements and the system architecture design, a technology review has been conducted and it was decided to develop the application based on a single comprehensive platform. Consequently, the digital family folder and the RMNCH modules were developed and integrated using a CommCare platform. In addition, the configuration and setup of CommCare HQ for local hosting have been done in parallel to the development of the mobile app.

- The current major functionalities of the application of electronic community information(eCHIS) include among others: Household registration and management; household member registration and management; Capturing data during household visits (HH properties); Training registration and HH graduation; ANC, Delivery, and PNC; Family Planning; Essential Nutrition Actions (Growth Monitoring, Malnutrition); Expanded Program on Immunization (EPI)and Monthly and quarterly reporting.

Gaps identified

- Women are not a homogeneous group and their needs and priority differ according to their socio-economic status, their location, and other determinants. The kind of health issues the women in rural areas and urban is different in terms of access, and other factors. However, the majority of the reports overlook how the services are equitably accessible and affordable to all women – in rural and urban areas, women with disabilities, etc. For instance, traffic or workplace accidents caused by disability is one of the problems for urban women, but the reports do not show how the health centers are accessible to these segment of the population and women. In addition, if supportive devices and artificial limbs are available and affordable not indicated.

Occupational safety is not covered by the health sector and it is not indicated in the majority of the reports if there is or no collaboration with MOLSA or other concerned bodies. Comprehensive and coherent programs for the prevention, diagnosis, and treatment of osteoporosis, a condition that predominantly affects women are missing. A mechanism that is put in place to inform women about the factors that increase the risks of developing cancers and infections of the reproductive tract and the problem of old age also missing.

- Addressing gender in any sector is a very challenging task requiring a multi-dimensional approach. Gender mainstreaming needs sensitization about gender issues and requires skill and knowledge to mainstream gender. Thus, the provision of trainings and preparation of materials that are in line with the policy and legal frameworks are necessary. Sex and gender-disaggregated data are also critical for prioritizing subsequent interventions in this regard. However, the gaps in terms of continuous sensitization, trainings, and comprehensive data capturing on gender and women-specific health intervention.

- Unsatisfactory quality of services, inadequate compassionate care, failure to perceive risk associated with pregnancy, and distance are mentioned as barriers to the achievement of reduction of maternal mortality through skilled birth attendance. Addressing cultural practices, poor service-seeking behavior, geographic and infrastructure barriers, and distance to health facilities and can also be considered as a gap for the achievement in delivery by skilled birth attendants in rural areas.[19]

- Even though, expansion of health services, health extension workers (HEW) active engagement, and increased availability of free long-acting contraception methods could be attributed to the success. Addressing, fear of side effects, cultural/traditional restrictions, low women's autonomy, and poor service provision can also be identified as gaps in terms of FP and sexual and reproductive rights of women.[20]

- Monitoring mechanism on research regarding human genome and related genetic issues from the perspective of women health and disseminate information is also a gap to determine individual or specific group of people's health needs.

- Gender-sensitive and women-centered health researches related to treatment, technology, and the link between traditional and indigenous knowledge with modern medicine on women's health is very limited. There is a gap in conducting region-

[19] *Federal Ministry of Health: Evidence Synthesis preliminary finding*

[20] *Ethiopia 2017 Voluntary National Review on SDGs, Report. National Planning Commission, June 2017*

specific health problems of women that aims to advocate location-specific interventions.

- There is no information on the provision of Adolescent and Youth Friendly (AFY) sexual, reproductive, and maternal health services scaled up in all public health centers, hospitals, clinics, youth centers, and selected private health service outlets with a defined minimum service package. No information is available regarding the adolescent and youth component integrated into data collection tools of the health management information system and RMNCH scorecard and disaggregated by sex and age.[21]

- Gaps identified related to maternal and reproductive health services and related M&E mechanism and data availability. For instance, in Ethiopia, 59% of infants less than 6 months are exclusively breastfed. Contrary to the WHO recommendation those children under age 6 months should be exclusively breastfed. The consultants recognize the fact that there has been a promotion on TV sponsored by various donors. However, this is not captured in the MOH reports.

- Monitoring and follow-up and data disaggregated by sex and gender regarding women's health rights and their access to different services are limited.

- No special and comprehensive services for survivors of sexual abuse/violence and domestic violence in rural and urban settings, expect for one-stop centers established in 26 locations.

