The compromises of providing abortion among physicians in Jimma, Ethiopia

A qualitative study

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Abstract

Background: Ethiopia changed its abortion law in 2005 in order to reduce their maternal mortality. Termination of pregnancy is legal if the pregnancy results from rape or incest, when the health or life of the woman and the foetus are in danger, in cases of foetal abnormalities and when the woman have a physical or mental disability or age below 18 years. The abortion care providers play a crucial role in securing access to safe abortion care. The physicians providing abortion must negotiate sometimes conflicting interests considering their responsibility towards the patients, the society, the hospital and their religious and personal beliefs.

Methods: The objectives of the study was to examine the physicians' attitude towards induced abortion, how the physicians understood and practiced the abortion law, ethical questions arising and to consider if the physicians' attitude towards abortion and understanding of the law had an impact on women's abortion seeking journey. 12 in-depth individual semi-structured interviews were conducted at Jimma Medical Centre in western Ethiopia in the period of February-Early April 2019. All the study participants were physicians providing abortion care in the hospital. The data material was transcribed and analysed inspired by grounded theory.

Results: The physicians reported conflicts while providing safe abortion care (SAC). This was handled differently among the physicians according to their attitude towards abortion. They possess good knowledge of the abortion law but met several dilemmas in the practice of providing SAC due to different uses of the criteria. Especially the criteria concerning rape could make unfavourable tensions between the patient and the health care provider. All the physicians had what they thought of as the abortion-seeking women's best interest in mind and were particularly interested in giving advice on family planning and counselling.

Conclusion: This study revealed how the physicians must make difficult considerations while providing SAC, due to their responsibility towards the patients, their professionality, the abortion law and their moral and religious beliefs. This could interfere with the provision of SAC to the Ethiopian women. The complexity of induced abortion in Ethiopia should be further studied.

Preface

First, I would like to thank my supervisor at the University of Oslo; Prof. Johanne Sundby. Thanks for giving me the opportunity to discover the world in a new way! You've shown me how to use curiosity and passion to make changes and challenge set thought patterns.

There are many special people in Jimma who made my stay warm and welcoming. Greetings are in its place to staff in the OB-GYN dep., Birtukan Tufa, Dr. Demisew, Ass. Prof. Getenet Rebrie and Prof. Zeleke Mekonnen. I would also especially give thanks to Ass. Prof. Muluemebet Abera (JU) for supervising while I was staying in Jimma

A special thanks to Hannah and Kiya - two wonderful nurses and friends, and lastly Helene, Kristine and Ingvild for support and a great time together in Jimma. I could almost put Ingvild as a co-supervisor - which says a lot of how much you helped me in the data collecting period.

And of course; there would not have been a single result to report if it weren't for the positive responses, time and wise thoughts of all the study participants – thank you so much for your participation in this project!

Abbreviations

CSA: Central Statistical Agency
ESOG: The Ethiopian Society of Obstetricians & Gynecologists
FP: Family Planning
GA: Gestational Age
HIV: the Human Immunodeficiency Virus
IRB: Institutional Review Board
JMC: Jimma Medical Centre
JU: Jimma University
MI: Medical Intern
MVA: Manual vacuum aspiration
NGO: Non-Governmental Organization
NICU: Neonatal intensive care unit
OB-GYN dep.: Obstetrics and Gynaecology Department
OPD: Outpatient Department
PAC: Post Abortion Care
R1: A doctor in the first year of residency
SAC: Safe Abortion Care
SNNPR: Southern Nations, Nationalities and Peoples' Region
STI: Sexually Transmitted Infection
UiO: University of Oslo
WHO: World Health Organization

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1 Background

One of the greatest challenges in global health is the remaining high numbers of women dying in relation to pregnancy. World Health Organization (WHO) estimates 358 000 maternal deaths to occur worldwide each year (1). The definition of maternal mortality is «the death of a woman whilst pregnant or within 42 days of delivery or termination of pregnancy, from any cause to or aggravated by pregnancy or its management but excluding deaths from incidental or accidental causes» (2, p. 1). To reduce maternal mortality has long been a global health priority. Globally, abortion accounts for 4.9-13.2% of maternal deaths (2). One of the ways to reduce the maternal mortality is to make abortions safer, by liberalizing the abortion laws. An example is that sub-Saharan Africa have a higher proportion (5.1-17.2%) of deaths due to abortion than the global average, while eastern Asia, where access to abortion generally are less restricted, have an estimation of 0.2-2.0% (2). Unsafe abortion and inadequate post-abortion care are significant contributors to maternal mortality, and unsafe abortions is more likely in settings where there are strong legal prohibitions or where more liberal laws have not translated into access to safe and comprehensive services. A maximal impact on abortion-related maternal mortality is within reach when reforming abortion laws is combined with other supportive programs and services. Broader access to safe abortion care after liberalization is for instance dependent of distribution of the health service, enough health care providers, and knowledge of the liberalization among both the women and the health care workers (3). Even though liberalization leads to a reduced maternal mortality, abortion is debated ethically and can possibly give rise to controversy among both health care providers and women. The overall aim of this study is to examine the possible controversies among physicians providing abortions in Ethiopia, and to explore the influence on the abortion services.

1.1 Abortion laws in Ethiopia

In 2005 Ethiopia changed their abortion laws in a liberal way, a change brought forward to reduce the maternal mortality due to unsafe abortions. In Ethiopia the maternal mortality ratio in 2005 was an estimated 743 deaths per 100 000 live births (4). Ethiopia has the fourth highest number of maternal deaths in the world, and in 2015 lifetime risk of maternal death was 1 in 64 (4). In *the Penal Code of Ethiopia 1957* abortion was only permitted to save the

life or health of a woman. A health care provider had to diagnose and certify the termination of pregnancy and two doctors had to authorize the procedure (5). Unsafe abortion is defined by WHO as «the termination of an unintended pregnancy either by persons lacking the necessary skills or in an environment lacking the minimal medical standards, or both», and unsafe abortion is one of the leading causes to maternal mortality and morbidity in Ethiopia. After the reform in 2005, a woman can legally terminate a pregnancy under the following circumstances:

- When pregnancy results from rape or incest
- When the health or life of the woman and the foetus are in danger
- In cases of foetal abnormalities
- For women with physical or mental disabilities and for minors who are physically or psychologically unprepared to raise a child (6)

In the cases of pregnancies resulting from rape or incest, or when the woman is a minor (defined as age below 18 years), the woman is not required to submit evidence. The word of the woman is enough proof to proceed safe abortion care (6).

Although the abortion law is reformed, some aspects of conducting an abortion is still criminalized. Pregnant women procuring abortion under criminal circumstances is punishable with imprisonment. Notably, poverty may be grounds for reducing the criminal penalty for abortion. If the crime is committed by a professional (a doctor, pharmacist, midwife or nurse), the punishment is imprisonment, fine and prohibition of practice for a limited period, or, where the crime is repeatedly committed, for life (7).

Even though unsafe abortion was one of the three leading causes of the maternal mortality-deaths, it's quite surprising that Ethiopia reformed their abortion law. Most Ethiopians regard themselves as religious: 44% are Orthodox Christians, 34% are Muslims and 19% are Protestantic Christians (8). Major religious groups proscribe abortion except to save the life of the woman, and 63% of the Ethiopian population views abortion as "never justifiable" (5). Even so, the law was approved, and the present question is how the law is practiced. The Ethiopian Society of Obstetricians & Gynecologists (ESOG) actively and publicly supported reform of national law on abortion, based on lowering the maternal mortality and professional training and work experience (5).

