Navigating abortion dilemmas: Attitudes and practices among Ethiopian health care professionals

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Research Article

Keywords: abortion, abortion law, ethical/moral challenges, ethical/moral dilemmas, fetal anomalies

Posted Date: March 3rd, 2021

DOI: https://doi.org/10.21203/rs.3.rs-243919/v1

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Abstract

Background: Ethiopia’s 2005 abortion law improved access to legal abortion. In this study we examine the experiences of abortion providers with the revised abortion law, including how they view and resolve perceived moral challenges.

Methods: Thirty healthcare professionals involved in abortion provision in Addis Ababa were interviewed. Transcripts were analyzed using systematic text condensation, a qualitative analysis framework.

Results: Most participants considered the 2005 abortion law a clear improvement – yet it does not solve all problems and has led to new dilemmas. As a main finding, the law appears to have opened a large space for professionals’ individual interpretation and discretion concerning whether criteria for abortion are met.

Regarding abortion for fetal abnormalities, participants support the woman’s authority in deciding whether to choose abortion, and although several saw these decisions as moral dilemmas, all thought that abortion was a justified choice when a diagnosis of fetal abnormality had been made.

Conclusion: To make practice more predictable and uniform, more detailed official guidance on the law and how it should be interpreted is warranted.

Introduction

Abortion in Ethiopia

The 2003 Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa (the ‘Maputo protocol’) asserts that access to safe abortion is a human right. Following the Maputo protocol, Ethiopia liberalized its abortion law in 2005. Now, termination is allowed if it endangers the life or physical health of the pregnant woman, in cases of rape or incest, if she is a minor or mentally or physically disabled, or if the fetus has an ‘incurable and serious deformity’[1]. Concerning the rape/incest criterion, the law specifically states (art. 552) that ‘the mere statement by the woman is adequate to prove that her pregnancy is the result of rape or incest’.

In Ethiopia, both public and private health institutions offer safe abortion services and healthcare practitioners from different professions are involved in the provision. Private institutions, in which two-thirds of abortions are performed, are often run by non-governmental organizations (NGOs)[2]. Studies show that Ethiopian abortion services have both expanded and improved in terms of quality since the 2005 law[3]. While abortion services are at the recommended level in some cities and regions, they are poorly developed rurally and in other regions [4]. In the capital, Addis Ababa, where the abortion rate is the nation’s highest, estimated to be 92 per 1000 women of reproductive age, abortion is performed by institutions ranging from primary health care centers up to referral hospitals. Although access to safe abortion has increased since the liberalization of the law, there are still underground unsafe abortion
practices. In 2014, an estimated 294,100 induced abortions occurred outside of health care centers in Ethiopia and this is perceived as a significant problem [5]. In Sub-Saharan Africa in general, unsafe abortion is still a significant concern and maternal deaths due to unsafe abortions are still high [6].

**Recent research on Ethiopian abortion providers’ attitudes and practices**

Research on Ethiopian abortion practices and providers has been limited. A recent study with professionals providing abortion in Addis Ababa found that they were familiar with the abortion law but that it gave rise to three main types of moral dilemmas for them: whether abortion should be provided or not; how providers should handle a situation where they suspect that the patient lied in order to qualify for the abortion; and how they should weigh and evaluate different reasons for abortion [7]. The authors state that providers’ assessment of the patient’s reasons for abortion ‘did not always follow the lines of the law’. Many providers were willing to ‘stretch’ the law’s criteria; as one informant put it, ‘the legal part [i.e., the abortion law] has a slightly open door’.

In a national survey mapping moral dilemmas experienced by physicians from Ethiopian public hospitals, abortion was an important source of dilemmas [8]. In particular, some respondents viewed the abortion law as too restricted, and it was a dilemma when the woman did not meet the legal criteria for abortion. In another study, health care providers with previous experience with induced abortion were 2.5 times more favorable towards it than those without the practice [9].

In a previous analysis from the present interview study, our group reported that for some abortion providers reconciling the demands of their jobs with their religious convictions and moral values was a source of moral conflict [10]. Several attempted to reconcile their religion with their work through framing the provision of abortion as something that helps and that prevents harm and suffering. In general, providers from the private/NGO sector reported less moral anguish/dilemma than did colleagues working in public hospitals.

