CORHA

Lessons Learned, Successes and Challenges on the implementation of abortion services since 2005

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Abebe Kebede

Executive Director of CORHA Ethiopia

Abbreviations

CAC	Comprehensive Abortion Care
FDRE	Federal Democratic Republic of Ethiopia
FGAE	Family Guidance Association of Ethiopia
FMOH	Federal Ministry of health
FP	Family Planning
HEP	Health Extension Program
HEW	Health Extension Worker
HMIS	Health management information System
KI	Key Informant
KII	Key informant Interview
LB	Live Birth
MA	Medication Abortion
MCH	Maternal and Child Health
MLP	Mid-level Provider
MOH	Ministry of Health
MSI	Marie Stopes International
MVA	Manual Vacuum Aspiration
PAC	Post Abortion Care
RHB	Regional health Bureau
SAC	Safe Abortion Care
SRH	Sexual and reproductive health
TPGL	Technical and Procedural Guideline
UNFPA	United Nation Fund for Population Activities
VHL	Village Health Leaders
WHO	World Health Organization
WoHO	Woreda Health Office
ZHB	Zonal Health Bureau

Contents

Introduction

In 2005, Ethiopia's parliament amended the penal code to expand the circumstances in which abortion is legal. Since enactment of the new law, efforts have been undertaken to improve access to abortion-related services through providing trainings to midlevel providers. The Ministry of Health also subsequently published national standards and service guidelines on safe abortion care in accordance with World Health Organization (WHO) clinical recommendations on safe abortion. The liberalization of the abortion law in 2005 led to changes in abortion services resulting in substantial increases in the number of women obtaining legal abortions and post-abortion care. Two decades after revising its abortion law, Ethiopia has achieved major progress in making safe abortion a reality for many women in the country. The proportion of abortions that occur outside of health facilities has declined dramatically, suggesting that women with unintended pregnancies now have greater access to safe abortions than they did prior to 2005. Subsequent demographic and health surveys show significant progress has been made in almost all health indicators. However, a full range of abortion services is not readily available to women due to range of factors including accessibility of services, shortage of supplies and shortage of skilled providers.

Share-Net International (SNI) is a global knowledge platform on SRHR that is organized in seven country hubs in Bangladesh, Burkina Faso, Burundi, Colombia, Ethiopia, Jordan, and the Netherlands. Share-Net Ethiopia one of the country hubs of Share-Net International hosted by the Consortium of Reproductive Health Association (CORHA). The Share-Net knowledge platform mainly focuses on knowledge dissemination, knowledge translation, and network building among practitioners, students, researchers and policy makers in SRHR.

Share-Net Ethiopia commissioned a desk review to organize and document the available

evidence on abortion care in Ethiopia. This report is a systematic collection of published studies based on search of multiple electronic databases and libraries, program reports, Ministry of Health directives, guidelines, policy briefs and key informant interviews in order to extract relevant lessons, challenges, gaps, successes, opportunities and come up with policy and program recommendations on key areas of abortion care.

Purpose

This desk review is aimed at assessing factors influencing abortion care services in Ethiopia, in order to document lessons learned, successes and challenges in both policy and practice.

Research Questions

- What are the impacts of the implementation of the amended law?
- What changes have been observed in abortion services in Ethiopia?
- What factors affect abortion and post abortion service utilization in Ethiopia?
- What are the challenges and successes of abortion and post abortion care service provision in Ethiopia?
- What are policy and implementation bottlenecks of abortion services in Ethiopia?
- What lessons can be drawn as an input to improve further abortion policy and practice in Ethiopia?

Methodology

Desk review is a research methodology that involves analyzing and summarizing existing secondary data sources. It is a cost-effective way of gathering information and can be used to identify gaps in knowledge or areas where further research is needed. This desk review analyzed and summarized research and articles provided by the Share-Net Ethiopia team and also other sources like government and non-governmental organizations' published data, online research and articles.

As all information in may not be available in published documents, key informant interviews (KIIs) were carried out by two interviewers. The interviewees included program

managers in the Ministry of Health (MOH) of Ethiopia , NGOs such as Ipas , Marie stopes, Family Guidance association of Ethiopia , DKT with knowledge and experience of abortion care in Ethiopia. The information Gathered from KIIs are summarized and presented as policy and Governance , Human resources , finance ,Health information system issues .