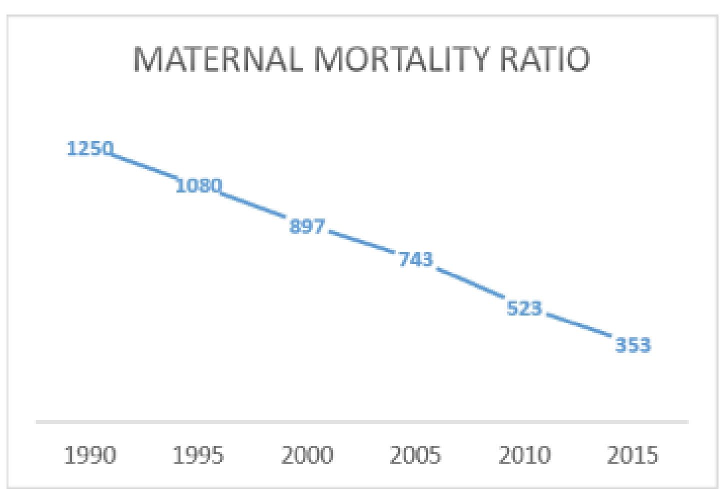
Implementation of a reformed abortion law poses complex and multifaceted challenges. To achieve successful implementation, one must disseminate information about the new law to government agencies, public and private health care providers and the general public, publish and disseminate regulations. Then one needs to provide new guidelines and protocol for providing safe abortion services, train health workers to perform safe abortions, and provide supplies and equipment for safe abortion at authorized facilities, monitor and evaluate of the incidence of safe and unsafe abortion and the health impact of new abortion services (9).

1.2 Abortion care in Ethiopia

The Family Health department in Ethiopia made a guideline for safe abortion in 2006 to ensure that all women obtain standard, consistent and safe termination of pregnancy services as permitted by law. The guideline describes abortion as termination of pregnancy before foetal viability. Ethiopia considers a foetus to survive at 28 weeks gestational age or a birth weight of 1000 grams. This means that induced abortion can be carried out until 28 weeks of gestation or an estimated foetal weight below 1000 grams. Over 12 weeks of gestation is defined as a second trimester abortion and should be performed in a hospital by specialized doctors. First trimester abortions can be carried out in primary care and performed by several groups of health care providers: health officers, midwives, nurses, doctors (general practitioners or residents or specialists in obstetrics and gynaecology). The guideline is describing pre-procedure care, procedures during termination (medical abortion and surgical methods) and post-procedure care (6). Access to the legal abortion services have been improved after the distribution of the guideline (9).

Where is Ethiopia today, regarding maternal mortality and safe abortion services? A systematic review on maternal mortality gathered numbers in Ethiopia between 1980 and 2012. It shows that there has been a huge decline in abortion related maternal deaths. Abortion complications was among the top four causes in year 1980-1999 responsible for 31 % of deaths but have declined by more than three-fold in the past 30 years (10), about 10% in 2014 (11). One possible explanation of this decline is the liberal nature of the new abortion law and expansion of abortion services after the liberalization (12). Considering maternal mortality, the biggest challenge in the following years will probably be obstructed labour, a reflection of a very high prevalence (90%) of home deliveries (10). In 2015 Ethiopia's

maternal mortality ratio was lowered to 353 per 100 000 live births, reflecting 11 000 maternal deaths (4).



Ethiopia's Maternal Mortality Ratio (MMR) in 1990-2015 per 100 000 live births. MMR is calculated for women 15-49 years (4).

As the guideline from the Ethiopian government states, unsafe abortions can further lead to short- and long-term morbidities, including infertility, in addition to maternal deaths (6). The guideline do also shed light on the enormous economic cost of the abortion complications, both affecting the health system directly and the women's loss of productivity due to absence from work which burdens both her and her family and the overall economy (6, p. 5-6).

Availability and utilization of safe abortion services has changed in the last decade in Ethiopia (11). An estimated number of 382,000 induced abortions in 2008, only 27 % were legal procedures performed in a health facility. By 2014, it was increased to 53%, despite the number of induced abortions increasing to about 622,000, which gives us an annual rate of 28 abortions per 1000 women aged 15-49. In 2008 the same calculations gave 22 abortions per 1000. For East Africa as a region, the number is 34 per 1000, and the region also includes countries with highly restricted abortion laws (11). In Ethiopia it's been a rise in the number of public health facilities providing basic safe abortion care. An increase of over fivefold from 149 facilities (25 % of the recommended level of 591 facilities) in 2008 to 823 facilities (117% of the recommended level of 704 facilities) in 2014 was demonstrated in whole of Ethiopia. When it comes to comprehensive safe abortion care, a minimum of 176 hospitals in 2014 must provide the services to meet the recommended levels. Nationally, the actual number of facilities where 66 in 2014, 38 % of the recommended level (11). These numbers

are a small part of a big and complex picture on ensuring women's access to safe abortion care. Even if the service is available, there's a need to motivate women still having abortions outside of facilities to access safe and legal care in health facilities. Likely explanations to why women fail to use the facilities are barriers to access, limited knowledge of services and legality, and abortion-related stigma in the communities (11). The expansion of abortion services has also led to an increase in use of contraception, as information of providing such is part of the post procedure care (6).

1.3 Health care providers' role in access to safe abortion care

The health care provider's attitude towards induced abortion and their knowledge about and views upon the abortion law have a substantial effect on the accessibility to abortion services and the quality of these services. 23,7% of the clients in Jimma were found to be not satisfied with the abortion service they had (13). To explore why the care was not satisfactory, it's important to explore how the caregivers interact with the clients in health care, especially with abortion. We can make a comparison with the low utilization of labour and delivery care in Ethiopia, despite a national scale up of the numbers of trained providers and facilities. S. Burrowes et al. (14) showed that both health care providers and patients report physical and verbal abuse during labour and delivery, which most likely contributes to the low utilization of care.

A systematic literature review concluded that health care providers in sub-Saharan Africa and Southeast Asia have moral-, social- and gender-based reservations about induced abortion. 9 key themes were identified as influencers on their attitude towards induced abortion: 1) human rights, 2) gender, 3) religion, 4) access, 5) unpreparedness, 6) quality of life, 7) ambivalence, 8) quality of care and 9) stigma and victimisation. This review did only include one study from Ethiopia, which was a structured, self-administered questionnaire (15). In another study from Adama, Ethiopia, they also used a quantitative questionnaire. 184 (48%) of the respondents had a favourable attitude towards safe abortion care services. Religion (42,3%) and personal value (15,1%) were the most common reasons why the respondents were not comfortable working in sites where abortion was done. Nearly 60% of the respondents were orthodox, and around 20% each belonging to Islam and the protestant church (16). Another study was made in Addis Ababa, measuring health providers perception

towards safe abortion with a structured, self-administered questionnaire. This study showed that the health providers reported that they knew what a safe abortion was, but that their definition not were consistent with "the termination of pregnancy by qualified and skilled persons using correct techniques in sanitary conditions", and also that were familiar with the surgical ways to abort, but 6% of the respondents were not familiar with a single one of the medical procedures. Only 29,4% affirmed that they had formal training on the procedures. Far from all the respondents did perform the procedures, and the main reasons were personal reasons, lack of permission from employer and service unavailability in the facility (17). The providers of abortion care are also reported to face challenges like stigma and professional isolation (18).

1.4 Aims and objectives

The overall aim of this research project has been to examine physician's attitudes and perceptions towards induced abortion and abortion-seeking women. The follow research questions were developed during and after fieldwork in order to reach this overall aim:

- Which factors are influencing their view and attitude?
- How do physicians understand the abortion law and practice it?
- Which ethical problems do they meet?
- Will the physicians' attitude towards abortion and understanding of the law have an impact on women's abortion seeking journey?

This requires study participants that have experience with abortion, and is best answered with a qualitative approach, where a deeper understanding is accessible. A similar study was conducted by McLean et al. in Addis Ababa which led to the conclusion of several dilemmas and coping mechanisms the abortion providers faced. A call for further research on this topic was also included in the conclusion (18). Another recent qualitative study, also conducted in Addis Ababa, explores how health care providers' moral dilemmas surrounding abortions, especially focusing on how the providers balanced their view on the foetus and foetal moral status with the right of the woman and the role of religion in their considerations (8). The research project aims to elaborate on knowledge on the dilemmas the health care professionals negotiate.

2 Methodology

We have applied a qualitative study using semi-structured individual in-depth interviews with key strategic informants. A qualitative study was chosen as suitable in order to gain an in-depth and nuanced understanding of the liberalisation of the abortion law. There is scarce knowledge concerning this topic, and a qualitative approach was used to provide insight into induced abortion as a contextual phenomenon in Ethiopian hospitals and society. Future research and policy topics may be suggested based on the findings of this study. The semi-structured interview is a tool for the scientist to expand the understanding of the study participant's attitudes, reflections, opinions, knowledge and reasons for acting as they do (19). The methodology will be presented in the following sections. First the study setting, study design and data collection will be presented. Then some words about the transcription, data analysis and methodological strengths and weaknesses, and in the end the ethical considerations.

