

Barriers to access safe abortion services in East Shoa and Arsi Zones of Oromia Regional State, Ethiopia

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Abstract

Background: Unsafe abortion continues to be a major public health problem especially in the developing world. Despite abortion being legally available under several circumstances in Ethiopia after a change in legislation in 2004, a host of barriers and challenges restrict access to safe abortion services, resulting in unintended pregnancies and unsafe abortions, with deleterious consequences for the health and lives of women.

Objective: The main objective of the study was to assess the barriers to accessing safe abortion services from the clients', health extension workers' and service providers' perspective.

Methods: A qualitative research design was used which included 38, 9 and 7 in-depth interviews with women who sought medical abortion, Health Extension Workers and Service providers respectfully. The study was conducted at three purposively selected health facilities found in Adama and Asella towns of East Shoa and Arsi zones of Oromia Regional State. The analysis was done using ATLAS Ti version 7.0 software.

Results: Financial constraints, lack of awareness, stigma and discrimination, religious belief, male dominance and pressure from the family or community, poorly equipped health facilities particularly in the rural areas and weak referral system were mentioned as barriers to accessing safe abortion services.

Conclusion: These barriers deprive women from accessing safe and timely abortion care, thus exposing them to unwanted births or to unsafe abortion and its devastating consequences. Thus, building community awareness about the service, the existing abortion related policies or laws, increasing service delivery points especially in rural areas, and strengthening referral linkages are essential intervention mechanisms to increase accessibility and utilization of safe abortion service. [*Ethiop. J. Health Dev.* 2015;29(1):13-21]

Introduction

The health evidence, technologies and human rights rationale for providing safe, comprehensive abortion care have evolved greatly. Despite these advances, an estimated 22 million abortions continue to be performed unsafely each year, resulting in the death of an estimated 47 000 women and disabilities for an additional 5 million women (1). Almost every one of these deaths and disabilities could have been prevented through family life education, family planning, and the provision of safe abortion and care for complications of abortion (2).

The incidence of unsafe abortion is influenced by the legal provisions governing access to safe abortion, as well as the availability and quality of legal abortion services. In some countries, access is highly restricted; in others, abortion is available on broad medical and social grounds (3). Even where it is legally permitted, safe abortion may not be easily accessible; there may be additional requirements regarding consent and counseling, and countries often impose a limit on the gestational age during which abortion may be performed. In addition, the attitudes of health care workers may be discouraging, and abortion services may be insufficient to meet the demand, unevenly distributed or of poor

quality. On top of these, women themselves may be unaware of the availability of abortion services or their right to access the service within the legal framework (3, 4).

In this study, a barrier is defined as any obstacle that a woman encounters when seeking or accessing to safe abortion services. A host of barriers and challenges result in unintended pregnancies and restrict access to safe abortion services. There are various non-legal obstacles which can be structural (like remoteness of a village), procedural (like waiting periods, authorization requirements, and cost), moral (for example, conscientious objection on the part of providers) (5).

In 2004, the Ethiopian Parliament approved a new, progressive law that broadly specified the indications for legal abortion. According to the revised criminal code, abortion is allowed by law in the following conditions: Cases of rape or incest, if the woman has physical or mental disabilities, to preserve the woman's life or her physical health, in cases of inevitable fetal abnormalities, if the woman is a minor or physically or mentally unprepared for childbirth. No consent from a spouse, partner or parent is required to obtain a legal abortion and

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no evidence is required to prove rape or incest in the court of law to obtain a legal abortion. The word of the woman is enough (6).

The Ethiopian Ministry of Health (MOH) has also issued guidelines for the implementation and expansion of safely induced abortion services in 2006 (7). According to this guideline, health care providers at all levels are expected to be knowledgeable about the law. They are not only expected to be knowledgeable but also inform and educate women and the community at large.

Task shifting and task sharing are plausible and feasible options as many of the interventions for safe abortion care, particularly those in early pregnancy, can be provided at the primary care level and on an outpatient basis (2). Service providers are uniquely positioned to influence their peers, the public, the media and policymakers when it comes to the provision of safe abortion care for women (8).

While the Ethiopian government has made great progress since adopting the revised penal code, women continue to be confronted with obstacles to seeking and accessing safe abortion services.

