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# POLICY BRIEF[1]

## Gender Barriers in Ethiopia's National Laws and Policies on Sexual, Reproductive, Maternal, New-born, Child and Adolescent Health (SRMNCAH)

### Rights and Access to SRMNCAH Services in Humanitarian Settings

August 2021

Since 2018, UN Women Ethiopia intensified its engagement in Gambella Region (hereinafter referred to as Gambella Region), focusing on gender equality and women's empowerment (GEWE) interventions. Using its comparative advantage, UN Women Ethiopia has worked to address the barriers preventing women, children and adolescents from demanding and realizing their rights to sexual, reproductive, maternal, new-born, child and adolescent health (SRMNCAH) services.

Universal access to SRMNCAH services is central to the 2030 Agenda for Sustainable Development and related Sustainable Development Goals (SDGs), particularly SDG 3, to ensure healthy lives and promote well-being for all at all ages, and SDG 5, to achieve gender equality and empower all women and girls.

To ensure that women, children and adolescents have equal access to SRH services, it is necessary to address gender biases in cultural, institutional, legal and economic structures. This can be achieved, but it requires an assessment of gender barriers in national legal and policy frameworks for SRMNCAH services, including in humanitarian settings. In 2021, UN Women supported an assessment to identify barriers in legal and policy frameworks that may hinder women and girls from claiming their rights and accessing SRMNCAH services. This research builds upon UN Women's existing work in the humanitarian sector that focusses on eliminating all forms of violence against women and girls (VAWG) through a multipronged approach which includes addressing gender norms and stereotypes, and improving sexual, reproductive and maternal health for women and girls.

Findings from this assessment are presented in this brief and should be used to inform the Government of Ethiopia (GoE) and civil society organizations (CSOs) to address the legal and policy barriers that prevent women, children and adolescents from accessing and realizing their rights to SRMNCAH, and achieving the establishment of national, regional and local rights-based SRMNCAH frameworks.

1. This policy brief is grounded in findings, conclusion, and recommendations from the Analysis of Gender Barriers in National Laws and Policies on Sexual, Reproductive, Maternal, New-born, Child and Adolescent Health (SRMNCAH) Rights and Access to SRMNCAH Services in Humanitarian Settings in Ethiopia (Gambella Refugee Camps) commissioned by UN Women Ethiopia with funding from Austrian Development Cooperation and written by Yimegnushal Takele in 2021, and copy edited by Prof. Robin N. Haarr, PhD, UN Women Senior Consultant. This policy brief was prepared by Prof. Robin N. Haarr, PhD. Opinions and views expressed in this policy brief do not necessarily reflect those of UN Women or their donors.

# Ethiopian Context

In 2020, Ethiopia's population was estimated to be 114,963,588[2], of which 25 percent of the population were estimated to be women of reproductive age (15-49 years). In addition, adolescents ages 15-19 comprised 23 percent of the population and children under the age of five made up 15 percent of the population.

In the past two decades, Ethiopia has seen significant improvement on indicators related to SRMNCAH, including slight increases in the median age at first marriage among women ages 25-49[3], declines in the proportion of women married before 15 and 18 years of age[4], and a decrease in the adolescent fertility rate.[5] Ethiopia has also made significant achievements in reducing maternal and child mortality. In addition, there have been increases in the proportion of women ages 15-49 who used contraceptives (any method) and who used modern methods of contraceptives; however, this has been coupled with a decrease in the proportion of women who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care. [6]

The Ministry of Health (MoH) has drafted and implemented various policies and strategies, as well as protocols and guidelines to improve maternal and new-born health outcomes. In addition, there are national policies and guidelines on SRMNCAH, including, but not limited to: minimum number of antenatal care (ANC) visits for pregnant women; the right of every woman to have access to skilled health care during childbirth; postnatal care for mothers and new-borns; management of low birth weight and preterm new-borns; and requirements for maternal and neonatal deaths to be reviewed.

In regard to child health, there are policies and guidelines on management of critical causes of child morbidity and mortality, including clinical standards for management of pneumonia, diarrhoea and malnutrition, which have contributed to progress achieved. In addition, national policies and guidelines specifically address adolescent health, including SRHR, standards for health promotion in schools and delivery of health services to adolescents.