2.1 Study setting

The field work was conducted at Jimma Medical Center (JMC) in Jimma in January until the beginning of April 2019. Jimma is a city in the Oromia region in Western Ethiopia. In 2007 the population of the town was 128 330, according to the Central Statistical Agency (CSA) census report (20). The religious demography of the city is mixed, and mosques, orthodox, protestant and catholic churches are localized throughout the city. The area is famous for being the birthplace of coffee, as well as having one of Ethiopia's finest universities.

There's an academic cooperation between Jimma University (JU) and the Centre of Global Health at the University of Oslo (UiO), and I was lucky to receive a mobility scholarship from the EXCEL SMART program. This led me to Jimma. The EXCEL SMART program is part of the EXCEL SMART JUiO NORPART project, where strengthening and expanding the academic cooperation between JU and UiO is the overall aim (21).

JU are one of the universities in Ethiopia with medical students, and JMC is a teaching hospital for undergraduate health professionals of different categories since 1983. Since 2005 it has also been a teaching site for different postgraduates, including Obstetrics and Gynaecology. JMC is a tertiary hospital run by the Ethiopian government and is one of the

oldest hospitals in the country, initially established in 1937 by Italian invaders for the service of their soldiers. Today, it's the only referral hospital in the South-West part of Ethiopia with a total catchment population of over 15 million. People are coming for medical assistance from Oromia region, Southern Nations, Nationalities and Peoples' Region (SNNPR) and Gambella, and even from South Sudan (personal message from hospital staff, can be made available on request).

The department of Obstetrics and Gynaecology provides service as both out- and inpatient subunits. Abortion is offered in first and second trimester, using both medical and surgical abortion methods. The hospital has its own guideline for all sorts of cases in Obstetrics and Gynaecology, including induced abortion. The abortion service is provided free of charge, and induced abortion is provided if there is an indication. As described in the background the indications are pregnancies resulting from rape or incest, when the mental or physical health or life of the woman are in danger, in cases of foetal abnormalities and if the woman is a minor (6). Generally, induced abortions during first trimester are performed in the outpatient department (OPD). The patients either seek the OPD themselves or are referred from health clinics or other hospitals. The OPD is open from 8 am - 5 pm Monday to Friday. JMC, as a tertiary hospital, is the only place in the area who provides abortion service in second trimester. For the second trimester abortions, the women are admitted in the gynaecology ward. One of the rooms in the ward are in use only for abortion patients. It was reported that these beds were occupied at all time. The guideline includes description of induced abortion until gestational age 28 weeks but describes week 24 until 28 as grey zone. There is also a description of special issues in second trimester abortion, including induction of foetal demise using digoxin in cases of transient foetal survival following abortion of pregnancies greater than 18 weeks (6).

The health care providers in the department of Obstetrics and Gynaecology (OB-GYN dep.) are consisting of physicians in different stages of their education, as well as nurses, midwives and anaesthetists. Due to language barriers and consideration of which roles the different professions played in determination of providing of safe abortion care, only physicians were included in the study. The physicians in the department consists to a huge extent of medical interns (MI), which means post graduate medical students rotating in different departments over a year, as a mandatory part of their training. They have different skills they need to perform (e.g. manual vacuum aspiration (MVA)) in order to continue their way to

specialization, as well as the responsibility of patients; history taking, examination, ordering tests, present patients in the morning meetings etc. They are also rotating within the department, between the different subunits (e.g. maternal ward, gynaecology ward, OPD). It's most likely that it's a MI the abortion-seeking woman meets first when seeking abortion service in the OPD. The other physicians in the department have started their specialization in OB-GYN and are called residents. It takes four years as resident to become a specialist, named senior. I will name the residents R1 if they are in their first year of training, R2 if second year and so on. By the time the field work were conducted, 9 consultant obstetrician and gynaecologists (= seniors) were attached to the department, as well as 40 residents in OB-GYN from the first to the fourth year. The residents are also rotating in the different subunits, and therefore all the participants in the interviews have experience from both the OPD and the gynaecology ward even though it was not their main attachment at the time of the interview.

2.2 Study design

2.2.1 Interviews

To approach the questions surrounding perspectives on induced abortion among physicians and their daily use of the abortion laws, semi-structured interviews was used. The interview guide (see appendix) consisted of the following three key questions:

1. What's your experiences with induced abortion?
2. How do you relate to induced abortion and the abortion-seeking woman?
3. What are your thoughts about the abortion law in Ethiopia?

The interview guide did also contain several follow up questions based on what I knew about the research participants prior to the interview. I also made several changes in the interview guide based on what I learnt in the interviews. Since the knowledge of physicians' experience with and attitude towards abortion in Ethiopia is scarce, this was also considered important to raise the possibility to uncover unexpected phenomena. While reading about attitude towards the abortion seeking woman and induced abortion in advance, it seemed that patient mistreatment and lack of training and insecurity on how to perform the procedures was something that needed focusing. I did not experience either of these as findings in the interviews, hence focusing less on the subjects in the later interviews. A possible explanation is that I was only interviewing physicians, and no midwives, nurses or patients as it is often

done in similar studies. The focus shifted rather to the process of decision making and how the abortion law served in and was interpreted in the physician's daily use. I did also make small changes in every interview to ensure relevant questions regarding whom I was interviewing (for instance a medical intern versus a fourth-year resident). I discovered that being frank and curious in the interviews gave me a lot of information and created a trust between the interview object and myself.

2.2.2 Non-participant observation

In this project the data from the interviews are the focus, but the observation during a 13 week stay in Jimma has been significant for my understanding of the cultural and social horizon the interview data is interpreted against. I spent some weeks at JMC before starting up the interviews while waiting for ethical clearance, and during those weeks a general observation helped me getting acquainted with the setting and to build a network in the OB-GYN dep. The longest period of observation with a duration of approximately 5 weeks were spent in the delivery ward, but otherwise I spent time in gynaecology ward and OPD. During my time in the OB-GYN dep. I met lots of nice health personnel, and did often discuss abortion, rape, abandoned babies and other issues relating to induced abortion "off the record". Also, I got to see parts of their working routines and environment. The residents and medical interns are working a lot, with a heavy load of duty declining as they gain experience. There was a prominent hierarchy, especially in the morning meetings and formal settings as teaching groups. Even the R4s considered themselves as students and would do so until they graduated as seniors. I was in the department both in day and night shifts, participated in some of the classes for medical students and talked to different staff in the hospital. I did also spend time with some of the physicians and nurses in my spare time and was lucky to make good friends.

2.3 Data collection

I interviewed 12 physicians in total. The first three interviews were pilot interviews. One of the later interviews was disrupted and ended after approximately 15 minutes. The one I was interviewing was on duty and got an urgent call.

Of the 12 study participants, 4 were females and 8 were males. This is reflecting the unbalanced distribution of the two genders in OB-GYN-residency. Of approximately 40

residents, less than 25 % are females. Another important issue in choosing study participants was to interview physicians with differences regarding to experience and responsibility considering safe abortion care. I therefore interviewed two people from each year of residency meaning eight people in total, two medical interns and one senior, and additionally the short interview with another resident. There was a variety of experience among the female participants, meaning that for four of the stages in post graduate education (MI, R1, R2, R4), I interviewed one male physician and one female physician.

All the study participants were Christians; a mix of protestants (5 participants) and Ethiopian orthodox (7 participants). The study participants came from all over Ethiopia, meaning that they belonged to different ethnical groups. Some of them had studied medicine in Jimma, but also in other cities and universities (e.g. Addis Ababa). The interviews were conducted in English, which isn't the mother tongue to neither of the study participants or me.

I recruited by asking one of the seniors at JMC to introduce me to some of the physicians that was currently in gynaecology OPD and asked them directly. I also had many contacts among both the residents and other medical staff who helped me to find participants (the snowballing method). One of the easiest ways was to ask residents I already knew from the long period I spent in delivery ward. This resulted in a mix of participants whom I knew quite well and some I had never met before. I asked one person to join the study who gave a negative reply related to lack of time to participate, and also there is the coincidence with the interview who was interrupted of an urgent call who was never continued due to shortage of time. All the other asked participants were interviewed.