**Methods**

**Aims**

In the present paper we aim to shed light on experiences of abortion providers with the revised Ethiopian abortion law, including how they view and resolve any moral challenges both related to the law and unrelated. Views on abortion for fetal abnormalities were examined specifically; both because these are of specific interest in themselves, and because we hypothesized that they give rise to particular moral challenges.

**Setting and recruitment**

A qualitative design was deemed appropriate due to exploring in-depth the experiences and reasoning of healthcare professionals involved in abortion services. The first author recruited practitioners with diverse
professional backgrounds working with abortion in private (NGO) or public healthcare settings in Addis Ababa. Participants worked in one of two public hospitals or seven NGO clinics. The first author approached potential participants by phone and by going to their working site, after first getting permission from the local manager. As compensation participants were given 100-200 Ethiopian Birr (equivalent to $2.50-5.00).

Data collection

Interviews were semi-structured, aided by an interview guide which contained open-ended questions on views on abortion, abortion law and abortion for fetal abnormalities, the influence of religion, experienced moral challenges, and conscientious objection. Interviews took place between February and July 2017, at the participants’ workplace, where they were interviewed by the first author in Amharic. Interviews were recorded digitally, transcribed verbatim, then translated into English by an independent Ethiopian researcher fluent in English.

Analysis

Analysis was performed within the systematic text condensation (STC) framework, a qualitative analysis framework developed by Malterud which builds on DiGiorgi’s method [11]. The method involves four steps:

1. From chaos to themes: the transcripts and field notes were read several times to create an overall impression and identify candidates for main themes.
2. From themes to codes: each unit of meaning was identified and coded according to topic using the nVivo 11 software package. Codes and sub-codes were created.
3. From code to condensation: all units of meaning coded with the same sub-code were then read in order with a view to identifying their meaning and content. This was done by creating so-called ‘artificial quotations’, which are condensed summaries of salient points formulated as if phrased by the participants. All sub-codes were condensed in this way.
4. From condensation to analytic text: the artificial quotations then provided the basis for the final analytic text which was then incorporated into the results section of the paper. In the analytic text, genuine (not artificial) quotations from the transcripts are used to illustrate and confirm the findings.

Data were collected in accordance with conditions in the research ethics approvals and relevant guidelines and regulations. The data were analysed and findings were reported in accordance with recognized standards for qualitative research.

Research ethics

Ethics approval was obtained from the institutional review board of St Paul’s Hospital Millennium Medical College, Addis Ababa. The study was also evaluated and approved by the Data Protection Official at the Norwegian Centre for Research Data (ref. 53104). Informed consent was obtained from all
participants after providing detailed information on the study both orally and in writing. As the interviews concerned sensitive topics, we limit demographic and other information about individual informants in order to protect their anonymity.

**Results**

Thirty (30) healthcare professionals agreed to be interviewed. Of these, most (22) provided abortions directly, while eight participants provided contraceptives and post-abortion care and/or worked with abortion in an administrative capacity. Participants had experience with abortion provision ranging from two months up to 14 years. The genders were equally represented with 15 being female and 15 being male. Twenty-one participants identified as Ethiopian Orthodox, five as Protestant/Evangelical, and two as Muslim. One was religiously unaffiliated and one did not want to disclose.

A general finding was that there was a range of viewpoints both on the abortion law and on potential moral challenges. Informants' viewpoints clearly correlated with their moral views on abortion. For instance, informants who regarded abortion as a moral problem typically also were critical or ambivalent of aspects of the new abortion law thought to be too liberal/open, whereas informants who did not see abortion as a moral problem typically welcomed liberal interpretations of the law and sometimes found it to be too restrictive.

*Views on the abortion law*

A majority of informants, especially from private/NGO clinics, stated that they were content with the law, even though they pointed to shortcomings. The most important consequence of the law was that it reduces the incidence of unsafe abortion, and thus saves women's lives and reduces the number of complications significantly.

