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Abortion Care in Ethiopia: Challenges and Opportunities

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Abstract

Introduction: Every year, approximately 210 million women globally experience pregnancy, with roughly one-third of these pregnancies resulting in miscarriage, stillbirth, or induced abortions. The presence of restrictive abortion laws not only hinders women from accessing abortion care but also creates hurdles for healthcare providers in delivering this service within legally authorized health facilities

Objective: To identify the challenges and opportunities experienced in receiving and providing abortion care in the public health facilities of Ethiopia.

Methods: A facility-based cross-sectional study was carried out in SNNPR, Ethiopia, where data was collected from abortion care users through face-to-face questionnaires administered by trained midwives. Healthcare providers also completed a self-administered questionnaire. The data collected underwent thorough checking, cleaning, and entry into EpiData version 3.1 software. Subsequently, the data was exported to IBM Statistical Package for Social Sciences software (SPSS) version 25 for analysis. Data collection and analysis were from 2020 to 2021.

Results: Women who attended abortion care at public health centers and public hospitals enrolled in the study. In addition to abortion care, 162 (39.2%) women had the opportunity to received HIV/AIDS services, 139 (33.7%) received family planning services and 8 (1.9%) had received both HIV and FP services. These abortion care users identified several challenges, including increased waiting time, concerns about confidentiality, fear of stigma and discrimination, healthcare providers may be overwhelmed and decreased service quality. Healthcare providers also mentioned challenges such as a lack of trained staff, socio-cultural issues in the community, insufficient medical supplies, and inadequate equipment for providing abortion services. On the other hand, opportunities for improving abortion care were identified as enhanced teamwork, increased access to other health services, reduced stigma and discrimination, more efficient use of staff time, and fewer visits required for healthcare services.

Conclusion: Increasing the number of and access to integrated services, adequate equipment and medication, as well as ensuring that healthcare providers are trained to be competent to offer an integrated service, would enhance the utilization of abortion care and enable the provision of comprehensive services.

Keywords: abortion care; ethiopia; challenges; opportunities

Introduction

Abortion is a sensitive matter that involves religious, moral, cultural, and political considerations [1]. Between 2010 and 2014, around 25% of global pregnancies concluded in abortions, with 85% of these instances occurring in middle and low-income countries. Notably, there was a decline in abortion rates from 39% to 28% in developed countries during this period, while developing countries witnessed an increase from 21% to 24% [2]. Importantly, it is noteworthy that among all abortions during this timeframe, approximately 55% were categorized as safe, 31% as less safe, and 14% as not safe [3]. Unintended pregnancies are at a higher risk of concluding in abortion [4], driven by factors such as economic constraints or a desire to pursue education, among others [5, 6, and 7]. In Ethiopia, the rate of unplanned pregnancies varied between 80 to 86 per 1,000 women of reproductive age [11, 12]. Unfortunately, these unplanned pregnancies frequently result in unsafe abortions [13], even though effective access to family planning services could prevent such occurrences. In developed nations, women typically have access to safe abortion care, whereas those in developing countries encounter substantial barriers. Alarmingly, nearly half of all abortions globally are deemed unsafe, with a staggering 98% of these unsafe procedures occurring in the developing world [8]. In Ethiopia, the estimated national abortion rate stands at 28 abortions per 1,000 women of reproductive age [9], which is

comparatively lower than the estimated rate of 34 per 1,000 women in the East Africa region [10].

Restrictive abortion laws not only impede women from seeking abortion care but also create obstacles for healthcare providers in delivering the service within legally authorized health facilities [14]. Such restrictions not only limit the availability of abortion services but also drive up the costs of care and promote unsafe abortion practices [14]. Consequently, this contributes to a surge in unsafe abortions, exacerbating high maternal morbidity and mortality rates [15]. The impact of unsafe abortion practices is profound, leading to approximately 70,000 maternal deaths and 5 million cases of permanent or temporary disabilities annually [16]. These grim outcomes could be prevented through the availability of comprehensive abortion services [17]. To ensure the delivery of quality abortion care services in accordance with national standards and guidelines [18 and 19], it is imperative that all abortion care providers possess adequate knowledge and competencies, a principle underscored during their pre-service education [20]. In recent years, Ethiopia has formulated technical and procedural guidelines for safe abortion services, with a specific emphasis on the skill set required by healthcare providers [20]. These guidelines also address the attitudes and beliefs of service providers towards abortion care [20]. Consequently, pre-service education aims to acquaint healthcare providers with existing policies, strategies, and guidelines related to abortion care, imparting the essential knowledge and skills needed for the provision of comprehensive abortion care [21].