The interviews lasted from 40 minutes to 1 hour and 10 minutes, except for a short one lasting only 15 minutes (as already mentioned). The first interviews lasted longer than the ones in the end, as the saturation point was soon to be reached. All the interviews were conducted face to face at the hospital in offices attached to the OB-GYN dep, sometimes during work hour if they had some time to spare or after work. The interviews did mostly take place undisturbed. I used a recorder in all the interviews, and none of the participants opposed to this. The recorder was kept in a safe when it was not in use, and none of the recordings were sent to other devices.

2.4 Transcription

The interviews were transcribed by me on my personal computer, playing the soundtrack from the interview and writing the exact words in English. I deleted the soundtrack when the transcription was finished. Sometimes it was impossible to catch the words, and this is a rather small, but existing, weakness of the methodology.

2.5 Data analysis

I analysed the data with inspiration from grounded theory (19). The aim while using grounded theory is to generate new theories that can be used as tools in other research questions. Research should lead to conceptualization of human actions and phenomena, and the data is transcended to wider contexts of meaning. There are six steps in grounded theory:

1. Data collection. In this case semi-structured interviews taped on a recorder.
2. Documentation. Transcribing the words from the tapes.
3. Open coding. Reading through the transcripts, get a sense of the main subjects and ideas, and writing down codes that reflect what information in the material that seems to be most important.
4. Selective coding. Decide which open codes that are important, and cluster them together to categories. Going through the material again, now better knowing what to look for.
5. Theoretical coding. Link cores and afterwards categories together. Trying to construct hypotheses and concepts.
6. Integration. Integrate new discoveries and theories in existing theory (19, p. 111).

Coding word by word or sentence by sentence in 12 interviews as grounded theory proposes exceeded the time-frame of this project, and the coding process was replaced by a sorting process where the material was broken into smaller sections, making it easier to compare the different interviews. The sorting was initially coarse, and then I tried to break it into further smaller fractions. I ended up with 12 categories:

1) Knowledge of the abortion law,
2) Use of criteria and attitude towards the criteria,
3) The rape criterion and it's dilemmas,

4) Abortion = sin = immoral act = murder,
5) Placing of guilt and responsibility,
6) Organizational and structural challenges,
7) Personal (not professional) attitude towards (induced) abortion,
8) Reflections considering women and especially abortion-seeking women,
9) Ethiopian society meeting induced abortion,
10) Aborting late in pregnancy,
11) Family planning,
12) Their perception of what rape is.

After making of the categories I tried to conceptualize the opinions, reflections and attitudes the study participants had in common, started writing and tried to find good quotations to illustrate the points from the material. After finishing the analysing, I read through all the interviews once again to double check the correspondence between the raw material and the analysis. The discussion part is where I tried to integrate new theories with existing theories, as the sixth step in grounded theory states.

2.6 Methodological strengths and weaknesses

Working language in the hospital among the physicians was English, meaning that the journals and records were all in English, and they used it while talking together. In practice Amharic was widely spoken, especially in conversations with the nurses. Few of the patients could speak English. The natural choice of language with patients was Amharic (the official language of Ethiopia), and in some cases other languages like Oromo (the language of the Jimma region). This limited some of the observation I did spending time for instance in the OPD clerking patients with the MIs, especially regarding how the abortion-seeking women were informed and evaluated. Hence, the information couldn't be applied directly in the analysis. Still, the observational part contributed to a social knowledge and understanding of the context.

English worked most of the time in the interviews, though it probably limited the expressions both for the study participants and me. Still there is an advantage of consistency as interviews, transcriptions and quotations in the results are the exact same words. And this whole chain was performed by me, also making consistency and additionally making me well known with

the material. A limitation of a single transcriber is on the other hand a limitation of the ability to conduct a systematic quality assurance of transcript translations. It was a goal to transcribe within a short period of time after the interview session, but there are still some words and sentences missing because of bad and unclear sound. The questions in the interview guide was intentionally open-ended, but misunderstandings and a need for explanations resulted in questions that could easily be answered with yes or no. This is probably also linked to me being a little experienced interviewer.

A strength is that a saturation point was reached. The questions in the guide were overseen by the supervisors. The pilot interviews were discussed among researchers within this field at an international conference, that contributed advice on which areas to focus on.

At first the plan was to interview a wide range of health personnel (e.g. nurses, midwives, physicians), but the plan had to change due to language barrier. Subsequently I appreciate the decision, partly because the focus area narrowed down to a more appropriate size for this kind of thesis, and, I got in touch with many physicians during observing in OB-GYN dep., which eased the recruiting. Focusing on physicians gave me a chance to really investigate their dilemmas, and as the staff carries out different tasks and have responsibility to varying degrees, this did in the end turn out to be beneficial. For instance is it the physicians at JMC who decide whom of the women that fulfil a criterion for induced abortion.

A limitation of the study is a small study sample and data collected limited to a single geographic region, but I did not intend to generalize the findings in detail.

2.7 Ethical considerations

The study was notified to Norwegian Centre for Research Data (Norway) and to the Institutional Review Board (IRB) at Institute of Health, Jimma University (Ethiopia) (See appendix), and the ethical clearance was obtained prior to data collection. 3 pilot interviews were conducted before the existence of ethical clearance from JU as an exception, but the study participants were informed of this and I had an oral agreement with a participant of the IRB.

The study participants signed a consent form (See appendix) in the beginning of the interviews. All of them were informed that their names and any information that could be used to identify them would not be revealed, as well as they would be anonymized in the

finished paper. The recordings were on a recorder with no possibility of transferals to other devices and internet.

3 Results

3.1 Abortion as an "area of conflict" on the personal level

Abortion is an *"area of conflict"*, as said by one of the participants (ID1). Abortion in a social perspective is sure an area of conflict, but it's a conflict also in a personal level for the participants. Independent of their attitude towards legalization of abortion, the participants were in general regarding abortion as an act of killing. This belief was broadly based on their definition of when life starts and religious convictions. *"Life starts with conception, because something is growing, so that is life. That is life."* (ID10). This view towards abortion is in a direct conflict with the act of performing abortion service. If abortion is seen as killing, a logical response for the participants was to ask oneself whether they were conducting an immoral act. The participants had different ways of handling the conflict. Analysing revealed two main strategies: thinking of abortion as obligatory and thinking of abortion of prevention of a greater evil. The participants told in different ways about these strategies, some using both, some using one, and sometimes other aspects were included. In general, the physicians with a negative view towards the current criteria for legally induced abortion were using the obligation-strategy, while those with a more liberal approach towards abortion were using the prevention-strategy.

3.1.1 "The obligation"-strategy

First, I will explain what I think of with an obligation-strategy. The physicians interviewed were all but one in educational positions in the hospital, and they regarded themselves as students even though some were in their fourth year of residency. You are expected to perform SAC when you're undergraduate, and it's part of your work. *"...I'm a resident. I'm a student. So I have to obey the rules. ... I have to forget my beliefs. I have to, just have to forget my religious stand. And I have to do this."* (ID11) I observed the hierarchy at the hospital myself, and it was especially clear during the morning meetings in the OB-GYN dep. I did also follow Medical students in clinical classes a couple of times, and they were all acting with great respect and kept almost silent towards the teacher, who were usually a fourth-year resident or a senior. *"We have to abort the baby. Whether you like it or not. ... it's*

part of my work, and if I say that I don't want to do it, like it will, that's something I will be evaluated for, a part of a job, so if you say that you don't want to do that, that means you have no interest in the job. So just you have to." (ID5) It seems as they are displacing what they believe their actions are leading to. A part of the obligation-thinking strategy is that you must operate on the safe side of the law, and abort according to the criterion the woman is presenting to you. The woman's words are all that matters as a criterion in case of rape, incest and often being a minor (many Ethiopians don't know their exact age or don't hold a birth certificate). The participants using the obligation-thinking strategy were often stating that they had to take the women "word by word", which could be understood as relying on the woman. This may seem obvious, but it is important to note, because the participants who on the other hand were more liberal and using the prevention-strategy were more likely to interfere with the women, maybe "helping" them change their words unto a legal indication. The ones using the obligations-strategy are less likely to "help" the women and will continue safe abortion care (SAC) only if the woman says the correct words to fulfil an indication. This topic will be furthered discussed in the paragraph concerning indications in practical use.