Although the GoE is a signatory to most international legal frameworks related to GEWE, and has made some progress in areas of SRMNCAH, there are still challenges and gaps in the implementation of these international agreements and commitments. Across Ethiopia, women are negatively impacted by cultural, institutional, legal and economic issues that directly contribute to their low access to SRH services, which is a basic human right. The lack of access to SRH services has negative consequences for women and girls, including: increased risks of early, child and forced marriage; polygamy; pressure on women to have multiple children; lack of awareness of the role of women in deciding the number of children they will give birth to; and challenges in accessing inheritance rights. These are also common problems faced by refugees living in refugee camps and host communities in Ethiopia, but even more common in Gambella Region.

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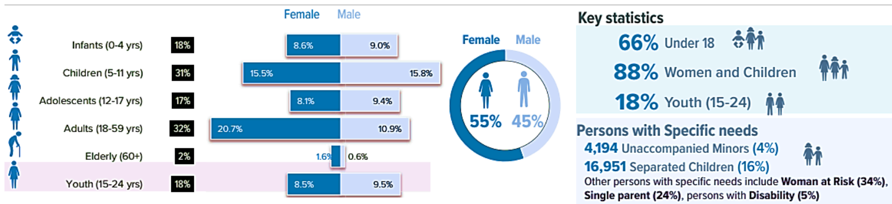
2. Population Total – Ethiopia. UN Population Division. Retrieved on 22 July 2021 from: Population, total - Ethiopia | Data (worldbank.org)
3. Central Statistical Agency (CSA) [Ethiopia] and ICF (2016). Ethiopia Demographic and Health Survey 2016. CSA and ICF: Addis Ababa, Ethiopia and Rockville, Maryland, USA. Retrieved on 22 July 2021 from: Ethiopia Demographic and Health Survey 2016 [FR328] (dhsprogram.com)
4. Ibid, 2016.
5. Adolescent fertility rate (births per 1,000 women ages 15-19) – Ethiopia. Retrieved on 22 July 2021 from: Adolescent fertility rate (births per 1,000 women ages 15-19) - Ethiopia | Data (worldbank.org)
6. Demographic and Health Survey data compiled by the United Nations Population Fund (UNFPA). Retrieved on 22 July 2021 from: Women making their own informed decisions regarding sexual relations, contraceptive use and reproductive health care (% of women age 15-49) - Ethiopia | Data (worldbank.org)

Figure 1. Demographics of the refugee population in Gambella Region




Source: UNHCR Sub-Office Gambella Region, Ethiopia, as of 31 July 2020

Ethiopia is the third largest refugee hosing country in Africa, sheltering 801,451 registered refugees and asylum seekers as of 28 February 2021. The overwhelming majority originate from South Sudan, Somalia, Eritrea and Sudan. In 2020, among the 321,014 refugees in Ethiopia, women and children made up 88 percent of the refugee population in Gambella Region (Figure 1). Thus, it is important to identify and understand the legal and policy barriers that limit or hinder refugees from claiming their SRMNCAH rights and accessing SRMNCAH services.

# Ratified International and Regional Refugee-Related Legal Frameworks

As a founding member of the UN and the African Union (AU), the GoE has ratified several international and regional legal frameworks that codify human rights, including rights to equality and non-discrimination, and to the enjoyment of the highest attainable standard of physical and mental health. In keeping with international and regional legal frameworks, these rights are extended to refugees and asylum seekers, including in humanitarian settings (Table 1).