Search terms

The following search terms were used: Abortion care, Abortion Law, Safe Abortion, Anti-Abortion movements, Availability, accessibility, Quality and Task shifting on Abortion. A total of 337 articles were retrieved and all references were captured on to Endnote 20 and every document reviewed. The years of publication were from 1972 to 2023. While 45 of the articles were prior to 2005, the rest 292 were from 2005 to 2023.

Abortion Law in Ethiopia.

Throughout the late 18th to 19th century Ethiopia was engaged in the dissemination of Christian teachings and the church had influence on state matters, diplomatic, economic, and political power relations were all manifested through religion [1]. F ormal separation of government and religion was proclaimed in the mid-1970s As a result, Ethiopia had through the years adopted a legal system that has a religious root known as *Fitha negist* [1]. During such a time there was no distinction between the state and the church, there was no distinction between crime and sin, and punishment was expiation of sin, in as much it is social censuring of the offender. It is under this context that the Ethiopian criminal code of 1949 criminalizing abortion was developed, which lasted 56 years till 2005. The criminal code of 1949 condemns the thought and act of abortion, criminalizes both the woman and provider of abortion with imprisonment unless abortion is performed to save the life of the woman, as agreed upon by two physicians one of whom was an expert on that disease condition . Article 2 of the criminal code [2].

The enactment of such a strict law in the country has made abortion a serious public health issue by endangering the life and health of women and making unsafe abortion a number one killer and driver of maternal mortality. Studies in the capital city and elsewhere have shown the contribution of unsafe abortion to maternal mortality was in the range of 22% to 54% of all maternal deaths [3-5]. While the law was meant to restrict abortion, it made abortion clandestine and unsafe and a criminal act.

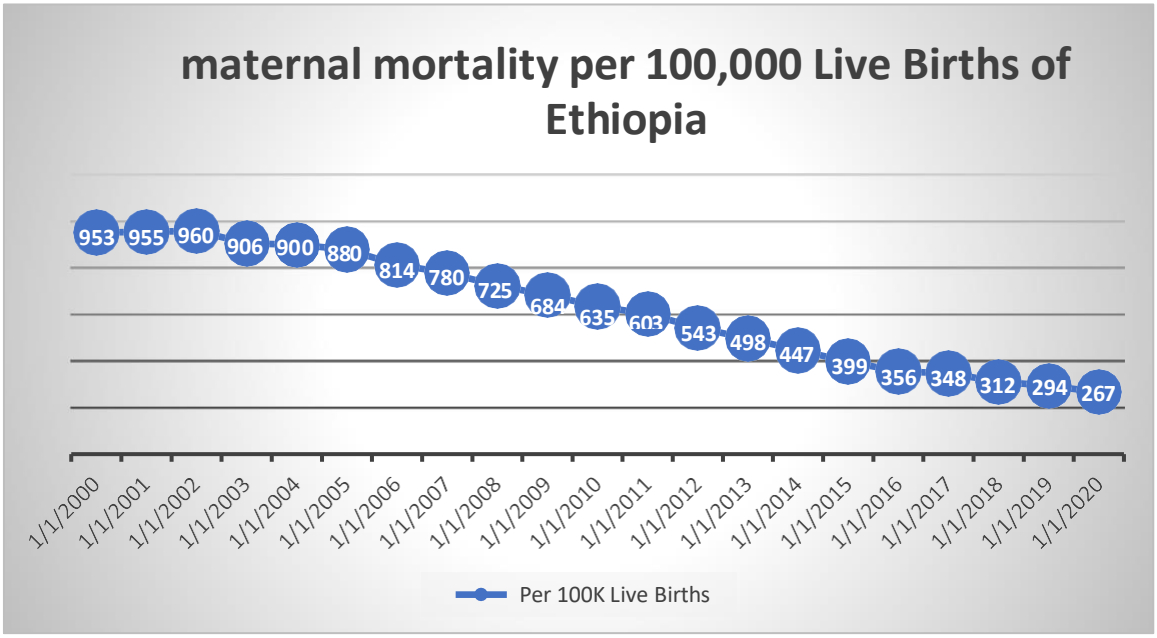
The Federal Democratic Republic of Ethiopia (FDRE) amended the penal law of the country in 2005 which also led to revision of the abortion law at the same time. The rationale for enacting the new law was to reflect the dramatic social, economic and political transformation of the country which also adopted a new constitution in 1995 [6], embody international treaties which the country has signed, modernize the law, address harmful