This study is part of a wider WHO multi-country eligibility and follow up care for early medical abortion study which has quantitative and qualitative components.

In a given country or place, assessing the laws and legal and other obstacles concerning access to safe abortion is a necessary preliminary step, if we want to know exactly how women can obtain legal, safe and comprehensive abortion care (5). Exploring the complex factors which affect the provision of safe abortion services could provide important insights for policy makers and program managers working in abortion service area. Therefore, this study was carried out to understand the socio-cultural, economic and institutional barriers to accessing safe abortion services.

The main objective of the study was to assess the barriers to accessing safe abortion services from the clients', health extension workers', and service providers' perspective.

Methodology

Study Design and Area:

This is an exploratory qualitative study. This design selected to explore the barriers women face while accessing safe abortion care, how health extension workers and service providers view women's access to safe abortion care and their experiences in treating women seeking this service. This approach was chosen because abortion is a sensitive and controversial topic and required detailed and close examination of the complex issues.

Exploring this controversial and contested topic would be difficult to validate with quantitative approaches. The design used in-depth interview with women who had access to abortion services, purposively selected health extension workers and service providers.

The study was conducted at three purposively selected health facilities found in Adama and Asella towns namely: Adama Health Center, Adama and Asella Marie Stopes International (MSI) Reproductive Health clinics from July-August, 2013. These health facilities are the major providers of safe abortion services in East Shoa and Arsi Zones of the Oromia Regional State. Three experts with graduate degree in public health and previous work experience in conducting qualitative studies managed the in-depth interviews after receiving a three-day training from the research investigators. The focus of the training was rapport building, obtaining consent, privacy and confidentiality issues, and clarification of contents of the interview guide.

The interviewers approached the women immediately after they had finished their evaluation and consultation with the HEWs and service providers and got written informed consent to proceed. Then, women were interviewed during their appointment schedule, which was two weeks after performing medical abortion.

Health extension workers and service provider interviews were conducted at the end of their participation in the quantitative study. All of the interviews were conducted at a time that was convenient for the participants in a separate room which protected both the visual and auditory privacy of study participants. All types of participants were progressively included until information saturation level was reached.

In relation to study site, 20 women, 4 HEWs and 3 service providers were interviewed at Asella MSI clinics and 18 women, 5 HEWs and 4 service providers were interviewed at selected health facilities in Adama (Adama health center and Adama MSI clinics).

Data Processing and Analysis:

Data were analyzed using a thematic analysis approach, in which main themes and categories were identified and analyzed using ATLAS Ti version 7.0. The analysis was done by an expert in qualitative data analysis and qualitative software use. This software enabled the research team to identify themes, connections and patterns, to make systematic comparisons, and develop interpretations. The steps followed are described as follows.

Step 1. Data preparation for analysis: Transcripts were checked for accuracy, translated into English from the original recording language (Oromiffa) and verbatim

transcription was made by experts who conducted the interviews. Two Hermeneutic Units (HU) were created by loading the interview texts into ATLAS Ti software. The first HU contains 38 primary documents from women's interview transcripts and 16 primary document families were created for comparison purpose. The second HU includes 16 primary documents gleaned from interview transcripts of service providers and health extension workers.

Step 2. Coding the transcriptions: The analysis commenced by reading all the data and then data segments or units were initially coded. The codes were developed inductively as the coder moved through transcripts and discovered new themes of interest. At the beginning 189 and 205 first level descriptive codes were created under the first and second HU respectively.

Step 3. Identifying themes: Once all the text has been coded, themes were abstracted from the coded text segments. By looking at the data with the research questions in mind and after several processes of recoding, renaming and deleting, 67 code families/themes from the first HU and 55 code families from the second HU were created.

Step 4. Construction of networks: After the data had been coded and classified, substantive connections by associating categories or linking data were established. Many links between different categories were established and a variety of networks were created. Throughout the process of data analysis the coder wrote memos i.e. recording reflective notes from the data.

Ethical Considerations:

Ethical approval to undertake the study was obtained from the WHO Ethics Review Committee and the Internal Scientific Review Committee of the Ethiopian Public Health Association. All study participants provided written informed consent prior to the interview. Privacy and confidentiality were maintained at all steps of the research process. In order to maintain the confidentiality, the names and identities of the participants were not attached to the transcripts and will not be shared to the third party.