| Table 1. International and regional legal frameworks related to refugees ratified by Ethiopia |
|---|
| **International legal frameworks** |
| Universal Declaration of Human Rights (UDHR), 1948 |
| Preamble to the Constitution of the WHO, 1946 |
| Convention Relating to the Status of Refugees, 1951 |
| Convention Relating to the Status of Stateless Persons, 1954 |
| Convention on the Elimination of All Forms of Discrimination against Women, 1979 |
| Convention on the Rights of the Child, 1989 |
| Committee on Economic, Social and Cultural Rights, General Comment No. 3 on the Nature of States Parties' Obligations, 1990 |
| UN General Assembly Special Session, Declaration of Commitment on HIV/AIDS, 2001 |
| World Health Assembly (WHA) Resolution 61.17 on the Health of Migrants, 2008 |
| Transformational Agenda of the Global Compact on Refugees (GCR) and Global Commitment on Implementing a Comprehensive Refugee Response Framework (CRRF) |
| **Regional legal frameworks** |
| Convention Governing the Specific Aspects of Refugee Problems in Africa, 1969 |
| African Charter on Human and Peoples' Rights, 1981 |

There are also international global refugee initiatives to which Ethiopia is a party, including the UN Global Compact on Refugees (GCR) and the Comprehensive Refugee Response Framework (CRRF). The GCR represents the political will and ambition of the international community as a whole for strengthened cooperation and solidarity with refugees and affected host countries.

In September 2016, during the UN Leaders' Summit on Refugees in New York, New York, USA, Ethiopia became one (1) of 17 refugee-hosting states to endorse the UN Declaration for Refugees and Migrants and to sign on to the CRRF. The nine (9) pledges made by the GoE in the CRRF are praised as reflecting a shift in the GoE's policy and response toward refugees from an 'only encampment' policy to a mix of encampment, out-of-camp and local integration policies.

# Translation of International and Regional Commitments into National Action

## National Refugee-Related Laws and Policies

The 1994 Constitution of the FDRE declares that "all international agreements ratified by Ethiopia are an integral part of the law of the land" (Chapter II, Article 9(4)). Principles of equality and non-discrimination provide the foundations for the realization of all other human rights, including the right to health. In keeping, the Constitution entitles all people in Ethiopia to the same rights and freedoms, and prohibits discrimination based upon race, nationality, gender, color, language, religion and political opinion (Chapter III, Article 25).

In addition, Refugee Proclamation No. 1110/2019 states that every recognized refugee and asylum seeker shall have access to available health services in Ethiopia (Part IV, Article 25), and is entitled to the rights and subjected to the obligations contained in the International Refugee Convention, the OAU Refugee Convention and other applicable international laws (Part IV, Article 22). Refugee Proclamation No. 1110/2019 enables refugees in Ethiopia to be more independent and better protected, and to have greater access to local solutions. Refugee Proclamation No. 1110/2019 has been praised by many as "one of the most progressive refugee policies in Africa."

The passage of Refugee Proclamation No. 1110/2019 was followed by the development of a ten-year National Comprehensive Refugee Response Strategy (NCRRS). The NCRRS has been accompanied by a multi-sectoral RRP 2020-2021. The RRP 2020-2021 is grounded in the spirit of the GCR and aims to contribute to the ten-year NCRRS. In keeping, the RRP 2020-2021 outlines the collective response of concerned humanitarian and development partners in support of registering all refugees in the country. Among its strategic objectives and operational priorities, the RRP 2020-2021 calls for improving documentation and strengthening refugee protection through the expansion of improved community-based and multi-sectoral child protection and sexual and gender-based violence (SGBV) programmes, as well as improving access to health-related services.

In keeping with the RRP 2020-2021, the modality for improving refugees access to health services is intended to occur by strengthening existing health care facilities in refugee camps. To ensure sustainability, the plan is to integrate refugee health services into health service delivery provided by RHBs and the MoH.

## Health Services in Ethiopia's Humanitarian Sector

RHBs and woreda health offices manage health facilities that provide health care services to national populations in host communities, but they do not manage administration of primary health care facilities in refugee camps; this is ARRA's responsibility. ARRA acts as both a

coordinator and implementing partner for primary health care services for refugees living in refugee camps, with funding from UNHCR. In some refugee camps, NGOs also provide health services (e.g., during the assessment period, Medecins Sans Frontieres Holland provides health care services to refugees in Kule refugee camp).