traditional practices, and deal with societal matters that bring great harm and suffering to women and children [7]. The revised law is still restrictive with more exceptions in offering safe abortion services under certain circumstances as described in article 551 and 552. The law has provided for the Ministry of Health to develop implementation documents to realize the legal points that were inscribed in the articles mentioned above. Article 552(B) has provided a mandate to the Federal Ministry of health (FMOH) to issue the technical and procedural guidelines for the implementation of safe abortion services in Ethiopia. The first version of the document was issued in 2006 and the second and current version in 2014 [8]. The combined outcome of legal revision and development of the guideline has expanded the legal grounds on which abortion can be accessed from strictly to saving the life of the women to broader life, health, social and economic reasons.

The Impact of Law Reform

Before the promulgation of the new penal code and subsequent issuance of the technical and procedural guideline (TPG), maternal mortality rates in Ethiopia were among the highest in the world. The graph below shows the dramatic decline in maternal mortality of Ethiopia from close to 1000 per 100,000 live births (LB) to 267 per 100,000 LB in a time span of 20 years and more importantly after 2005.

Figure 1 trends of maternal mortality in Ethiopia from 2000-2020



This dramatic drop is attributed to increased access to safe abortion services and drop in abortion-attributed maternal mortality [9, 10].

Apart from personal observation that abortion is no longer a major cause of admission to hospital and maternal mortality, two national studies conducted in 2008 and 2014 have shown improvement in access to care [10, 11]. Dibaba et al. documented that There has been a rapid expansion of health facilities eligible to provide legal abortion services in Ethiopia since 2008. Between 2008 and 2014, the number of facilities reporting basic and comprehensive signal functions for abortion care increased. In 2014, access to basic abortion care services exceeded the recommended level of available facilities providing the service, increasing from 25% to 117%, with more than half of regions meeting the recommended level. Comprehensive abortion services increased from 20% of the recommended level in 2008 to 38% in 2014. Smaller regions and city administrations achieved or exceeded the recommended level of comprehensive service facilities, yet larger regions fall short. Between 2008 and 2014, the use of appropriate technology for conducting first and second trimester abortion and the provision of post abortion family

planning has increased while abortion-related obstetric complications have decreased [10]. A downward trend in abortion related maternal mortality has also been documented in a university hospital as early as 2 years after legal revision [12]. It is also very interesting to note that none of the literature reviewed disclosed any safe abortion service prior to 2005 although it is public knowledge that some facilities were providing "safe services" prior to 2005. However, the true magnitude is not known nor reported.

Changes observed in abortion service in Ethiopia.

Ethiopia stands out for having reformed its penal code to enable women to obtain legal abortion on the basis of their own assertion that their pregnancy has resulted from rape or incest. Further, its *Technical and Procedural Guidelines for Safe Abortion Services* set evidence-based procedure and counseling guidelines for abortion and postabortion care. These guidelines mandate that to prevent repeat abortion, contraceptive services and counseling must be provided as an essential component of both types of care.

From the provider side, Ethiopia's guidelines authorize nurses and midwives to be trained in and provide first-trimester abortions using vacuum aspiration and the combination medication protocol (mifepristone plus misoprostol). As a result, the proportion of procedures done by such midlevel practitioners rose considerably between 2008 and 2014, from 48% to 83% [13]. The guidelines further specify that minors who qualify for an abortion by virtue of their age do not have to present proof of age.

As a result of the Ministry of Health's firm commitment to improving access to all medical services, including abortion, the number of public health centers increased by 250% between 2008 and 2014 [13]. The overall impact of these reforms—a trend toward safer procedures—likely contributed to the decline in obstetric admissions for complications of unsafe abortions, which fell from 47% of all such admissions in 2008 to 39% by 2014.

In 2008, an estimated 382,000 induced abortions were performed in Ethiopia, and 52,600 women were treated for complications of such abortions. There were an estimated 103,000 legal procedures in health facilities nationwide, accounting for 27% of all abortions [14]. Nationally, the annual abortion rate was 23 per 1,000 women aged 15-44, and the abortion ratio was 13 per 100 live births. The abortion rate in Addis Ababa (49 per 1,000 women) was twice the national level. Overall, about 42% of pregnancies were unintended, and the unintended pregnancy rate was 101 per 1,000 women [14].

