ETHIOPIAN MEDICAL PRACTITIONERS AND ABORTION PROVISION AFTER 2005: MORAL DILEMMAS, ETHICAL CHALLENGES AND CONSCIENTIOUS OBJECTIONS

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Dedication:

To Prof. Morten Magelssen

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1.Acknowledgments

I praise and worship the Holy Trinity (Father, Son and Holy Spirit) who created, preserve and provide for the whole universe. It is my duty to venerate the saint of all saints, the Ever virgin, Theotokos (Mother of God), the co-mediatrix in whom the world is saved, believe and witness her intercession for sinners, of whom I'm chief.

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2. Summary

This thesis studies abortion in Addis Ababa, Ethiopia. It studies both the practices of healthcare workers in private and public healthcare institutions, and their inner thoughts/beliefs on the practice itself. Currently, induced abortion is practiced in all regions of Ethiopia. After the liberalization of the law in 2005, safe abortion is now practiced in centres ranging from primary health care centres to tertiary referral hospitals.

The thesis contains three papers which deal with the viewpoints and experienced moral dilemmas of health care workers.

The first article examines the health care practitioners' professional obligations and religious-moral convictions towards the practice of abortion. Here, professionals' reconciliation of the provision of abortion with their moral/religious views is addressed. It was found that health care professionals weighed value considerations and religious norms differently. There were some who reported conflicts of conscience. Several had attempted to reconcile religious norms and values with provision of abortion through framing such provision as preventing harm and suffering.

The approaches of the healthcare professionals are rooted in reflection on the demands made of them from medical ethics and from their institutions' policy and regulations. In addition, a number of respondents referred to religious convictions. The chief arguments for why they accepted working with abortion concern the prevention of harm and the promotion of the pregnant women's autonomy. Informants argue from human rights, public health and the legality of the abortion practices. They believe deciding on the termination of unwanted pregnancy belongs within the ambit of the sexual and reproductive rights of women. They emphasize the phenomena of abortion complications as a result of clandestine abortion and maternal mortality due to unsafe procedures. Furthermore, they want governments and

stakeholders to acknowledge the privacy of pregnant women and support a liberal abortion law based on the needs and interests of pregnant women.

In the second paper, the abortion dilemma experienced by practitioners was explored. We examined the experiences of abortion providers with the revised abortion law, including how they view and resolve perceived moral challenges. Most participants considered the 2005 abortion law as a clear improvement although 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 individual's interpretation and discretion concerning whether criteria for abortion are met.

Regarding abortion for fetal abnormalities, participants supported the woman's authority in deciding whether to choose abortion. Several participants saw these decisions as moral dilemmas. On the other hand, all thought that abortion was a justified choice when a diagnosis of fetal abnormality was made. As authors our conclusion was that if practice is to become more predictable and uniform, then more detailed official guidance on the law and how it should be interpreted would be warranted.

In Ethiopia conscientious objection (CO) to abortion provision is not allowed due to government regulations. In our third paper it was found that CO is practiced despite the regulation forbidding it. Most informants appeared to be unfamiliar with the prohibition or else did not accord it weight in their moral reasoning. Proponents of institutionalization/toleration of CO claimed that accommodation was often feasible in a hospital setting because other colleagues could take over. Opponents pointed to threats to patient access, especially in rural settings. Both proponents and opponents invoked tenets of professional ethics, viz., the right not to be coerced into actions one deems unacceptable; or the duty to provide care, respectively.

Summary in Norwegian

Denne ph.d.-avhandlingen studerer abort i Addis Abeba, Etiopia. Den studerer både praksisen til helsepersonell i private og offentlige helseinstitusjoner, og deres indre tanker og oppfatninger om selve praksisen. For tiden praktiseres indusert abort i alle regioner i Etiopia. Etter liberaliseringen av loven i 2005, praktiseres trygg abort nå i sentre som spenner fra primærhelsestasjoner til tertiære henvisningssykehus.

Avhandlingen inneholder tre artikler som omhandler helsepersonells synspunkter og opplevde moralske dilemmaer.

Den første artikkelen undersøker helsepersonells faglige forpliktelser og religiøse-moralske overbevisninger i forhold til utøvelse av abort. Her behandles fagfolks forsøk på å forene tilbudet om abort med deres moralske/religiøse synspunkter og innvendinger. Det ble funnet at helsepersonell veide verdihensyn og religiøse normer på ulike måter. Det var noen som rapporterte om samvittighetskonflikter. Flere hadde forsøkt å forene religiøse normer og verdier med tilbud om abort ved å fortolke det å utføre abort som en måte å forhindre skade og lidelse på.

Tilnærmingene til helsepersonell er forankret i refleksjon over kravene som stilles til dem fra profesjonsetikken og fra deres institusjoners policy og regelverk. I tillegg refererte en rekke respondenter til religiøs overbevisning. Hovedargumentene for hvorfor de aksepterte å jobbe med abort handler om forebygging av skade og fremme av gravides autonomi. Informantene argumenterer fra menneskerettigheter, folkehelse og det at abortpraksisen er blitt lovlig. De mener at det å bestemme seg for avbrytelse av uønsket graviditet hører hjemme innenfor rammen av kvinners seksuelle og reproduktive rettigheter. De legger vekt på forekomsten av abortkomplikasjoner som følge av abort i det skjulte og mødredødelighet på grunn av utrygge prosedyrer. Videre ønsker de at regjeringer og interessenter skal anerkjenne gravide kvinners personvern og støtte en liberal abortlov basert på gravide kvinners behov og interesser.

I den andre artikkelen ble abortdilemmaet som utøverne opplevde, utforsket. Vi undersøkte aborttilbydernes erfaringer med den reviderte abortloven, inkludert hvordan de ser på og løser opplevde moralske utfordringer. De fleste deltakerne betraktet abortloven fra 2005 som en klar forbedring, selv om den ikke løser alle problemer og har ført til nye dilemmaer. Som et hovedfunn synes loven å ha åpnet et stort rom for individers fortolkning og skjønn om hvorvidt kriteriene for abort er oppfylt.

Når det gjelder abort for fosteravvik, støttet deltakerne kvinnens myndighet til å beslutte abort. Flere deltakere så på disse avgjørelsene som moralske dilemmaer. På den annen side mente alle at abort var et berettiget valg når diagnosen fosteravvik ble stilt. Som forskere var konklusjonen vår at dersom praksis skal bli mer forutsigbar og enhetlig, så vil det være berettiget med mer detaljerte offisielle retningslinjer om abortloven og hvordan den skal tolkes.

I Etiopia er reservasjon mot abort ikke tillatt på grunn av offentlige forskrifter. I vår tredje artikkel ble det funnet at reservasjon praktiseres til tross for at forskriften forbyr det. De fleste informantene så ut til å være ukjente med forbudet, eller tilla det ikke vekt i sine moralske overveielser. Tilhengere av institusjonalisering og toleranse av reservasjon hevdet at tilpasning ofte var mulig på sykehus fordi andre kolleger kunne ta over. Motstandere pekte på risikoen for redusert tilgang til abort for pasienter, spesielt utenfor byene. Både tilhengere og motstandere påberopte seg grunnsetninger i yrkesetikken som støtte for sitt syn, henholdsvis retten til ikke å bli tvunget til handlinger man anser som uakseptable; eller plikten til å yte helsehjelp.

3. List of papers

Paper I

Ewnetu DB, Thorsen VC, Solbakk JH, Magelssen M. "Still a moral dilemma: how Ethiopian professionals providing abortion come to terms with conflicting norms and demands". *BMC Medical Ethics* 2020; 21: 16.

Paper II

Ewnetu DB, Thorsen VC, Solbakk JH, Magelssen M. "Navigating abortion law dilemmas: experiences and attitudes among Ethiopian health care professionals". *BMC Medical Ethics* 2021: 166.

Paper III

Magelssen M, Ewnetu DB. "Professionals' experience with conscientious objection to abortion in Addis Ababa, Ethiopia: an interview study". *Developing World Bioethics* 2021; 21(2): 68-73.

4.Abbreviations

ASRH: Adolescents sexual and Reproductive Health

DHS: Demographic and Health Survey

EOTC: Ethiopian Orthodox Tewahedo Church

EPRDF: Ethiopian people revolutionary democratic front

ESOG: Ethiopian Society of Obstetricians and Gynecologists

ICPD: International Conference on Population and Development

IPAS: International Products and Services

MSIE: Marie Stopes International Ethiopia

MVA: Manual vacuum aspiration

NGO: Non-governmental organization

OB/GYN: Obstetrician/Gynaecologist

HEP: Health Extension Program

MDG: Millennium Development Goal

SDG: Sustainable Development Goal

TPLF: Tigrean People Liberation Front

WHO: World Health Organization

YFSRHS: Youth Friendly Sexual and Reproductive Health Services

5. Introduction and Background

Induced abortion is a common phenomenon globally. Worldwide about 50 000 000 abortions are performed yearly. Of the 600 000 maternal deaths from pregnancy-related causes each year, an estimated 13% are attributed to complications of induced and unsafe abortion (Okonofua, 2006). As is well known, abortion involves ethical issues that are often contentious and give rise to divisive public debates.

A wide spectrum of views exists on the morality of abortion and how society ought to regulate it. In a liberal[1] approach which is prevalent in Western liberal democracies, the issues relating to the pregnant woman – her experiences, needs and autonomy – take centre stage. More restrictive approaches place limitations on the woman's autonomy in order to safeguard the fetus's right to life.

In the US, where the abortion debate has gone on quite heatedly for decades, there are two clear "camps" that have been allowed to frame the way abortion is perceived and approached: The pro-choice camp and the pro-life camp, respectively. These designations provide a tidy categorization – which certainly risks oversimplifying things.

In the Ethiopian context, apparently strong religious affiliation is associated with pro-life views on abortion, and vice versa. However, we know that most healthcare professionals consider themselves religious, and this most likely also includes those involved in abortion. So, there is a tension here. An important task for the project is, therefore, to examine whether and how any experienced moral dilemmas introduce nuances to the tidy categorization of pro-choice vs. pro-life.

[1] The choice of terms is also contentious. Throughout the thesis, I will use the terms «liberal» and «permissive» interchangeably to denote the position that abortion rights should be wide and inclusive, that abortion ought to be accessible and that the criteria that have to be met to procure an abortion should be few; similarly, the terms «conservative» and «restrictive» denote the position that abortion rights should be more narrow and that abortion should only be accessible if criteria are met.

Even though consensus is not reached, the pro-life and pro-choice parties argue with a view to convincing the other about their own attitude towards induced abortion. If one considers views on abortion in the health sector, the trend is that those who have clinical experience with abortion have more favorable attitude towards the practice than those without the experience of it (Holcombe et al., 2015).

Induced abortion can be discussed within different, complementary frameworks. Induced abortion can be considered as a public health concern, a human rights issue and a challenge of legal regulation within a given country. Liberalizing abortion law doesn't necessarily lead to a decrease in abortion rate, whereas a restrictive law might increase maternal mortality through increasing unsafe practices. Different circumstances will determine the magnitude and rate of abortion in a given country. If we take the Ethiopian context, then age, educational level, monthly income and societal norms have been argued to be important predictors of abortion rates (B. Alemayehu et al., 2019) .

Background

This research aimed to contribute to the understanding of the practice of induced abortion in Ethiopia and the moral dilemmas that practitioners experience; with special emphasis on the interplay between abortion provision, healthcare practitioners' views, and the legal regulation of abortion since 2005. At the outset, we planned to compare secular and religious approaches towards induced abortion in Ethiopia. We later decided that the interviews with health professionals provided more than sufficiently rich data for the thesis. A further set of interviews with religious leaders where therefore not used in the thesis. By way of in-depth interviews with participants working with abortion provision, we have studied their thoughts on their practice, their experienced moral challenges and the topic of conscientious objections towards abortion. Therefore, what follows is a presentation of their diverse approaches and attitudes, their perceptions and framing of induced abortion practices.

6. Different perspectives on induced abortion

The issue of abortion can be approached from different perspectives, of which five will be briefly introduced here. A common approach towards induced abortion is to perceive it with a medical gaze and as a public health concern. The second approach is from the perspective of human rights, where the right to abortion on request is often presented as an integral part of a set of sexual and reproductive human rights. A third approach is the philosophical-ethical approach to abortion where questions of fetal moral status at different stages of development and the morality of the act of abortion are discussed. A further perspective is to apply one of many different religious frameworks which often, but not always, emphasize the embryo and its moral status. Lastly induced abortion can be seen from a legal perspective. Each of these approaches will now be commented upon.

6.1 Medical or public health perspectives

From a medical and public health perspective, abortion can be spontaneous or induced. Induced abortion can be performed in a safe or an unsafe way. Furthermore, it can be performed medically (as is now typically preferred) or surgically. There are medically indicated abortions which are performed to protect the mother's health. Unsafe abortion is one of the main causes of maternal death worldwide. Safe abortions, hence, greatly reduce risks of complications and safeguards the health of the mother.

6.2 Human right perspectives

In many jurisdictions, deciding on abortion has become the decision of pregnant women solely, despite its still being controversial. A forceful argument is being made that this right to self-determination should be regarded a human right. The sexual and reproductive and health right framework is one aspect of a reproductive health right issue that has received recognition in several international human right conventions. The woman who is pregnant is then the point of departure and the central actor and decision-maker in matters concerning abortion. Most

feminists and activist support and advocate women's autonomy in matters of abortion decisions. Their main underlying ethical-legal arguments are: she is autonomous, so she can decide whatever she wants; it is her body so she has the sole right to decide on her body; the fetus is contained within the body of a pregnant woman who has a right to autonomy; it is her sexual and reproductive health right which follows from the general right to health.

Research indicates that in many countries, debates between those who are in favor of liberal abortion law and those who are in favor of restrictive abortion law are heated, and sometimes appear to be fueled by emotions rather than by rational argument and research findings (Lopez, 2012). The act of abortion is a sensitive issue in developing nations also. In particular, it is a gender-sensitive issue in the sense that a partner or a husband is typically involved in the abortion decision issue in some way.

6.3. Philosophical perspectives

Philosophers approach abortion with a view to asking fundamental questions and evaluating potentially relevant arguments. They ask and answer questions such as: Does the fetus have a right to life? When does life begin? When does personhood begin? What is the moral status of the fetus at different stages? When is abortion morally permissible?

Several different potential criteria for moral status have been proposed (Tom L. Beauchamp, 2013). Five of them will be mentioned next. One basic candidate criterion for moral status is *rationality*. It is argued that not only the unborn child lacks rationality, this also characterizes post partum infants until a certain age has been reached. Those who take this stand will regard the fetus as non-person; as a result, abortion is typically not morally problematic.

A second criterion is self-consciousness. Fetuses are not self-conscious, yet a requirement for an individual life to have moral worth is to be self-consciousness. Therefore, since the fetus is

not self-conscious, it is not a person. This is also likely to justify abortion at any stage of gestation.

A third argument considers an individual as a person with regards to its abilities for social interaction. Socialization, interaction with others, is what makes a human being that is homo sapiens biologically a *person* in a moral sense.

Fourthly, philosophers like Martha Nussbaum (Nussbaum, 2011) argue that a basic criterion to be a person is the ability to feel (having sentience). The fetus is a developing entity that will attain sentience gradually. Thus, abortion before development of sentience is not problematic, but abortion thereafter might be.

Fifth, another criterion is the possession of a rational nature (e.g., Kaczor, 2014). Philosophers who hold this view typically argue that the fetus possesses a rational nature already from conception, and that moral value is tied to this nature. Thus, even early abortion becomes more difficult to justify.

6.4. Religious perspective

Despite often being excluded from the realm and discourse of secular bioethics, religions typically have fundamental concepts on the origin and purpose of the human being, and its moral status from conception onward. Of particular interest for this thesis are the two major religions in Ethiopia, i.e. Christianity and Islam. A traditional EOTC (Ethiopian Orthodox Tewahedo Church) Christian approach takes a perspective from an account of theology from the creation of man in the image and likeness of God. EOTC teaching promotes procreation and justifies a pro-life approach to issues of abortion. Christian thinking traditionally sees the embryo, whether formed or not, as one substance and as belonging to humankind. Due to its full genetic material that is inherited from the parents, it is fully a human being. Beside its biological personhood, religion introduces the concept that the fetus is fully human because it

has a rational soul. Different religions have different perspective in the time of ensoulment. While most Christians believe conception to be the time of ensoulment, Islam traditionally believes 120th day post conception to be the time of ensoulment. The respective groups typically prohibit termination of pregnancy after ensoulment. In the Christian tradition it is typically argued that the unborn child is an innocent human being. Killing an innocent human being is wrong. In conclusion, abortion is wrong (Khitamy, 2013). In comparison, a more liberal attitude regarding abortion is possible in Islam as long as traditional principles are taken into account (Oren Asman, 2004).