For various reasons, there are few collaborative agreements among key stakeholders to provide integrated health care services to refugee communities. In most of the health interventions, there are fragmented efforts in some regions to include the refugee population in the health planning. In some regions, UNHCR and ARRA have participated in the development of disease-specific micro-planning exercises at the regional level, however this is not consistent across regions and does not cover all segments of the population that need these services. Most of the life-saving components of SRMNCAH services are among the interventions run by parallel health systems led by ARRA and UNHCR.

MoH and RHBs collaborate with ARRA, UNHCR and UNICEF to deliver emergency preparedness and response to epidemics, as well as national disease control programmes, national HIV prevention campaigns, national expanded programmes on immunizations, and national malaria prevention and control programmes. These are important areas of engagement and collaboration.

Advocating for integration of refugee health in humanitarian settings to be part of the national health system is a strategic and sustainable way for addressing the SRMNCAH needs and access to such services. To this end, legal and policy frameworks play critical roles in addressing the needs of refugees in humanitarian settings and access to live-saving SRMNCAH services. The challenge is that legal and policy frameworks can either facilitate or serve as barriers to refugees in humanitarian settings who demand their rights health care services and access to life-saving SRMNCAH services.

As part of the study, 31 national SRMNCAH-related policies, strategies and guidelines were reviewed for their inclusiveness of refugees, particularly women and children in humanitarian settings. The policy review found that 58 percent of SRMNCAH-related policies, strategies and guidelines never mentioned or considered the humanitarian sector, and 10 percent did not directly mention the needs of refugees, but did focus on internal displacement and other emergency situations. Only 32 percent of SRMNCAH-related policies, strategies and guidelines directly included the needs of refugees in humanitarian settings (Table 2).

**Table 2. National SRMNCAH-related policies that address women and girls in humanitarian settings**

| Category of policy, strategy, guideline referred to: | No. documents reviewed | % | Humanitarian setting are mentioned in the document: | | |
|---|---|---|---|---|---|
| | | | Yes, Directly | Not, Directly | Not at all |
| SRH | 5 | 16% | 1 | 1 | 3 |
| Maternal health | 7 | 23% | 1 | 0 | 6 |
| New-born health | 6 | 19% | 0 | 0 | 6 |
| Child health | 5 | 16% | 2 | 1 | 2 |
| Adolescent health | 6 | 19% | 3 | 1 | 2 |
| SRMNCAH (all population categories in MNCA) | 5 | 16% | 4 | 0 | 1 |

| | | | | | |
|---|---|---|---|---|---|
| Sector-wide (beyond and including SRMNCAH) | 9 | 29% | 2 | 1 | 6 |
| Multi-sectoral (beyond health sector policies) | 2 | 7% | 0 | 0 | 2 |
| TOTAL | 31 | | 10(32%) | 3(10%) | 18(58%) |

Among the ten (10) documents where the needs of refugees were directly mentioned or referenced, seven (7) addressed refugees as part of the analysis of vulnerable groups, but with no indication of defined strategies, targets or activities, and no indication of financial or human resource allocation.

At the time of the assessment, the National Health Policy was under revision and incorporated into Section II was a mention of refugees as a specific population group, along with elderly, disabled and others.  Given the National Health Policy is a high-level strategic document that provides overall guidance and direction, having a focus on refugees is important and helps to bring national policy in line with international commitments of the GoE and with the Refugee Proclamation No. 1110/2019.

In light revisions to the National Health Policy, it is reasonable to expect that Health Sector Transformation Plans (HSTPs) will be more considerate of the country's legal commitments to address the health needs of refugees, particularly those in humanitarian settings, including women, children and adolescents. HSTPI, on which many of the current guidelines are based, never referred to refugees; however, HSTPII 2021-2025 mentions refugees and IDPs in its SWOT analysis and risk mitigation sections. The strategy outlined in HSTPII 2021-2025 is to establish service delivery points at IDP sites and refugee centers, and to strengthen health services in these sites.  The plan is also to expand family planning and SRH services which will be delivered through existing parallel systems in refugee camps and IDP sites.