The estimated annual number of women seeking a legal abortion in the types of facilities sampled increased from 158,000 in 2008 to 220,000 in 2014, and the estimated number presenting for postabortion care increased from 58,000 to 125,000. The proportion of abortion care provided in the public sector increased from 36% to 56% nationally. The proportion of women presenting for postabortion care who had severe complications rose from 7% to 11%, the share of all abortion procedures accounted for by medical abortion increased from 0% to 36%, and the proportion of abortion care provided by midlevel health workers increased from 48% to 83%. Most women received postabortion contraception [11].

An estimated 620,300 induced abortions were performed in Ethiopia in 2014. The annual abortion rate was 28 per 1,000 women aged 15-49, an increase from 22 per 1,000 in 2008, and was highest in urban regions (Addis Ababa, Dire Dawa and Harari). Between 2008 and 2014, the proportion of abortions occurring in facilities rose from 27% to 53%, and the number of such abortions increased substantially; nonetheless, an estimated 294,100 abortions occurred outside of health facilities in 2014. The number of women receiving treatment for complications from induced abortion nearly doubled between 2008 and 2014, from 52,600 to 103,600. Thirty-eight percent of pregnancies were unintended in 2014, a slight decline from 42% in 2008 [15].

Till 2005, almost all official documents did not mention safe abortion and there were no MOH led planning strategies to expand and roll out such services. However, after 2005, the

MOH through its Health Sector Transformation plans I and II, expanding access to quality comprehensive abortion care services has been a major strategic initiative under family planning and reproductive health services [16]. In addition, FMOH generates data to monitor progress towards achievement of the strategic initiative.

According to the MoH annual report, in 2021/2022, 247,682 women received comprehensive abortion care services. Among these, 137,670 (56%) were safe abortion services while 110,012 (44%) were post-abortion care services. The proportion of safe and post abortion services among the total abortion services is similar to the previous year. Of the total women that received comprehensive abortion service, 16% were teenagers, aged 10-19 years of age. Most abortion services were provided for age group 20-24 (35%) followed by the age group 25-29 (30%). Regarding the timing of the abortion service, the majority (79%) of women received comprehensive abortion services in the first trimester (before 12 weeks of gestation); but still 21% of those accessing abortion services received the service during the second trimester [17]. Consistent with research from Sumon et al. demonstrating that maternal mortality is lower when abortion laws are less restrictive, the percentage of maternal mortalities attributed to abortion has dropped to 6% [18] from the previous level of 32% [9]. Sumon et al. also suggested that there is a need to reform abortion laws in countries with the most restrictive abortion laws, and to provide safe abortion services to protect women from unsafe and illegal abortions [19].

Factors affecting abortion and post abortion service utilization in Ethiopia.

There are many factors associated with service utilization. Studies have indicated that the educational level of women, knowledge of the law, stigma and discrimination, religious influences, place of residence, social status of women, and provider attitudes are among some of the factors that limit or curtail post-abortion care (PAC) and safe abortion

care (SAC) service utilization [20]. Apart from the above individual-level factors, external factors like the global gag rule, antichoice propaganda, the covid pandemic, and the recent lack of peace and security in some parts of the country have all influenced access to care [21].

The most important determinant to resort to safe or unsafe abortion is unwanted pregnancy. A cross sectional study was conducted on 907 patients from February 1, 2002 to January 31, 2004 with diagnosis of abortion and admitted to the gynecological ward of Adigrat zonal hospital, Tigray Region, Ethiopia. Abortion accounted to 13 % of all hospital and 61 % of gynecological admissions. Most of these women (70%) had unwanted pregnancy. Modern contraception methods were not in use in 76 % of unwanted and 58 % of wanted pregnancies. Interference was reported in 81% of unwanted pregnancies. unwanted pregnancy was associated with increased risk of maternal morbidity and mortality [22]. In the two national studies conducted in 2008 and 2014, 42% and 38% of women who had safe abortion or PAC were unwanted pregnancies respectively [15].

Despite legal reform, the knowledge and attitude of women towards abortion services is quite low/negative, resulting in reduced demand for services. A community-based study in Arba Minch in January 2017 revealed that only 23% of women had knowledge about the legalization of abortion. Of all the respondents 323 (56%) preferred abortion on demand to be legalized while 241 (42%) do not want abortion to be legalized. Again about 57% of women believe that women should be able to use legal abortion, but the rest (43%) believe even if legally allowed, women should not use legal abortion. From all participants, 59% don't want to use abortion services even if legally allowed and 53% don't think that women have the right terminate their pregnancy even if the pregnancy meets the legal criteria for termination of pregnancy [23]. A similar study done in northwest of Ethiopia concluded that a significant number of women knew little about the law and several protested legalizations of abortion [24]. In Harari a similar study done among female students in five higher education institutions demonstrated that

only slightly more than a third of the study participants (36%) have good awareness of legalization of safe abortion [25]. A global study by Assifi et al. [26] reported that less than 50% of women have knowledge of the abortion laws in their respective countries.