6.5 Legal perspective

Countries' legal framework can be placed in categories of fully liberal, semi-liberal, or restrictive (Guttmacher, n.d.). Those who champion liberal laws point out that it will bring the unsafe, clandestine abortions into the abortion clinics, thus preventing complications and maternal mortality. Those who favor restrictive laws point to religious and ethical justifications, especially concerning the fetus's right to live. Through conscientious objection, the legal framework might give a degree of freedom and regulation for practitioners as well as the patients seeking abortion. Factors or criteria pertaining to legalization of abortion across countries have similar perspectives. Some will have restrictive, others semi liberal and the rest liberal approaches. For example the forces that helped lead to legalization in US include health professionals' concerns about the dangers of illegal abortions, the woman's movement, changing social mores, and, for some groups, concerns about overpopulation (Kunins & Rosenfield, 1991)

7. Abortion, policy and adolescent pregnancy in sub-Saharan Africa (SSA)

Sexual and reproductive health (SRH) matters are common concerns in sub-Saharan Africa (SSA). One of the concerns is for legislation to cater to the needs of marginalized and vulnerable

groups, including adolescent girls. Findings from a recent systematic review and meta-analysis showed that health-related legislation and policy promoted an increase in service utilization over time, especially for antenatal care, skilled birth attendance and facility-based delivery. However, social health inequalities persisted among subgroups of women (Mac-seing et al., 2020)

In a research done in SSA, sociocultural, environmental and economic factors as well as individual factors and health service related factors were the determinants of adolescent pregnancy (Yakubu, 2018). There is a considerable proportion of unintended pregnancy in SSA (14 million annually i.e., in SSA). According to a study that used the demographic and health survey (DHS) data of 29 SSA countries, the overall prevalence of unintended pregnancy was 29%, ranging from 10.8% in Nigeria to 54.5% in Namibia. Married women were 6 times more likely to report unintended pregnancy compared with women who had never married (Kwabena et al., 2019).

Experiences of Ghanaian midwives with abortion can perhaps be seen as representative of the impact of religious influence on the handling of contentious issues in abortion practices. A study highlighted the dilemma of abortion-condemning approach versus the practice of safe abortion care to save the mothers' lives and ultimately decrease the maternal mortality (Oppong-darko et al., n.d.). Another research on adolescent SRH in SSA by Melesse et al., demonstrated major inequalities and uneven progress in many key Adolescents SRH indicators. Gender gaps are large with little evidence of gaps in age at sexual debut and first marriage, resulting in adolescents girls remaining particularly vulnerable to poor sexual health outcomes (Melesse et al., 2020). A systematic review on health care workers' behavior and personal determinants associated with providing adequate SRH services in SSA indicated that negative behaviors and attitudes of health care workers are associated with provision of inadequate SRH services (Jonas et al., 2017). The review also revealed the knowledge and implementation of specific SRH

components which are still below optimum levels considered against the WHO recommended guidelines (Jonas et al., 2017). Another systematic review in SSA found that important structural barriers were the health workers' negative attitude and lack of skill. In addition there were individual barriers, such as lack of knowledge among youth regarding youth-friendly SRH services (Ninsiima et al., 2021). The prevalence of pregnancy termination ranged from 7.5% in Benin to 39.5% in Gabon with an average of 16.5%. Women who were capable of taking reproductive health decisions had higher odds of terminating a pregnancy than those who are incapable (Id et al., 2020).

Reduction of unsafe abortions is a key to reduce maternal mortality and subsequently support achieving SDG 3. Pregnancy termination is one of the key issues that require urgent attention in achieving the third SDG of ensuring healthy lives and promoting wellbeing for all at all ages. The above-mentioned research in SSA indicate the potential impact of policies and laws to govern SRH for now and for the future.

8. Ethiopia

Ethiopia is a land-locked country in the eastern part of Africa, commonly called the Horn. The name Ethiopia means "sun-burnt faces" – an ascription from the Greek language *Aithiops*. According to the Bible, the people of Ethiopia are descendants of Cush. Some scholars argue that the name Ethiopia is coined from the ancient king of the country, Aethiops I. Others, e.g. Arabs, refer to Ethiopia as Abyssinia. Ethiopia is known for its origin of mankind, *Ardipithecus ramidus*, or "Ardi" and *Australopithecus afarensis*, or "Lucy" which are 4.4 million and 3.2 million years old, respectively. They were found in Ethiopian Rift Valley, Afar region, Ethiopia. Ecclesiastically/biblically, Ethiopia is the first country to be mentioned in the Book of Genesis. Ethiopia is thus a country important for both evolutionary and ecclesiastical origins.

Modern Ethiopia is the home of multiple ethnic groups, diversity of culture and more than 80 languages. The country is known for "thirteen months of sunshine" and being the only country

in Africa that possesses its own alphabets. Alongside with Haiti and Liberia, Ethiopia maintained her status as one of the three historical independent black nations and, with the exception of a five year occupation by Italy under Benito Mussolini, successfully defended herself against the European colonization of Africa. (Adejumobi, 2000). Ethiopia is also the seat of the African Union and many international organizations.

Currently, Ethiopia is a secular state that follows ethnic federalism. Secularism identifies 'religion' and separates it from the domains of the state, the economy and science. As there are two types of secularism, passive and assertive, the nature of Ethiopian secularism also will impact the professional's perception towards abortion practice. The constitution directly states that the state and the church are separated (article 11). In 1994 Ethiopia's new constitution divided the country into regions based on ethnicity. The country is now constituted with 11 national regional states and 2 city administrations. The ethnic federal system is formed by the Ethiopian People's Revolutionary Democratic Front (EPRDF), which is a coalition of four party groups. EPRDF took power after overthrowing the communist military regime in 1991. Soon after taking power, Eritrea separated from Ethiopia using referendum in 1993 and Ethiopia became a land locked country.

Both the committee regime known as *Derg* and the EPRDF, dominated by the Tigrean People Liberation Front (TPLF), came to power by armed forces. Even though there are now approximately 40 political parties in the country, most of them are unknown to the general public. The political parties are known only when the time of election approaches. Among many, in the past, none emerged except the coalition for unity and democracy (CUD) to be considered a genuine competitive party to the EPRDF. So far, only the 2005 or 1997 EC election was considered to be free and fair, yet these also culminated in vigorous violence and unrest. Therefore, Ethiopian democracy is aspirational and is in its infancy period.

Ethiopia has advanced from the strong economic recovery of the 1990s to rapid growth since the early 2000s. The underlying economic structure exhibits only modest changes as industrialization has yet to take root.

While policy reforms and public expenditure on infrastructure and basic services since 1991 have triggered rapid growth by reducing major inefficiencies, structural transformation requires action to boost productivity, alter the structure of demand, and build productive capacity. Productivity remains below that of other developing countries both in the production of food and agricultural raw materials. Manufacturing firms exhibit lackluster levels of investment while import penetration rates continue to rise. Inequality of asset ownership in urban areas, and the weak response of asset positions to income growth in rural areas suggest challenges in raising household demand for non-food consumption items.

A number of general observations concerning some of the pervasive traits of the 'political culture' dominant in much of the country may provide a background for the subsequent discussion.

Hoben has suggested that

> [i]t is a fundamental postulate of Amhara culture […] that social order, which is good, can be created and maintained only through hierarchical, legitimate control deriving ultimately from God (Adejumobi, 2000) .

In other words, 'Abyssinian' political culture emphasizes a strict hierarchical understanding of society, where each member's socio-political position and status is clearly defined and understood. Social and political interaction and behavior are guided by an elaborate set of norms and rules, which establish socio-political order on the basis of a rigid system of deference and sanction. This is not to say that all Ethiopian cultures can be compared to the Amhara tradition. Levine, for instance, in a much-cited and much-criticized account, asserts that

> The Oromo are in many ways the antithesis of the Amhara. […] Where the Amhara system is hierarchical, the Oromo is egalitarian. Where the Amhara is individualistic, the Oromo is solidaristic (Vaughan, Sarah, 2003).

The Oromo are the largest ethnic group among Ethiopian society and the second largest is the Amhara society or community. However, since the control of the Ethiopian state has historically been associated with the Abyssinian, or Amhara/Tigrayan, socio-political tradition, it may be argued that it provides the context for the formation of the dominant trends in the 'political culture' of contemporary Ethiopia (Vaughan, Sarah, 2003).

Ethiopia is known as a religious country within and outside of its nations. With more than 110 million people, roughly 98% consider themselves religious. The two prevalent religions are Orthodox *Tewahido* Christianity and Islam .. Tewahido means "made one''. However, there are traditional faith communities as well, that counts more than 4000 in the country. In Addis Ababa only there are more than 170 churches and more than 100 mosques. The two monotheistic religions of Ethiopia are unique in their relatively peaceful coexistence and the tolerance between them became an example for foreigners. According to the Bible, the introduction of Christianity to Ethiopia is linked with the baptism of the Ethiopian eunuch in the 1st century. According to other historical records, Christianity was introduced in the country in the 4th century, even though worship of one God precedes this time. The Ethiopian church is one, holy, catholic and apostolic. Islam became indigenous after the advent in the 7th century.

9. Health care in Ethiopia

The health care system of Ethiopia is constituted by the public health sector supplemented by a flourishing private health care sector. It is a three-tiered system, from primary level health care comprised of the primary health care unit (health posts, health centers and primary hospitals) to secondary level health care (zonal hospitals) and tertiary level health care (specialized hospitals) (Assefa et al., 2019)(FMOH, 2021).

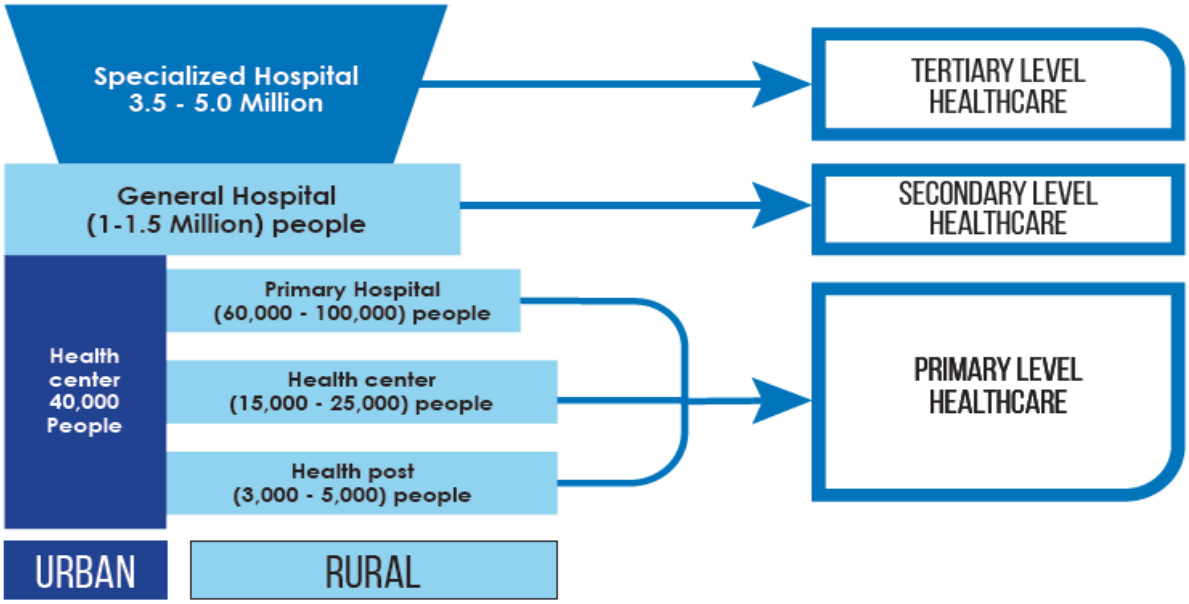

Fig 1. Health care tier system (from FMOH, 2021)

The three major financing sources for health in Ethiopia are (a) external assistance(foreign funds) , at 39 percent; (b) out-of-pocket expenditure, at 37 percent; and (c) the government, at 21 percent (Workie & Ramana, 2013). Primary health care has been established in all the three governments – from under the feudal regime (during the time of Emperor Haile Selassie), the socialist/military rule of Mengistu Haile Mariam to the budding democracy under Meles Zenawi (Kloos, 1998). Health extension programs (HEP) have been launched since 2003 to promote primary health care coverage throughout the country to meet the millennium development goal (MDG). The health care system is moving toward a decentralized or devolved system. The health service system in Ethiopia is federally decentralized along the nine regions (currently 11 regions and 2 city administrations) (Wamai, 2009) Ethiopia is working to attain universal health coverage by 2035 (Habtemariam & Semegn, 2018).

Ethiopian health policy is designed with a main emphasis on prevention. There is great variation in the quality and extent of healthcare services between the major cities and the rural and remote

countryside. Access to abortion services in rural areas depends on the availability or presence of a sufficient number of skilled health professionals. Presence of health professionals ultimately determines whether the abortion seekers are offered surgical (manual vacuum aspiration, MVA or medical abortion.

9.1 Abortion in Ethiopia

The 2005 abortion law, presented in detail in the next chapter, represented a watershed for abortion in Ethiopia. Before the 2005 abortion law, abortion was allowed only to save the mother's life when it was at stake. Different statistics and studies, however, revealed the great magnitude of maternal death due to clandestine abortions as pregnant women's last choice when there was no other option (Gebremedhin et al., 2018). The Ethiopian Society of Obstetrics and Gynaecology (ESOG) and International Products And Services (IPAS) were among the prominent parties that conducted a survey research nationally and lobbied for the abortion law to be revised to decrease the complication of abortion and the maternal deaths as a result of unsafe abortion (EMA, 2010).

After a heated debate between ESOG, IPAS and other professionals and pro-life groups and religious organizations, the abortion law was liberalized so as to permit abortion of an unwanted pregnancy in circumstances where pregnancy fall under abortion's law criteria.

The International Conference on Population and Development (ICPD) was introduced in Africa in 1994 to address the challenge of unsafe abortion and create a conducive receptive legal framework that could tackle maternal mortality and serve women in need. African leaders then agreed to cope with this public health challenge.(Leila Hessini, 2006)

9.2 Research on abortion and abortion providers in Ethiopia

A significant amount of qualitative and quantitative research on abortion in Ethiopia has been conducted. Here we emphasize research performed within the last seventeen years, i.e., after the enactment of the law.

A study about the prevalence and determinants of unintended pregnancy found that nearly one in three (32%) births were unintended, and about two-thirds of these were mistimed (Tebekaw et al., 2014) Even though abortion is still stigmatized in Ethiopia, findings also indicate that there is a shift in views of abortion in Ethiopian society in certain preconditions, and that is a promising indicator for future implementation and realizing of safe abortion care in the regions (Connell et al., 2022)

A study from Southern Ethiopia showed that there are five groups of barriers of abortion-related services: lack of appropriate skill by providers themselves, health facility-related barriers, adolescents' lack of information, community-related factors and broader health system incapacities (Habtu et al., 2021). Another institutional cross-sectional study among providers from University of Gondar graduates indicated that 190 students out of 424 (44.8%) were willing to perform induced abortion according to the criteria of the law. Sex, religion, being Muslim rater than protestant and religious attendance weekly or less often were factors associated with willingness towards performing induced abortion (Enyew, 2020). Another study by Taddele et al., showed that there was significant gap in the knowledge of healthcare providers towards abortion care. Their multivariate model showed that midwifes and nurses (compared to health officers), being female, and absence of training or practice of manual vacuum aspiration were associated with lower knowledge level (Taddele et al., 2019).

9.3 Research on abortion law, prevalence and knowledge attitude and practice (KAP) of abortion

The law gives some freedom to pregnant women in the sense that no further requirement or evidence is asked or required to abort unwanted pregnancy except their verbal statement that the pregnancy was due to rape or incest.

A study showed that knowledge of abortion law is a key determinant of the utilization of safe abortion services. A study conducted among women of reproductive age in Bahir Dar City found that 43% had good knowledge and 38% had favorable attitude towards the current Ethiopian abortion law (Bantie et al., 2020). Another related research among university students in the Oromia region showed that the majority (79%) of the study participants were not able to identify all the conditions under which abortion is legally available in Ethiopia. Factors such as receiving health education on abortion law, knowledge where safe abortion can be performed, and being member of a health club in university were predictors of better knowledge (Mekuria et al., 2020). A cross sectional study from Guraghe Zone revealed that the lifetime prevalence of induced abortion among young preparatory school students aged 15-22 years was 13.6%. The odds of having induced abortion were 2.3 times higher among rural family residents as compared with that of urban residents. Moreover, students without sexual health education were 6.4 times more likely to undergo induced abortion as compared with those who got sexual health education at school (Lentiro et al., 2019). An unmatched case-control study in the Northern part of Ethiopia found that 79.0% of women having abortion care had their sexual debut before 18 years of age compared to 57.0% of controls; 42.2% of controls and 23.8% of cases cited rape as the reason for having an abortion. In this study, the independent predictors of repeated abortion were not understanding their fertility cycle, having had a previous medical abortion, having had multiple sexual partners in the preceding 12 months, perceiving that abortion procedure is not painful, initiating sexual practice before the age of 18 years, and disclosure to a third party about terminating a pregnancy (M. Alemayehu et al., 2017). A cross-sectional study from Jimma Town also indicated that the factors related to increased likelihood of second trimester abortions were age less than 19 years, being single, widowed or divorced, attending school, being unemployment, being nullipara, or para 3+ and having low education (Bonnen et al., 2014).