While this inclusion is commendable, it is important to critically examine how the HSTPII implementation strategy is in harmony with national and international commitments to integrate refugees into the national health system, considering the implementation period of the HSTPII 2021-2025, which was prepared after the adoption of Refugee Proclamation No. 1110/2019 and the CRRF, and the development of the ten-year NCRRS and multi-sectoral RRP. In this regard, a lot more should have been expected of the HSTPII 2021-2025.  For instance, the HSTPII could have included a clear integration strategy and mainstreaming of national health services protocols in refugee camps, along with standardized pre- and in-service training for health care workers, regulations for facility design and infrastructure, and supportive supervision. These policy gaps indicate that there is a lack of understanding of the health service needs of refugees in humanitarian settings, including the need for quality SRMNCAH services, and a lack of political will to take the necessary actions to ensure refugees have access to these live-saving health care services.

## SRMNCAH Laws, Policies and Guidelines Alignment with WHO Recommendations

Given the National Health Policy and HSTPII 2021-2025 are in the early stages of addressing the health needs of refugees in humanitarian settings, it was too early for this assessment to link improvements made to access to SRMNCAH services to reduction in maternal and child morbidity and mortality rates.

Between 2009 and 2016, the WHO conducted four rounds of SRMNCAH Global Policy Surveys to track country progress in adopting WHO recommendations related to national health policies, strategies and guidelines on SRMNCAH. Findings from the 2018-2019 Global SRMNCAH Policy Survey Report revealed that Ethiopia developed and implemented 44 or 81 percent of the 54 SRMNCAH-related laws, policies and guidelines recommended by the WHO (Table 3).

Table 3. Progress toward implementing SRMNCAH laws and policies recommended by WHO

| Laws, policies and guidelines | Recommended | No. available by MOH | % Available |
|---|---|---|---|
| Cross-cutting SRMNCAH laws, policies and guidelines | 18 | 14 | 78% |
| SRH laws, policies and guidelines | 11 | 9 | 82% |
| GBV-related laws, policies and guidelines | 2 | 2 | 100% |
| Maternal and new-born health-related laws, policies and guidelines | 8 | 7 | 88% |
| Child health-related laws, policies and guidelines | 7 | 5 | 71% |
| Adolescent health-related laws, policies, guidelines and programmes | 8 | 7 | 88% |
| Total | 54 | 44 | 81% |

Source: WHO (2020). Sexual, Reproductive, Maternal, Newborn, Child and Adolescent Health Policy Survey 2018-2019: Report. WHO: Geneva, Switzerland.

## Barriers Faced by Refugees Accessing SRMNCAH Services

The more challenging aspect of ensuring access to SRMNCAH services in humanitarian settings requires addressing gender barriers embedded in legal and policy frameworks, particularly barriers that hinder demand and access to SRMNCAH services in humanitarian settings. Although the GoE has made some progress to address barriers faced by refugees in accessing SRMNCAH services, there are barriers that remain at national, regional and local levels.

At the national level there is limited enforcement of existing laws and policies that ensure the rights of women and girls; this among one of the major challenges, including addressing gender disparities in health care. According to MoH, for the period of 2021-2025, the budget for SRMNCAH services accounts for only 20 percent of the ministry's five-year programme cost. Data on SRMNCAH performance indicators revealed that coverage of SRMNCAH services are lower in Gambella Region, on average, than at the national level.

Consultations with key stakeholders revealed some interesting findings about barriers faced by refugees when it comes to accessing SRMNCAH services. Data from this assessment revealed a discrepancy between policy and current practices in delivery of SRMNCAH services in humanitarian settings, as revealed in two refugee camps in Gambella Region. A few of the barriers that exist include:

- Denial of registration rights of babies born outside of health care facilities.
- Challenges of women and adolescent to receive STI treatment in the absence of their sexual partners.

- Lack of enforcement and justice system responses to child marriage and intimate partner violence.

Advocating for the integration of refugee health care into the national health system, and working toward bridging the gap between policy and local practices is a strategic and sustainable way to address and improve refugee's access to SRMNCAH services. To this end, legal and policy frameworks play critical roles in addressing the needs of refugees in humanitarian settings, either by facilitating or serving as barriers to demand their rights and access to life-saving SRMNCAH services.