3.1.2 "The prevention of a greater evil"-strategy

Now I will focus on the prevention-thinking strategy. *"...illegal abortion is not good. If that woman... so that is the most killing, abortion complication is the most serious. So to avoid this I will not refuse to do."* (ID2) For many of the participants, performing SAC was a way to avoid the complications following unsafe abortions and unwanted pregnancies. They were comparing maternal death against abortion as killing and saw maternal death as a greater evil. It was regarded as the most important reason for providing, and for the ones that wanted abortion services to be restricted or were not personally in favour of providing, it seemed especially important in the cases where a continuation of pregnancy is risking either the life of the mother, the life of the baby or both lives. Some of the participants would extend the prevention to include for instance social and economic problems following unwanted pregnancies and the social stigma attached to giving birth after for instance being exposed to incest or rape. *"Abortion by itself is a crisis. ... Abortion managing is solving the crisis of abortion, and it does not taken as part of family planning. ... You are providing abortion service, so you are preventing the complications of unwanted pregnancy. ... What if she dies of unsafe abortion? You know, I'm going to blame myself even more."* (ID4) Some of the participants were also describing how their attitude towards abortion had changed after

gaining experience of women dying after unsafe abortions: *"...I used to oppose the abortion. But once I started in the practice I have seen many women dying of septic abortion. ... That's why I changed my mind, actually, because I don't want to see women dying of unsafe abortion."* (ID3)

To provide SAC is by some regarded as a great responsibility, a responsibility for the mother's life, especially when the physician is thinking of the consequences of denying the service. *"... terminating a pregnancy it is a sin, I know God has created that one, but if she go home, I know she's going to interfere with that, and like I told you early – she is going to die. And that's even more sadder. Because I'm responsible for her days. But I denied the medication for her."* (ID9) The same physician is using this consequence thinking when uniting her actions with her religious thoughts:

"I: I'm making a sin

M: So it's not that you feel like the woman is making the sin? You feel that you're participating?

I: Yeah. I'm making... I'm giving her another chance, that's why.

M: And how is that to...

I: You know, it's difficult, and when I go home... "God, you know my inside".

M: Because you have a reason to provide abortion care?

I: Yeah" (ID9)

Who should be blamed for the sinful action of abortion? This is a question many of the participants were asking themselves, and the answer they came up with were important for how they were thinking of the patients and their own responsibility. One participant was placing the guilt on the mother and regarded himself as a tool to fulfil the mother's wish. *"I'm not like in the condition of like sense of murdering or killing somebody. I'm not thinking that. She's the one. ... when she came she already made her mind, and she decided not to have that baby."* (ID1) Otherwise, most of the participants blamed themselves alongside with the woman. *"It is a sin we are doing... I'm giving the medication. So the woman and me have agreed to do it. I accept, because the complication is high if the woman go somewhere else, illegally..."* (ID2) The feeling of committing a sin is a strong feeling, and even though one of

the participants stated that he was helping the woman with an unwanted pregnancy - a crisis in her life - he still had a feeling of doing something wrong. *"...Still it is just my mind sometimes ask myself, I'm not doing the right thing… But I'm providing."* (ID4)

If you're no longer considered a student, meaning that you've finished the residency, you are free to choose whether you will perform abortion or not. The physician will still have a responsibility of referring the patient to someone willing to perform SAC. Even in this situation, the feeling of participating in something considered sinful was present. *"There is a chain of problems coming after a single abortion. So I have to counsel her, I have to tell her, I have to teach her what to do. And if she says "still I insist on termination of the pregnancy", I have to send her. But still I feel I have participated."* (ID11)

3.2 Knowledge about the abortion law

Soon after the implementation of abortion laws in 2005, the Family Health department of Ethiopia provided a guideline for safe abortion service in order to improve women's access to SAC (6). The official guideline is integrating the laws in practical use. Department of obstetrics & gynecology at JMC have their own management guideline, with a chapter describing abortion (22). Comparing the two guidelines, JMC has added "Extreme poverty" as indication for induced abortion. Extreme poverty is not a part of neither the guideline from the Family Health department or the Ethiopian law (6, 7). To assess whether the guideline is successfully implemented, an important part of the interviews was to ask about the participants' knowledge about the indications for induced abortion. While discussing the indications for receiving legally induced abortion, all the participants of this study were well acquainted with either of the mentioned guidelines. That means they listed up the indications that's written in the guideline from the Family Health department, but also that the majority added the "Extreme poverty"-criteria to the list. There was a certain suspense regarding this criterion, and complaints about interpretation of the criterion. Some of the participants problematized that "extreme poverty" was not described in a more specific way dependant on daily income, family size, marital status etc. Also, it was mentioned that the criterion was meaningless and not in use, considering the economic status of most people in the area being poor. Another finding regarding to their knowledge about the criteria is that it seems to be a change in how they are trained to use them. The participants were describing a more liberal use of the indications, and some were even saying that a woman can have an abortion on

demand according to training the abortion care providers were receiving from NGOs. Biased by their personal view towards abortion, this was regarded as either an evil or a good.

3.3 Who should have the induced abortion?

The study participants were facing many challenges in their daily use of the criteria derived from the Ethiopian law. Firstly, they are obliged to follow the criteria to operate on the safe side of the law, meaning the woman should have an induced abortion when at least one of the criteria is fulfilled. The criteria are, as told *"clearly written"* (ID3), but was even so a source of frustration among the study participants.

3.3.1 The rape criterion

This especially counts the criteria concerning rape and incest, which allow induced abortion based on the words of the woman. *"These days, anyone can terminate a pregnancy in Ethiopia."* (ID7) This is not the common opinion among all of them, but here's a story to give an understanding of the perception: *"...if a lady come in and say "I want to terminate", "then what is your reason to terminate the pregnancy?" "I don't want it [the baby]. I don't want it" she says. So they will tell her, either she have an indication or it will be very difficult for us to terminate. So what should I say if she say "I'm raped". So they will add "Secondary to rape" [on the chart of the woman]."* (ID7) There were several stories like this, were the woman in the first place didn't have one of the criteria from the law, but got her words changed to proceed in SAC. This changing of reason for termination was considered both a problem and a blessing. Another story from one of the study participants is as follows: *"...for those who have no indication, we advise them just to go on the line of continue pregnancy. But if she refuse again, just, we will tell her the risk, then we attach some indication, secondary to rape – like that, and continue termination. Still, it is up to her to decide. ... Sometimes lady comes like they have friend, they have start to live together, after some time she become pregnant, the husband leave and went. The pregnancy was with consent. ... Other time she may come: "the pregnancy was planned with my friend, but he left me and went". When she say like that, we will advise the risk and complication, and if she still insist on termination, just we terminate.*

M: does she fulfil one of the criteria then?

I: no, she doesn't fulfil. In the currently what is said, especially in training given, even if she doesn't fulfil criteria, even if lady says "I'm raped", whatever, we'll take her, and say she is raped. So no need to deal a lot about whether she's raped or not. It's not our job. Just, once the lady says "I'm raped", so we should accept and go on the line of management." (ID6)

Besides illustrating how the physicians provide induced abortion in a grey zone, a specific point should be mentioned. Since the abortion law states that induced abortion is allowed when the woman discloses rape or incest, this disclosure was often considered one of the most important factors making the woman eligible for abortion. *"So if the woman has give me the exact word - it seems clear and direct. But some woman will complicate the cases. They will not say "I was raped", and they will say something I didn't ... some of them say it happened by accident or something other, so it's difficult to terminate this kind of pregnancy regarding the law. But if they said the direct words, we have no right to investigate even further."* (ID12) There was a broad agreement among the study participants that the rape criterion often was used by the women to get access to SAC. And as this one is stated, the information is gathered in another health facility: *"…They will tell them, in other place even they told "go and say I'm raped and they will do it". So every termination is secondary to rape. Every woman."* (ID2) Another story touching this specific theme is: *"She came in, she came and asked me in the OPD, she found me, and I told her just she was.. actually she came with pregnancy following her other pregnancy only 8 months after, so she wants to terminate the pregnancy. Pregnancy was from her husband. So I told her "this is acceptable to have pregnancy this time with different incidence, you have to have contraceptive. If the pregnancy occur, it is very difficult to terminate with this situation, so you can continue." So in other, just after a week, she came and see my friend, another person, and she told him that she was raped. You know, just she gathered information, and she came with indication. She came with indication, and finally I think termination was done for that lady."*(ID8)

