

The Provision of Abortion Care in Ethiopia: Current situation and trends

Yirgu Gebrehiwot, Ann M. Moore, Tamara Fetters, Yohannes Dibaba, Akinrinola Bankole, Hailemichael Gebreselassie, Mengistu Hailmariam, Susheela Singh

Abstract: In 2005, the Ethiopian Parliament amended the penal code to allow abortion in cases of rape/incest, if the woman has physical or mental disabilities, if it is needed to preserve the woman's life or physical health, or she is a minor who is physically or mentally unprepared for childbirth. Since the law was passed, there has been a national effort to implement the law and increase access to safe abortion care. In 2014 we conducted a study to understand whether access to safe abortion has changed in the intervening period. This study documents the provision of abortion care in Ethiopia in 2014 with a nationally representative sample of health facilities from both the public and private sector. Provision is compared with provision documented in 2008.

Background

An estimated 22 million unsafe abortions take place every year worldwide, resulting in the deaths of approximately 47,000 women and the temporary or permanent disability of an additional 5 million (1). The tragic deaths and suffering continue to occur even though they are almost entirely preventable with the appropriate training, skills, technology, and commitment.

Cognizant of the public health importance of unsafe abortion, the Ethiopian Parliament amended the penal code on abortion in 2005. The new law improves access to safe abortion care by expanding the legal indications. According to the amended law, safe abortion can be performed legally in cases of rape or incest, if the woman has physical or mental disabilities, if it is needed to preserve the woman's life or her physical health, or if she is a minor who is physically or mentally unprepared for childbirth. The reforms were intended to prevent unsafe abortion through the expansion of safe abortion services throughout the health care system.

In the years since enactment of the new law, the Ethiopian Ministry of Health has led a range of partners to make comprehensive abortion care available at all levels of the public health-care system. Ethiopia's thorough, systematic approach has ensured that women throughout the country – and especially poor, rural and young women – are experiencing greater access to safe abortion-related care. Efforts have included the development and dissemination of national standards and guidelines for provision of abortion care in 2006 based on internationally endorsed guidelines from the World Health Organization; training health care workers for their essential roles in service provision; ensuring that health-care facilities are equipped to offer high-quality care on a reliable basis including planning for the sustainable supply of required equipment and medications; enabling private-sector providers to expand services; and integrating safe abortion and postabortion contraception into existing reproductive health services. The health sector in Ethiopia has expanded greatly in the last few years. In the past 5 years, more than 5,000 health care workers (mostly mid-level providers) have been trained in comprehensive abortion care. While significant efforts have been made over the past six years, the effects of these efforts has not yet been assessed.

In Ethiopia, where one in four births is unintended or mistimed (2), researchers estimated that 382,000 induced abortion procedures were performed in 2008, and as many as 73% of them were performed outside of the designated health facilities (3). Several studies have also estimated deaths due to unsafe abortion contribute about 31% of all maternal deaths in Ethiopia. Using the method employed in the 2008 study, this study estimates will be compared with those documented in 2008 so as to determine the impact of the reformed law and service implementation on access to safe abortion services (3, 5-6). Using the 2008 study as a baseline enables us to know the extent to which increased access to abortion has been achieved.

Methodology

The study was developed by a research team consisting of the Ethiopian Federal Ministry of Health (FMOH), Ethiopian Society for Obstetricians and Gynecologists (ESOG), Guttmacher Institute, Ipas and an independent consultant (YD). The Ethiopian Public Health Association (EPHA) was also involved in the administration and management of the study.

Study design:

The study used a study design previously used in Ethiopia as well as other African nations. The results presented here come from a retrospective Health Facilities Survey (HFS), a nationally representative survey of health facilities likely to provide abortion services and /or treat abortion complications. In early 2013, a list of public hospitals and health centers was obtained from the Food, Medicine and Health Care Administration and Control Authority of Ethiopia (FMHACA)¹; the list of private hospitals, higher and medium clinics was obtained from FMHACA and DKT²; the list of Blue Star clinics (Marie Stopes Ethiopia (MSE)-franchise clinics) and MSE clinics was obtained from Marie Stopes Ethiopia; the list of FGAE clinics was obtained from the Family Guidance Association of Ethiopia; and the list of Ipas facilities was obtained from Ipas. These multiple sources were assembled to create a listing of the universe of health facilities in Ethiopia. The list was cross-checked to remove redundant and closed facilities.