9.4 Research on abortion in the capital, Addis Ababa

A cross-sectional study done in Addis Ababa by Marie Stopes International Ethiopia (MSIE) found that the magnitude of repeat induced abortion was 33.6% and several factors such as age, educational level, monthly income, years in marriage and last time of abortion were significantly associated with repeat induced abortion (B. Alemayehu et al., 2019).

The overall knowledge and practice of medical abortion were 72.1% and 33%, respectively. Participants' level of education, male partner's education, participants' way of living, income, and history of unwanted pregnancy were some of the factors associated with knowledge and practice of medical abortion (Wassie, 2021)

There has been a significant reduction of abortion rates in high income countries, while the rates remain unchanged in low- and middle-income countries. An unmatched case-control study conducted in the capital of Ethiopia with 147 cases and 295 controls showed that the mean age (+SD) of cases was 26.5±5.7 years and of the controls was 28.1 ± 4.8 years. The study found that being unmarried, having primary and tertiary education, having a monthly income of 100-300 USD, having sexual debut between ages of 15 and 19, marrying before the age of 18 and having two children or more were independent predictors of induced abortion (Megersa et al., 2020).

Yet, before our study there was no study in Ethiopia that assessed the providers' perspective regarding their views on and their experiences and moral challenges with abortion. Furthermore, the knowledge gaps about conscientious objection towards abortion provision by the current health professionals were not studied. Our study thus aimed to fill these gaps and generate new knowledge on these issues.

10. Regulation and practice of induced abortion in Ethiopia

Abortion in Ethiopia is regulated by WHO's technical and procedural guidelines which clinics are expected to follow. These guidelines apply at both the private NGO sector, mainly Marie Stopes International Ethiopia (MSIE), and the public health sectors, that open *michu* clinic (Safe clinic) as one (stand alone),separate and independent unit to practice induced abortion. Both surgical and medical abortion cares are given in these two branches. As mentioned above, the political will of the Ministry of health, the research, views and experiences of the Ethiopian Society of Obstetrics and Gynaecologists, and the expertise of the NGOs were essential to the implementation of the service (Bridgman-packer et al., 2018)

To meet the demands of the clients, the safe abortion care service has been expanded to different health facilities and it is widely being practiced by mid-level health professionals (nurses, midwives and other non-doctor personnel) (Berer, 2009). Post abortion care (PAC) consumes a large portion of the total expenditure of the reproductive health service in Ethiopia (Vlassoff et al., 2015).

10.1. The 2005 abortion law

After the ICPD initiative and the Maputo Protocol Agreement, the abortion law in Ethiopia was liberalized in 2005. The reform, however, created a hot debate between groups of pro-lifers, mainly religious groups, and the pro-choice groups of medical professionals, lawyers and human right activists. The implementation of the law contributed to the significant decline of maternal mortality due to abortion complications. The law created an environment in which safe abortion could be done legally in private as well as public health facilities. In Ethiopia, the majority of abortion services are being provided by private/NGO clinics.

Currently, the law permits termination of pregnancy in cases of the mother's mental and physical health, when her life is endangered, when she is underage, if she has been raped or incest and when there are confirmed fetal abnormalities (Mclean et al., 2019).

The semi-liberal law of Ethiopia hence provides an open room for the pregnant women with unwanted unborn children. The law only prohibits or doesn't allow only on grounds of socio-economic and on demand or on request approaches.

10.2. Conscientious objection to abortion

Conscientious objection is a refusal to do to legally established courses of medical services like abortion, blood transfusion and provision of contraceptives based on one's moral or religious belief. Conscientious objection is prohibited in Ethiopia. It is stated in government regulations that health professionals do not have a right to refrain from performing abortion due to conscientious objection: «A health professional may not refuse on grounds of personal belief to provide services such as contraceptive, legal abortion and blood transfusion (Chavkin et al., 2018).»

According to our knowledge, prior to our own study no studies have been published about conscientious objection in Ethiopia.

11. Research questions and objectives

11.1. Research questions

The main research questions are: What, if any, moral dilemmas and ethical challenges do abortion providers in Addis Ababa experience, and how do they resolve them?

The sub-questions are:

- *Biology and moral status:* How are the moral status of the human fetus and the autonomy of pregnant women perceived and weighted among abortion providers?

- *Ethical challenges:* What are the perceived and experienced moral challenges and ethical dilemmas towards abortion practice?
- *Abortion provision in practice:* How does the underlying controversy about the ethics and politics of abortion play out in the daily practice of healthcare workers affiliated with Christianity or Islam? What moral dilemmas do they experience?
- *Practitioners' perception:* How do abortion practitioners resolve any conflicting demands of ethics, law and professional requirements, with special emphasis on conscientious objection?

11.2 Objectives

O1: To compare and contrast health care providers' perception on the autonomy of women accessing safe abortion on the one hand and the moral status of the fetus on the other hand (Paper I)

O2: To characterize dilemmas and practical attitudes to abortion among health care workers. (Paper II)

O3: To examine how conscientious objection on abortion plays out with abortion providers (Paper III)

12. Study design and methodology

12.1 Qualitative case study design

As the study aims at understanding phenomena and explores issues related to abortion, a qualitative case study design with a semi-structured interview guide was employed. Qualitative research is a form of social enquiry that focuses on the way people interpret and make sense of their experiences and the world in which they live. It seeks to understand a given phenomenon from the perspectives of the target population/informants. Moreover, qualitative research

design is highly appropriate for sensitive topics such as abortion, and for research questions where pre-emptive reduction of the data will prevent discovery.

The case study research strategy is an empirical inquiry that investigates a contemporary phenomenon within its real-life context, especially when the boundaries between the phenomenon and context are not clearly evident. In other words, the case study method has been chosen because the researcher deliberately wants to cover contextual conditions (e.g., not only clinical, but also socio-cultural factors) because it is believed that they are highly pertinent to the phenomenon of study.

12.2 Study site and participants

Data collection was conducted in the capital of Ethiopia, Addis Ababa. The study targeted healthcare workers working with abortion provision in private/NGO centers and public hospitals.

12.3 Sampling of participants and inclusion criteria

For the study, we employed purposive sampling. That is, the participants were not randomly selected, but selected with a purpose, which was to provide rich, in-depth information from which one can glean key insights central to the purpose of the research. We deliberately selected a heterogeneous sample in order to cover the broad spectrum of perspectives, observing and documenting the uniqueness, and concurrently the commonalities, of their views (Sharp, 2003). The principle of 'saturation' was achieved when during data collection, which was done between March to July 2017, no new insights or concepts emerged. Thirty health care professionals were recruited and interviewed.

The inclusion criteria were experience in working in medical fields related to abortion, voluntariness/willingness to participate, ability to speak the local language, Amharic and working in Addis Ababa as a health care provider.

12.4 Recruitment

Participants from healthcare professionals were recruited mainly from public hospitals and private clinics in Addis Ababa. First, information about the study was presented to the heads of the institutions and departments. Then potential participants were contacted via phone or in person. After providing information about the study I was able to ask for their voluntary informed consent. Most of those invited were willing to be interviewed and give their phone number to me so that I could arrange a convenient period for interview. 3.5 USD for each public participants, and 7 USD for each private providers were given as an incentive to participate. Interviews were performed in their own office at their work place.

12.5 Data collection strategies

The following data collection strategies were employed:

In-depth interviews (IDI): The goal was to bring forth rich, detailed material that could be used in analyses. A semi-structured interview guide, developed in order to cover the research questions and objectives, was used to ensure that pertinent topics were addressed. All interviews were recorded with a digital voice recorder. Each interview lasted between 40 and 90 minutes. An independent researcher originally from Ethiopia, residing in Norway, and proficient in Amharic and English, translated the verbatim Amharic transcripts of the interviews into English. These English versions were then used in the subsequent analysis.

Field notes: Throughout each interview, the researcher took additional notes which elaborated on the participant's language, choice of words, and attitude to being interviewed, including any reluctance. Salient points from the field notes were integrated into the interview transcripts.

Secondary data are pre-existing data that may or may not have been analyzed or published and have not been gathered for the purpose of the study in question. In this study, secondary data were obtained through review of published ethnographic, historical, and sociological literature or unpublished government and non-government organization reports, systematically

evaluating their relevance to the proposed study. Gathering and reviewing secondary data are not only a great starting point for background information but also useful for setting the research topic in a wider context or for revising the data collection process if necessary. The secondary and other data sources will help to validate or crosscheck statements made by participants and filled in any missing areas. The secondary data also provided the historical, economic, and political, legal and religious contexts at varying levels.

12.6. Data analysis

The analysis has been conducted simultaneously during the data collection, data interpretation, and narrative writing. Guided by systematic text condensation (see below), interview transcripts were analyzed using NVivo11 software to code and condense texts. Through an iterative process of reading and rereading transcripts, etc., recurring, emergent themes were identified. The transcripts were read carefully to form a general impression of participants' views. The transcripts were then re-read to understand the context and to derive codes. The aim was to identify frequent issues in the accounts given. Categories were drawn directly from transcript text (systematic text condensation). Emergent themes were compared across transcripts and categorized.

We used the systematic text condensation (STC) qualitative framework developed by Malterud (Malterud, 2012). STC involves four steps:

1. **From chaos to themes:** First, we established an overview of the data. The transcripts were read several times to create an overall impression and identify candidates for main themes.
2. **From themes to codes:** This step involved identifying and sorting meaning units. Each unit of meaning was identified and coded according to topic using the NVivo 11 software package. Accordingly, 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 identify 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 article. In the analytic text, genuine (not artificial) quotations from the transcripts were used to illustrate and confirm the findings.

13. Research ethics

Ethical approvals were obtained in both Ethiopia and Norway, in line with the requirements of the respective systems. In Ethiopia, the Institutional Review Board of St Paul's Hospital Millennium Medical College (SPHMMC) gave its ethics approval on 26 Dec 2016. In Norway, the Regional Ethics Committee evaluated that the study falls outside of the scope of the Health Research Act and thus was exempt from formal approval. Instead, the study was evaluated and recommended by the Norwegian Centre for Research Data (NSD) (application sent 17 Feb 2017, approved 18 Apr 2017). However, because of a misunderstanding, data collection was commenced before NSD had approved the project. When this was discovered, Dr. Magelssen as main supervisor immediately contacted the head of the Institute of Health and Society at the University of Oslo, and the NSD. In the dialogue with NSD it was emphasized that the data collection had indeed taken place in line with the conditions detailed in the application. NSD's advice was then to provide some supplemental information about the project to the participants in writing. This was then done (see appendix).

Participants were informed about the project in writing and orally. Informed written consent was obtained from every participant.

14. Researchers' normative pre-understanding

In qualitative research, the researcher is the instrument. In the analysis process, being aware of one's own preconceptions, is necessary in order to strive towards a greater degree of transparency and objectivity. This is all the more important when the subject matter is morally charged, such as it is with abortion.

As a researcher, being an Ethiopian and raised in the capital with the same culture and language as the participants, the researcher can be called an insider. I am familiar with the respondents' feelings and impressions because we speak the same language, and we all live in the capital.

I am an Orthodox Christian by faith and have a bachelor's degree in Christian Theology. In addition, by training, I am physiologist (with master's degree) and radiographer (with bachelor's degree). What I am concerned with here is the health care workers' perception as they identify themselves either with Christianity or Islam faith, and their corresponding attitude towards the practice of abortion. As a Christian, according to my belief (corresponding to traditional Orthodox teaching), abortion is condemned. However, the question posed here concerns the many different scenarios and dilemmas that can arise in practice, not least the so-called 'hard cases' of induced abortion (e.g., fetal abnormality). The subject matter requires one to look in-depth into the nature of induced abortion. Previously, my own normative view on abortion was in line with traditional Orthodox teaching. However, as a junior research fellow in the field, I prefer to be neutral rather than grouping to a certain group. Also, my co-authors might hold different normative views on the practice of induced abortion.

As a researcher also, I consciously attempted to keep from taking a stand or signaling my own views throughout all interviews. I preferred to learn about the normative approaches of the participants without my own normative views interfering. As I kept searching and exploring

the values and norms of the participants, I understood that one cannot adequately judge about the outcome of abortion and consequences of induced abortion, just by sitting outside.

My viewpoint before the research was that abortion in general involves the taking of life and is thus morally problematic. However, in the case when the mother's life is endangered the Church would have a place to handle and implicitly support such cases; however, this policy has not been declared officially.

15. Summary of main findings

15.1 Paper I

Still a moral dilemma: how Ethiopian professionals providing abortion come to terms with conflicting norms and demands

This paper describes the moral dilemma that Ethiopian health care professionals face in the private and public sector in their work with induced abortion. As shown, the abortion scenario in Ethiopia has changed after the revision of the (abortion) law in 2005. Several of the dilemmas that professionals face spring from considerations of whether the fetus is ensouled or not, and whether the fetus/unborn child has a right to life.

The paper showed practicing induced abortion by itself is a dilemma to many practitioners. The dilemma stemming from uncertainty of whether the embryo is a life with human dignity and moral worth, is highlighted by many of the informants. Nonetheless, they believed that it has *biological* life. In addition, most of them admitted that the right to life should be either by the 28th week of gestation (at viability) or at birth.

Respondents also perceived the right to life of the fetus as a with attachment of law and their normative approaches or understanding. Several were "gradualists" in that they perceived the

moral worth and importance of the fetus to increase gradually from conception until 28 week of gestation and then to the moment of birth.

Many emphasized respecting the mothers' reproductive rights, and argued on the basis of helping and reducing maternal mortality and suffering. Many also pointed to the life of the embryo/fetus and its inherent moral value. Several argued that in principle, the fetus has a right to life from conception. In fact, respondents' reply on the moral status of the embryo/fetus was not easily handled by providers. Most of them hesitated to reflect on the issue. Whereas some informants appeared to have experienced severe conflicts of conscience, another group were able to reconcile religious norms and values with their work, especially through framing provision of abortion as a way of helping and preventing harm and suffering. In general, informants from private health sectors appeared to experience moral dilemmas less severely than their counterparts from public hospitals.

The dilemma they encountered increased in line with the gestational age of the fetus. Many pointed out that the earlier the detection of pregnancy, the easier the means of termination. Interestingly, respondents appeared to have been mostly on their own in trying to reconcile conflicting interests and find ways to handle the moral conflicts.

15.2 Paper II

Navigating abortion law dilemmas: Experiences and Attitudes among Ethiopian health care professionals

This paper identifies problems and challenges pertaining to abortion that medical practitioners encountered. Even though abortion is semi-liberalized in Ethiopia, the abortion law revision in 2005 did not solve all problems. Still, there are ethical challenges, some which arise from the specifics of the new law.

Practitioners' attitudes and their practices influence whether abortion will be provided or not. Providers have to handle situations where they suspect that the patient lied in order to qualify for the abortion. Providers also had to weigh and evaluate different reasons for abortion. These are main moral dilemmas connected to the abortion law.

Besides, the legal grey zone that the practitioners are allowed to practice, has also opened the loophole in the interpretation.

Most private sector providers did not base their evaluation only on the law, but also saw and evaluated from the account of the woman's interest and preferences more generally. They evaluated her condition and gave her what they thought of as the proper care and service. Sometimes who should get access to abortion and who should not constituted a dilemma. Patients falling outside the legal criteria were another source of dilemma. Another one was, since the law states that 'the mere statement' of a woman that she has been raped or subject to incest is sufficient, providers thought that this could motivate lies. This raised a dilemma for the practitioner.

Some thought that the abortion law criteria were still too restrictive. They wanted to expand the law by allowing for abortions due to socioeconomic hardship or leave the choice entirely to the women regardless of reasons. These informants experienced a dilemma when the women did not meet the legal criteria. On the other hand, some thought that the law had gone too far and become too liberal, and it seemed that abortion was de facto accessible on request.

The major ethical dilemma encountered by the health professionals were the interpretation and application of the law's criteria. Some were comfortable to interpret it widely, but others were not. Respondents from private clinics appeared more liberal and more open to "wide" interpretations than their public hospital counterparts.

Concerning the termination of fetal anomalies, most informants responded that terminations ought to take place but that the decision should be left for the woman herself. Practitioners distinguished lethal malformations from milder ones and they recommended termination mainly for the former ones. Their argument was if this disabled child is going to be born, the burden will be to the family, to society and to the country. Some also pointed the shortcoming of health care sector of Ethiopia. But few in contrary argued that aborting such a fetus would conflict with the right to life of the disabled. Informants were given Down Syndrome as an example to reflect on, and most favored termination while a few were ambivalent.