Abortion was prohibited by law in nearly every country until the close of the 19th century. Contemporary laws and policies regarding abortion continue to exhibit corrective or protective measures, specificity or non-specificity, as well as limitations or facilitation of abortion care [22]. Historically, restrictions were primarily imposed by colonizing powers such as Britain, France, Portugal, Spain, and Italy [23]. Many countries, including Ethiopia, have since reformed their abortion laws [23 and 24]. However, the legislation in numerous countries was often composed in ambiguous terms, leading to uncertainty regarding abortion services [22 and 25]. In the case of Ethiopia, the revised 2014 abortion law explicitly outlines the roles and responsibilities of various healthcare providers operating in both public and private health sectors, with a focus on providing safe abortion care [20]. The alarming maternal mortality rate attributed to complications arising from unsafe abortion prompted a serious consideration for legal reform in Ethiopia [26]. Consequently, the government of Ethiopia took a decisive step in 2006 to liberalize the abortion law [24]. Subsequently, the Ministry of Health in Ethiopia issued guidelines outlining the legal indications for safe abortion, which include: [1] Pregnancy resulting from rape or incest; [2] A threat to the life of the mother or the child if the pregnancy continues; [3] Congenital malformation affecting the healthy growth and development of the fetus; or [4] The woman being physically or mentally incapable of raising the child [22 and 24]. In Ethiopia, as of 2014, there were around 4,033 facilities with the potential to offer abortion-related care. Among these facilities, 72% provided induced abortions, post-abortion care, or both. The majority of public hospitals (98%), 67% of public health centers, and 80% of private or NGO facilities were involved in offering these services. Notably, private or NGO facilities accounted for 66% of safe abortions, while public facilities were responsible for 72% of post-abortion care [9]. The Technical and Procedural Guidelines for Safe Abortion Services in Ethiopia [20] have the objective of enhancing access to abortion care by increasing the number of healthcare facilities providing these services and engaging the private sector in the provision of abortion care [27].

Challenges and opportunities of abortion care

Abortion is deemed a criminal offense in Ethiopia, and women seeking abortion care may encounter discrimination from healthcare providers, family members, and society at large [28]. The presence of restrictive policies acts as a barrier, preventing women from accessing safe and legal abortion care, thereby increasing the risk of serious health complications or death [20]. Unsafe abortions posed a significant public health challenge in Ethiopia before the enactment of the 2005 Ethiopian Penal Code, accounting for an estimated 32% of maternal deaths and ranking among the leading causes of maternal mortality in the country [20]. Since 2006, there has been a legal shift, and abortion care in Ethiopia is permissible in cases of rape, incest, fetal impairment, or when the mother's life is at risk [24]. In Ethiopia, legal and policy impediments to delivering safe abortion care encompass restrictive abortion laws, a lack of clear guidelines, and insufficient training for healthcare providers [20]. The scarcity of healthcare facilities offering abortion services [28], coupled with

a shortage of healthcare providers delivering abortion care, particularly in rural areas, contributes to the utilization of unsafe abortion practices, consequently escalating maternal morbidity and mortality rates [20]. A prevailing factor hindering the seeking of abortion care or making informed decisions about service utilization in legally provided healthcare facilities is the poor awareness among many women in Ethiopia regarding the legal provisions for abortion care [28].

Abortion services hold significant benefits for both users and healthcare providers [29]. For abortion care users, obtaining safe abortion services can positively impact their health status [29]. The care provided by trained healthcare professionals in health facilities significantly reduces the risks of complications and death associated with unsafe abortions. Stigma and discrimination are less likely when abortion care is delivered in healthcare facilities by trained healthcare providers [30]. Conversely, healthcare providers stand to enhance their clinical and communication skills by collaborating with peers and functioning as a cohesive team [29]. Offering abortion care in health facilities may lead to improved job satisfaction and higher retention rates among healthcare providers, enabling them to deliver a comprehensive range of reproductive healthcare services to their patients [31]. Furthermore, providing safe abortion care services in public health facilities can enhance access to comprehensive reproductive healthcare services, including family planning and post-abortion care. A study conducted in Ghana revealed that offering safe abortion care services in public health facilities increased the uptake of post-abortion contraception by 30% [32]. In Uganda, a similar study indicated that providing safe abortion care services in public health facilities saved the healthcare system US $1.2 million by preventing and treating complications arising from unsafe abortions [32].

