The implementation of safe abortion services in Ethiopia

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Abstract
In 2005, a new criminal code was established to align Ethiopia's laws with its new Constitution. Following a period of intense activism and debate, abortion remained criminalized, but several significant exceptions were made, allowing for the expansion and integration of services within the public health system. The passage of the law and the establishment of technical guidelines each served as essential steps in determining the extent to which services were implemented. The integration of safe abortion services expanded the scope of practice for multiple cadres of healthcare providers, including emergency surgical officers, nurses, and health extension workers. The political will of the Ministry of Health, the research produced by the Ethiopian Society of Obstetricians and Gynecologists, and the expertise of nongovernmental organizations were essential to the implementation of services.

KEYWORDS
Advocacy; Ethiopia; Implementation; Legalization; Maternal mortality; Public health; Safe abortion; Women's rights

METHODOLOGY FOR ALL CASE STUDIES
This case study is one of six comprising a comparative examination of varied countries’ approaches to the implementation of national abortion service programs, after changes in laws or policy guidelines that established or expanded access to services. In addition to Ethiopia, case studies were conducted in Colombia, Ghana, Portugal, South Africa, and Uruguay, as they had all either implemented new abortion laws or policies, or changed interpretations of existing laws or policies, within the past 15 years. Each study used the Integrated Promoting Action on Research Implementation in Health Services (i-PARIHS) framework to organize the analyses. i-PARIHS posits successful implementation to be a function of the innovation to be implemented and its intended recipients in their specific context, with facilitation as the “active ingredient” aligning innovation and recipient.1 For each country case, two types of data sources were used: an in-depth desk review and 8–13 semistructured, in-depth interviews with key stakeholders and experts in each country, selected in collaboration with in-country partners. Respondents provided written informed consent and were guaranteed confidentiality. Several respondents from each country served as in-country coauthors, in doing so giving up their anonymity as participants of the study, although no quotations provided as respondents are directly attributed to them. Respondents included healthcare providers, public health and government officials who had been involved in establishing or expanding the service, academics, and members of nongovernmental organizations (NGOs) and legal and feminist advocacy groups; in some countries, interviewees came from the full range listed, in others, from a subset (Table 1). Interviews were conducted in English by a physician member of the team. Quotes presented are from interviews without attribution as we promised confidentiality. Data analysis comprised a multistep iterative thematic analysis, with coding structured to follow the i-PARIHS framework. The WHO’s Research Ethics Review Committee approved this study (protocol ID A65920). A full discussion of methodology can be found in Chavkin et al.2
1 | CONTEXT

Abortion has been criminalized in Ethiopia since the first penal code of 1930. The law was amended in 1957 to include exceptions for “grave and permanent danger to life or health” with the approval of two physicians, which resulted in limited expansion of services. However, a new constitution was ratified in 1994 enumerating the rights of women, including the establishment of equal rights, access to maternity leave, political participation, and “the right of access to family planning education, information and capacity”. In 2000, a broad redesign of the criminal code began to align the law with the new Constitution. Advocates proposed integrating new norms for reproductive health advanced in the International Conference on Population and Development (ICPD) and the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW).5,6

The high maternal mortality rate due to complications of unsafe abortion framed the conversation of legal reform. In 2005, Ethiopia’s maternal mortality ratio, although declining, was 687 deaths per 100,000 live births, with estimates at the time attributing 32% of maternal mortality to complications of unsafe abortion; later estimates would range between 19.6% and 31%. In this context, a movement developed across the medical, political, and women’s rights communities to reduce maternal mortality and fulfil the rights enumerated by the new Constitution. Increasing access to contraceptive services, postabortion care, and safe abortion care was a critical component of this mission.3

Ethiopia’s healthcare system has expanded significantly following the political reforms of 1991. Healthcare policy is directed by the Ministry of Health, with government services administrated at a regional level and supplemented by nongovernmental and private providers. A series of 5-year programs has been implemented to increase access to the healthcare system through the expansion of primary care and task sharing with new cadres of healthcare workers.11,12

2 | INNOVATION

With concerns around the high rates of maternal mortality linked to unsafe abortion, changes in abortion law were primarily driven by public health arguments. One interviewee stated:

When you talk about it at the ministry level or these government meetings, it’s always maternal deaths... [the government] saw the solution to maternal death as safe abortion services. And that is always how it’s talked about.

Rights-based arguments also resonated and were used to complement the health-based justification. However, several interviewees felt that the rights-based argument carried less weight in the national debate and could become too politically charged to result in meaningful legislation. One interviewee described this decision:

I know people will take it, will take this an extra mile and talk about the rights perspective. Yes, there is the rights perspective, but in a conservative society like ours...people will ask whose right are you talking about, you know?