There is mounting evidence that health workers are having dilemmas and concerns about providing services. Evidence shows that some feel that the law is wide open for interpretation, women may not be telling the truth, or they could be stigmatized for offering services [27]. This is however in contrast to findings stated in a study conducted in one big hospital in the country where many mid-level providers claimed to know the current abortion law; however, many failed to understand the specific provisions of the law [28]. Blystad et al. describes this as access paradox, in a study conducted in three countries Zambia, Ethiopia and Tanzania. He described Ethiopia's law as semi liberal and encountered a seeming paradoxical relationship between national abortion laws, abortion policy and women's actual access to safe abortion services. The study findings moreover reveal that the texts that make up the abortion laws are highly ambiguous , and call to move beyond a narrow focus on the content of policy. They suggest that the connection between law, health policy and access to health services is complex and critically dependent on the socio-economic and political context of implementation [29].

Summary of the findings from key informant Interviews

Leadership and Governance

A key informant stated that "[There is] no restriction on providing abortion related information to the public but abortion is not legal under the penal code. However, the 2004 revised penal code and the 2005 and the revised 2014 technical and procedural guideline for safe abortion care permitted abortion under specific circumstances. At the same time the lack of open discussion is attested by the fact that "There is not clear direction about advertising abortion care including using posters, leaflets, and public

announcement or using speech, radio, TV etc." However, abortion related information can be given to women or communities, or can be published in medical journals. Lack of openness in communication and different views can affect the views of providers, may contribute to conscientious objection and lack of awareness of the public in general and women in particular. As suggested by another key informant there may be a need for value clarification among key leaders and stakeholders.

The KIIs also revealed that although the HEWs and HEP is a flagship program, and currently more than 42,625 HEWs have been deployed to their communities with at least 2 HEWs available at each health post, in some health posts the number of health extension workers may vary between 1 to 4. Level III HEWs are limited to information provision, including on where and when to get abortion care services, as well as offering referrals to nearby facilities. However health Extension workers do not provide termination of pregnancy.

Currently, based on disease burden and population size of the community there are approved roadmaps for optimizing the health extension program with new health post structures. These are:

1. Comprehensive health post: which comprise midwifes, nurses and health officers
2. Basic Health Post which maintained the previous structure for HEWs
3. Integrated health post: that merges health post with health centers and currently the MoH planned to merge 2713 health posts with health centers as an integrated health post.

In this regard there is a possibility of offering comprehensive abortion care (CAC) information and services at comprehensive and integrated health post level and information, counseling, and referral at basic health post level.

Regarding level-4 health extension workers, they are upgrading HEWs with one year training. Currently, more than 42,625 HEWs (approximately 50% of HEWs) are

upgraded to level-4. All level-3 HEWs can be promoted to level-4 HEWs as per the required career policy. Level-4 HEWs can offer safe abortion care information and service after receiving basic CAC training at integrated and comprehensive health post level. While the revised road map for optimizing the Health Extension Program (HEP) is expanding its accessibility, the scope of practice of the existing health service providers remains the same.

Harmonization of guidelines and public private partnerships have also been identified as a key governance and leadership issue by key informants. The guidelines and standards issued by FMOH and the Ethiopian Food and Drug Administration (EFDA) have differing facility standards that require harmonization. Key informants stated that conscientious objectors refer to whichever standard is most stringent to rationalize denial of services. While it is recognized that private medical institutions are providing a major share of sexual and reproductive health (SRH) services (particularly in urban settings), medium and primary clinics are barred from providing SAC. This requires the attention of policy makers.

Service delivery

The organization of the health system is such that at a grass root level the health extension program and primary health care conduct SRH services. There are 131 standards for primary health care services, and abortion care services are included under the maternal and child health (MCH) program.