Materials and Methods

Design

A cross-section study in the public health facilities of Ethiopia was conducted.

Population and Sample

The study population included healthcare providers, such as Physicians, Midwives, health officers, and Nurses, actively involved in providing abortion care within public health facilities. Additionally, women within the childbearing age range (18-49 years old) who received abortion care in public health facilities in the Southern region constituted part of the study population. The sample sizes for the study population were determined using a single population proportion formula. Given the absence of a similar study conducted in the public health facilities of the study areas, a 50% proportion was employed to derive the maximum sample size [33]. Fifty-eight public health facilities were randomly chosen to be included in the study. The allocation of healthcare providers and abortion care users was done proportionally within the randomly selected public health facilities. A total of 413 abortion care users and 306 healthcare providers [comprising 157 Nurses, 72 Health officers, 60 Midwives, and 17 Physicians] were enrolled in the study using a stratified simple random sampling method.

Data Collection and Analysis

Trained midwives collected data from abortion care users, using a questionnaire in a face-to-face manner while trained public health officers were used to distribute and collect self-administered data from healthcare providers. The collected data were coded and entered into EpiData 3.1 version and subsequently exported to Statistical Package for Social Sciences software (SPSS) version 25 for analysis. The study results were presented using tables and figures to facilitate comprehension and interpretation.

Validity and Reliability

Validity and reliability are often complementary concepts [34]. **Validity** refers to the degree to which a study measures what it is intended to measure (35 and 36). Pretesting of the questionnaires has been done to evaluate the weaknesses and strengths of the questionnaire and ensure the required information can be captured from abortion care users and healthcare providers. **Reliability** is the consistency and stability of a study's results over time. It refers to the degree to which the study's results can be replicated [37]. The scientific review committee (UNISA) reviewed the questionnaires, and they underwent pre-testing to ensure reliability.

Ethics

Ethics approval for conducting the research has been obtained from the Research Ethics Committee, Department of Health Studies from the custodian University (Certificate Number: HSCDC/923/2019). The South Region Health Bureau Human Research and Technology Transfer Support Core Process (Certificate Number: ፃ/19/492 12//102012) has also provided ethics

approval to conduct the research in all selected health facilities. Voluntary informed participation of abortion care users and healthcare providers was ensured by providing a detailed information letter and thereafter signing the consent forms before the data was gathered.

Results

A total of 413 individuals seeking abortion care were included in the study. The participants' ages ranging from 18 to 44 years. Among the respondents, 66.6% fell within the 20-29 years. The majority (70.5%) had completed elementary school or pursued higher education, while 13.8% were literate, and 15.7% were unable to read and write. Of the abortion care users, 263 (63.7%) were married, and were single (divorced, widowed, separated, and unmarried but in relation). Occupationally, 44.1% identified as housewives, 14.3% as self-employed, 13.6% as public servants, and 12.8% as students. The respondents' mean monthly income was US $96.5, with a median of US $77.5 and a standard deviation of ±US$ 65.7 (See table 1).

Table 1: Socio-demographic and economic status of abortion care users, SNNPR, Ethiopia.

Abortion care users	n=	f=	Cumulative Frequency	Cumulative Percent
Age group				
15-19	39	9.4	39	9.4
20-24	122	29.5	161	39
25-29	153	37	314	76
30-34	64	15.5	378	91.5
35-39	30	7.3	408	98.8
40-44	5	1.2	413	100
Educational status				
Cannot read and write	65	15.7	65	15.7
Able to read and write	57	13.8	122	29.5
Elementary school	101	24.5	223	54
High school (12 or 10 completed	106	25.7	329	79.7
TVET/Diploma level				
Basic degree	50	12.1	379	91.8
	34	8.2	410	100
Marital status				
Married	263	63.7	263	63.7
Single	150	36.3	413	100
Occupation status				
Housewife	182	44.1	182	44.1
Self-employed	59	14.3	241	58.4
Public servant	56	13.6	297	71.9
Student	53	12.8	350	84.7
Private employee	33	8	383	92.7
Farmer	22	5.3	405	98.1
Entrepreneur	8	1.9	413	100
Monthly income				
0-40	92	22.3	92	22.3
40-80	118	28.6	210	50.9
81-120	83	20.1	293	71
121-160	58	14	351	85
161-200	26	6.3	377	91.3
201 and above	36	8.7	413	100