Our study tentatively concludes that it has to be resolved whether the individual practitioner can decide on whether abortion is required and on whether the criteria set in the abortion law are met. Clearer guidance is warranted in order to protect the provider and the abortion seeker as well. Therefore, the authorities should revisit the guidance and it ought to be clearer, more precise and less ambiguous.

15.3 Paper III

Professionals' experience with conscientious objection to abortion in Addis Ababa, Ethiopia: an interview study

Conscientious objection (CO) is clearly relevant to abortion, but a subject that is very little discussed in Ethiopia. This study zooms in on the practice of conscientious objection, and finds that it is practiced even though it is officially prohibited.

CO is often debated from two sides. Those who tolerate CO will typically argue based on the availability of colleagues to take over the task, and that respecting individual conscience is both at human rights issue and a tenet of medical/professional ethics. Those who oppose toleration argue that access to the service is compromised especially in rural settings where there is no colleague to take over that task and responsibility. This was the pattern found in our study also.

Albeit its prohibition by the legal guideline, most healthcare practitioners were not aware of the prohibition. However, by the nature of their work they did not consider CO necessary for themselves in their own practice.

Informants answered based on the setting they were working and the personal reasoning they held. Private sector practitioners were less often positive to CO than their counterparts from the public sector.

In conclusion, we ask whether it would be possible to develop guidelines that preserve both respect for individual conscience and patient access to abortion.

16. Discussion and appraisal of main findings

Our study is based on the views and reflections of healthcare workers towards induced abortion from different perspectives. We approached our investigation with an open mind set, and sought the participants' own understanding and perspectives. The practice of health practitioners in contentious practices of induced abortion, and the experiences and attitudes of both secular and religiously affiliated practitioners towards the 2005 law in Ethiopian society was studied in the overall project of this thesis. Indirectly, we have also studied some aspects of the influence of religion on the Ethiopian health care system. Some main findings will now be highlighted and discussed in the context of other relevant research.

16.1 Moral dilemmas concerning abortion provision

The first paper discusses professionals who hold different understandings about the ethics of abortion. As the participants indeed work with abortion provision, it was expected that they give great weight to the arguments for such provision. Nevertheless, many of them appear to have experienced such provision as a moral dilemma, and experience "moral residue" emanating from the dilemma. They have had to face reconciling the moral status and the right to life of the fetus with the autonomy and needs of pregnant women. The clash of conscience

for some participants is clearly seen throughout the interviews. On the one hand, a core principle they hold is that they are trained to save life not to eliminate it. Hence, practicing abortion yet considering the "secret" life going on in the womb leads to difficult questions about at what stage does it acquire life, moral status, "personhood".

Primary concern is given to pregnant women's physical and psychological health. Participants perceive or think termination of pregnancy mostly as a medical case or indication mainly (therapeutic abortion), such as fetuses with gross malformation.

The medical practitioners' moral reasoning was shaped by secular understanding of the nature of the fetus and the human right approaches, sole right of women to access abortion services. They perceived the embryo which is not mature, formed or not socialized, in such a sense that termination of this pregnancy will not produce a strong moral condemnation. Still some of the participants held a moral attachment as the embryo grows and transforms to fetus and there is a feeling towards the unborn child when intervening with it.

The findings certainly nuance the pro-life/pro-choice dichotomy. It is not helpful to attempt to place the participants into any one of the groups. Although they all work with abortion provision and thus have accepted this to a certain extent, as shown there were many who had moral qualms and harbored ambivalence towards the practice.

Some participants hesitated to answer some of the posed questions, indicating that this is indeed sensitive terrain. Others were trying to reconcile their moral qualms that produce conflict of conscience with their practices. Some will recall their religious moral convictions and others reconcile their work with their own understanding – seeing the act as a way of helping those who are in need and danger. One prominent perception towards the women who are in need are applying the principle of autonomy as it is the factual principle in medical ethics which is universal.

Also previous research has found the moral reasoning of medical practitioners to emphasize stronger the need and interest of the pregnant women (Sullivan & Barbara, 1987). The embryo/fetus takes second seat when decisions are made to terminate the pregnancy.

From the participants' view, it appears that even though they are affiliated with Christianity or Islam, their religious observance did not have decisive impact on their practice, and for many appeared to have little impact at all.

An additional concern investigated is whether the experienced moral dilemma and anguish actually led the professionals to treat clients in a different manner than they would have if they had felt no moral qualms related to abortions, as suggested by Loi's study (Loi et al., 2015).

As Blystad and her co-authors argue, the interplay between law, health policy and implementation is sophisticated. In the case of Ethiopian abortion regulation, this dynamic has resulted in profound room for individual providers' discretion (Blystad et al., 2019).

Among the various dilemmas that the practitioners expressed, one found a dilemma when the women seeking abortion fall outside the legal criteria. Decision making by professionals also creates a dilemma. In decision making whether the abortion seeker receives a medical abortion or MVA particularly when the client come from far place is a question. For example, there is a case when practicing in rural areas, as it is presented by one participant who had had an experience in rural areas.

The impact of religion on their own work has contributed to dilemmas, as shown. Most of the public health sector participants held a strong religious conviction and some exempted themselves from directly participating in induced abortion, while most private sector practitioners did their task willingly. There is evidence that when abortion for fetal anomaly is detected, the decision will be left for a pregnant woman after she had been informed by the

practitioner. As prior research from Ethiopia indicated, for most fetal anomalies that is incompatible for life, women would prefer termination of the pregnancy (Brooks et al., 2019).

A study from Nepal indicated that even though abortion law prevents maternal mortality and morbidity, still practitioners held many reservations about the practice (Puri et al., 2012). This included perceptions on the part of providers such as, “They come for an abortion without having a justifiable indication”. This is consistent with our findings and also described that clients ‘sometimes they used to whisper in their ears’’. In the Nepalese study, providers also differentiate clients by whether they are married or not for the sake of getting treatment and concerning repeated abortion.

We underlined our finding that there are strong connotation or favor towards the pregnant women in matters of decision or terminating the pregnancy. This is in line with a finding that women’s autonomy is prioritized, central to women’s welfare and is an anathema for most societies (Purdy, 2006). It is also in line with the general emphasis increasingly placed on patient autonomy in healthcare, including in health law, as exemplified by a British study (Jackson, 2000).

In empirical studies on practices of abortion, the moral status of the fetus is often not raised as an issue. In particular, there is scarce research about this from Africa. A study from London is an exception; here, participants were classified with this in mind. Practitioners managed the interface between their professional and private moral values in a variety of ways. Two key categories emerged: “tolerators”, and “facilitators”, describing two different attitudes towards the morally contested field of antenatal screening (Farsides et al., 2004).

This contested issue has divided society so that many hold starkly opposed views on abortion. While some groups give great weight to the issue (and research finding) of the consequences of unsafe abortion, others question the basic moral acceptability of abortion and assess it from

the moral status of the unborn. These different views are again shaped by public policy, sexual and reproductive health, legal status and a human rights agenda.

In all circumstances induced abortion is a public health issue. In the Ethiopian situation, health care providers understood the impacts of abortion as an important component of public health. Our research findings are a reflection of medical practitioners' judgements as they get involved in abortion services. The situation that resulted from the ratification of the law has made possible the registration of safe abortion services both in private and public health sectors.

The notion that maternal autonomy should be respected without giving significant weight to the unborn is still controversial in large segments of the population. But no one denies that unsafe abortion service will affect the integrity and life of pregnant women. Since health is a broad concept, the implications will be determined by the way we interpret "health" itself and the corresponding scope of the human right to health.

Most countries have shifted from criminalizing to decriminalization of abortion. In the process, public debate about the legality of abortion in a given country have been opened. There exist a clear distinction between the Christian religious perspective and secular understanding of abortion. Since public health issue by itself is a social aspect, it encompasses a religious aspect as well.

Those who work in private sectors apparently experience less moral dilemma towards abortion practices. This may be due to their active choices to enter into this specific service.

Providers who were trained in abortion policy, regulation and practices held more of a liberal understanding in the area of implementation and practices. Younger health professionals are seen to defend the right and interest of women. Even though most participants (midlevel providers) don't receive medical ethics courses during their training, still they reflect ideas in defense of maternal autonomy.

Providers noted that the accessibility of medical abortion has made the process of getting the service easier and more convenient. Women who seek abortion in the city have choices to choose either the public or the private sector. All in all the public health burden of abortion is reduced because of greatly increased access. The 2005 abortion law spurred a radical change which made possible bringing the service to wide coverage in the regions.

Our finding also points to whom abortion is accessed due to various reasons. This is true especially in private sector different criteria are presented to those who need abortion. The criteria could be either who rest in the abortion law criteria or fall outside the abortion law criteria. There exists a common understanding in the private sector to see women's statement mainly in line with or at the side of the interest and right of pregnant women. They tend to prioritize the women over the fetus. Even though the moral status of the fetuses is vague or not clear for most providers, they apparently typically prioritize women, with emphasis on different socio-economic profiles and needs, poverty and unwanted pregnancies.

If a woman seeking abortion fulfils the criteria stated in the law, she will receive the service. However, as shown, there are times when abortion seekers fall outside the law's criteria. Even though this brings some discomfort for providers, apparently they sometimes reconcile the

woman's preference with the law's formulation that, in the case of rape, 'the mere statement [that rape has taken place]' of the woman is sufficient to get the service.

Most services are given because women present a justification based in health to get the service. Issues such as stress, illness and socio-economic problems can be superimposed and come together.

The concept of 'human right' agenda to get the service is not promoted in the country. However, public health perspective of getting safe abortion care is promoted. Even though 'human right' agenda is not promoted, women get the service in other means. This may be due to lack of local activists in the country or because the service they get in other options that don't degrade their interests. All options are there to give guarantee to pregnant women. A wide range of criteria has been given to protect women who seek abortion services. Since the law is in favor of pregnant women, they simply need to know what the law says and grants privilege to get the service.

There are multiple factors that influence the impact of human rights-based arguments, such as societal mores, and religious perspectives. Since Ethiopia is a developing country, it is governed mostly by social and religious norms which are basically conservative. Such attitudes are prevalent also in the capital, yet even more prevalent in the rural area. All such factors will work also on the individual level, and influence pregnant women's decision making towards abortion. The journey of pregnant women in the process of decision making is thus interwoven by culture and norms of the society. The complex nature of finding a solution for unwanted pregnancy, sometimes led women to search for unsafe, clandestine abortion mainly facilitated by abortion brokers.

Most participants gave less emphasis to the moral status of the fetus. Many were at a loss about what to answer on questions concerning the nature of the early-stage human being. This might be because there is no clear, generally accepted, public understanding of the nature of the unborn. The theological perspectives on abortion typically take place in its own field of inquiry, separated from e.g. scientific and secular discussions.

16.2 Ethical challenges relating to the law

Our participants had diverse educational background and varying time of experience, in addition to working in either public or private health care centers. When we investigate the moral qualms and challenges they face in connection to the abortion law in the country, several give voice to a clear, morally underpinned challenge towards it. This is, firstly, because there are potentially relevant criteria that are not included in the law; and secondly that there is a possibility of pregnant women to manipulate through lying in order to get the service. In the first case, the moral challenge emerges as whether to attend to such clients who fall outside the law's criteria, or deny them the service, thus violating what is perceived as the inherent right of the pregnant woman. Therefore, practitioners face such moral challenges whether to accommodate or whether to stick to the law's criteria narrowly interpreted.

A study very similar to ours was performed by McLean and co-authors (Mclean et al., 2019). The study explores the practitioners' perception of and reflection on the abortion law, and the ethical dilemmas that Ethiopian medical practitioners experience during abortion provision. The dilemmas that the providers face can be categorized as follows:

(1) whether abortion should be provided or not: Providers fall in a dilemma whether abortion should be provided for whatever reasons the woman seeks the service. This finding is in line with those of our second paper.

(2) whether practitioners should accept or not what appears to be a lie: Practitioners also face what they see as intentional and deliberate lies concern e.g., rape. So providers often experience the dilemma of whether they shall accommodate lie and tolerate the misrepresentation facts. This is also in line with our second paper.

Other findings that were raised in the study were the fairness concern, moral distress and religious and ethical justification for abortion. Providers have a kind of gate keeping mechanism to screen the eligible vs. the non-eligible patients. But providers interpret and apply the criteria differently, as shown both by McLean et al. and in our own study. Hence, this power on the part of practitioners could create discrimination and inequality in the access to safe abortion services.

Most countries in the world have not fully liberalized their abortion laws. A considerable proportion of the world countries have less liberal or moderate abortion law that permits in certain criteria (physical and mental health) binding by the law. And the rest of countries have restrictive abortion laws. This category may allow abortion only to save the mothers' life. Several research documents reveal the accessibility of abortion in relation to positive legal ground to the health care system: In a study, 32% of countries allow or permit abortion as the woman's request with no requirement for justification (Lavelanet et al., 2018). Approximately, 82% of countries allow or permit abortion to save the woman's life. 64% of countries specify health, physical health and/or mental (or psychological) health criterions. 51% allow or permit abortion based on a fetal condition, 46% of countries allow or permit abortion where the pregnancy is the result of rape, and 10% specify an economic or social ground. Laws may also specify several additional indications that are non-equivalent to a single legal ground.

Sometimes there is ambiguity whether to categorize the law as liberal, restrictive or moderate. From the African context one can look at Zambia where study findings show that the law is not easily placed into the standard categories. The archival material reveals that restrictive elements were in focus when the Zambian Termination of Pregnancy Act was passed (1972). The restrictive aspects of the law were emphasized further when Zambia was later declared as a Christian nation. Some of these restrictive elements are still readily recognized in today's abortion debate. Currently there are multiple opinions on whether Zambian abortion policy is liberal, restrictive or neither. The law emerges as ambiguous, and this ambiguity is actively used by both those working to increase access to safe and legal abortion services, and those who work to limit such access. Coupled with a lack of knowledge about the law, its ambiguity may work to reduce access to safe abortion services on the grounds permitted by the law (Haaland et al., 2019).

Professionals in the secular health care system use different knowledge to perform their tasks apart from medical ethics in which they are abiding by different guidelines and instruments which are used. A study reveals that healthcare professionals around the world generally employ (to varying degrees) four broad strategies to manage different types of challenges regarding information, which can be categorized as challenges related to confidentiality, communication, professional duty, and decision making. The strategies employed for managing these challenges include resolution, consultation, stalling, and disclosure/concealment (Ewuoso et al., 2021).

16.3 Conscientious objection

Even though Ethiopia is (to our knowledge) the only country in Africa to prohibit conscientious objection legally, still there is a gap in knowledge about CO among the current practitioners.

Our findings clearly indicate that most practitioners are unaware of the governmental regulation forbidding CO to abortion.

In Ethiopia, CO is not allowed in abortion practices, in providing contraceptives and in blood transfusion. As shown, participants are not aware of this. Even the booklet entitled 'Medical ethics for doctors practicing in Ethiopia' does not include a chapter on CO (EMA, 2010). Therefore, there is a gap that medical ethics books do not presently fill. The knowledge gap of CO implementation by providers is also consistent with a study from South Africa, where there are no guidelines in the system that can be abided by (Harries et al., 2014). In most public sector facilities there was a general lack of understanding concerning the circumstances in which health care providers were entitled to invoke their right to refuse to provide, or assist in abortion services. This finding corresponds to our study on CO by providers and also the finding that "providers seemed to have poor understanding of how CO was to be implemented, but were also constrained in that there were few guideline or systems in place to guide them in the process" (Harries et al., 2014).

Because some professionals refuse to perform abortion only in certain cases, as the result shows, CO appears to come in degrees. This corroborates Freeman and Coast's findings from Zambia, where they concluded, 'CO in practice could be understood as a continuum of behaviors rather than a binary position' (Freeman & Coast, 2019).

CO in abortion practice is seen by several of the current practitioners as an individual right. These participants strongly argue their right to decline a service that goes against their conscience, and this should by any means be respected as their individual right. Participants held a notion that respecting individual right is a universal norm in medical ethics globally.

CO is apparently a widespread phenomenon in abortion services in Ethiopia. A main argument from practitioners who supported the practice of CO is that there exists enough medical

practitioners who can take over the required task. Therefore, they insist to encourage those who already practicing against conscientious objection (CO). The other way round, those who permit conscientious objection (CO) must be legally acknowledged.

CO is not discussed publicly to any degree in Ethiopia. Because of that it creates a knowledge and awareness gap, and there is no clear cut understanding of the concept and how it plays out in practice. Our findings indicated the importance of creating a link between the legal document and medical ethics books/training.