With several components of reproductive health and women’s rights regulated in the criminal code, revised legislation was needed to address multiple elements of reproductive health, including the provision of abortion services. With new norms established in the Constitution, the Criminal Code of 1957 was no longer applicable, creating a policy window for significant legal reform. Some interviewees described the push to reform the criminal code as partly due to a sense that the old code was foreign, copied from European criminal codes, and unsuited for the Ethiopian context.

Interviewees reported that initial opposition to the revised criminal code was well organized by domestic and international advocacy groups, joined by religious organizations. Concerned about a potential backlash to the law, the drafting committee retained abortion in the criminal code with exemptions for specific indications. In exchange, it permitted pro-choice advocacy groups to have a strong negotiating presence in drafting the exemptions. One interviewee who advocated for legal reform described the process as follows:

They say so long as it’s in the penal code, it’s criminal. We say ‘Ok, so now we are the ones who are being restricted. You know? How about the women’s rights? How about secularity? Where is the secular government you’re talking about?’ So they said, ‘Ok, to compensate for that, we’ll sit with you and then you guide us on what language’...That’s a compromise we got and now because we were the party that was being restricted, they gave us the opportunity to work with them, to negotiate all of the wording.

This opportunity allowed for collaboration among different sectors of the healthcare system. Another interviewee identified that “the coordination between a number of civil societies, professional associations, and then elements of the government that have really understood the issue we are trying to address has really helped us.” This alliance created sufficient momentum to advance the issue in Parliament.

The revised criminal code came into effect in 2005. Abortion remained criminalized with the following exceptions: rape or incest, a
risk to the life or health of the mother, fetal malformation, and maternal disability or age younger than 18 years. Two features of the law allowed for the creation of guidelines that expanded access to safe abortion services. First, the law was crafted to shift liability away from providers, who were permitted to accept that “the mere statement by the woman is adequate” when determining if the patient met the criteria for an abortion in the case of rape or incest. Formalizing legal deference to the patient’s statements created a regulatory framework in which implementing organizations could apply the exemption broadly. Second, the law empowered the Ministry to interpret the law and determine how broadly the exemptions could be applied by developing technical guidelines. No limits on gestational age or level of provider training were initially established in the statute. Instead, they were deferred to the Ministry for clarification. One interviewee stated that through the drafting process “we wanted to push for a more liberal law without specifying in it the specific language.” Interviewees reported that after the process moved to the Ministry of Health, opposition groups did not participate in developing the technical guidelines.

3 | RECIPIENTS

Population-based mortality data and the publication of provider experiences shaped health providers’ attitudes toward expanding access to safe abortion care. Initially, the medical community did not focus on abortion, as there was a misperception that abortion affected a small proportion of the population. One interviewee recalled that “people [were] talking about stereotypes, you know, this is a problem of the elite; this is a problem for a woman under 18; it’s a problem of a student, etc.” In an effort to change the dominant perceptions of medical professionals, a study overseen by the Ethiopian Society of Obstetricians and Gynecologists (ESOG) documented the high prevalence of unsafe abortion across different demographics and the high mortality associated with unsafe abortion.13 Interviewees recalled that the tenor of the debate shifted with the introduction of these data, establishing a cause for action by ESOG.

Interviewees also stated that the attitudes of providers toward abortion were strongly influenced by their experiences addressing the complications of unsafe abortion. Some recalled how hospital obstetrics wards had been occupied primarily by cases of unsafe abortion complications. The experience of losing patients motivated them to speak out about their experiences. “They have seen it in their eyes, and they come out and talk about [it],” one interviewee observed. Another interviewee recalled:

> When I was a resident, half of the obstetrics department was taken up by septic abortion...most of the patients had gangrene and infection, and we also lacked strong antibotics; it was difficult to manage most of the time.

As the debate for legal reform reached Parliament, several physicians testified about their clinical experiences managing the consequences of unsafe abortion.

The expansion of abortion services occurred in the context of a system-wide push to develop new cadres of healthcare providers and shift components of care away from physicians. In the years that followed the publication of the technical guidelines, the introduction of abortion services expanded the scope of practice of new cohorts of nonphysician providers. One interviewee working in the public health system reported that “we have a very critical shortage of surgeons and obstetricians especially...and we need to shift tasks.” Under the first edition of the guidelines, nurses became eligible to provide first-trimester medical abortions and manual vacuum aspiration (MVA) procedures. Family planning education and referrals to abortion providers were integrated into the scope of practice of the health extension worker’s portfolio. The second edition of the guidelines integrated second-trimester services into the work of emergency surgical officers to supplement the limited number of physicians providing second-trimester services. One interviewee working for an international organization compared the Ethiopian setting to prior experiences: “I think what’s particularly advantageous is that they allow a broad spectrum of medical practitioners to provide medical abortion or MVA as long as they’ve been trained, so it’s not just the purview of OB/GYNs as it is in so many other countries in which we work.”