Similarly, 306 healthcare providers enrolled in the study from public health facilities of South Ethiopia. One hundred sixty-four (53.6%) were females by sex. Among them, 164 (53.6%) were females by sex. The age of the respondents ranged from 21 to 45 years, with a mean age of 29.1 years and a median age of 28 years. Out of the 306 participants, 157 (51%) were nurses, 72 (23.5%) were public health officers, 60

(19.6%) were midwives, and 17 (5.6%) were medical doctors. Regarding work experience, 109 (35.6%) healthcare providers had accumulated 36 months or more, while only 30 (12.1%) respondents had served for a period ranging from 0 to 11 months (see table 2).

Table 2: Socio-Demographic Characteristics of Healthcare Providers Experience of Healthcare Providers, SNNPR, Ethiopia.

Abortion care users	n=	f=
Sex		
Male	164	53.6
Female	142	46.4
Age group		
21-25	70	22.9
26-30	154	50.3
31-35	44	14.4
36-40	23	7.5
41-45	15	4.9
Professions		
Nursing	157	51.3
Health officer	72	23.5
Midwifery	60	19.6
Medical doctor	17	5.6
Work experience in months		
0-5	17	5.6
6-11	20	6.5
12-17	37	12.1
18-23	34	11.1
24-29	41	13.4
30-35	48	15.7
36 and above	109	35.6
Marital status		
Married	168	41.8
Single	128	1.6
Divorced	5	1.6
Windowed	5	

Abortion care users

Opportunities

Data was collected from women primarily seeking abortion care at public healthcare facilities. The public health facilities enabled 237 (57.4%) respondents to receive abortion care. A further 162 (39.2%) respondents received HIV services and 274 (66.3%) Family planning services in the same facility, in addition to abortion care. Nearly three-fourths (74.8%) of respondents received abortion care free of charge, 42 (10.2%) respondents' cost was covered by community healthcare insurance, and the remaining 62 (15%) abortion care users cost was covered out of pocket. The healthcare providers delivering these services were perceived by abortion care users as very skillful by 265 (64.2%), moderately skillful by 142 (34.4%) and less skillful by 6 (1.5%).

Challenges

Despite 250 respondents (60.5%) managing to reach public health facilities within 46 minutes, a significant concern arises from the fact that 254 respondents (61.5%) experienced a wait time exceeding 30 minutes before receiving healthcare. Notably, in this study, a substantial majority of abortion care users (67.6%) demonstrated unawareness of the existing abortion laws. The primary reasons cited for seeking abortion care included personal problems (40%), premarital pregnancy (36.8%), financial difficulties (32.7%), contraceptive issues (26.4%), pregnancy spacing concerns (17.7%), and a desire to avoid additional children (16.5%). Worryingly, the respondents exhibited limited knowledge about the associated risks, with only 119 (28.8%) being able to

identify just one adverse effect of abortion complications.

Healthcare providers

Opportunities

The majority of respondents 252 (82%) received in-service training that equipped them to provide healthcare services. Out of these healthcare providers, 132 (52.6%) had received integrated health service training. Non-governmental organizations played a significant role in providing these training to 188 (72.1%) healthcare providers. The majority of participants 136 (89.9%) reported that abortion services were offered at no cost in public health facilities, allowing women to access these services. According to healthcare providers' perspectives, the provision of abortion care in public health facilities, 208 (68.0%) participants expressed it would improve access to other health services, 236 (77.1%) believed it would enhance teamwork among healthcare providers, 165 (53.9%) believed it would lead to cost reduction, and 182 (59.5%) anticipated that offering abortion care in public health facilities would contribute to the reduction of stigma and discrimination experienced by both clients and healthcare providers.

Challenges

One hundred twenty-five (40.8%) participants in this study reported being aware of at least one abortion-related regulatory document. The respondents mentioned seven different types of abortion-related regulatory documents, with only 96 individuals (31.4%) indicating the availability of at least one such document in public health facilities. Healthcare providers who offer abortion care in healthcare facilities identified several challenges in delivering this service to the community. These challenges included a lack of trained healthcare providers, socio-cultural issues within the community, insufficient medical supplies, and a lack of equipment. Furthermore, of 153 abortion care providers, 72 (47.1%) indicated that abortion care was given in a room that had no adequate space and 49 of them were providing the abortion services in the delivery rooms.