Most public health centers provide comprehensive abortion care services; however, some facilities do not provide abortion care services due to lack of training and supplies. Abortion care services are also provided at private clinics in specialized hospitals, general hospitals and at higher level clinics but are not allowed in medium, primary clinics, pharmacies, and drug vendors. The expansion to lower-level private facilities would result in improving access to much-needed services. Despite the partial

involvement of the private sector, there is a weak reporting system by the private health sector and the government is trying to enhance public-private partnership. The government is also demanding a report from private health facilities on the lifesaving essential services including delivery, family planning and comprehensive abortion care services. This is reflected in lower number of abortion services provided in the country as private facilities are not included in official reports.

The KIIs revealed that there are several issues that need to be considered in improving and modernizing service deliveries. These included the need to introduce self-care in all its components as per WHO recommendations. This includes self-eligibility, self-access to medication and administration, and ascertaining completeness. In addition, self-care using medical abortion (MA) in humanitarian care settings, for IDPs, and in outreach service settings. The introduction of technologies like Tele-Health, hotlines, and apps to address issues in self-care can be an innovative approach. Together with self-care, more task sharing of mid-level providers to address medication-based second trimester abortion up to 16-18 weeks, involvement of pharmacies and lower level private facilities, over-the-counter availability of medications, improving physical infrastructure where CAC services are offered and involvement of HEWs in the full spectrum of abortion care are raised as possible areas of service improvement.

Health system financing

There is no separate budget allocation for abortion care programs. The program is mostly donor dependent. In 2021/2022 the budget utilized for abortion care commodities was 531,989 USD for MA and 61,831 USD for manual vacuum aspiration (MVA) while in 2022/2023 budget allocated for MA and MVA were 436,758 and 80,000 USD respectively. MA drugs can be purchased and issued based on consumption and based on facility request using Report and Requisition Form (RRF). The out-of-pocket cost of care is not known although at primary health care setting such services are provided exempted from fee for services.

Health workforce

Although there seems to be over production of health work forces, service delivery points complain of shortage in critical manpower for providing MCH services. Even those that are deployed show lack of commitment and interest in offering CAC services. Additionally, in most facilities (particularly in rural settings) the staff turnover is significantly high. Field visits showed a rising number of conscientious objectors as providers feel that the law is not clear enough and, in some circumstances, they are afraid of being prosecuted, stigmatized, or discriminated against for offering such services. These feelings are more prevalent in those providing second trimester abortion services.

One key informant stated that he has witnessed providers that tend to push medication without availing the choice of MVA as it seems easy to do, provide no counselling services about options and not checking contraindications for MA. In addition, most service providers in private settings need capacity-building to do MA. There is a consensus that there is inadequate information and awareness about the Technical and Procedural Guideline for Safe Abortion Care.

Medical products

The supply for MA has improved, while there is a shortage of MVA in many facilities. Ethiopian Pharmaceutical Supply Services (EPSS) avails MA to the regions and delivers it to Zonal Hubs, after which facilities submit RRFs and collect MA at their respective facilities. At times because of lack of training the RRF may not be properly filled and that may result in stock out at woreda level.

Another challenge that is faced is the lack of peace and security in the northern part of Ethiopia meaning either access is limited, or facilities are destroyed, both of which are a

challenge not only for the health system but also for the country.

Facilities have no complaints about MA products, and they feel that they are effectively using the medication. The rise in the number of PAC cases has been attributed to use of MA, as when women witness bleeding they worry and visit facilities to expediate the process of abortion with MVA. In addition, this may reflect the lack of quality counselling on the part of providers who fail to explain the options, effects, and possible side effects of medication abortion.

Regarding MVA in 2022/2023 fiscal year, the equipment was distributed using a quota system. This has led to some facilities getting more MVA than others. Because of procurement from different suppliers, there was a quality issues resulting in equipment not fitting with existing MVA cannula. Key informants raised the issue of the need for post marketing surveillance of commodities.

Health information systems

Abortion data is collected almost exclusively from the public sector through DHIS 2 with potential for underreporting as result of undercounting and misclassification. The 2014 TPG has demarcated gestational age into three categories i.e. under 12 weeks; 13 to 24 weeks; and 24 to 28 weeks. However, the reporting format categorizes abortion into first trimester (under 12 weeks) and second trimester (13 to 27 weeks) which shows discordance between what is recommended and the information tool. In addition, there is no disaggregation of methods of termination and this data is therefore hard to come by.

Besides, there is either serious underreporting or no reporting at all from private facilities resulting in underreporting of abortion in national documents like the health and health indicators of MOH which are published yearly by the Policy and Plan Department (PPD) of FMOH. This is in contradiction to HSTPs I and II which state “expanding access to quality comprehensive abortion care services has been a major strategic initiative under family

planning and reproductive health services."