In this last story, the rape criterion is in use as a cover, but this is certainly not always the case – lifetime prevalence of rape among Ethiopian women are approximately 13% (23). Still, the SAC providers will never know whether the woman is lying or not when she comes claiming rape. They must operate in this insecurity. *"…most of the patients that come here are saying they are raped. And eh it doesn't seem like that. Hehe. Because… I don't know, as I said I can't judge, and we don't have anything to prove. We accept. I look at all these people and… there are so many patients in this hospital! So many patients will come to the gyn OPD saying*

they are raped and, I thought they might heard about these things, that's why they are saying like this – maybe. I don't know." (ID9) The study participants are suspecting that the women are lying in a various scale. In one end one participant is stating that rape almost never happen in Ethiopia, and in the other end another one is stating that most of the women is genuine in their disclosures. All the study participants defined rape as a sexual act without consent. To know whether she is lying or not, one is simply stating: *"If she says she is raped, you will when you are discussing with her, you will, if she, remembers, that she is raped, emotionally, she will be sad, she will cry. Really, she is raped. The woman who is laughing, smiling, and say she is raped, it's not true. That she was counselled already "Go and say that you're raped".* (ID2)

3.3.2 Which women are considered eligible for the induced abortion?

For the providing of SAC itself, the woman lying or not is not the most important. They will have to provide SAC and trust her words. *"...if the mother came and says it's rape, we don't do anything. We just write it's secondary to rape, so we induce to abort the baby. Nothing else. It's a logical."* (ID5) When the woman says the correct words, the criteria are easy in use. These women will have an abortion. But still there are some women who are not eligible for abortion, according to the law, as it isn't abortion on demand in Ethiopia. We have already seen some examples of physicians "helping" the women and giving her an indication, thereby making her eligible. This is not practiced by all the physicians, and those practicing it are not providing this kind of help to all abortion-seeking women. It seems that they are deciding which of the women will suffer most with an unwanted pregnancy, and what kind of consequences a negative response to SAC will cause. *"Socially and also medical complications with the abortion, it is her to decide. If she decide still despite my advice, my counselling, if she still continue on the line of termination, I will continue abortion. So I just, I … just… my conflict, my mind conflict is balanced with her life, future life, what she is going to face if she continue pregnancy. So I will, I have just my mind problem, just considering life .. problem associated with continuing pregnancy."* (ID6) Some consequences are considered as better reasons for providing SAC, specifically mentioned woman seeking unsafe abortion if they are not providing or if she will end up in a social and economic catastrophe. Young women such as students and those working as maids are often mentioned as a typical abortion seeking woman whom they tend to care for. In the same way, many of the study participants

felt especially sorry for women from the rural areas with little knowledge of pregnancy, sexuality and SAC. The other way around, married women were in general only considered eligible for having SAC in case of rape or if they were in danger of losing their marriage if they continued the pregnancy. *"...I remember I refused because of she get pregnant from her husband. The problem she said was the "I want space. I already have a baby one year back, and I want this to be terminated." Then I said this abortion service is not FP, so if you want to have space, why don't you use FP? Unfortunately you got pregnant, but the law doesn't allow, and I denied her. But she didn't come back."* (ID4) Marital rape is not criminalized in Ethiopia, but most of the study participants recognized it as possible and an insult towards the women. This is also reflected in that they would provide abortion for married women if they disclosed rape, in the same way as for non-married women. *"It is not about marital status. If she claims that she is raped, nobody will ask about whether she's married or not. But if she said "I'm married. I don't want this pregnancy" she will not have the service, based on the law."* (ID10)

3.4 A mix of understandings of the abortion law

The criteria for abortion was described as clear, open, a gift for the physician, not functioning, liberal, too liberal, restricted and encouraging. These words are reflecting the variety of the physicians' view towards abortion and the various dilemmas they are facing in their daily work with abortion-seeking women.

Even though the criteria can be criticized or welcomed, most of the study participants agree that the abortion should be legal when the criteria are fulfilled with certainty, stating that the criteria are expedient in the matter of reducing maternal mortality. Even so, sceptic thoughts concerning the criteria were revealed when talking of the use of them in practice. One major problem described was to know who fulfils the criteria. I've already written about the uncertainty surrounding the woman and her eligibility. Was she really raped? The study participants wanted a more specific guiding in how to decide. The question is how, and none had any idea of how it should be solved. Another way of thinking of this was that the open-ended criteria made it easy to work with, and it was often not a problem to proceed induced abortion with the law on your side. The problems came with moral thinking, interpreting abortion to be a sin and an act of killing. The Ethiopian law legalizes abortion with indication until week 28. This was problematized by several of the study participants. One of the study

participants told me from one of the first experiences with induced abortions: *"It was during my last duty, and it was very scary. The baby came out alive, and that was the most… it was like… I was really scared at that time. It was the worst thing that happened. I'm against abortion. So it made me to think and not to support… like... I'm against abortion. Because it's like killing a baby or a person that have life."* (ID5) The foetus was 6 months old and survived for thirty minutes. This story was not unfamiliar to the other study participants, and it can be described as an unwelcomed mental load for both the health care providers and the woman. In addition the study participants described it as a grey zone, as the gestational age in many cases are quite uncertain, making it impossible to know whether they are operating on the safe side of the law and difficult to intervene because of the risk of complications following the abortion.

Another concern of the study participants is that the abortion law as practiced now is encouraging the women to have unsafe sex, or at least making unsafe sex a little less unsafe. This was also a concern for the ones that wanted to liberalize it even more. Some of the study participants wanted to expand the law and make abortion legal when the pregnancy was unwanted, but not make it available on demand because they were afraid the women would change their behaviour and risk infections with STIs (with HIV as typically mentioned). *"I am confused, cause if we allow the termination for all of them, they will come for termination and since they can have the termination, they will not take care. Which means not only they will be exposed for the pregnancy, but also for the STIs, including HIV. So if we allow it, we are exposing them for so many things. But by having this one [the present abortion law] also, we are denying termination for those who don't want it [the baby] and don't fit the criteria."* (ID9) Some of the participants were afraid that abortion could be regarded as prevention and promoted family planning as the main focus.

3.5 Caring for the abortion-seeking woman

Independently of the participants' opinions of induced abortion, almost all the participants showed empathy towards the abortion-seeking woman and told stories of desperate situations were difficult considerations had to be made by her. They were concerned of her future due to economic and cultural circumstances and knew very well what kind of problems she might would have to face (e.g. ending of studies or work, lack of support from family, difficulties finding a husband in the future). This awareness made them feel bad if the woman were not

eligible for induced abortion according to the criterion or gestational age above 28 weeks, and many spoke of emotional support and counselling on how the woman could proceed, for instance if adoption of the baby was a possibility. *"…it's hard, most of the time it's not easy decision for physician to abortion. Like, they need emotional support, they really need to know the that how we're going to do the abortion, how it can affect her future fertility and how it can effect her future life. Yeah, she can have severe complications. … We are poor. And our social economic life, our economic status is very poor and.. it may be normal if you have enough money to raise the baby, she can have like, she can add another year in her study and she can finish that school. But it's not like that. You can have the baby, and you can continue if you have stable economical status, but here it's not like that."* (ID1) The women were also described as "illiterates" and "unaware", which made the participants feel sorry for them and stating their support for education and liberation for women. Despite empathy and support, the participants told stories were the women were discredited. A meeting with an abortion-seeking woman could make the physician feel anger of several reasons; in the case of rape, some of the physicians expressed anger towards the rapist who could freely live his life with no sanctions or there could be anger towards the woman putting them in a difficult situation. The nature of the rape criterion makes it essential for the physician to trust the woman. Some of the participants didn't always feel comfortable with the story of the woman, hence inducing an abortion based on something considered a lie. This could lead to difficulties in the consultation where the physician is supposed to care for the person whom he feels is playing him a trick. Both the dilemma of feeling fooled by the woman you want to help and moral anguish with abortion as a phenomenon biased the physicians and gave them non-beneficial attitudes towards the woman. This is not the case for all the participants, and it doesn't count for all the consultations. It seemed that it was especially present in the case of women seeking multiple abortions, as well as some of the participants recognised the duality among colleagues. They could have witnessed colleagues sending the women out of the office in the morning, turning her request of abortion down, but calling her back in again in the end of the day sending her home with the medications or admitting her to the ward. Another variant of mistreatment reported was to rush the woman through the consultation, not exploring her request or using time to treat her kindly.