Among the many contributions to the academic debate on CO, Magelssen has given general arguments for why CO should be accepted yet also for what might make it morally unacceptable (Magelssen, 2012). A balance must be struck, attempting to safeguard the professionals' moral integrity, yet also maintaining the duty of care. Magelssen argues that certain criteria should fulfilled in order for CO to be morally justified. This could perhaps also be possible to build on in developing countries like Ethiopia. This should be explored in future research.

In general, CO is a less known topic among current practitioners. There is a need for a clear definition of CO in the Ethiopian context, and clear guidelines. In this sense, our article might initiate a dialogue about CO and will serve as an input for further research in the area. As the research pointed out as a middle way, there could be a possibility of accepting CO based on serious moral or religious conviction whilst still safeguarding patient access. This might, however, be less feasible in rural areas with few providers.

On matters of conscientious objection (CO) in developing countries one finds little literature. Furthermore, CO is mostly framed by the writer's perspective, emphasizing views and arguments in favor or against a certain thesis on the matter. Bkahuni and Miotto held that CO should be denied as a matter of public health policy in developing countries, even in the cases where adequate referral services are possible (Bhakuni & Miotto, 2021). This assertion or

position is in line with Ethiopia's present legal regulation of CO, but, in my view, not practice case scenario or not practicable. In another claim, the view that CO can only be accommodated if the grounds for the objection meets a 'reasonability standard' is found to be unsatisfactory by McConnell's analysis (McConnell, 2021).

A survey study among Chilean university students, showed that almost all participants endorse requirements for CO clinicians to inform (92%) and refer (91%) abortion seeking patients. A minority (18%) however would personally use CO to avoid caring for patients seeking abortion (12% among non-religious and 39% among religious students). About half of religious students (52%) and one–fifth of non-religious students (20%) students support objections at the institutional level (Biggs et al., 2020).

Denial of abortion services by groups of practitioners is not only exceptional to Ethiopia providers. When we look the findings from Mexico and Bolivia, denial was primarily employed for reasons other than moral, religious and ethical considerations. The main reasons for denial of services based on CO were lack of knowledge about abortion related laws and fear of legal problems in abortion services provision. Most respondents cited training and education on abortion law as the foremost way to counteract the negative consequences of what was seen as the misuse of CO (Küng et al., 2021).

17. Methodological considerations

17.1 Trustworthiness

The study was done in close collaboration with the co-authors/supervisors. To ensure trustworthiness, some important techniques were used. As mentioned, transcripts were translated from Amharic into English by an independent and proficient translator. Furthermore, the analysis was done as per the STC framework detailed above both by the first and the second

author of the published articles, before analyses were reconciled, so that a robust, common understanding was reached.

The rigor and the integrity of the findings of the qualitative methods were strengthened by addressing the four–point criteria of trustworthiness proposed by Lincoln and Guba for qualitative research. They are 1. Credibility - the ability to capture and reconstruct the subjective realities of those studied, 2. Transferability - how applicable are findings from a qualitative study to other contexts, 3. Dependability - the ability to account for the constantly changing conditions of the phenomenon studied, for the interactions with study participants, and for the entire research process carried out with an emergent design, and 4. Conformability - refers to neutrality in data rather than neutrality for the researcher and conclusions are grounded in the data.

17.2 Credibility

Credibility is the first aspect, or criterion, that must be established. It is seen as the most important aspect or criterion in establishing trustworthiness. This is because credibility essentially asks the researcher to clearly link the research study's findings with reality in order to demonstrate the truth of the research study's findings. To ensure this, we adopted an appropriate research method; in-depth interview. Furthermore, to enhance credibility of the study, interview data (English transcripts) were shared with the participants for verification.

17.3 Transferability

Transferability is whether the research study's findings are applicable to other contexts. "Other context" can mean similar situations, similar populations and similar phenomena. In essence, this is whether the findings from a study can apply beyond the sample and context of the research itself. According to Malterud, irrespective of the method used, no study can provide universally transferable findings although most research aims at producing information to be

used beyond the sample setting. The study findings suggest that abortion providers have different pros- that favor practice and cons- that inhibit or hinder safe legal practice, towards their practice. However, the information gathered in this study can be used in a related context. The components from each respondent's expressions may be used to gain knowledge applicable to others.

17.4 Dependability

Dependability is the extent that the study could be repeated by other researchers and that the findings would be consistent. Dependability is the stability of data over time and over conditions. It is an evaluation of the quality of the integrated processes of data collection, data analysis and theory generation. It is also helpful to assess the quality of the integrated processes of data collection, data analysis, and the theory generation (ref) To achieve this, we used the stated data collection and we included detailed description of the study methodology and interview guides.

17.5 Confirmability

Finally, conformability is the degree of neutrality in the research study's findings. In other words, the findings are based on by the participants' responses and not by any potential bias or personal motivations of the researcher. This involves making sure that researcher bias does not skew the interpretation of what the research participants said to fit a certain narrative. Conformability is also the measure of how well the findings are backed by the data. To ensure this, all interviews were audio recorded, transcribed, and translated into English. In addition, all the findings, paper I-III, are supported by quotes from a broad range of study participants as indicated in the articles.

Thus, using the qualitative methods and analyses of the data, we were able to get in-depth information about the challenges and experiences of abortion providers, in Addis Ababa, Ethiopia.

18. Limitations and strengths

Our published articles have their own limitations, discussed in each separate paper. A general limitation is that all three papers used the same method, i.e. systematic text condensation. This could be considered as a limitation because adding or using more methods would potentially allow for more comprehensive perspectives and increased trustworthiness through method triangulation.

As the study intended to explore the in-depth account of induced abortion in Ethiopia, and constitute selection of various degrees of participants, purposive sampling was used. Therefore, participants were selected from health care sectors affiliated from Christian and Muslim faith followers.

As a strength of the study, one can see from the published papers that the qualitative studies do indeed explore the account of moral reasoning and accounts of induced abortion, their perspectives, dilemmas and religious aspects in an in-depth approach. There is a considerable number (30) of participants, and they give voice to a range of different viewpoints.

19. Conclusions and recommendations

The nature of abortion in Ethiopia with the perspective of secular health care workers was analyzed and presented in three papers. we believe the findings in our papers will add some knowledge in the abortion provision after the legal reform.. The professionals were affiliated either with EOTC or were Evangelical Christians, or with Islam in Addis Ababa.

Our articles reflect the nature of abortion provision after 2005 in Ethiopia. Different perspectives about abortion and the conscientious objection scenario will be the starting point for future studies.

. Such insights might inform guidelines and healthcare ethics education specially in developing nations. The law places significant authority, burden and responsibility on each practitioner. Both proponents and opponents of abortion invoked tenets of professional ethics, viz., the right not to be coerced into actions one deems unacceptable, or the duty to provide care, respectively. More societal and professional discussion of the ethics and regulation of CO, and a clearer link between legal regulation and ethical guidance for professionals are called for.

The health care system is dominated by the secular principles and regulations in abortion provision. As the society is strongly religious, theological perspectives about the unborn children should gain a space to alleviate the moral tensions of the providers.

19.1 Recommendations

Other quantitative research can address the prevalence of CO, and qualitative research can explore and give an account of religious aspects on bioethical reflections among other health professionals. The discussion of legal aspect of CO within the ethics documents and training of health care professionals should also be conducted.

Health policy or regulatory guide ought to clarify and guide health care practitioners how the abortion law's criteria should be interpreted and applied in a practical level, whether in urban or rural areas. Health care ethics education has to be given as continuous educational development specially for senior health care professionals.

The concept and place of autonomy should be explored further with a view to its application in health care centers in developing countries. The role of religious texts and beliefs for other

bioethical issues such as IVF, euthanasia, and embryonic stem cell research need to be explored. In general, embryology and nature of human being have to be reflected both from scientific and theological perspectives in future studies.

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RESEARCH ARTICLE Open Access

Still a moral dilemma: how Ethiopian professionals providing abortion come to terms with conflicting norms and demands

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Abstract

Background: The Ethiopian law on abortion was liberalized in 2005. However, as a strongly religious country, the new law has remained controversial from the outset. Many abortion providers have religious allegiances, which begs the question how to negotiate the conflicting demands of their jobs and their commitment to their patients on the one hand, and their religious convictions and moral values on the other.

Method: A qualitative study based on in-depth interviews with 30 healthcare professionals involved in abortion services in either private/non-governmental clinics or in public hospitals in Addis Ababa, Ethiopia. Transcripts were analyzed using systematic text condensation, a qualitative analysis framework.

Results: For the participants, religious norms and the view that the early fetus has a moral right to life count against providing abortion; while the interests and needs of the pregnant woman supports providing abortion services. The professionals weighed these value considerations differently and reached different conclusions. One group appears to have experienced genuine conflicts of conscience, while another group attempted to reconcile religious norms and values with their work, especially through framing provision of abortion as helping and preventing harm and suffering. The professionals handle this moral balancing act on their own. In general, participants working in the private sector reported less moral dilemma with abortion than did their colleagues from public hospitals.

Conclusions: This study highlights the difficulties in reconciling tensions between religious convictions and moral norms and values, and professional duties. Such insights might inform guidelines and healthcare ethics education.

Keywords: Abortion, Abortion politics, Moral status, Religious convictions, Moral values

Background

A central issue on the global public health and human rights agenda is abortion services. In many countries where the abortion law has been liberalized, abortion still gives rise to controversy both among health professionals and among the general public, not the least in countries where faith traditions and practices are prevalent, as is the case in sub-Saharan Africa.

The path to liberalization of the abortion law in Ethiopia

The 1994 International Conference on Population and Development highlighted the need to prevent unsafe abortions and provide safe abortion services where lawful [1]. In the aftermath of the conference the liberalization of abortion laws in Africa has been promoted. African leaders agreed to address the problems constituted by unsafe abortion and lack of access to safe abortion through reforming national laws and policies, preparing service delivery guidelines and regulations, strengthening training programs, and expanding community outreach programs [2].

Throughout the 1990s, the abortion issue was put on the political agenda in Ethiopia. Advocates of liberalization wanted to reduce the incidence of unwanted pregnancies and save lives. Yet, they were met with opposition, often rooted in religious faith traditions and religious practices. In Ethiopia, the majority of the population regard themselves as religious: 44% are Orthodox Christians, 34% are

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Muslims and 19% are Protestants [3]. A 2007 study of the Ethiopian population showed that a majority (67%) regarded induced abortion as 'never justifiable' [4].

Relatedly, the Ethiopian population policy goal set in 1993 was to harmonize the rate of population growth with that of the economy. Among its many objectives were reduction of the high fertility rate from 7.7 to 4, and increasing the prevalence of modern contraceptive use among married women of reproductive age from less than 5% to at least 44% [5]. The principle that every pregnancy should be planned and wanted was incorporated into Ethiopia's population policy.

In 2005, the Ethiopian abortion law was liberalized, making induced abortion legal after rape or incest, if the woman's life or physical health is endangered, if she is physically or mentally disabled, or if she is a minor (less than 18). In addition, abortion is legal in the case of fetal impairment [6, 7].

Abortion in Ethiopia

In Ethiopia, abortions are performed by several different healthcare professionals: nurses, midwives, health extension workers (community health workers with one and a half year of training), health officers, integrated emergency surgical officers, and doctors who are general practitioners or specialists or in training as gynecologists-obstetricians (GYN-OBS). The 2014 guidelines authorize integrated emergency surgical officers to give comprehensive abortion care for second trimester abortions [8]. From 2008 to 2014, the proportion of abortion-related services provided by non-physicians increased from 48% in to 83% [9]. Not much research exists about health professionals' attitudes towards abortion; in one study, most practicing midwives were positive to provide abortion services and their attitude was positively associated with clinical experience [10].

Studies in 2008 and 2014 show that abortion services in Ethiopia have undergone rapid expansion and improvement since the introduction of the law in 2005, as assessed by the standards of the well-established 'safe abortion care' and 'emergency obstetric care' frameworks [11, 12]. An estimated 620,000 abortions were performed in 2014, corresponding to an annual rate of 28 per 1000 women aged 15–49. The proportion of abortions performed in health care facilities rose from 27% in 2008 to 53% in 2014. Two-thirds of abortions are performed in private/non-governmental organisation (NGO) centers (henceforth termed 'private', for ease of expression) [9].

Ethiopians' knowledge of the abortion law is moderate. For instance, a survey of women aged 15–49 from Bahir Dar in North-Eastern Ethiopia revealed that two-thirds were aware of the existence of the new law, yet 57% had little knowledge of it [13].

Research on abortion providers

Research on Ethiopian abortion practices has been sparse. In particular, the political, medical and ethical struggles over abortion among health professionals tasked with performing and assisting with abortion themselves have not been given much attention. A recent study from Addis Ababa, which parallels ours in involving interviews with abortion providers, describes health professionals' struggle to balance religiously- and morally-based opposition to abortion against their professional duty to provide abortions and their concern for the women [14]. A key finding in this study was that religious anguish and the stigma associated with the job appeared to lead to burnout for some. Seeing as how the health care workers' own attitudes towards the law and abortion practices varied, the researchers hypothesized that such attitudes would be likely to influence which patients would get access to abortion.

A national survey of physicians working in Ethiopian public hospitals showed that the respondents often experienced dilemmas related to reproductive health issues [15]. Respondents pointed to moral doubt and regrets in cases of abortion, as well as obligations to mitigate harm to women who might otherwise seek out unsafe abortions. Some respondents thought the abortion law was too strict, and that they were put in a dilemma when they found the abortion to be justified yet the woman did not fulfill the law's criteria.

In a review of studies on Sub-Saharan and Southeast Asian healthcare professionals' perceptions of and attitudes towards abortion, Loi and colleagues found that religion, among other factors, influenced attitudes towards abortion, and that professionals' attitudes subsequently affected the relationship to the patient seeking abortion [16]. They noted that a majority of professionals support abortion after rape or incest to save the woman's life, or when severe fetal abnormalities were discovered [16].

Study setting and aims

Ethiopia's total population is 105 million, of which about 3.4 million live in the capital Addis Ababa where the study took place. The capital is the most well-developed region in the country. Ethiopia spends on average $7.6 per capita on all dimensions of health care yearly. The fertility rate at 1.5 is half the national average [17]. The abortion rate is the highest in the country's capital, estimated at 92 per 1000 women age 14 to 49. The 2014 national abortion rate 2014 was 17.6 per 100 live births [18].

As described above, in Ethiopia in the preceding three decades the international normative framework of reproductive human rights has clashed with traditional and religious opposition to abortion. In this study, we

wanted to explore how health professionals experience and negotiate presumably conflicting allegiances. Thus, the aim was to shed light on health professionals' moral reasoning and experience with regard to moral dilemmas surrounding abortion. In this article we report on the professionals' views on the fetus and fetal moral status and how this is balanced with the right of the woman, and on the role and place of religion in professionals' moral deliberations.

Methods

Design, study area and recruitment

Because the aim was to explore in depth the viewpoints and moral reasoning of healthcare practitioners assisting, performing or otherwise involved in abortion services, a qualitative study design was chosen. The intention was to recruit healthcare practitioners from a range of professional backgrounds involved in abortion services in either public hospitals or private abortion clinics in Addis Ababa.

The first contact was through the first author's phone calls to the institutions. Each participant was given 100 to 200 Ethiopian Birr (approx. 3–6 Euro) for transport and compensation of time. Most of the 30 participants (22) provided abortions directly, while eight participants worked with abortion in an administrative capacity and/or provided contraceptives and post abortion care services. Half (15) of the participants were female. The participants had experience with abortion services ranging from 2 months up to 14 years.

Interviews

Participants were interviewed at their workplace by the first author. Interviews were conducted between February and July 2017, and lasted on average 40 min. An interview guide was used, with open-ended questions on views on abortion, fetal moral status, the influence of religion on the participant's views, and perceived moral dilemmas in abortion provision. All interviews were conducted in the Amharic language. Upon obtaining informed consent, interviews were recorded digitally. Then they were transcribed. The first author took field notes. An independent researcher translated the Amharic transcripts into English.

Analysis

The transcripts were analysed by the first and last author using systematic text condensation (STC), a qualitative analysis framework developed by Malterud [19]. STC is a four-step model:

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 article. In the analytic text, genuine (not artificial) quotations from the transcripts are used to illustrate and confirm the findings.

Results

In total, 30 health professionals (nurses, midwifes, public health specialists, general practitioners and OB-GYNs) were interviewed. Of these, 17 participants worked in public hospitals and 13 in private clinics. Participants presented a diversity of viewpoints on the moral status of the fetus and its implications with regard to abortion. Similarly, they exhibited different strategies to reconcile conflicting religious, ethical and professional duties. These viewpoints and strategies are presented below.