A stratified random sampling plan was used, with an intention to include representation in all 14 regions. The sample consists of a census of all hospitals and a proportion of facilities in each of the remaining levels of health facilities: we maintained sampling fractions greater than 8% overall for each facility type in each region. Sampling fractions were for the whole country as well as within each region-facility type combination. Sampling was done without replacement and no attempt was made to identify abortion-providing facilities prior to inclusion in the sample. All facility types allowed to provide abortion care, either with manual vacuum aspiration (MVA) or medication abortion (MA), by the FMOH was entered into the sampling universe. This rendered a nationally representative sample of public and private including non-governmental health facilities responsible for treating women with abortion-related care.

¹ FMHACA distributes food, medicine and medical equipment to public health facilities in Ethiopia.

² The DKT list of facilities is a documented list of to whom DKT distributes their contraceptive supplies as they sell contraceptives to all facilities.

One abortion care provider knowledgeable about postabortion and/or safe abortion care provision at the facility was selected for participation in the survey. The health provider was interviewed in person to answer questions on behalf of the health facility. The same provider also provided information on various aspects of postabortion care including the availability of trained providers and appropriate technology to provide care.

14 interviewers were selected, most of whom came from regional health bureaus. They all had backgrounds in both clinical and family health. They were trained over a three day training in Addis Ababa by members of the study team during which time they were given information about the overall study, and the HFS questionnaire was explained in detail and every question was discussed. They had time to practice mock interviews with one another during the training. The training was conducted in English with Amharic translation by Ethiopian co-investigators when necessary to make sure that comprehension among the field team was high. The study underwent an expedited review with the Guttmacher Institute's IRB panel. Following Guttmacher IRB approval, the study was submitted and reviewed and approved by the Ethiopian Ministry of Science and Technology's IRB. Fieldwork took place December 2013-April 2014.

Of the facilities sampled for HFS (n=955), 885 were visited. The rest could not be reached due to their remoteness and security concerns). A total of 821 facilities responded to the survey.

Preliminary Key Findings:

Between 2008 to 2014, the proportion of all public hospitals and public health centers providing PAC services increased, but decreased among facilities in the private sector. From 2008 to 2014, the proportion of public hospitals providing TOP services increased from 67% to 93% but the percentage of private facilities providing PAC decreased from 92% to 73%. In 2014, the 9/10 public hospitals report providing termination of pregnancy (TOP) or safe abortion services; almost all reported providing PAC. Forty-one percent of public health centers provided TOP and 65 percent provided PAC. By comparison, almost three-fourths of private sector facilities reported providing TOP and PAC. In 2014, in all three facility categories, there are a larger proportion of facilities providing PAC than TOP services.

In 2014, almost all public hospitals and private sector facilities had access to a consistent supply of clean water and electricity. Just over half of public health centers had access to a consistent supply of clean water, and less than 3/4 had access to a consistent supply of electricity.

Public hospitals have the highest proportion of staff trained in Basic Emergency Obstetric Care (BEmOC), PAC, Comprehensive Abortion Care (CAC) and manual vacuum aspiration (MVA) compared to public health centers and private sector facilities. Approximately 3/4 of public hospitals, a little more than half of public health centers, and less than 1/5 of private facilities have staff trained in BEmOC. Less than half of public health centers have staff trained in PAC, CAC or MVA, compared to slightly more than half of private facilities.