Permission was also obtained to digitally record all interviews and records were erased once they had been cross checked after data transcription.

In order to minimize the interviewees' social desirability bias and the effect of post abortion psycho-emotional feelings, female interviewers were recruited and trained in creating comfortable and supportive environment during the interview.

Results

Characteristics of Study Participants:

Among the total 38 women interviewed, 24 were between 20 to 30 years of age and 8 were below 20 years

of age. More than half of the informants (n=22) were married. Twenty women were urban and the rest were rural residents. Twenty one of the interviewed women were Orthodox Christians and 16 were Muslim. Twenty nine of them had completed primary school and 7 were illiterate. Regarding the occupation of the respondents 16 were housewives, 9 were students, 5 petty traders while the rest were housemaids.

Nine health extension workers participated in the study. All of the HEWs were in the age group of 20 - 30 years. Six of them had five years and above work experience (four of these at the community where they were based at the time of interview). Seven abortion-related service providers (five nurses and two health officers) were interviewed. Three of them are male. Four of the interviewed service providers were aged above 30 years. All service providers had work experience of five or more years.

Barriers to Accessing Safe Abortion Services:

The study identified various barriers to seeking and accessing safe abortion services. The major ones include: financial constraints, lack of awareness, stigma and discrimination, religious belief, male dominance and pressure from the family or community. Unavailability of appropriately equipped health facilities providing safe abortion service particularly in the rural and remote areas was also mentioned as a barrier to access and use of the service.

Financial constraints/lack of money: Financial constraints were frequently cited as a barrier to accessing safe abortion services by interviewed women. Lack of money to pay for transportation, registration fee and cost of services was mentioned. A woman from a rural area around Asella said:

"Most of the time lack of money is the problem. I myself have borrowed 240 Birr from my mother and came here. Even now I don't have money for transport because I have already finished what I brought from home". (30 year, married)

Another informant elaborated the financial challenge to seek and get safe abortion service from skilled providers:

"There are women who don't have a penny (a quarter of a birr). If I didn't have this money I could not have come here and got served? I would stay at home. Let alone other things, there are women who cannot afford the payment for registration to get the client card which is 5 birr". (34year, urban resident).

In addition, the perceived amount of money needed to have safe abortion service at health facilities from skilled provider was reported to hinder women from seeking and getting abortion care. In line with this a woman stated:

"..... and she (a woman) may also be afraid of being asked a lot of money to cover the cost of the service".

Lack of awareness about safe abortion services:

Informants mentioned lack of awareness regarding legal conditions for abortion in Ethiopia, lack of information regarding safe abortion service availability and being unaware of the location or place where the service is provided as barriers particularly for most of the rural women. An illiterate woman from the rural area elaborated the challenge:

"I came alone by asking people the direction of the clinic. I didn't know it previously. The main problem of women from the rural community is that they don't know where such kind of service is available."

Moreover, a 29 year old woman from urban area also expressed her feeling:

"Actually this service is not known by the community. I myself did not know the availability of this service here and I never expected getting abortion service here. I came here only to know whether I am pregnant or not. There are women who lost their lives by trying different things to terminate the pregnancy. So I am very happy with the availability of this service here."

Interviewed abortion service providers also shared the above idea:

"Particularly those women in the rural community do not know about the availability of safe abortion services and the place where the service is provided, this puts them at risk."

In relation to lack of awareness of the legal conditions of abortion services, a 19 year old woman said:

"There is nobody in our area who teaches the public about abortion and thus people are not aware of abortion laws and the available services. Even if such education is given, it does not involve adolescents because they think that adolescents are not sexually active."

A 30 year old woman noted:

"Lack of information and knowledge about safe abortion services is the barrier. If they (women) do not have information, they hesitate to decide and as time goes, they do not have the chance to terminate their pregnancy. The only option they have maybe giving birth"

On the other hand, a service provider, recommended awareness creation before making abortion services available in the community:

"In the community there are people who oppose abortion services, thus, at the beginning awareness creation about abortion is very important."

Fear of stigma and discrimination: Stigma and discrimination is another challenge to access safe abortion services. Fear of being seen by family members, friends, neighbors or others while receiving abortion service was reported as a barrier by interviewed women, health extension workers and safe abortion service providers.