The moral status of the fetus

We noted that when asked to give their view on when life begins, what moral value the fetus has and when it acquires a right to life, many of the participants hesitated and took time before answering. For some, for the fetus to have 'life' or to be considered 'being alive' was synonymous with being a 'human being' and having 'human rights' and a 'right to life'. Some participants appeared to use the terms just mentioned both descriptively (e.g., biologically) and normatively (i.e., ethically and/or legally) at the same time. A majority, however, were clear in separating the descriptive and normative domains. Among the latter participants, a prevalent view was that life in a biological sense starts at conception. This was so even though they all went on to defend abortion in at least some situations as a matter of ethics and law, as exemplified by this participant:

> Life begins at conception. I believe it has got a right from the beginning. … [Abortion] contradicts the fetus' right to live. However, the mother also has to have a right, isn't that right? Priority should be given to the mother. (#1, female nurse, private clinic)

There was a large variety of views on when the fetus acquires moral value and a right to life. Broadly, these fell into three main categories. First, there were those who stated that moral value and a right to life begin already at conception or implantation:

> I say that [life] is from fertilization. Because, if it doesn't have life, it doesn't grow. [The embryo] is a proper person. That is the basis. … It has a right to live. It has a right from the moment it is conceived. (#7, female nurse, private clinic)

> An unborn child has a right to life. God knows the fetus even before it is conceived. … I don't have a right to abort it after conception. It has an owner. (#29, male OB-GYN, public hospital)

Second, some claimed that moral value and rights of the fetus come gradually throughout the development of pregnancy:

> We do not believe that [the fetus] is a complete human being. … We do not look at it from a moral perspective. We look at it from the mother's perspective. As [it is] a human being there are some feelings attached to it. However, we prioritize the mother. (#2, female nurse, private clinic)

Third, for others, moral value and a right to life begin either at birth, at viability, or at 28 weeks as per the Ethiopian abortion law:

> I do not believe that a fetus just created has life. … When it is born and begins to breathe, I [say] that it has life. Especially after the 28th week. For me, after it is born … it has a right to live. (#5, male health officer, private clinic)

In general, more participants from private clinics held the second or third views than did those from public hospitals, who more often held the first view.

Abortion in a religious perspective

When asked about the influence of religion on their abortion practices and viewpoints, several clearly had experienced a dilemma and a conflict of conscience. Most were clear that their religion had moral norms and values that condemn abortion more or less unequivocally.

For some, there was a genuine conflict between their practice and the religious condemnation of abortion, a conflict which continued to trouble their conscience. Some stated that they would also conceal the nature of their work from their acquaintances.

> I am an Orthodox believer. I have a debate in my conscience, I have a guilty feeling. For me [abortion] is shortening life. I am not happy. … There are some who find it difficult. Everyone is doing it, although complaining. There are some who wonder [whether they should] change their field. (#19, female nurse, public hospital)

> Previously I was not affected, but now as I am growing older, I sustain some feelings of guilt. Because this is definitely a sin. Nowadays I do not tell [people] that I work in [the abortion clinic]. (#9, female public health specialist, private clinic)

For others, the act of providing abortion services appealed to their religion's moral norm of helping people in need, and they argued that this norm should have priority. They did not doubt that their religion in fact condemned abortion. However, they attempted to reconcile the conflicting moral norms and duties, whilst retaining a religious moral outlook.

> Even though [abortion] stands in stark contrast with religion, at the same time people should not suffer. Therefore, when I do my job I reconcile the two. (#3, male public health specialist, private clinic)

> Sometimes [abortion practices] get in conflict with religion. I reassure myself when I look at it from the angle of helping. I look at it from the angle of helping others, so, I do not believe that it is counted on me as sin. … God had said help those who are in need. (#5, male health officer, private clinic)

Several reflected on the experiences they had, especially with complications from unsafe abortions and on having changed their views in the course of their work.

> When I started to see things and do them, I became more and more persuaded. I know, in religion, [abortion] is not permitted. I used to, from that perspective, think that all pregnancies must be born. I changed as time goes. [Whether] you are involved here or you see it from the outside, it is not the same. When you sit and hear people's stories, your view changes gradually. (#17, female nurse, public hospital)

> I am a Muslim but I am liberal. My view on abortion is liberal. The reason for that is that I had worked in the rural area. … I have seen 3–4 who lost their lives. … As long as they meet the requirements of the law, I have no reservation. … We need to save her life. Islam does not prohibit the

> termination of the pregnancy. … I have seen those who died because I rejected them. … I prefer to [perform abortion] because it is a matter of life and death. That is how my logic works. (#20, male GYN/OBS, public hospital)

For this group, performing abortions was justified by the serious needs it met in safeguarding the woman's health. This also implied that only particularly weighty reasons for abortion (e.g., the woman's health) would be sufficient to condone it:

> I would like to do only reasonable and convincing abortion scenarios. I terminate early pregnancies, less than 5 weeks of gestation and incomplete abortions. Non-reasonable ones are not acceptable for me. (#30, male GYN/OBS, public hospital)

A final group stated that even though they were religious, their religion had little or no influence on their views and practice concerning abortion. This group had deliberately set religious norms and values aside and displayed no need to justify this further in the interview.

> My thoughts are based on helping people in need of help, I do not bring it to my religion. (#10, female nurse, private clinic)

Discussion

Balancing allegiances and concerns

The aim of the study was to understand how professionals involved in abortion services experience and come to terms with presumably conflicting allegiances. The results provide an insight into this 'balancing act'. Religious norms and the view that the early fetus has a moral right to life count against providing abortion; the interests of the pregnant woman count for it. This kind of experienced conflict has been described in other developing countries, such as Kenya [20]. Similarly, a study from South Africa indicated that abortion providers formed their views on abortion in light of personal, moral and religious factors [21].

Seen this way, it is natural that the professionals weigh the interests differently and have different positions. One would expect that the (presumably large) portion of healthcare professionals who have held on to a traditional ethical condemnation of abortion avoid employment in healthcare institutions where they would be expected to perform or assist with abortions. These are not represented in the study. However, it is interesting to see that also among those who have chosen to work with abortion, many have a troubled, ambiguous and/or unresolved attitude towards abortion. This corroborates McLean et al.'s finding [14], and also Yang et al.'s interviews with Taiwanese nurses [22].

Among the participants, a common view was that life in a biological sense starts at conception. This was so even though they all went on to defend abortion in at least some situations as a matter of ethics, professional duty and law. This in itself does of course not imply any contradiction. However, it was also found that some participants contradicted themselves throughout the interview, perhaps indicating that these were topics that they had not necessarily thought much about, at least not in these terms. One interpretation of the contradictions and hesitation seen with several of the participants is that not all the participants have given the issue that much thought. Although abortion is controversial in Ethiopia and hotly debated, starting to work in abortion services apparently has not necessarily 'forced' some of the participants to critically reflect on ethical dilemmas involved. Apparently, the 'balancing act' required to reconcile the conflicting norms and duties was one that each practitioner would have to perform on their own. No participant mentioned any communal deliberation about the dilemmas they faced. In our view, healthcare education ought explicitly to address the dilemmas of conflicting norms, values and duties in issues connected with abortion, to aid future practitioners in developing their own views. Furthermore, a safe forum for moral deliberation and discussion might be of help to some professionals.

One group appears to have experienced genuine conflicts of conscience. Here, some have also felt the need to conceal the true nature of their work from neighbors and acquaintances, as was also found among some of McLean et al.'s participants [14]. A significant group had attempted to reconcile religious norms and values with their work. In this group there appeared to be two argumentative strategies. One part of the group admitted that the abortion practices they were engaged in actually did contradict religious norms, but that the arguments *for* the practices were stronger. Here, several point to their own experiences of how lack of access to safe and legal abortion have caused suffering, complications and death for women. Apparently, such experiences were powerful lessons for several practitioners, leading them towards greater acceptance of legal abortion. Another strategy involved juxtaposing the religious prohibition on abortion with norms and duties of rescuing and helping, and pointing out that also the latter are valid religious considerations. This strategy, then, involves interpreting the demands of the religion, using its inherent ethical resources to show that it can also justify a practice of providing abortion to those with a significant need for it. This argumentative strategy might be thought to parallel how several Western Christian

denominations nuanced their teaching on the ethics of abortion throughout the 20th and early 21st centuries [23].

In general, participants employed in the private sector displayed less anguish and discomfort with abortion as a religious-ethical dilemma than did their colleagues from public hospitals. If there is indeed a substantial difference between the groups, one explanation could perhaps be that those in the private sector have abortion as a larger part of their job, and thus their choice to work with abortion has been more of an active choice.

Different views on the biological and moral status of the fetus and the ethical and legal permissibility of abortion

The same conflation of issues which, arguably, is prevalent also in Western discussions of the abortion issue leads to some apparent or genuine contradictions. Perhaps in future research the questions should be framed differently. It might be that it would have been helpful for the participants in the interview situation if from the start the interviews had been structured around four explicit questions; i.e. i) biology, ii) moral status, iii) *moral* acceptability of abortion, and iv) *legal* acceptability of abortion. As for the question of biology, most participants stated that the fetus was in fact human and that biological life started at conception. With regard to the second question on what moral status the fetus has at different stages of development, we find both the view that moral status (and a corresponding right to life) starts at conception, and the view that moral status comes later, either gradually throughout the pregnancy, at viability, or at birth.

With the third question about whether and when abortion is morally acceptable, we see that the interests of the pregnant woman come to the fore [24], and several participants, from the private clinics, asserted that the interests of the woman should outweigh considerations for the fetus and its moral status. Finally, the fourth question about when the law ought to allow abortion shows that it is possible to support a liberal abortion law yet maintain that most abortions are in fact morally problematic. In our study, most participants did not distinguish explicitly between the domains of law (question iv) and ethics (questions ii and iii).

An additional question is whether the experienced moral dilemmas and anguish lead the professionals to treat patients in a different manner than they would have if they had felt no moral qualms connected to abortion, as suggested by several studies [14, 16] This topic will be addressed in a future article.

Limitations

Limitations inherent to the study merit discussion. While findings may be relevant to other similar settings, they cannot be generalized because of the purposive nature of the sample. All participants worked in Addis Ababa which may have introduced selection bias; recruiting participants from other parts of the country might have added depth to the findings. The first author is Ethiopian, trained in physiology and in Orthodox Christian theology, and is well conversant with such religious practices, which may have biased the way questions were phrased and translated. To minimize this effect, interview questions were developed in close collaboration with the co-authors; supervisor debriefing sessions were also held during the analysis phase; and an Ethiopian researcher independently translated all the transcribed interviews to assess quality and accuracy.

Conclusion

Though circumscribed in scope, this study contributes to the research on abortion in low-income countries. It documents some of the complexities in reconciling value tensions (or paradox) perceived and expressed by participants, and ways Ethiopian healthcare professionals involved in abortion services try to balance their different allegiances and concerns. The study indicates that several experience conflicts of conscience. Such insights might inform guidelines and healthcare ethics education.

Abbreviations

GYN/OBS: Gynecology/obstetrics; NGO: Non-governmental organization; STC: Systematic text condensation

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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.

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Availability of data and materials

In order to protect participants' anonymity, the data (transcripts) will not be shared.

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.

Competing interests

The authors declare that they have no competing interests.

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Navigating abortion law dilemmas: experiences and attitudes among Ethiopian health care professionals

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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 provisions 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 or not. Regarding abortion for fetal abnormalities, participants support the woman's authority in deciding whether to choose abortion or not, 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: Ethiopian practitioners experience moral dilemmas in connection with abortion. The law places significant authority, burden and responsibility on each practitioner.

Keywords: Abortion, Abortion law, Ethical/moral challenges, Ethical/moral dilemmas, Ethiopia, Fetal abnormalities

Background

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. Since then, 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]. Abortion is performed free of charge in public institutions. At the time of data collection, it cost approximately 400–1500 Ethiopian Birr (9–34 US$) in the private institutions. Studies show that Ethiopian abortion services have both expanded and improved in terms of quality since 2005 [3]. While abortion services are at the recommended level in some cities and

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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 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. This is perceived as a significant problem, still contributing to an estimated 10% of maternal mortality [5, 6]. In Sub-Saharan Africa in general, unsafe abortion is still a significant concern and maternal deaths due to unsafe abortions are still high [7].

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 [8]. 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 perceived as an important source of dilemmas [9]. In particular, some respondents viewed the abortion law as too restrictive, 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 the law than those who were inexperienced [10].

The present study

The present paper is the third and final paper from an extensive interview study with abortion providers in Addis Ababa. The first paper specifically examined participants' *views on the moral status of the fetus*, and *the impact of their religious views on their work* [11]. In particular, it was highlighted how the participants attempted to reconcile the tension between the demands of their moral and religious views and their professional obligations. It was found that the providers were left to perform this 'balancing act' on their own. Whereas some continued to experience a troubled conscience, others had justified participation in abortion through framing it as helping and preventing harm.

The second paper examined participants' *views on and experiences with conscientious objection (CO) to abortion* [12]. Despite being forbidden by government regulations, CO was practiced. Supporters of CO claimed that accommodation could often be achieved when colleagues were available to carry out an abortion and related tasks, while opponents saw CO as a potential threat to patients' access to abortion services.

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 and dilemmas both related to the law and unrelated. Moral challenges were defined as situations in which there was doubt or disagreement about the right or best course of action. Views on abortion for fetal abnormalities were examined specifically for two reasons. Firstly, experiences from other countries indicate that this gives rise to particular moral challenges; secondly, the topic had not been explored through interviews with providers in Ethiopia before.

Methods

Methods have been described in detail in the two previous papers [10, 11]. The most salient features of the approach used are summarized here.

Setting and recruitment

A qualitative design was deemed appropriate for 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 a practical and/or administrative capacity 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 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). Informed consent was obtained from each participant.

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 [13]. 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 findings section of the paper. In the analytic text, genuine (not artificial) quotations from the transcripts were used to illustrate and confirm the findings.

The first and fourth authors analyzed the data independently following these steps. They then met to discuss and harmonize their analyses. Three main themes were decided on: 'differing views on abortion law', 'experienced dilemmas', and 'abortion justified by fetal abnormalities'.

Data were collected in accordance with conditions in the research ethics approvals and thus also the relevant Norwegian guidelines and regulations. The data were analyzed and findings were reported in accordance with recognized standards for qualitative research, as per the STC framework presented above.

Research ethics

Ethical approval was obtained. 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

Participant background

Thirty healthcare professionals agreed to be interviewed. Of these, most (22) provided abortions directly, while the remaining eight participants had managerial roles in abortion provision, and patient-directed work such as providing contraceptives and post-abortion care. Participants had experience with providing abortion that ranged from two months up to 14 years. The sexes 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 his/her views.

Differing views on the abortion law

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

A majority of participants, especially from private/NGO clinics, stated that they were content with the law, even though they pointed to some shortcomings. They asserted that the most important consequence of the law was that it reduced the incidence of unsafe abortion, and thus saved women's lives and reduced 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 resident, public hospital).

Many respondents, while content that the law gives many women access to abortion, would like further liberalization with wider or alternative criteria. Several 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, a minority of informants thought that the law went too far in not requiring additional evidence; or in being too liberal, as abortion was still in their view a moral dilemma. They 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 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).

Experienced dilemmas

Participants were asked about which moral challenges, if any, they encountered in their work with abortion. Although most had experienced several challengeses, some stated that they had not encountered any significant moral challenges. A few 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 they were uncertain whether criteria were met. Sometimes this led to discussions and disagreement among colleagues. In general, participants from public hospitals appeared somewhat less liberal and less comfortable with applying a broad (inclusive) interpretation of the law's criteria than did participants from the private/NGO sector.

Sometimes they were expected to perform abortions beyond the law's gestational stage 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. A few of the participants 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).

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)

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 tells us. We do not assess whether Ethiopian law allows that or not (#4, female nurse, private clinic).

As noted above, some participants 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. They expressed that this could potentially give women seeking abortion incentives to lie in order to fulfill the law's criterion. Similarly, a few participants 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 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 a moral problem.

Abortion justified by fetal abnormalities

When asked about termination of pregnancy in cases of fetal abnormalities, the majority of the participants said that they believed termination should be performed/offered. They highlighted serious negative consequences of having children with abnormalities for the woman, her family, and also society. A few explicitly pointed to the economic burdens for society, and several 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).*

There were only a few who expressed serious ambivalence about termination in case of fetal abnormality:

> *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).*

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 a minority 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).*

Participants were unanimous in wanting to leave the decision whether to terminate a pregnancy with abnormalities to the woman herself as illustrated in this remark:

> *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).*

Discussion

Exploring the ways in which the revised Ethiopian abortion law was being interpreted and experienced among abortion providers shed some light into the nuances of their practices and the resolution of moral challenges and dilemmas [14]. 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 [8, 9].

Interpreting the abortion law's criteria

The law's criteria are brief and open to interpretation which has been viewed as problematic in how criteria are applied [15]. 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 [16].

As a result of the law being broadly open for interpretation, abortion is viewed as de facto available on request, and from a providers' perspective somewhat burdensome because potentially the clients choose where to draw the line. Both of these findings are in line with McLean's study [8].