Discussion

The distance from an individual's home to the nearest healthcare facility negatively affects health service utilization [38]. This negative impact is not solely due to distance alone, but also factors such as poor road infrastructure and lack of transportation to the nearest facility. These challenges can result in delays in managing life-threatening complications, particularly in cases of obstetric emergencies like abortions [39]. It is important to establish healthcare care facilities within a 5-kilometer radius. This proximity ensures that individuals in need of abortion services can access them in a timely manner, reducing potential delays and increasing the likelihood of receiving appropriate care [40]. A growing number of public health facilities in rural areas [41] and deploying an adequate number of healthcare providers with an appropriate skills mix (Doctors, Health officers, Midwives and Nurses) are essential in boosting the provision of abortion care services to the rural communities [42, 43]. The long waiting time after reaching the healthcare facilities is often negatively associated with service utilization [44] as it is indicated in this study that 254 (61.5%) abortion care users waited for more than 30 minutes before healthcare services were initiated. Research findings have highlighted that woman seek abortion care for various reasons, with socioeconomic factors being commonly cited, followed by considerations like child spacing, pressures from parents or partners, and women's health issues [45]. However, within the scope of this study, the identified reasons for seeking abortion care encompassed personal problems, premarital pregnancies, financial challenges, and contraceptive failures. Knowledge of abortion legislation is crucial for accessing services and is subject to existing laws and regulations [42]. Alarmingly, less than one-third (32.4%) of the respondents in this study were aware of the amended abortion law. Notably, the study revealed a concerning lack of knowledge about the risks associated with unsafe abortion, as only 119 individuals (28.8%) could identify just one adverse effect of abortion care.

Addressing this knowledge gap is vital, as enhancing community awareness of abortion laws has the potential to bolster the utilization of abortion services and improve women's health outcomes [20]. Furthermore, feedback from abortion care users in the study emphasized the importance of ensuring the availability of all necessary materials and equipment, fortifying the referral system, offering free health services, and integrating comprehensive health services within healthcare facilities to enhance both the accessibility and quality of abortion care. To enhance the quality of healthcare services, healthcare

providers require a foundation of knowledge, skills, ongoing training, and opportunities for professional development, allowing them to continuously refine their capacities. The significance of work experience in this context cannot be overstated, as evidenced by the findings of this study, where 109 healthcare providers (35.6%) possessed 36 months or more of work experience. The study indicated that less experienced healthcare providers demonstrated lower levels of teamwork and delivered healthcare services of comparatively lower quality, often associated with a higher frequency of medical errors [48]. Out of the 306 healthcare providers surveyed, a substantial majority, 251 respondents (82%), underwent one or more types of in-service training, contributing to their ability to deliver intended health services. Specifically, 65 healthcare providers (25.9%) received training within the last 12 months, 74 (29.5%) between 12 and 23 months, 47 (18.7%) between 24 and 35 months, and 35 (13.9%) had training experiences exceeding 36 months ago. The findings underscore the importance of periodically providing in-service training to healthcare providers, as it has the potential to enhance their skills and knowledge, ultimately contributing to the improved provision of health services [47].

Ensuring abortion services align with national standards and guidelines [20] is essential, as regulatory documents play a key role in guaranteeing the safe delivery of such services [43]. Of the participants in this study, 125 individuals (40.8%) affirmed their awareness of at least one abortion regulatory document. Maintaining healthcare providers' knowledge of these regulatory documents is crucial for delivering healthcare of high quality in accordance with national standards [25]. However, among the 306 healthcare providers examined in this study, only 96 respondents [31.4%] acknowledged the presence of at least one abortion-related regulatory document within their health facilities. The availability and utilization of these regulatory documents in public health facilities hold significant importance [48]. Improving the distribution of an ample number of regulatory documents to public health facilities has the potential to enhance the provision of abortion care.

Conclusion

Analyzing the challenges and opportunities associated with delivering abortion care in public health facilities is instrumental in devising effective strategies. By addressing barriers to abortion care services, it can be enhanced the provision of maternal health services that are safe, effective, and respectful, thereby contributing to the strengthening of health systems. Policymakers can leverage insights from identified challenges and opportunities to formulate appropriate regulations, ensuring the comprehensive provision of abortion care services.

Supporting information

S1 abortion care user's questionnaire
S2 Healthcare Providers questionnaire

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Author Contribution

Conceptualization: Professor Lizeth Roets.

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