A 22 year old college student said:

"I think fear to be seen by family or neighbors is the main barrier. They think that somebody can see them at the health facility while they go there to terminate their pregnancy."

Similarly, a 19 year old rural resident expressed her opinion saying:

"The main problem is fear of people. Even I myself was frightened at first. But after I met the health extension worker and discussed, she encouraged me and I got relieved. Especially women in the rural areas fear to discuss such kind of issues with other people and they hide it."

In addition, another 19 year old participant expressed her concerns about women's fear to have abortion:

"For example, I did not want this to be known to my family. If they knew this, they could force me to give birth. I might face problems since I was not married"

Stigma and discrimination affect not only women who seek services, but also health care workers who provide abortion services. Concerning this issue, a service provider remarked:

"I think if health extension workers begin to provide this service they may face discrimination from the community and their work may be viewed from this angle only. In addition, it may affect their other work and decrease their performance in other areas."

Husband/male partner opposition: Husbands' disapproval of seeking abortion service is a key barrier to accessing safe abortion service. A 30 year old trader, who participated in the follow-up assessment study, noted the pressure women face from their husbands when they think of seeking abortion services. She expressed her feeling saying:

"My husband was not willing to terminate the pregnancy. I terminated the pregnancy without getting my husband's consent and awareness. When a woman faces unplanned

pregnancy, her goals or plans cannot be achieved, thus the woman has to pass her own decision and take action."

One of the informants, a 21 years old rural resident, had also shared this opinion:

"Sometimes a husband may not allow his wife to go to such kind of place (health facilities; rather, he wants his wife to deliver the baby."

People may have different opinions concerning the provision of safe abortion service. In relation to this an illiterate and rural resident woman, a mother of 5 children the said the following in favor of abortion services:

"Even I and my husband do not have the same opinion. It may differ depending on age. Old aged people might not accept abortion since they believe that children are a gift from God."

A health extension worker expressed her opinion in relation to male disapproval and pressure saying:

"If we begin providing safe abortion service (medication abortion) women will come and utilize the service. But there are males or husbands who do not support termination of pregnancy. In that case we may serve women separately and secretly."

Concerning the importance of creating awareness among the whole community to reduce the pressure from husbands, another HEW stated:

"Some men may go against the service and influence their wives not to use the service. So all concerned should cooperate to create awareness for the whole community of the importance and purpose of termination of unwanted pregnancy. This is not the only responsibility of health extension workers; it should get attention by government, NGO and media."

Religious beliefs: Religious beliefs influence a woman's behavior of seeking abortion service and it may also influence service providers' attitudes towards abortion. A 34 year old client stated her concern as follows:

"The first thing is religious influence; I myself come here under big pressure because abortion is just life killing for me. Is it not? But the existing problem on the ground forces you to accept things."

Service providers also held similar perception concerning the influence of religious beliefs. One of them highlighted:

"In our community abortion is not acceptable. Women would not come and use the service even if it is made available at the nearby health facility. This is because the community as a whole believes that abortion is unacceptable due to religious doctrine."

Another service provider reported that there were some members of the community who have negative attitude towards abortion service providers. He stated:

"People can consider them (abortion service providers) as those who are destroying the generation and relate the issue (abortion) to their religious doctrine."

Health facility related barriers: Lack or shortage of the necessary equipment and supplies especially at the lower level was reported as a barrier to seek safe abortion service. A health extension worker narrated her worry or difficulty to provide this service at health post level.

"I may face problems in relation to the needed materials and supplies to provide this service (medication abortion). For example if there is no pregnancy test kit, it will be a great challenge."

A 22 year old woman who shared the idea also noted:

"Some women may assume that at the health post there may not be enough equipment."

Weak referral system between health care facilities was also cited by interviewed service providers and health extension workers as a barrier to access health care at the next higher level. A service provider elaborated the poor referral coordination by stating:

"Our communication and sharing of feedback is very poor. Commonly, a referred woman doesn't visit the referral facility but rather return home or go to other nearby informal/traditional places."

Health extension workers also raised similar idea concerning the referral system and communication gap between health facilities. A HEW expressed her concern:

"I can refer the women to higher health facility providing this service but it is not as expected, the woman will not come to me again for follow-up care."