- Limited comprehensive services for women who undergo abortion including counselling services for prevention of unwanted pregnancy.

[21] *The Motion Tracker, Prepared by Consortium of Reproductive health Associations- developed by the contribution of the local non-governmental organization, international NGOs, and Government, 2019*

Section Three
Conclusion and Recommendations

3.1. Conclusion

Ethiopian have made encouraging achievements on several actions that are indicated under the BPfA. In this regard, formulating policies, strategies, and programs such as National Nutrition Strategy, Women Development Strategy and Adolescent and Youth Health Strategies can be cited among achievements. The revision of laws that deals with working conditions and the maternity rights of women are also achievements with regard to women's right to health at the workplace. The progress made on maternal health (pre- and post-natal health) care services is tremendous, which resulted in a reduction of maternal mortality rate. Progress has been made on information, knowledge dissemination, and access to resources on FP. Initiatives that focus on women -specific health issues, such as breast and cervical cancer, can be taken as the commencement of addressing women's specific needs concerning health rights. Besides, initiatives regarding the GBV response mechanism (one-stop care and support centers) for survivors of sexual violence can be a good start to provide services to survivors of GBV/VAW in the country.

However, there is a huge gap in fulfilling the women's health rights and their access to health services for all women in their lifecycle due to lack of comprehensive strategy on women's rights to health. The efforts made to achieve women's health rights and their access to health services are not well articulated, coordinated, and implemented by all actors and, in turn, left out in addressing the health needs of specific groups. The data or information does not show the whole picture regarding women's health rights and their access to health services in the country.

3.2. Recommendation

Develop a comprehensive strategy/program on women's health rights and access to health care services is necessary to ensure women's rights to health of all ages. Such a strategy/program facilitates monitoring, follow-up and sharing information among stakeholders and partners. It also supports collecting comprehensive data on women's health rights and their access to health services.

Increase enjoyment of women's human rights at the grassroots level through strengthened government efforts in promoting and protecting such rights at a community level. Engaging the Women Development Army and Community-based Organizations and Women Associations and use Community Conversation (CC) approach is recommended to engage communities to discuss cultural norms and values that affect women's health. Participation in the CC series encourages individuals to think critically

about gender issues, HIV/AIDS, HTPs/VAWC, family planning, and more. It will improve consensus building among members to take collective actions against HTPs/VAWC.

Improve access to and demand for quality, gender-sensitive and integrated reproductive health care, including HIV/AIDS prevention services at all levels: strengthen the accessibility, affordability, and quality of women's health service. Identify gaps in women's health services such as old age issues, and provide the services.

Develop cross-sectoral collaboration: Some of the interventions needed to enhance women's health are mandated to other organizations. Hence, develop an efficient partnership and networking system to work together.

Collect, analyze and disseminate gender-responsive health data: revise the existing gender health indicators visa vis the international data comparability and update the health indicators accordingly. Collect, analyze and share the data with relevant stakeholders to track progress.

Reference

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(UN Women, 2014): Preliminary Gender Profile of Ethiopia, Addis Ababa, Ethiopia, 2014

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Annexes

Annex 1: List of Documents reviewed

- Beijing Declaration and Platform for Action, 1995
- Ethiopia Mini-Demographic and Health Survey, 2019 Key Indicators Report, MoH
- FDRE- National Nutrition Program II' 2016 -2020
- FDRE MoH, Health Sector Transformation Plan- Health and Health Regulated indicators 2019/2020
- FDRE MoH: Evidence Synthesis based on DHS Data
- FDRE MoH, Health Sector Transformation Plan 2015/16-2019/20, August 2015
- FDRE MoH, Annual Health Sector Performance, 2017/18, October 2018
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- FDRE MoH, Annual Performance Report,2019/2020
- FDRE Planning and Development Commission, Women's Economic, Social and Political Participation and Benefit, Desk Review Report, 2019
- FDRE MoH, Special Bulletin -21st Annual Review Meeting 2019
- The Fifth National Report on Progress made in the implementation of the Beijing Declaration and Platform for Action by the Government of Ethiopia, 2019
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- Health Care and Financing Strategy (1998)
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- Ethiopia 2017 Voluntary National Review on SDGs, Report. National Planning Commission, June 2017