# RECOMMENDATIONS

SRMNCAH services can be life-saving and concern the lives of over 85 percent of the population in the humanitarian settings. In Ethiopia, even if health care services for refugees are not yet fully-owned by MoH and RHBs or integrated in the national health system, it is essential that steps be taken to remove barriers that hinder refugee women and girls from demanding their rights and access to SRMNCAH services. The recommendations that follow are based on this premise and grounded in findings from this assessment.

Recommendation 1: Advocate for integration of health care services in the humanitarian sector into to the national health system. There is a need to advocate for integration of health care services in the humanitarian sector into the national health care system. This requires dialogue with all key parties concerned, including the government, development partners and nongovernmental organization providing SRMNCAH services to refugees in humanitarian settings. The lead role should be play by ARRA, UNHCR and H6 partners with the support of nongovernmental organizations (NGOs) and women's rights organizations.

Recommendation 2: Develop a multi-stakeholder national refugee health strategy to facilitate integration of refugee health care into the national health care system. The process of integrating refugee health care into the national health system most likely would lead to the need for development of a national refugee health strategy. Any effort to integrate refugee health care into the national health care system is a process that requires time and resources. This requires developing a clear and comprehensive multi-stakeholder integration strategy that includes mainstreaming national health service protocols into health care facilities at refugee camps, standardizing pre- and in-service health care worker trainings, regulating facility design and infrastructure, aligning supportive supervisions, and more. It is imperative to develop a strategic phased-in approach with clearly defined timeline, allocation of resources and responsible agencies/institutions.

Recommendation 3: Develop a multi-stakeholder reference group to support integration of refugee health care into the national health care system under the aegis of MoH and RHBs. ARRA, UNHCR and UN Women work together to support MoH and RHBs to initiate consultation sessions on how to find ways to start incorporating refugee health care services, particularly SRMNCAH services, into the remaining four years of HSTPII 2021-2025 and annual work plans.

Recommendation 4: Draw upon good practices and lessons learned from other government efforts at refugee-integrated programming. MoH and RHBs have experience implementing certain refugee-integrated programming (e.g., emergency preparedness and response plans, conducting national health surveys and disease surveillances, rolling out immunization and malaria prevention programmes), thus there are good practices and lessons to be learned from these processes that can serve as a point of departure to commence immediate actions through

joint planning to integrate refugee health care services into the national health care system. There are good practices and lessons to be learned from the national Refugee Education Strategy and steps taken in the process of integrating refugee education into the national education system.

Recommendation 5: Allocate resources to support integration of refugee health care services into the national health care system. Any effort to promote the integration of refugee health care services into the national health care system, while maintaining quality health care services to the existing host population, cannot come without a demand for additional resources. Therefore, international humanitarian organizations will need to support the national government (as per their pledges) to execute its commitments and to improve the country health outcomes across populations.

Recommendation 6: The GoE should work to adopt and implement all WHO recommended laws, policies and guideline related to SRMNCAH. Ethiopia has made progress at adopting and implementing 81 percent of the WHO recommended laws, policies and guidelines for implementing SRMNCAH programmes. At this stage, it is important that the GoE towards adopt and implement the remaining 19 percent of WHO recommended laws, policies and guidelines related to SRMNCAH, which would add value to standardization of performance.

Recommendation 7: Include refugees in national level data collection, such as the EDHS 2021/22. It is important to advocate for the inclusion of refugees in ongoing national level data collection, such as the EDHS 2021/22. Doing so would enable better comparisons between refugees and non-refugees in regions, zones and woredas, and to track changes on standardized indicators. This is important because some refugees live a decade or more in the same area.

Recommendation 8: Coordinate dialogue on further analyses needed to understand and support ongoing efforts to improve refugees access to their rights and SRMNCAH services. There is a need for further discussion and analyses of individual, community and institutional level factors that contribute to or serve as barriers to refugees' abilities to access SRMNCAH service in humanitarian settings, and that will impact abilities to integrate refugee health care services into the national health care system. These factors need to be better understand so that they can be address in strategic planning and programming going forward.

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