Table 1: **Background characteristics of women participants in the medical abortion eligibility and follow up study, July – August, 2013**

| Characteristics | Number | | |
|----------------------------------|--|--|-------|
| | Eligible women for Medication abortion | Follow up women to Medication abortion | Total |
| Age | | | |
| < 20 years | 6 | 2 | 8 |
| 20 – 30 years | 15 | 9 | 24 |
| >30 years | 5 | 1 | 6 |
| Residence | | | |
| Urban | 14 | 6 | 20 |
| Rural | 12 | 6 | 18 |
| Marital Status | | | |
| Married | 15 | 7 | 22 |
| Not Married | 11 | 5 | 16 |
| Religion | | | |
| Christian Orthodox | 14 | 7 | 21 |
| Muslim | 11 | 5 | 16 |
| Protestant | 1 | 0 | 1 |
| Educational Status | | | |
| Illiterate | 5 | 2 | 7 |
| Grade [1 – 5] | 2 | 0 | 2 |
| Grade [6 - 10] | 14 | 8 | 22 |
| Above grade 10 | 5 | 2 | 7 |
| Number of living Children | | | |
| None | 14 | 7 | 21 |
| 1 – 2 | 5 | 3 | 8 |
| ≥ 3 | 7 | 2 | 9 |
| Occupation | | | |
| Housewife | 11 | 5 | 16 |
| Business Woman | 4 | 1 | 5 |
| Privately Employed | 4 | 0 | 4 |
| Student | 3 | 6 | 9 |
| Housemaid | 3 | 0 | 3 |
| Study site | | | |
| Adama (East Shoa Zone) | 14 | 4 | 18 |
| Asella (Arsi Zone) | 12 | 8 | 20 |

Discussion

Despite the favorable legal environment and increasing availability of safe abortion services, this study revealed major barriers that could influence women's access. This result is supported by the findings from a multi-country study in six settings: Cambodia, Colombia, Ethiopia, Mexico City, Nepal and South Africa where expanding access to legal abortion does not in itself guarantee a decrease in unsafe procedures (9).

Financial constraint was one of the barriers mentioned by informants. Expenses include perceived and actual fees for the services, the cost of prescribed drugs, transportation and registration. Most of the women who can't afford these expenses are economically dependent on their husband/partner, have low income and lack independent source of income. This is a reflection of poverty and gender inequality. A similar finding was reported from a qualitative study in Kenya on barriers to formal emergency obstetric care utilization that difficulty to pay for these services and the availability of funds

plays a major role (10). The study conducted in the United States also established evidence of the connection between financial constraints and difficulties in accessing abortion that poor women were about twice as likely to be delayed in accessing abortion services (11). This may lead to self-induced abortion attempts which is very dangerous and can result in severe medical complications such as infection, infertility and death (12). In Ethiopia, services exempt from fees are set at the regional level, often including deliveries, antenatal and postnatal care. Legal abortion services in Ethiopia are not free. The survey of unsafe abortion in selected health facilities found out that direct average medical cost for incomplete abortion treatment per woman in governmental health facilities was estimated at birr 309.08 [1USD= 20.50 Birr] (13).

Lack of awareness of the legality of abortion and availability of the existing service is widespread. Many still perceive that abortion services are illegal practices. This implies that information on the new abortion law

and the availability of safe abortion services has not been adequately and widely disseminated; not properly popularized in the community, and to the target beneficiary (women) as well as among service providers.

This finding is also consistent with a study that assessed minors' awareness of the new abortion law and access to safe abortion services. It was found that most of the discussants did not have the knowledge about the Ethiopian abortion law and believed that abortion was illegal (11). Another research in Ethiopia also corroborates this fact that dissemination of information about the new abortion law has been weak, and many within the health care system as well as the general population have limited knowledge about the issue (15).

These findings were observed in the quantitative studies done in Nigeria in which lack of awareness among women about the law was identified as one reason for the slow uptake of safe abortion services (16). Further, the findings of the study in six settings tally with this finding that health care professionals' knowledge about the new law was often limited (9).

In addition, unawareness of the presence of facilities which provide safe abortion service was found to be influential in women's access to the service.