As Blystad and colleagues 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 [17]. Because some respondents acknowledged practicing 'abortion on request' with little regard for whether the law's criteria were met, it appears that it is the individual practitioner's stance that could potentially determine 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.

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 an abortion is justified without deference to the law's criteria.

Abortion in light of fetal abnormalities

None of the participants mentioned abortion for fetal abnormalities as a moral challenge they experienced prior to being prompted to reflect on the issue. They referred to the moral value of the fetus and the rights of the disabled versus values of the woman's autonomy and the difficulty in providing the child with requirements for a good life. However, abortion was considered a reasonable alternative in the case of fetal abnormality (albeit different attitudes concerning the severity of the disability), and they all appeared to want to leave the choice to the woman. Their main arguments align with Muderedzi and Ingstad's observations that "[d]isability can cause poverty by preventing the full participation of disabled people in the economic and social life of their communities, especially if the proper supports and accommodations are not available" [18]. 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 abnormality. 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 [19]. Conversely, 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 abnormalities [20]. The attitudes of the Ethiopian population, including health professionals on these issues should also be assessed in surveys.

Strengths and limitations

The qualitative design provided in-depth accounts of moral challenges and dilemmas experienced by providers practicing induced abortion. Only providers in Addis Ababa have been interviewed; experiences in other parts of Ethiopia, including rural settings could be different. Exploring actual practices directly fell out the scope of the current study, and thus we couldn't verify or triangulate 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.

Conclusion

Although most abortion practitioners in our study considered the 2005 abortion law a clear improvement, they acknowledge new dilemmas. The large space for abortion participants' individual interpretation and application of the abortion law's criteria appears to place a considerable authority, burden and responsibility on each practitioner. For patients, it might conceivably mean that access to abortion is dependent on the views and practices of the practitioner encountered.

Abbreviations

CO: Conscientious objection; NGO: Non-governmental organisation; STC: Systematic text condensation.

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Authors' contributions

All authors contributed to the design of the study. DBE performed and analyzed the interviews and wrote the first draft. MM analyzed 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.

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Availability of data and materials
The data generated during and analyzed 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.

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 gave written informed consent. The study was carried out in accordance with the Declaration of Helsinki.

Consent for publication
Not applicable.

Competing interests
The authors declare that they have no competing interests.

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SPECIAL ISSUE

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Professionals' experience with conscientious objection to abortion in Addis Ababa, Ethiopia: An interview study

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Abstract

In Ethiopia, conscientious objection (CO) to abortion provision is not allowed due to government regulations. We here report findings from a qualitative interview study of 30 healthcare professionals from different professions working with abortion in Addis Ababa, Ethiopia. CO is practised despite the regulations forbidding it. Most informants appeared to be unfamiliar with the prohibition or else did not accord it weight in their moral reasoning. Proponents of institutionalization/toleration of CO claimed that accommodation was often feasible in a hospital setting because colleagues could take over. Opponents pointed to threats to patient access in rural settings especially. Both proponents and opponents invoked tenets of professional ethics, viz., the right not to be coerced into actions one deems unacceptable, or the duty to provide care, respectively. More societal and professional discussion of the ethics and regulation of CO, and a clearer link between legal regulation and ethical guidance for professionals, are called for.

KEYWORDS

abortion, conscientious objection, Ethiopia

1 | INTRODUCTION

Conscientious objection (CO) in healthcare refers to a health professional's refusal to provide services due to moral or religious reasons. The classic case of CO in healthcare is CO to abortion; however, CO can become a topic in any situation in which what is expected of the professional is at odds with their moral/religious convictions and the professional goes so far as to refuse to perform or participate. In recent years, the academic debate on the ethicality of CO has become voluminous. Some argue for broad toleration of CO, whilst others argue that it is rarely or never acceptable. Yet many also argue broadly in line with the so-called 'conventional compromise',[1] where CO is judged morally acceptable if it is based on a serious moral objection, yet the professional is willing to inform the patient and refer to a colleague, and any burdens to the patient are deemed acceptably small. The responsibility to refer is also emphasized by the World Health Organization (WHO), which states that 'Conscientious objection, where allowed, should be regulated, and provision of alternate care for the woman ensured'. It is also pointed out by The International Federation of Gynecology and Obstetrics (FIGO) with the statement that 'If a physician is either unable or unwilling to provide a desired medical service for non-medical reasons, he or she should make every effort to achieve appropriate referral'.[2]

[1]A term coined in Brock, D.W. (2008). Conscientious refusal by physicians and pharmacists: who is obligated to do what, and why? *Theoretical Medicine and Bioethics*. 29, 187-200. For examples of this approach, see Wicclair, M. R. (2011). *Conscientious Objection in Health Care*. Cambridge, Cambridge University Press; Magelssen, M. (2012). When should conscientious objection be accepted? *Journal of Medical Ethics*. 38, 18-21.

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Access to abortion is legally restricted in most African countries. Several have institutionalized conscientious objection to abortion; Ethiopia is the only African country explicitly to forbid this.[3] Because practices of conscientious objection are shaped by the social, religious and health care contexts in which they take place, more empirical research on how practices and policies influence patients and providers has been called for.[4] Tadele et al. describe the Ethiopian political and religious landscape with regards to abortion well; the 2005 liberalization of the penal law pertaining to abortion has been described as an 'uneasy compromise' between the government's public health concerns and religious organizations.[5] Religion exerts a significant influence on the moral views of Ethiopians, including health professionals. The majority of Ethiopians is Christian (62%) or Muslim (34%).

In the 2005 law revision, induced abortion became legal after rape or incest, if the woman's life or physical health was in danger, if the woman is a minor or disabled, and in case of fetal impairment.[6] Government regulations specifically state that health professionals do not have a right to CO in the case of abortion: 'A health professional may not refuse on grounds of personal belief to provide services such as contraceptive, legal abortion and blood transfusion'.[7] However, it is known that CO to abortion does occur in that some Ethiopian professionals do not offer abortion, either in general or in specific situations.[8]

So far, there has been little research on CO among Ethiopian professionals, and the scope of the practice is unknown. In a 2013 survey of Ethiopian midwives' attitudes towards abortion, 66% agreed that 'Health care providers should be able to refuse to provide any procedure with which they have religious or moral objections', whereas 52% agreed that 'Midwives and doctors should be required to provide abortion services to women even if it goes against their personal beliefs'. The inconsistency of the answers might indicate uncertainty and ambivalence on the issue. Fifty-six per cent were themselves willing to provide abortion.[9]

Since the 2005 liberalization, abortion services have been expanded and improved considerably, especially in cities. Mid-level professionals have gained responsibility and may perform abortion independently. Two-thirds of safe abortions now take place in private/non-governmental organization centres (termed 'private' from here on).[10] Liberalization has been successful in reducing abortion-related maternal mortality and morbidity, yet unsafe abortion is still a significant problem.[11]

The present paper is based on a project involving research interviews with health professionals involved in abortion provision in Addis Ababa in order to understand their experiences with abortion and any moral problems they have had to face. In a previous paper from the project studying professionals' reconciliation of the provision of abortion with their moral/religious views, we found that professionals weighed value considerations and religious norms differently.[12] There were some who reported conflicts of conscience. Several had attempted to reconcile religious norms and values with provision of abortion through framing such provision as preventing harm and suffering. The aim of the present study is to examine the views, practices and experiences of health professionals involved in abortion provision with regards to CO, and thereby also to contribute to the broader conceptual debates about CO.

2 | METHODS

A qualitative study design was deemed appropriate in order to explore in-depth the experiences, views and moral reasoning of healthcare professionals assisting, performing, managing or otherwise involved in abortion provision. In order to get a broad view of practices and attitudes, we tried to recruit practitioners from different professional backgrounds, of both genders, with different religious affiliations, working in either private/NGO abortion clinics or public hospitals in Addis Ababa, Ethiopia. After receiving permission from institution leaders, the second author visited the institutions and spoke to employees about participation. Thirty-three people were invited, and 30 accepted to be interviewed. Of the 30 participants, 22 provided abortions directly. The remaining eight participants had managerial roles concerning abortion provision, in addition to themselves performing patient-directed work such as providing contraceptives and post-abortion care; these informants were thought to have experiences with and views on abortion provision although not presently directly involved in such provision. Seventeen worked in two different public

[3]Federal Negarit Gazette, Vol. 20 No. 11, p. 7216. Retrieved September 30, 2020, from https://www.rrfa.co.za/wp-content/uploads/2014/08/Regulation-No-299_2013.pdf.

[4]Harris, L. F., et al. (2018). Conscientious objection to abortion provision: Why context matters. *Global Public Health*. 13, 5, 556-566.

[5]Tadele, G. et al. (2019). 'An uneasy compromise': strategies and dilemmas in realizing a permissive abortion law in Ethiopia. *International Journal for Equity in Health*. 18, 138.

[6]Wada, T. (2008). Abortion Law in Ethiopia: A Comparative Perspective. *Mizan Law Rev*. 2, 1, 1–32; Proclamation No. 414/2004. Criminal Code of the Federal Democratic Republic of Ethiopia. Addis Ababa: Berhanena Selam Printing Enterprise; 2005. See also Abdella, A., et al. (2013). Meeting the need for safe abortion care in Ethiopia: results of a national assessment in 2008. *Glob Public Health*. 8, 417-34.

[7]The Federal Democratic Republic of Ethiopia, op. cit. note 3. See also Chavkin, W., et al. (2018). Implementing and expanding safe abortion care: An international comparative case study of six countries. *Int J Gynaecol Obstet*. 143 Suppl 4, 3-11.

[8]Bridgman-Packer, D., & Kidanemariam, S. (2018). The implementation of safe abortion services in Ethiopia. *Int J Gynaecol Obstet. 143 Suppl 4*, 19-24.

[9]Holcombe, S. J., Berhe, A., & Cherie, A. (2015). Personal beliefs and professional responsibilities: Ethiopian midwives' attitudes toward providing abortion services after legal reform. *Studies in family planning*. 46, 73-95.

[10]Dibaba, Y., et al. (2017). A decade of progress providing safe abortion services in Ethiopia: results of national assessments in 2008 and 2014. *BMC Pregnancy Childbirth*. 17; Guttmacher Institute. (2017). Fact sheet. Induced Abortion and Postabortion Care in Ethiopia. Retrieved August 5, 2020, from https://www.guttmacher.org/fact-sheet/induced-abortion-ethiopia.

[11]Assefa Tessema, G., et al. (2017). Trends and causes of maternal mortality in Ethiopia during 1990–2013: Findings from the Global Burden of Diseases study 2013. *BMC Public Health*. 17. https://doi.org/10.1186/s12889-017-4071-8; Gebrehiwot, Y., et al. (2016). Changes in morbidity and abortion Care in Ethiopia after Legal Reform: National Results from 2008 and 2014. *Int Perspect Sex Reprod Health*. 42(3), 121–30.

[12]Ewnetu, D. B., et al. (2020). Still a moral dilemma: how Ethiopian professionals providing abortion come to terms with conflicting norms and demands. *BMC Med Ethics*. 21, 16.

hospitals, whereas 13 worked in seven different private clinics. The participants' experience with abortion services ranged from two months to 14 years; half of the participants (15) were female. Concerning religious affiliation 21 informants identified as Ethiopian Orthodox, five as Protestant/Evangelical, two as Muslim, whereas one was unaffiliated and one did not want to disclose.

Semi-structured interviews were performed between February 2017 and July 2017. The interviewer is a male PhD candidate in medical ethics, with degrees in physiology, radiography and theology. All interviews took place at informants' workplace and lasted on average 40 minutes. Participants were given 100-200 Ethiopian Birr for compensation. The interview guide had open-ended questions on abortion, the significance of religion, conscientious objection, and perceived moral problems related to abortion services. Interviews were performed in Amharic, recorded digitally, then transcribed. In addition, the interviewer took field notes. The Amharic transcripts were later translated into English by an independent translator.

The translated transcripts were analysed by the authors independently before analyses were harmonized. Analysis proceeded by way of systematic text condensation (STC), a qualitative analysis framework developed by Malterud building on DiGiorgi's method.[13] STC 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. It quickly became apparent that views and practices were diverse, with a notable difference between private and public sector providers, and that religious values but also norms of professional ethics were important for the informants.

2. From themes to codes: each unit of meaning was identified and coded according to topic. Codes (e.g., 'consequences for patients') and sub-codes were created. At this stage, it became clear that the bulk of the data on conscientious objection concerned informants' own moral stances and arguments and their thoughts about how patients were affected, whereas they had said comparatively little about policy issues and legal regulation. We therefore decided to emphasize informants' ethical reasoning and arguments in the analysis.

3. From code to condensation: all units of meaning coded with the same sub-code were then read 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. The purpose of this step is to transform the content of the meaning units into an abstract format, whilst retaining the format of a first-person utterance and, to some extent, the participant's own terminology.[14] 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 article. In the analytic text, genuine (not artificial) quotations from the transcripts are used to illustrate and confirm the findings.

2.1 | Research ethics

The project was evaluated and approved by the institutional review board of St Paul's Hospital Millennium Medical College, Addis Ababa, and the Data Protection Official at the Norwegian Centre for Research Data (ref. 53104). Participants were informed orally and in writing and signed a written consent form. As the interviews concerned sensitive topics, we limit demographic and other information about individual informants in order to protect their anonymity.

3 | RESULTS

Concerning conscientious objection to performing or participating in abortions, there were clear differences in viewpoints between informants from private/NGO clinics and informants from public hospitals. For the first group, objecting to abortion would make little sense as this was a central part of their job: *'You cannot decline if [the patient] meets the criteria. You would not have been employed in the first place.'* (#11, male public health specialist, private clinic). Among this group, most were also critical of the phenomenon of conscientious objection, as were also some of the public sector informants. Those who were critical worried about patient access to abortion, that patients might be troubled in the process, and that they might end up having an unsafe abortion somewhere else. This was a particular concern for rural areas with few providers. They also pointed to professional obligations to provide care and to the law.

> If you dismiss [patients] without performing [abortion] and the person proceeds to ones who do it an unsafe manner, and passes away, who is responsible for that? You are answerable before the law if you are unwilling to provide that service. (#3, male public health specialist, private clinic)

> As long as they accepted the employment, they have to deal with all sorts of health issues, whether this is in the government or private sector. (#2, female nurse/health officer, public hospital)

> [Conscientious objection to abortion] should not be professional. You promised [to perform abortion] when you accepted the job offer. If you say that 'I do not want to help', you [are falling] outside of medical

[13]Malterud, K. (2012). Systematic text condensation: A strategy for qualitative analysis. *Scandinavian journal of public health*. 40, 795-805.

[14]Malterud, op. cit. note 13, p. 799.

> ethics. (#3, male public health specialist, private clinic)

> The law says that one has to perform without one's religious beliefs interfering. (#12, male GYN/OBS, private clinic)

The informants from public hospitals, on the other hand, stated that conscientious objection to abortion was indeed a phenomenon in their own and other public hospitals. Most, but not all of these informants defended the option to refrain from participating in abortion. Common arguments among those who defended conscientious objection were that one should not be forced to do something against one's will, that respect for individual conscience is a right and a tenet of professional ethics, and that colleagues were available to take over the tasks. Some explicitly referred to religion.

> Individual differences are inevitable. It is better to encourage those who are willing to perform. It is difficult to force someone to do it. (#30, male GYN/OBS, public hospital)

> When it contradicts our belief, we transfer them to the ones who are willing to do it …

> For the medical professional, it might not be acceptable because of his faith. Therefore, we send them to those who can give them the service. (#23, female GYN/OBS, public hospital)

> I want [conscientious objection] to be my right. It is not fair to be forced to do what you do not accept for the sake of your livelihood. … The solution is to have equal rights. There are some who want to perform, there are also some who do not … forcing makes the physician a victim. (#22, female GYN/OBS, public hospital)

> As long as it is not an emergency, the physician has a right for reservation … If this happens in practice [i.e., the physician is forced to perform abortions], I resign my position, I will not perform … A physician also has a right. (#25, male GYN/OBS, public hospital)

None of the informants from hospitals thought that the practice of conscientious objection had created problems for patient access or for colleagues in their own institutions.

> It does not create problems for the health institution, someone willing is assigned. If you do not [perform abortion], you hand [the patient] over. There is not a single woman who left without getting the service. (#28, female nurse, public hospital)

> When some reserve themselves on an account of religion, I do their part as well. Many of the residents here, they do not participate. When they give ethical, religious reasons, I take over for them. … There are people who are willing to carry it out, so it does not create any problem. (#20, male GYN/OBS, public hospital)

Of note, several public sector informants were willing to provide abortion in some cases but not in others. These other cases could be situations where the law's criteria were not clearly met. They would then turn these cases over to colleagues. Some other informants would only perform abortions in emergencies.