Those days abortion was done by nonskilled individuals. ... Even if it was by professionals, it was not by skilled professionals. Many of our sisters, mothers have lost their lives. There are some who [have had to] remove their uterus and lost their chance to ever have children. Whose marriage became unstable, who faced psychological problems. (#17, female nurse, public hospital)

The good side [of the new law] is that it has helped her to receive a complete treatment by bringing the service to health institutions. It saves many mothers from death. (#18, male resident, public hospital)

Other positive effects highlighted were that the law provides freedom of choice to pregnant women, protects patient confidentiality, and reduces delay. It was pointed out as a problem for freedom of choice that many citizens are insufficiently familiar with the law. For several, an important argument in favor of legal access to abortion was that many women with unwanted pregnancies would choose abortion whether it is legal or not, as illustrated in the quote below:

If women have once made up their minds, nothing stops them. Their reason must be respected. That is her right. I have no problem [with that]. Therefore, it is better that we terminate it in a safe way. (#20, male...
Some respondents, while content that the law gives many women access to abortion, would like further liberalization with extra criteria. Some stated that it was good that they did not have to ask for evidence or witnesses beyond the woman's statement in relation to the rape criterion. However, some informants thought that the law went too far, in not requiring this evidence, or in being too liberal, as abortion was still in their view a moral dilemma. Some feared that the threshold for seeking abortion had become too low and saw women returning for multiple abortions as a sign of this. They thought that abortion had become *de facto* accessible on request.

Because we have made it loose, any woman can abort without any check. ... What it looks like now is that abortion is legal. It is open. It is not what was intended [when] the law [was passed]. ... Any woman can receive abortion... Even when [it is promoted] the message is that people should not go to private institutions, go to the governmental ones and say that you have been raped. (#22, female GYN/OBS resident, public hospital)

The law's criteria were considered open to interpretation. This could be seen as an advantage for those who supported liberal access to abortion. For instance, one female health officer from a private/NGO clinic stated:

It can be said that [the health criterion] indirectly has allowed everything. ... [Abortion] is not permitted completely, but it is permitted indirectly. For example, if you say mentally, it means that it is allowed if it involves stress. The majority of pregnancies are stressful. They come because they are stressed. When you think like that, [abortion] is allowed. (#6, female health officer, private clinic)

*Health care practitioners’ experienced dilemmas*

Informants were asked about which moral challenges, if any, they encountered in their work with abortion. Although there were many who pointed to different moral issues, others claimed that they experienced no significant moral challenges. Some pointed out that the decision whether to choose and perform abortion by its nature is a moral issue: "Abortion is an ethical dilemma both [for the patient] and the one who performs it." (#21, male GYN/OBS, public hospital)

The major moral dilemmas typically involved the interpretation and application of the law's criteria for abortion. Some admitted that they interpreted the criteria widely. Others appeared to feel burdened by expectations and pressure from patients in cases where criteria were not met, or where there was uncertainty with whether criteria were met. Sometimes this led to discussions and disagreement among colleagues. In general, informants from public hospitals appeared somewhat less liberal and less comfortable with wide interpretations of the law's criteria than did informants from the private/NGO sector.
Sometimes informants were expected to perform abortions beyond the law's gestational limit of 28 weeks:

We come across problems quite often, especially, a woman admitted late in the pregnancy in the name of safe abortion. ... This is not legal. ... I cannot assist in a delivery of [a] 1 kg [child] and call it an abortion. We have had a lot of conflicts over this issue. We know it. Things that are not acceptable for your conscience are done. (#22, female GYN/OBS resident, public hospital)

In some cases, the law's criteria for abortion were not clearly met. Some of the informants would then reject performing abortion, whereas others would sometimes accept it.

If she comes for abortion with no reason, I do not do it because I do not accept it ... but I transfer it to one who does it. Because I do not believe that is her right. Many of us do not do it. (#22, female GYN/OBS resident, public hospital)

There are [criteria] stated in the law. There are also some who approach us because of other factors. Many times, we do not base our service on the law. We base it on the case which the woman who approaches us tell us. We do not assess whether Ethiopian law allows that or not. (#4, female nurse, private clinic)

To be honest, if she says that she does not want to give birth, ... we do not [turn her away]. We perform the abortion. (#1, female nurse, private clinic)

As noted above, some informants remarked that in the case of rape the law does not require further evidence than the woman's own word that the pregnancy was due to rape. Informants expressed that this could potentially give women seeking abortion incentives to lie in order to fulfill the law's criterion. Similarly, some informants claimed that patients sometimes lied about their age, claiming to be minors when they clearly were not, in order to comply with the law's age criterion. This led to dilemmas for practitioners.