Services were primarily provided by public clinics. One NGO and several private facilities integrated abortion services into existing services. Interviewees representing NGOs viewed themselves as supporting the Ministry by providing technical expertise and by administering small networks of clinics to demonstrate best practices and perform operational research.16,17

Interviewees reported that information was primarily disseminated to the general population through the healthcare system by health extension workers supplemented by community meetings through community-based organizations. Interviewees stressed the importance of integrating safe abortion care into family planning education. Given the limited ability of education campaigns to reach a large and widely distributed population, several interviewees acknowledged that word of mouth played a large role in the spread of information. Interviewees reported that population education campaigns have primarily been conducted by NGOs with limited involvement by the Ministry of Health.

4 | FACILITATION

Interviewees reported strong support within the Ministry of Health, which “owned a desire to expand access to safe abortion” and was the natural locus for implementing and normalizing a service framed in public health terms. Working within the one-system health framework, the commitment of the Ministry to the expansion of services was essential to increasing access. The government included NGOs in implementation, enabling them to work openly with government agencies, advocate for services, and address policy issues. When reflecting on the relationship between NGOs and the government, one interviewee stated that “we can talk very openly with the government, and the government actually owns this and supports it.”
NGOs, in turn, participated in drafting the technical guidelines and advising the government on the regulatory framework. Interviewees representing NGOs perceived that timely government action had been contingent on continued NGO participation.

Interviewees reported that the drafting process for the technical guidelines was heavily influenced by international and peer-country models. The WHO guidelines strongly influenced the drafting process and provided legitimacy for advocacy groups, as international standards were well received by the Ministry of Health. One interviewee described the drafting process as “domesticating” the WHO guidelines to fit the Ethiopian context. A comparative review of other countries’ laws was also conducted. The South African model demonstrated that lengthy certification requirements for nurses and midwives as well as insufficient regulation of conscientious objection can limit access to services. The Zambian model persuaded the drafters that multiple-provider approval would not be feasible in Ethiopia. Finally, nongovernmental actors were able to share their global experiences establishing services in similar settings, further informing the guidelines.

In learning from prior examples of implementation, the guidelines were written to minimize both provider and patient-based restrictions. Interviewees cited the following examples: restricting abortion provision to physicians would have been inconsistent with the broad push toward task sharing occurring in the health system; a multiple-provider approval process would not have been possible, as access to a single provider was often limited; a court-based approval process for pregnancies resulting from rape or incest was deemed too slow to provide adequate access; the stated age in the medical record had to suffice, as not all patients had access to additional documentation of age.

In interpreting the health exemption, the technical guidelines applied the WHO definition of health as including the well-being of the patient independent of the presence of disease; the guidelines locate authority with the medical professional to apply clinical judgment in determining when a patient’s health is in jeopardy, and they specifically acknowledge that the “woman should not necessarily be in a state of ill health at the time of requesting safe abortion services.”

This interpretation broadened the indications for exemption under the criminal code.

Conservative choices were also made in drafting the guidelines to minimize adverse outcomes and internal conflict in the early stages of implementation. First, the recommended use of medical abortion was limited to less than 9 weeks’ gestational age, reduced from the WHO recommendation of 12 weeks owing to insufficient in-country safety data. Second, there was insufficient data to develop a standardized protocol for second-trimester abortions in the first edition of the guidelines. One interviewee recalled how this process:

...was intentional because there was so much contention on the issue, so much vagueness, and then it became a divisive issue among ourselves... It should not be a casting stone so let’s work on this and then later on, after pass 10 years, we’ll work on [second-trimester issues]. We’ll probably consult with other countries as well in terms of what they are doing, and we’ll have more clarity on how to move forward.

By deferring the issue, the drafters were able to maintain support for the guidelines.

The technical guidelines were revised in 2014 following a revision to the WHO’s guidelines as additional data were available both locally and internationally. The use of medical abortion was expanded beyond 9 weeks, as additional data demonstrated the safety of the procedure at later gestational ages. Second-trimester abortions were divided into two categories by gestational age and were assigned to either primary hospitals or general/referral hospitals. Finally, the guidelines clarified the role of community health workers in providing education and referrals, as well as extending the role of integrated emergency surgical officers to include second-trimester services.