Recognizing the importance of having a consolidated national database, the PPD has put a plan in place to include 2028 private clinics in reporting schemes and make regular reporting mandatory for relicensing.

Policy implementation bottlenecks and recommendations for improving of abortion services in Ethiopia.

Data related issues.

Routine data collection has been carried out in health facilities for years. Realizing the importance of quality health information for decision making, planning and evaluation of health programs, the Health Management Information System has been rolled out to all public (including health posts) and selected private health facilities as of 2008 in Ethiopia. Poor quality routine data and data that are not timely, accurate, and complete will contribute to poor decision-making, inefficient resource allocation and utilization, and loss of confidence in the health system. A number of studies have shown that routine data collection in PHC settings in the country have not reached acceptable levels of timeliness, completeness and accuracy [30-32].

One of the rationales for conducting two rounds of national surveys in 2008 and 2014 to determine the magnitude of abortion was that data from service statistics is neither accurate nor complete. Data from 2021/2022 service statistics show the number of clients served in facilities are 40% of what was estimated in the 2014 national survey. Considering the fact that there has been considerable population change in the last 10 years, it is reasonable to doubt the accuracy of the report. In the absence of reliable service-related data, it is inevitable one would resort to UN estimates or community-based data.

To mitigate this issue, there is a need for strong supportive supervision to facilities, resort to full eHMIS and roll it out in all public and private facilities and back up the information with timely EDHS and population censuses. Both are expensive but necessary.

Stigma in abortion

Abortion is a common and safe medical procedure. But abortion is surrounded by stigma in our society. Stigma keeps people silent about their personal experiences, and silence feeds public complacency with political attacks and destructive myths. The recent wave of anti-choice movements appearing on social media has waged a war on the provision of safe abortion services. Right from the enactment of the revised penal code anti-choice movements have tried to limit access to safe services. This has resulted in a policy of silence among the different stakeholders, fear among providers, and guilt and shame in women and girls accessing services.

There is a need for open dialogue in public fora, and for policy makers, opinion leaders and managers to speak out in public about the benefits accrued as a result of the limited legal revision. This would help to increase community awareness among youth and women and break the stereotype that abortion is only for young urban women rather than a necessary service for all women of reproductive age irrespective of her socio-economic status. It is high time SRHR champions from different walks of life shed light on this issue. After 18 years of legal review, it is high time to develop and run a proactive advocacy strategy to build public support, and to destigmatize and decriminalize access to safe abortion services.

Policy and regulatory issues

In increasing access to safe abortion, the law is necessary, but it is not sufficient as administrative barriers can curtail access to services. In this regard, there are a number of policy and regulatory issues that need to be addressed.

The policy issues that need to be addressed include: how far down the echelons of the health system can we task share the availability of medication abortion? Based on the

technical and procedural guideline, provision of MA is limited to public health facilities, health centers and above, and to higher clinics and above in private facilities. The 2022 WHO Guideline on abortion recommends that MA can be used for self-care (including self-diagnosis, self- administration, and self-ascertainment of completeness) [33]. The same document by WHO recommends the provision of MA services up to 12 weeks by community workers, traditional medical practitioners, and pharmacists including drug vendors. This helps in narrowing disparity, and in non-medicalization of some of the components of comprehensive abortion care. It is therefore time to consider involving private facilities like primary and medium clinics in abortion care provision as well as optimize the scope of practice of HEWs to involve safe abortion services under 12 weeks using medication, linked to facilities that can provide backup services if and when complications arise.

Through its technical procedural guideline the MoH has made it mandatory for institutions to offer safe abortion services to all who seek care. In addition, EFDA has also made it clear that "A health professional may not refuse on grounds of personal belief to provide services such as contraceptive, legal abortion and blood transfusion (article 84, Reg no. 299/2013). However, despite good knowledge about the law, on average one out of three providers have unfavorable attitudes towards abortion [34, 35]. This may potentially translate to conscientious objection. WHO in its 2022 guideline [33] states that "health services should be organized in such a way as to ensure that an effective exercise of the freedom of conscience of health professionals in the professional context does not prevent patients from obtaining access to services to which they are entitled under the applicable legislation". Therefore there is a need to continue to monitor the extent of conscientious objection and mitigate through continuous monitoring and supportive supervision.

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