The bad side [of the law] is that it makes it liberal. If a woman lies intentionally because the law is on her side, she is given the service. That affects us a bit. I have seen some who attempt suicide when they are told it is too late. If she is 40 but claims to be 13, I am obliged to carry it out, even if I know that she is not telling the truth. It opens up for things. Which means any woman as long as she knows where the service is offered, she can get it. I think that makes [the law] a bit liberal. It affects us. Other than that, the good side [i.e., the positive aspects of the law] weighs more. (#18, female GYN-OBS resident, public hospital)

Whereas most moral dilemmas experienced were directly related to interpretation and application of the abortion law, some further dilemmas were not. Specifically, dilemmas arose when professionals became involved in a patient's quarrels with partner or family members. Some patients were pressured to abort or to continue the pregnancy against their preference. Furthermore, many pointed to the low level of awareness of family planning and contraception in the population as an moral problem.
Abortion for fetal abnormalities

When asked about termination of pregnancy in cases of fetal abnormalities, the majority said that they believed termination should be performed/offered. Informants highlighted serious negative consequences of having children with abnormalities on the woman, her family, and also society. Some explicitly pointed to the economic burdens for society, and some cited the shortcomings of the Ethiopian healthcare system which would make it difficult to give the child proper care.

If there is disability, it has to be terminated. If it is early, the mother can also be affected psychologically. It would be difficult. [If] it is early, it is better to terminate quickly. Even [some] mothers who deliver a baby with cleft lip do not want to have another child. (#10, female nurse, public hospital)

Had the health system of our country been good, [the child] could grow up if delivered. But we do not have [a good health system]. If they are delivered the problem comes to the family, to the society, to the country. (#11, male public health specialist, private clinic)

Only a few expressed ambivalence to this view, such as this informant:

I want the decision to be taken based on the family situation and economic ability. However, this collides with the rights of the disabled. When you see it from a different angle there needs to be a balance. It needs to be approached from the human right aspect. It is very problematic. (#6, female nurse, private clinic)

Informants were unanimous in wanting to leave the decision whether to terminate a fetus with abnormalities to the woman herself:

It is the mother who takes care of [the child] at the end of the day. ... It means that a decision is made on her. Therefore, in my view, she should have a say. (#21, male GYN/OBS, public hospital)

Many were clear that one should distinguish between lethal malformations and milder abnormalities. Termination was considered the right choice for the former, whereas views differed on the latter. Informants were invited to reflect on Down syndrome as a specific case. Most favored termination, whereas some did not or were ambivalent.

I believe that Down syndrome has to be aborted. It is [costly] for the country. ... I think it is reasonable to abort that child. (#15, male, public health specialist, private clinic)

The degree [of being affected by Down syndrome] determines it. If it is severe, it is better that it is not born. But those who are mild or moderate, it is preferred that they live [and receive] training and support. They [can be], to a degree, independent. (#9, female nurse, public hospital)

Discussion
Most of the moral challenges experienced by the professionals turned out to spring from the interpretation and application of the abortion law, consistent with previous research.[7, 8] Our general interpretation is that for the most part, the liberal-leaning healthcare professionals perceived abortion as a moral conflict, but a conflict that is resolvable without moral residue and moral distress; while the professionals who are more restrictive appear to perceive abortion as a moral dilemma where no option is without a moral residue [12].

**Interpreting the abortion law’s criteria**

Most of the participants considered the 2005 abortion law good in that through increasing access to abortion, it had reduced the consequences of unsafe abortion. However, new problems arose from the law being indeterminate. The law’s criteria in themselves are brief and open to interpretation; the official guidance document comments briefly on the criteria but does not go much further in providing guidance for practitioners [13]. For instance, even though the law does not allow termination of pregnancy due to socioeconomic reasons, this might be taken to be indirectly allowed through the criterion of the mother’s health, since all pregnancies represent a certain risk to the woman’s health. In a study from the Guraghe zone in Southern Ethiopia, 36.7% of women having undergone abortion claimed that the choice of abortion was due to economic reasons [14].

Several informants pointed out that because the law can be so broadly interpreted, it has made abortion de facto available on request, provided you meet a professional willing to interpret the law thus. Some participants welcomed the law’s flexibility. However, the law’s ambiguity in how criteria should be interpreted also appeared to be a burden for several of the informants. Both of these findings are in line with McLean et al.’s study [7]. It would be up to the informants to choose where to draw the line, and they would sometimes also experience pressure from patients and next of kin. With the opportunity to interpret the law broadly also comes the burden of doing so, and a corresponding responsibility.