> I have [performed abortion] for those who approach us due to health concerns. However, for those who approach us because of … their own reasons, I do not participate. I have never participated on that which is done only because abortion is available. … I do not perform [abortion] because the mother wants it due to economic reasons, or they do not want [the child] … But I pass those on to those [colleagues] who perform. (#25, male GYN/OBS, public hospital)

> No one forces me to carry it out [i.e., perform abortion]. If it is an emergency case, of course, that is correct, I do it … Other than that, for example, if I am asked to do it due to economic reasons, I do not do it, because I have my own moral, religious aspect. This needs to be respected. The way it is going now, [patients/officials] are presenting issues that are not included in the law. They also need to see our needs. I say that it also needs to respect our rights. (#18, female GYN/OBS, public hospital)

Only two of the informants explicitly mentioned the current legal prohibition on conscientious objection to abortion. At least one of the informants appeared to have thought that there was indeed a legal right to abstain from participating in abortion.

4 | DISCUSSION

4.1 | Consequences for patients and other arguments made for and against conscientious objection

The main arguments made by the informants echo the main arguments in the international bioethics debate. Proponents of institutionalization/toleration emphasized the importance of freedom of conscience. Yet they also pointed to the practical issue of whether patients would be burdened by CO. Many contended that in hospitals where many colleagues were available, the refusal of some

professionals to provide abortion would not result in the patient not receiving the service. In practice, there might be a limit to how many objectors the hospital can sustain before patient access is impeded.[15] Opponents of institutionalization/toleration indeed worried about patient access, especially in rural areas where there are few providers and a lack of healthcare facilities.[16] Unsafe abortions with resultant morbidity and mortality might then become the alternative. In general, if institutionalization of CO is not to impair patient access, it might only be feasible in large cities and in hospitals where several alternative providers are available.

The differences between private and public sector providers were notable, regarding both attitudes to CO and own practices, with private sector providers less accepting of CO and all conscientious objectors interviewed working in public hospitals. Although this was not explicitly talked about in the interviews, for some of the private sector providers it might have been a condition of their contract that they were willing to provide abortion services. In contrast, many public sector professionals did not necessarily train with the expectation that they would be providing abortion services.

Drawing on empirical investigations form around the world, Harris et al. argue that 'the practice of conscientious objection may not always be a true expression of conscience, but rather can sometimes be understood as an option providers have to respond to various stresses and incentives in their distinct social contexts.'[17] We did not find indications of this in our study; all informants who refused to perform some or all abortions justified this with ethical arguments and the moral gravity of abortion, rather than with self-serving or practical reasons. The obvious caveat is that the study was designed to collect providers' own accounts only.

4.2 | Conscientious objection and legal grey zones

A recent study found that abortion providers varied in their attitudes towards different kinds of reasons for abortion.[18] Many used the term 'reasonable abortion', and their assessment of what was reasonable did not necessarily comport with the law. This resonates with the present findings, for instance in the quotes where the provider objects to abortions requested for economic reasons, whilst not commenting on the fact that such reasons would fall outside the law. If providers doubt the accuracy of women's rationales for abortion (e.g., rape), they might perhaps feel more inclined to refuse to provide abortion services. In McLean et al.'s study, providers thought the abortion law to have 'grey zones' which open spaces for the provider's own discernment and interpretation. In the context of conscientious objection, this creates a practically important question: when does a provider go from being someone who interprets the law's criteria for abortion restrictively to being a conscientious objector? Although denying to perform abortion because judging the patient not to fulfil the law's criteria would not constitute conscientious objection and would be lawful, the provider's own ethical views on abortion are likely to play a role in that judgment. Conceptually, the provider becomes a conscientious objector only when they deem the law's criteria to be fulfilled yet refuse to provide the abortion. Because some professionals object to perform abortion only in certain cases, as the results show, CO appears to come in degrees. This echoes Freeman and Coast's findings from Zambia, where they conclude that 'conscientious objection in practice could be understood as a continuum of behaviours rather than a binary position'.[19] Even in a context where CO is institutionalized, such 'degrees of CO' could create problems for patients and obstacles to access to services. A provider judging each case individually to decide whether he or she finds it morally acceptable to provide abortion would challenge the principle of upfront disclosure of any conscientious objections.

The latitude that providers have in making judgements about the legality and appropriateness of abortion also indicates that the woman/client has a relative lack of power when requesting abortion services in the Ethiopian context.[20]

4.3 | Legal regulations and ethics

The results indicate that many abortion providers *either* are unaware of the legal prohibition on CO[21] *or* do not accord the regulations much weight in their moral reasoning. Either way this might constitute a problem for legislators; if they want the prohibition on CO in the case of abortion to be effective, it must be promulgated more widely. There appears not be a link to connect the legal document's guidance with authoritative medical ethics guidance that health professionals are familiar with and abide by. Interestingly, both proponents and opponents of institutionalization of CO framed the issue as one of professional ethics and obligations, with proponents pointing to the professional's moral right not to be coerced into something they believe morally wrong, and opponents pointing to the moral obligation to serve and provide due care.

The explicit initial justification for abortion law reform in Ethiopia was to reduce maternal mortality, rather than to promote women's rights to reproductive freedom. Thus, as maternal mortality decreases, there might conceivably be increased calls for (or clandestine practices of) conscientious objection, as the justification for abortion is perceived to have weakened.[22]

[15]See the discussion of a variation of the same problem in Minerva, F. (2015). Conscientious objection in Italy. *Journal of Medical Ethics*. 41, 170-173.

[16]Lema, V. M. (2012). Conscientious Objection and Reproductive Health Service Delivery in Sub-Saharan Africa. *African Journal of Reproductive Health*. 16, 15; Seid, A., et al. (2015). Barriers to access safe abortion services in East Shoa and Arsi Zones of Oromia Regional State, Ethiopia. *Ethiopian Journal of Health Development*. 29, 13-21.

[17]Harris, et al., op. cit. note 4.

[18]McLean, E., Desalegn, D.N., Blystad, A., & Miljeteig, I. (2019). When the law makes doors slightly open: ethical dilemmas among abortion service providers in Addis Ababa, Ethiopia. *BMC Medical Ethics*. 20:60.

[19]Freeman, E., & Coast, E. (2019). Conscientious objection to abortion: Zambian healthcare practitioners' beliefs and practices. *Soc Sci Med*. 221, 106-114., 106.

[20]This point was made by an anonymous reviewer.

[21]Lack of knowledge about CO has also been found elsewhere, such as South Africa: Harries, J., et al. (2014). Conscientious objection and its impact on abortion service provision in South Africa: a qualitative study. *Reproductive health*. 11, 16.

[22]This point was suggested to us by an anonymous reviewer.

4.4 | Strengths and limitations

As a qualitative interview study, the study's strength is the in-depth accounts of professionals' moral reasoning and arguments. On the other hand, the study is unable to yield representative data which can answer questions about the prevalence of CO and its consequences, in cities and rural areas respectively. A further limitation is that we did not ask informants specifically whether they worked in several healthcare facilities.

5 | CONCLUSION

This study, then, while providing a picture of CO and professionals' different stances and arguments in Addis Ababa, also points to the need for further research about CO and its consequences for patients and providers. In conclusion, we ask whether it would be possible to create more nuanced regulation of the practice which would both preserve the rights of patients as well as freedom of conscience for providers. The experiences related in this study suggest that there are some healthcare settings in which CO does not threaten patient access to abortion. Although the Ethiopian societal climate on the topic of abortion has often been one of silence,[23] we hope the present paper can contribute to stimulating discussion – in Ethiopian society and among Ethiopian healthcare professionals – about the ethics and policy of conscientious objection.

ACKNOWLEDGMENTS

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[23]Tadele, et al., op. cit. note 5.

CONFLICT OF INTEREST

None to declare.

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Morten Magelssen, MD, PhD, is associate professor at the Centre for Medical Ethics at the University of Oslo, Norway. His main research interest is clinical ethics with a special emphasis on end-of-life ethics and priority setting. He has also published on conscientious objection in healthcare, and was a member of the Norwegian governmental commission on freedom of conscience in the workplace (2015-16).

Demelash Bezabih Ewnetu holds degrees in physiology, radiography and theology. He is a PhD candidate in medical ethics within the SACCADE project (Strategic And Collaborative Capacity Development in Ethiopia and Africa), a joint project involving Jimma University and St. Paul's Hospital Millenium Medical College in Addis Ababa, Ethiopia, and the University of Oslo, Norway.

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22.Appendices: Information to participants and interview guide

Appendix II. Participant's Information Sheet

Title of the Research Project: **Secular and Religious Approach to Abortion in Ethiopia: A Comparative Ethical Analysis**

Name of Principal Investigator: Demelash Bezabih (BSc.,BTh, MSC)

Advisors:

1. Prof. Jan Helge Solbak (MD, Theologian, PhD): Principal advisor
2. Viva Combs Thorsen (PhD post doctoral research fellow) : co advisor
3. Morten Mageelssen (MD, PhD, Researcher) : co advisor

Name of Sponsor: Strategic And Collaborative Capacity Development in Ethiopia and Africa (SACCADE)- NORHED funding

Introduction

This information sheet and consent form is prepared with the aim of explaining the research project that you are asked to join. The main aim of the research project is to analyze the secular versus the religious approaches on abortion: Mainly from the doctrines and canon of the Oriental /Orthodox Church (EOTC) and to some extent Islam's approach on matters of Abortion and abortion related deaths in Ethiopia. The proposed research is believed to benefit Ethiopians, As a servant of the church your participation will enhance the quality of the study and in the future if there is a change of policy and strategies by considering this study.

What does the study involve?

The study takes place in Ethiopia. Approximately 30 participants will be participate in the study. They include religious leaders, abortion advocates and health care workers. If you decide to take part in the study, you will be interviewed at a time and place most convenient for you.You will be asked some questions about abortion in general, the reformed abortion laws, and a scenarios where abortion may or may not be permissible. You will also be asked to give basic information such as your age, religious affiliation, marital status, and educational background. Depending on what you decide to share with us, the interview could last one to two hours.

The principal investigator will conduct the interview. With your permission, the interview will be tape recorded. The recordings will be transcribed, and any identifying information such as individual names will be removed. Only the research team will have access to the tapes. Otherwise, they will be locked in a secured storage area when not in use. Based on reviewing the transcribed interviews, you might be contacted again to clarify answers or answer additional questions. The tape will be destroyed five (5) years after conclusion of the study.

Risk and /or Discomfort

Ther is no risk in participating in this research project. However, you may feel some discomfort due to the sensitive nature of the topic**.**

Benefit

There will be no direct benefit for participating in this research. However, your answer will help us better understand abortion on a religious, secular and political level.

Incentives/Payments for Participating

You will not get paid for participating in the study. However, you will be given an amount to cover transportation cost and time spent with us doing interview (10 USD)

Confidentiality

The information collected for this research project will be kept confidential and information about you by this study will be stored in a file, without your name, but a code number assigned to you. In addition, it will not be revealed to anyone except the principal investigator and the data will be kept locked.

Right to Refusal or Withdraw

You have the full right to refuse from participating in this research. (You can choose not to response some or all the questions) and this will not affect you from getting any service. You have also the full right to withdraw from this study at any time you wish, without losing any of your right.

Person to Contact

This research project will be reviewed and approved by institutional review board of St Paul's Hospital Millennium Medical College. If you want to know more information, you can contact the NRB through the stakeholders. If you have any question you can contact the principal investigator through the following address.

Demelash Bezabih (BSc.,BTh, MSC), Addis Ababa, Ethiopia
Mob: 0913066805

I have read the written information and I

- Confirm that my choice to participate is entirely voluntarily,
- Confirm that I have had the opportunity to ask questions about this study and I am satisfied with the answers and explanations that have been provided, have received sufficient time to consider to take part in this study, agree to take part in this study.

Participant's signature ☐ Date _____

Regarding the research project, "Secular and Religious Approaches to Abortion in Ethiopia: A Comparative Ethical Analysis", to which you have contributed:

The information sheet that you received failed to mention that the project is headed by the University of Oslo, Norway, and by project leader Morten Magelssen, MD PhD. If you have any questions about the project you can email the project leader at morten.magelssen@medisin.uio.no.

The research project will end by 31 December 2020. By that date all the information you have contributed will be made anonymous, and audio recordings will be deleted.

Sincerely,

Demelash Bezabih Ewnetu
PhD Candidate, University of Oslo, Norway

Morten Magelssen
Researcher, University of Oslo, Norway

Appendix I. In-depth Interview Guides

A. Interview for religious representatives (revised)

Demographics

Age:

Marital Status (circle one): Married Single Widowed Divorced

Religious Level: Deacon Priest Bishop Preacher Monk

Highest Level of school completed:

Number of years working in/for the church:

"Ice Breaker"

After learning about what the study entailed, why were you willing to participate (willing to be interviewed?

1. what is your view in abortion?
2. *When does human life begin? At what stage of development should an unborn child have human rights?*
3. What makes abortion a religious issue in the church?
4. What are the prevailing doctrines of the church about abortion in general? What are your own views?
5. What is the church's teaching and your own views on abortion in the following situation:
   5.1 dangers to a woman life
   5.2 pregnancy due to rape
   5.3 the woman is mentally disabled
   5.4 the embryo/fetus has genetic conditions such as down syndrome
   5.5 the woman or couple is in a difficult social situation (eg poverty)
6. What reasons do you see for granting a pregnant woman herself the right to decide to terminate the pregnancy?
7. When abortions are carried out in unsafe conditions, complications even death may ensue for a woman. How does the church and yourself –view the problem of abortion related deaths and morbidity.
8. Is the present abortion law appropriate? What changes would you make and why? What would an appropriate or ideal abortion law look like-in your view?
9. What problems do you see with present abortion practice in Ethiopia?
10. What strategies do you think could reduce the number of abortion and abortion related deaths?
11. In your view, is there any way of reconciling religious teachings on abortion with the sexual and reproductive health rights, which asserts,among ather things, that when should be able to decide whether and when to have children, and how many to have, and have access to abortion services if needed? Can the two views co –exist?

12. Some health care workers refuse to participate in induced abortion services. What do you think of this? Do health care workers have the right to refuse provide abortion services (or even refer for abortion). Is such refusal a religious duty, in your view?

B. Interview Guide for CAC proponents

Demographics

Age:

Marital Status (circle one): Married Single Widowed Divorced

Religious affiliation: yes no

Highest Level of school completed:

Job Title:

Number of years working abortion advocacy work:

"Ice Breaker"

After learning about what the study entailed, why were you willing to participate (willing to be interviewed?

1. Are there any problem with the present abortion law in Ethiopia? What is the ideal abortion law, in your view?
2. Why do you think abortion should be legal and on demand**?**
3. What do you think about embryo's or fetal moral status,fetal interests and fetal right in this context?
4. When dous human life begin? At what stages of development should a conceived human being (embyo,fetus) have human right?
5. What do you think of abortion when the embryo or fetus has a genetic conditions such as down syndrome.?
6. Are there problems with the present abortion practices in Ethiopia?

   6.1 are there problems of access?

7. What is your stance on a health care worker providing a cervice that runs counter to their moral or religious conviction?

8. Should health care workers be allowed to opt out of providing (referring for) abortion services?

9. in your view, do such refusals lead to problems in today's health care service?

C. Interview Guide for HCWs

Demographics

Age:

Marital Status (circle one): Married Single Widowed Divorced

Ordination/role: Deacon Priest Evangelizer Bishop

Highest Level of school completed:

Number of years working in that specific health facility:

Number of years working with abortion-related services:

"Ice Breaker"

After learning about what the study entailed, why were you willing to participate (willing to be interviewed?

1. In what ways do your job involve abortion services?
2. What is your view on abortion? Does religion contribute to shaping your view? If so how?
3. What do you think of Ethiopia's abortion law? Does the law lead to any problem?
4. What dilemmas or challenges do you personally experience in connection with providing abortion services?
5. Do you yourself object participating in induced abortion cervices? Why? Why not?
6. Do colleagues refuse to provide abortion so? How many/ what proportion? What do you think of that?
7. Have such refusal lead to challenges for the department? Does it lead to problems in practice?
8. How does it impact women seeking abortion? Does it empede access to abortion?
9. How would you describe women/'s accesses to abortion (in your region)? What factors impede access?
10. What are your views on providing abortion services to minors?
    10.1 late abortions and?
    10.2 Abortions for fetuses with genetic conditions such as Down syndrome?
11. What are the common reasons patients give for seeking abortion services in your center?
12. How often do you see complications from unsafe abortions?

List of errata

Cor – correction of language

Cpltf – change of page layout or text format

Page	Line	footnote	Original text	Type of correction	Corrected text
20	18		’’Even though there are more than 135 political parties in the country…	Cor	“Even though there are now approximately 40 political parties in the country …”
20	22		So far, only the 2005 or 1997 EC election was considered to be free and fair by most…	Cor	…yet these also culminated in vigorous violence and unrest.
43	21		.(Farsides et al., 2004).	Cpltf	(Farsides et al., 2004).
52	10		.(Biggs et al., 2020)	Cpltf	(Biggs et al., 2020).