After legal reform, comprehensive abortion care training continued at the NGO level. Initial trainings focused on shifting practice from sharp metal curettage to MVA and medical abortion. Interviewees representing NGOs discussed the need to develop training programs independent of the Ministry during the early stages of implementation in order to quickly train sufficient providers and place pressure on the Ministry to nationalize the training. Indeed, the Ministry of Health then adapted the Ipas training manual and curriculum, which was installed as the national standard.

The Ministry faced the challenge of training sufficient providers to reach a large population distributed across rural communities. A system of training of trainers was established, with follow-up to ensure consistent quality. Interviewees reported that there were sufficient medical professionals willing to start providing abortion services. Providers are screened prior to training, which is only offered to those who agreed to provide services. Conscientious objection is not permissible by regulation, as referrals are often impossible: “We know that service provision centers are widely scattered. Now if a provider from a locality has to refer to another, then how would a woman go to a referred facility? It means we lose her.” However, de facto objection does exist among providers who choose to defer training or complete training but decline to offer services. In keeping with an integrated healthcare system, no financial incentives were offered for those who provide abortion services. While some interviewees reported stigma in both the providers’ professional and social communities, several interviewees reported that stigma has decreased as the role of abortion has been better understood in the years since that law was passed. One interviewee reflected that: “I think people understood that having such interventions can save the lives of [women] so I think it’s much better.” One organization developed a system of meetings where providers could share and discuss their experiences.

Interviewees emphasized the role of values clarification at the facility level to introduce abortion services to the healthcare workforce. For second-trimester services, they underscored that including all members of the clinical and administrative staff was essential to ensuring that services were provided, as any employee of the clinic, including the security guard and the receptionist, could serve as a gatekeeper to care.
Surveillance in the public health system occurs through the national Health Management Information System. The collection and digitization of data is a resource-intensive process that limits the number of health metrics that can be monitored. Fewer are followed than had been recommended in the technical guidelines. Interviewees reported concern that the centralized data are overly aggregated and inadequate to effectively monitor the provision of abortion services. Parallel monitoring systems exist in the private and NGO clinic networks; periodic studies combine retrospective and prospective methodologies and use both public and private data to fill the gaps in the public surveillance system. Interviewees stressed the value of publishing periodic assessments of national data to document the impact of the law.

5 | REMAINING CONCERNS

Interviewees identified several challenges remaining in Ethiopia’s implementation of abortion services. First, as the data gathered through government public health surveillance are overly aggregated and incomplete, it is not possible to adequately evaluate access to services at a national level. Second, as access depends in part on knowledge that the service is available, it is constrained owing to difficulties educating a large, geographically diverse population with limited Ministry of Health outreach. Third, the program to provide second-trimester services continues to expand, and there are insufficient providers to meet the need. The program of emergency surgical officers is still new, and it is not yet known if sufficient providers can be trained. Fourth, the technical guidelines mandate that medical abortion be administered in a healthcare facility, which is difficult for those who must travel long distances and remain at the clinic to take the multidose regimen. The safety and efficacy of medical abortions in the home continues to be studied, and this practice has not yet been adopted in the guidelines. Fifth, among the large number of women reporting rape and incest as the qualifying exemption for receiving an abortion, health provision centers have found it very challenging to differentiate and investigate intimate partner violence.

6 | LESSONS LEARNED

Increased access to abortion services in Ethiopia is a consequence of a carefully crafted law and the persistent efforts of multiple actors across the healthcare system. A health-based justification to reduce maternal mortality galvanized support among medical providers and within the healthcare system. A stepwise approach to advocacy began with a strong research program to document the harms of unsafe abortion; this was necessary to build and maintain support. However, further amplifying a rights-based approach could have expanded and solidified ownership of political reform for women, girls, and human-rights advocates. The government’s consideration of the concerns of opposition groups led to maintaining abortion within the criminal code. While the new law expanded the indications for legal abortion, the service remains unavailable for many women. The law explicitly placed responsibility for policy development in the Ministry of Health, and the development of technical guidelines was a key step in determining the scope of the law. The political will of the Ministry and regional administrators was essential in all phases of implementation, as was the strong and lasting alliance of supporting actors including NGOs, advocacy groups, and ESOG. The implementation of safe abortion services in Ethiopia has significantly increased access, advancing the obligation to uphold the rights and health of women.

AUTHOR CONTRIBUTIONS

DB-P: Contributed toward the initial proposal and interview instrument, conducted desk reviews for all case study countries, conducted Ethiopia interviews, coded transcripts, drafted the manuscript, and collaborated in reviewing and editing. SK: Advised on the interview instrument, served as in-country coordinator, interviewee, collaborated in writing, reviewing, and editing the manuscript.

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CONFLICTS OF INTEREST

SK functioned as the in-country partner, was interviewed, and is coauthor of this case study. The authors have no conflicts of interest to declare.

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