Some participants appeared to have gone further than ‘stretching’ the law’s criteria. As Blystad et al. also argue, the interplay between law, health policy and implementation is complex, and in the case of Ethiopian abortion regulation this has led to significant room for individual providers’ discretion [15]. Several of our participants conceded that they practiced ‘abortion on request’ with little regard for whether the law’s criteria were met. If this is the case, then it seems that it is the individual practitioner’s stance that decides whether abortion will be provided or not. This stance might again be influenced by the institution’s policy and the practitioner’s moral values including moral views on abortion. Although our study was not designed to study actual practices directly, according to participants’ own accounts it is likely that patients seeking abortion could be evaluated differently depending on to which institution they go and which practitioner they meet.

If the authorities want to avoid such consequences and restrict the space for each practitioner’s interpretation, they could consider making the guidance more precise and less ambiguous, either through amending the law or through providing more detailed guidance in how it should be interpreted. However,
this might not succeed if individual providers claim the authority to determine whether abortion is justified without deference to the law’s criteria.

Abortion for fetal abnormalities

None of the participants spontaneously mentioned abortion for fetal abnormalities as one of the moral challenges they experienced; however, when prompted to speak about the issue, it turned out to be a dilemma for some of the participants. These participants held up the moral value of the fetus and the rights of the disabled against values of the woman’s autonomy and the difficulty in providing the child with requirements for a good life. Nevertheless, most of the informants considered abortion a reasonable alternative in the case of fetal abnormality, and they all appeared to want to leave the choice to the woman. Their main arguments were the negative consequences for the woman, her family, yet also for society, in bringing up a child with disability. Also, several informants pointed to limitations in the Ethiopian healthcare system which would make it difficult to provide the child with proper care. Seen this way, improvements in welfare, health and social care might make it more feasible for Ethiopians to choose to complete the pregnancy in case of fetal anomaly. Such improvements would also improve women’s autonomy, as they would enable a choice between different options that are actually realistic.

In a study of the preferences of pregnant women at an Addis Ababa hospital, 89% would want prenatal testing, and more than 60% of the women reported interest in termination in case of anencephaly, lethal conditions, severe intellectual disability, hemoglobinopathy, and amelia [16]. In a 2013 nationally representative study from South Africa, more than half of the respondents (55%) considered it always wrong to choose abortion for fetal anomalies [17]. In our view, the attitudes of the Ethiopian population and health professionals on these issues should be assessed also with a nuanced survey methodology.

Interestingly, there are different attitudes and nuances in our findings, especially concerning the significance of the severity of the disability. Differences in attitudes and practices is often a good starting point for discussion to be helpful. Thus, it might be of help to spark a debate within the healthcare professions, and perhaps also in wider society, on this very issue.

Strengths and limitations

The qualitative design provided in-depth accounts of moral dilemmas experienced by providers practicing induced abortion. Only providers in Addis Ababa have been interviewed; experiences in other and rural areas are likely to be different.

Conclusion

Although most abortion practitioners considered the 2005 abortion law a clear improvement, it does not solve all problems, and has led to new dilemmas. The large space for abortion providers’ individual discernment in the interpretation and application of the abortion law’s criteria appears to place a considerable authority and responsibility on each provider. For patients, it might conceivably mean that your access to abortion is dependent on the views and practices of the practitioner you encounter. To
make practice uniform, more detailed official guidance on the law and how it should be interpreted would be helpful.

**Declarations**

*Ethics approval and consent to participate*

Ethics approval was obtained from the institutional review board of St Paul's Hospital Millennium Medical College, Addis Ababa. The study was also evaluated and approved by the Data Protection Official at the Norwegian Centre for Research Data (ref. 53104). Furthermore, the study was evaluated by the research ethics committee of the Southeastern Norway health region and found to be exempt from substantial evaluation (2016/875/REK sør-øst C). Participants were informed orally and in writing and signed a written consent form.

*Consent for publication*

Not applicable.

*Availability of data and material*

The data generated during and analysed during the current study are not publicly available as individual informants might be identified from the interview transcripts. Any requests about availability of the data should be directed to the corresponding author.

*Competing interests*

The authors declare that they have no competing interests.

*Funding*

This research was funded by NORAD (Norwegian Agency for Development Cooperation) under the NORHED-Programme, Agreement no. ETH-13/0024.

*Authors’ contributions*

All authors contributed to the design of the study. DBE performed and analysed the interviews and wrote the first draft. MM analysed the interviews and revised the article. VCT and JHS contributed to analysis and revised the article. All authors read and approved of the final version.

*Acknowledgements*

We would like to thank all the health professionals who contributed to the study as participants.

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