Stigma is a major inhibiting factor identified in this study to access safe abortion services. Seeking and having abortion is attached to a powerful stigma in most societies and cultures. The taboo surrounding both unintended pregnancy and abortion is one of the biggest obstacles in addressing unsafe abortion effectively. Abortion is considered as a criminal act, hence regarded as top secret. It is not a subject for open discussion. That is why it is difficult to disseminate information and create awareness of abortion. Similarly, stigma inhibits accurate discussion on the topic among community members. A systematic literature search that explored health care providers' perceptions and attitudes towards induced abortions in sub-Saharan Africa and Southeast Asia regions concluded that health care providers in these region have moral, social- and gender-based reservations about induced abortion and again these reservations influence their attitudes towards induced abortions and subsequently affect the relationship between the health care provider and the pregnant woman who wishes to have an abortion (17).

Moreover, results from an exploratory study done in Mexico, Nigeria, Pakistan, Peru and the United States (USA) demonstrated the influence of stigma in the disclosure of individual abortion behavior (18). The other most harmful manifestations of stigma are those within the health system such as health care workers' negative attitudes toward women seeking both abortion and post-abortion care and unwillingness to provide or participate in abortion care often on grounds of conscientious objection. In addition, fear of being identified as abortion

patients by community members, to avoid recognition, rumor and consequent social isolation, women may not seek safe abortion services (19) or often need to travel to other areas to ensure privacy and confidentiality. Because of this in many situations; women may not seek abortion services in their area of residence (20).

Husband, family and society pressure was reflected in the statements given by the informants as an obstacle to seek and access to abortion services. Shame and fear of disapproval and rejection by a husband, family members and society hinder women's access to this service. Even where abortion is legally permitted and available, women who choose to terminate pregnancy face disapproval or harassment from her partner, family members and neighbors.

It implies that abortion is not an issue to be discussed openly. Even if women seeking abortion are certain that their decision is right, due to fear of this pressure many feel alone and socially condemned, especially those girls and women who are young, marginalized, and unmarried girls may bear double burden stigma due to their high rate of rape or HIV/AIDS (19). In line with this, a retrospective study in Ghana demonstrated the importance of individual level autonomy in improving women's seeking and access to safe abortion services and recommended empowerment of women as a strategic intervention area (21). A multi-country study using focus group discussions (FGDs) and semi-structured in-depth interviews (IDIs) about factors influencing decision-making about abortion, indicated that some of the participants postulated that abortion availability influences couples' willingness to be lax about contraception and are more supportive of repeat abortion (22).

Religious and moral beliefs had major influence on women's decision to access the service and service providers' decisions to provide the service. Abortion may be considered as immoral, murderous and sinful act in the society (14). This view is also articulated in the findings of other qualitative studies. For instance, a study done in low income areas in five countries found that abortion is explicitly viewed by almost all respondents as against religious norms (22).

Cultural taboos relating to pre-marital sex, pre-marital pregnancy or pregnancy out of wedlock also aggravate the immorality and social isolation against abortion (14).

In rural Ethiopia, where the majority of the population resides, grassroots health facilities often may not have trained and competent abortion-related service providers to detect early pregnancy, determine eligibility, counsel, and/or provide the service and follow-up care. In certain instances even when a trained provider is present, service provision is impeded by absence or stock out of needed medical equipment and supplies.

Moreover, health care system related barrier was poor referral linkage between various levels of health care delivery points. Referral is often a complicated process, characterized by communication and transportation challenges where the woman often lacks the money to pay for transport to the health facility and not readily accepted. Even after arriving at a health facility, the woman may still need to be referred to a better-equipped facility due to frequent stock-outs of drugs and causing delays in receiving the required services. If the health facility is unable to provide appropriate information, the woman may not go to the facility she is referred to (10). On top of this, difficulty of maintaining privacy and confidentiality of a woman seeking the service were the main concerns that service providers raised.

The barriers and challenges described above are major factors that deprive women of accessing safe and timely abortion care and exposing them to unwanted births or to unsafe abortion with its devastating consequences of death and disability.

Building community awareness of the service, the existing abortion related policies or laws, increasing service delivery points especially in rural areas, and training of service providers especially primary health care workers are essential interventions to increase accessibility of safe abortion services. Strengthening the referral linkage is also an essential step to ensure the availability and accessibility of safe abortion services at various levels of service delivery points.

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