In all facilities, respondents report the loss of confidentiality and lack of information on services as the biggest barriers to women seeking TOP services. In all facilities, respondents report the lack of information on services and stigma as the biggest barriers to women seeking PAC services. Not surprisingly, in private facilities, more respondents identified cost as a barrier to safe abortion services (TOP) and PAC services. Over 1/3 of respondents identified distance and transportation as barriers to obtaining PAC services in public hospitals and public health centers, compared to less than 1/5 of respondents in private facilities. Hostile and unfriendly provider attitudes were named by less than 10% of providers as barriers for women to obtain either TOP or PAC services.

While just about 2/3 of public hospitals and private facilities reported having a copy of the safe abortion standards and guidelines available, only a little more than half of public health centers have a copy of the standards and guidelines. Across all facilities, respondents were most likely to know that rape and incest are criteria under which abortion is legally allowed in Ethiopia. Between 70-77 percent knew that it abortion is allowed to save the life and health of the mother; fewer knew that being a minor, fetal malformation incompatible with life, and mental/psychological reasons are other criteria under which abortion is legal. Overall, respondents from the different facility types had comparable knowledge of the grounds under which abortion is legal. However public hospitals had a greater knowledge about the criteria of fetal malformation (almost 70 percent), compared to public health centers and the private sector facilities (just around half). More than half of respondents from public hospitals and public health centers knew that mental/psychological reasons were an allowed justification for an abortion, compared to one in three private sector respondents.

In public hospitals, the biggest facility change since the introduction of the law was the introduction of medication abortion: around 60 percent of hospitals and private sector facilities compared to just below 40 percent of health centers reported introducing medication abortion. Among public health centers and private sector facilities, the biggest change was training about the law. Just over half of public hospitals and just under half of health centers reporting receiving provider training on new equipment.

Data on signal function services provided in the three months prior to the survey for public health facilities indicates facilities' ability to deal with obstetric emergencies. Whereas 100 percent of hospitals had administered essential antibiotics, administered intravenous replacement fluids and administered oxytonics, only 82 percent of health centers had provided antibiotics, 97 percent had provided IV fluids and 92 percent had provided oxytonics. Whereas 99 percent of hospitals had removed retained products of conception of uterine sizes less than 12 weeks and 93 percent had removed retained products of uterine sizes greater than 12 weeks, 76 percent of health centers had removed products from uterine sizes less than 12 weeks and 45 percent had removed products for uterine sizes greater than 12 weeks. Ninety-one percent of hospitals had performed induced abortion for first trimester abortions compared to 39 percent of health facilities.

Implications of the Research

This research is one of very few in the world to assess the impact of the reform of abortion policy and practice over time. The data are being used as vital input to the Federal Ministry of Health and Regional Health Bureaus for program planning, resource allocation, and the future evaluation of the long-term impact of existing and/or new interventions. Implementing partners working in the fields of safe motherhood, contraceptive services, safe abortion and postabortion care will also use the data to align their programs with the reality on the ground. The larger global reproductive health community may also benefit from this study as one of a few that examine improving access to safe abortion.

References

1. WHO. *Safe Abortion: Technical and Policy Guidance for Health Systems, Second edition*. Geneva, WHO, 2012.
2. Central Statistical Agency [Ethiopia] and ICF International. 2012. Ethiopia Demographic and Health Survey 2011. Addis Ababa, Ethiopia and Calverton, Maryland, USA: Central Statistical Agency and ICF International.
3. Singh S et al. 2010. The Estimated Incidence of Induced Abortion in Ethiopia, 2008. *International Perspectives on Sexual and Reproductive Health*, 36(1): 16-25.
4. Berhan Y and Berhan A. 2014. Causes of Maternal Mortality in Ethiopia: A significant decline in abortion related death." *Ethiopian Journal of Health Science*, September: 15-28.
5. Gebreselassie H et al. 2010. Caring for women with abortion complications in Ethiopia: national estimates and future implications. *International Perspectives on Sexual and Reproductive Health*, 36(1):6–15.
6. Vlassoff M et al. 2012. The health system cost of postabortion care in Ethiopia. *International Journal of Gynecology & Obstetrics*, 118(2): S127-S133.