3.6 The hope of family planning and counselling

All the participants were discussing family planning (FP) as an important part of their work. They were all agreeing that the number of induced abortions should be kept as low as possible and regarded FP as a natural part of the prevention of abortions as well as spreading of STIs. They were however meeting some difficulties when informing the women of family planning as part of post abortion care (PAC): misunderstandings of the side effects that made the women afraid of using contraceptives and ideas among the patients on who were fitting to use contraceptives (e.g. single women were in no need, as they were not going to be sexually active after the abortion, married women breastfeeding another baby, and therefore in no need of medical prevention). The physicians did also point out other general barriers to usage of FP: low access to the medications (living in far distance from a pharmacy or not fully-supplied pharmacies) and low awareness about FP, especially among adolescents and people living in rural areas. The participants were concerned with giving the information of FP to all abortion seeking women but regarded the final decision a right for the individual woman to do, as a counterbalance to an imposed action. Still, a couple of the participants told quite similar stories were colleagues misused their power: *"...I know some of my friends do.. they will counsel and they will say to them "We will not terminate this pregnancy if you don't take FP further". And if she refuse the FP, they are not going to terminate it. And if she said, "Ok, I will use the FP" they will insert implanon [contraceptive] before termination, and they will progress with the termination of pregnancy. Actually, I don't think that's also fair. It's her right to use FP also. It's difficult."* (ID12)

This imposed use of FP can be interpreted as a compensational penance for the physicians that are feeling guilty after performing induced abortion. There was a wide belief of avoidance of abortions if the women were empowered, taught how and when to use FP properly and some even regarded counselling during the consultation with the abortion-seeking woman as an alternative to induced abortion. Counselling can be explained as exploring which factors that led the woman to seek abortion and try to find another solution in cooperation with the woman, for instance to bear the baby until term and try to adopt it away. A participant thought the guidelines should accentuate the exploring rather than stating that the women's words of rape are enough for having an induced abortion. *"Because it [the guideline] says for example "don't explore, don't ask". So I think this is not appropriate, as a professional we are providing care for people, right? And then it is very important to tell the*

woman the advantages and disadvantages, because they just ask "provide". This is not right. It's a sort of prescriptive. Because you know, sometimes as I have told you, women seek abortion care for different reasons. Sometimes they may be emotional at the point of time when they decide these type of things. When they explore things, it's a very minor problem. They can continue the pregnancy, deliver safely and bring up the baby. So the law just closes this options - actually." (ID10) Further on, the participant told stories of how woman in despair after a supportive counselling changed their mind and kept the baby. This could of course end happily, but other aspects must be enlightened. Another story told was how physicians turned the woman away after counselling to make her rethink the choice of abortion before referring, and when she returned consistent with her request of abortion, this led to a delayed referral and procedure. Some of the participants described their counselling as giving both medical and religious advice on how the abortion would affect the life of the women but concluded that after counselling the choice to abort or not was still up to the woman.

4 Discussion

The aim of this study was to explore how the abortion laws in Ethiopia are understood and practiced by the physicians, and to understand their attitude towards induced abortion as a moral question. The results showed different strategies to integrate a religious and biological view on the unborn foetus and a view as the mother's helper and how different ways of understanding and practice of the abortion law can make differences in how the abortion-seeking woman are met and treated.

Recent studies (8, 18) have shown how the Ethiopian health workers in the matter of induced abortions are facing several ethical dilemmas in their daily work. In this study two coping mechanisms of providing abortion care were found: the obligation- and the prevention-strategy. The point of introducing these strategies was to show the main thinking of how the health workers combined the incompatible ideas of induced abortion as a sin and never justified on one hand, and how the providing of safe abortion care was expected of them as health care givers on the other hand. In some ways, the strategies seemed to be their personal justification – or at least a way to stay in the moral distress. Pointing out these two main strategies is a simplification of the reality, and there are lots of aspects concerning these strategies that could be raised and discussed, as well as problems evolving in the wake of these ways of thinking. It is for instance possible to think of individuals who wouldn't have any difficulties providing abortion care in the Ethiopian context: e.g. meaning that the foetus' claims for legal protection starting from week 28 or later, or not viewing abortion as a sin. It is also important to note that the prevention-thinking strategy is reducing for some, as a few of the participants viewed providing of SAC as a greater responsibility than just to prevent maternal mortality, but also interfering with the women's financial, social and future circumstances in a positive way.

Thinking of providing of SAC as a mandatory part of their work may help the participants in facing other people's stigmatizing thoughts about the abortion-provider as a sinner. The participants can blame their employees or the law and are not to be blamed themselves, thus giving them easier acceptance of providing the service when discussing the matter among friends and family. None of the participants reported any episodes or thoughts about being stigmatized by others, but it has been reported as a problem in other studies (18). On the other hand, SAC considered as a duty and no more, may predict how the health care worker will act

in the future when they have the chance to object on conscientious grounds after finishing their specialization or choosing another field for specialization than OB-GYN. As Magelssen et al. are discussing, there is a difference between legal and moral acceptability of abortion (8). Most of the obligation-thinkers agreed that there should be some kind of SAC-service, hence accepting abortion on legal terms, but that abortion on a wide range of indications were not morally accepted. One can ask if it is reasonable to discuss whether it should be possible to object on conscientious grounds earlier in the specialization, and at least advocate for a forum where the health care providers freely can discuss the ethical issues of induced abortion.

The central reason to provide SAC in prevention-thinking is that the health care workers are taking part in a public health issue of lowering the maternal mortality. As it is stated in the guideline for safe abortion distributed by the Family Health department, Ethiopia's high maternal mortality has been a national concern for several years, and prevention of unsafe abortion is one of the five strategies to reduce the maternal mortality. This is the context the health care providers are working in: a country where access to safe abortion within certain criterion is important to reduce maternal mortality. Studies have shown that the maternal mortality rate is lower in countries when the abortion laws are less restricted (24). However, none of the participants wants a SAC service on demand, which they believe could lead to an increase in STI and unwanted pregnancies as well as the question of SAC never was asked as a woman's right but rather a matter of public health.

The interviews revealed that all the health care workers' main interest is to do what's best for the abortion-seeking woman, but the better option was not unambiguous. In many cases the provision of induced abortion seemed to be a question of their story, words or circumstances, which physician they met in the OPD and whether they had the knowledge of the laws in advance. The nature of the Ethiopian abortion law is contributing to an unequal health service and creating suspicion towards the woman in the case where the criterion for induced abortion was not obvious from the beginning. Many stories from the participants witnessed of a consultation where the focus was to understand whether the woman was telling the truth for instance about being raped, and not to use time to find the best solution. A consultation regarding a request of abortion demands trust, a trust which probably is affected by this suspicious attitude. The suspicious attitude may be a result of the nature of SAC, as it is as already discussed a matter of difficult ethical considerations. On the other hand, some of the

physicians did not fear the women lying, because it was out of their control and in case of forensic investigation, the woman is punished for lying towards the physician and he/she cannot be hold responsible.

The most important question is the about who gets the power to make decisions regarding induced abortions? Is it the woman? The physician? The lawmakers? Furthermore, are the physicians aware of their possible power in decision-making?

Allowing induced abortion until week 28 of gestational age should be further discussed. What happens if the NICUs in Ethiopia are improved? Do the moral and human dignity of an Ethiopian 28 weeks old foetus differ from a foetus with the same gestational age (GA) elsewhere? Most countries have restrictions to abortion around GA of viability. The risk of complications while performing late abortions do increase both emotional and physical. Not to mention the insecurity in determining GA during pregnancy when there's lack of ultrasound apparatus. In addition to the foetus, performing abortion when the foetus is alive for 30 minutes afterwards can easily be imagined as burdensome for both the woman and the health care workers. It may influence on the attitude towards induced abortion among the health care workers afterwards as well as their thoughts about the abortion-seeking women. At least it should be a reformed protocol on how to manage these late abortions practically, as I witnessed late abortions where the foetus was lying and breathing between the woman's legs for several minutes after the abortion. For me, and possibly for others, it will feel problematic, wrong and against our own ethic to watch a baby die in that way, in a room filled with several other patients, and no one holding the hand of the mother or bringing the child to the NICU. The Ethiopian doctors face this several times a week. Efforts may have to be put in place to enable women to have their abortions as early as possible in their pregnancy.

Several areas in extension to this study should be further investigated, for instance induced abortion as a human right, autonomy as an ethical principle, the power of deciding who is eligible for induced abortion and the father of the foetus' role in the matter of abortion. Also, the induced abortion and its moral aspects should be part of the education of all future Ethiopian physicians.

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Appendix

Appendix 1

Last version of the interview guide

- What's your experiences with abortion as an Ethiopian living in your community? Generally about the attitude towards abortion in society. How and with whom, and in what contexts you are talking about abortion. Which arguments that's mentioned in discussions about abortion as an ethical issue.

- Can you give an example of one of the last times you discussed abortion at work? Abortion in work. How colleagues are addressing abortion, what impact that may have on your view, and if there is room for discussing it at all. Is there room for you to express your thought about abortion on work? Do you think your attitude towards abortion may have an impact on how your colleagues think about abortion?

- In the role as health personnel – how do you relate to abortion and the abortion-seeking woman? What are your thoughts about the abortion-seeking woman? How is the relation between your view regarding abortion as a private person and as health personnel?

- What do you think is influencing your personal view upon abortion?
  Suggestions to help the person think mentioned under (based on (11)):

  1) human rights and quality of life

  2) gender, stigma and victimisation

  3) religion

  4) unpreparedness and ambivalence

  5) access and quality of care

- What do you believe has the strongest influence? What is most important for you?

- Has your view regarding abortion changed during the years or has it been constant?

- Would you tell someone outside of work that you provide abortion care? For instance to family or in religious gathering

- How are you relating to sexuality, family planning and prevention? What's the challenges with family planning?

- Thoughts about illegal abortion?
- Alternatives to abortion like adoptions and better support for single parents for instance?
- How is working with abortion compared with other subjects in gynecology? What special challenges do you face?
- What do you think about the organization of the abortion services at this hospital?
- Can you please tell me about the abortion laws? What are your thoughts about the abortion law in Ethiopia? How are the laws working? Do you think/have you experienced that knowledge among health care providers about the laws are a limiting womens access to safe abortion services? Do you think/have you experienced that knowledge among women about the laws is a limiting factor for access to safe abortion services? In your clinical work with abortion; do you think there should be any changes in the abortion laws?
- About the criteria: clearness, easy to use in daily work, physician as a judge, power in decision making
- How is it so say no to an abortion seeking woman, if she doesn't fulfil the criteria?
- Have you ever observed abortion patient mistreatment? What is your experience of provider-patient interaction? What are your thoughts about the abortion-seeking woman?
- Have you ever experienced that medical interns/students hesitate to choose ob/gyn as a specialty because of abortion?
- Could you suggest a definition for rape? Could you suggest a definition for marital rape?
- Do you think that lack of knowledge among the women about abortion rules leads to more illegal abortions (that could have been avoided)? Awareness of pregnancy among young, unmarried women - could it be a factor in when they seek induced abortion?
- How can you as a physician help to empower the women?

Appendix 2

JIMMA UNIVERSITY

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Ref.No IHRPGD/392/19
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Date 11/03/2019

Institutional Review Board (IRB)
Institute of Health
Jimma University
Tel : +251471120945
E-mail : zeleke.mekonnen@ju.edu.et

To: Dr. Muluemebet Abera

Subject: Ethical approval of research protocol

The IRB of institute of health has reviewed your research project entitled:

"Health Workers attitudes and views regarding induced abortion and the abortion laws in Jimma, Ethiopia"

This is to notify that this research protocol as presented to the IRB meets the ethical and scientific standards outlined in national and international guidelines. Hence, we are pleased to inform you that your protocol is ethically cleared.

We strongly recommended that any significant deviation from the methodological details indicated in the approved protocol must be communicated to the IRB before they are implemented.

With regards!

Zeleke Mekonnen (PhD)
Associate Professor, Health Research and Postgraduate Director

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Appendix 3

Consent form for the participants

Do you want to participate in the research project
***"Health workers attitudes and views regarding induced abortion and the abortion laws in Jimma, Ethiopia"*?**

This is a question for you about participating in a research project where the aim is to explore the knowledge among health care providers about the abortion laws, how the law is practiced and what attitude the health worker has towards abortion. In this paper we give you information about the goals for the project and what a participation will mean to you.

Purpose
In 2005 Ethiopia changed their abortion laws to be more liberal. Complications after illegal abortion is estimated to count for 9% of maternal mortality in Sub-Saharan Africa (WHO). The abortion offer has grown after the reform, and several groups of health workers are dealing with abortion daily with the purpose of offering quality healthcare. Even though abortion in many cases are decriminalized, abortion is still a controversial subject in Ethiopia. Different views upon abortion may be attached to religious, social and cultural convictions, and the level of knowledge regarding abortion laws and offer may differ. The purpose with this project thesis is to explore which attitudes health workers that is faced with abortion daily contains regarding induced abortion and the abortion laws. A part of the project is to map the knowledge about the abortion laws and how it's practiced. Attitudes regarding sexuality, prevention and family planning, which factors that's influencing health care providers attitude and challenges with the daily work with abortion is also matters of interest in the project.

The project is mainly based on interviews with health care providers (doctors and nurses) who are working with abortion seeking women daily and speak English. The interviews will take place from January through March 2019 in Jimma.
The project is done by a Medical student at the University of Oslo as part of the Medical education, and is comparable with a Master's degree in size.

Who is responsible for this research project?
University of Oslo - Institute of Health and Science (Faculty of Medicine)

Why are you questioned to participate?
You're receiving this request because you are a nurse or a doctor who are meeting abortion seeking women daily.

What does it mean to you to participate?
If you choose to participate in the project, it means an interview which lasts around 1 hour in English where the scientist asks questions. The interview will be recorded, and the scientist will take notes. You will have questions about experiences with abortion, how you are dealing with abortion as a health care provider and what thought you have about Ethiopias current abortion law.

It's voluntarily to participate
It's voluntarily to participate in the project. If you choose to participate, you are free to withdraw the consent at any time without giving any reason. There will be no negative consequenses for you if you don't want to participate or withdraw the consent later.

Your privacy - how we use your information
We will only use the information about you to achieve the goals described in this paper. It's only the student and the supervisor who will have access to the information about you, and the information will be locked away when their not being used. Your name and contact information will be replaced with a code saved on a name list separated from the other datas. In the finished project thesis you will be anonymous.

What happens with the information about you when the project is finished?
After the interviews are done, there is still work to do with the project. It's planned to be finished before June 2020. The documents with information about you will be destroyed when the project is finished. The recordings from the interviews will be deleted at once after it's written down (a couple of days after the interview took place).

Your rights
As long as you can be identified in the data material, you have a right to:
- Have insight in what kind of information that's registered about you
- to correct the information about you,
- To delete information about you,
- To receive a copy of your personal data

What gives us the right to process the personal data about you?
We process the information about you based on your consent.

Where can I find out more?
If you have questions about the research project, or want to benefit your rights, please contact:
University of Oslo – Johanne Sundby (johanne.sundby@mail.uio.no) who is the supervisor in Oslo, University of Jimma – Muluemebet Abera Wordofa (muluemebet.abera@ju.edu.et) who is the supervisor in Jimma, or Margrethe Lans Syvertsen (m.l.syvertsen@studmed.uio.no) who is the student thats doing the interviews.

Kind regards

Margrethe Lans Syvertsen

Declaration of consent

I have received and understood the information about the project "Health workers attitudes and views regarding induced abortion and the abortion laws in Jimma, Ethiopia”, and I have had the oppertunity to ask questions. I consent:

- to participate in an interview
- That my personal data is treated in Ethiopia

I consent that my personal data is treated until the project is finished, approxomately June 2020.

(Signed by participant, date)