A National Assessment of the Magnitude and Consequences of Abortion in Ethiopia
(April 2009)

This study provides a comprehensive description of the incidence of abortion and its complications in Ethiopia. The specific objectives are to:
1. estimate the national incidence of abortion, abortion-related morbidity and the abortion case-fatality rate in Ethiopia;

2. describe the socio-demographics and reproductive characteristics of patients requesting legal, elective abortion services, and to describe these characteristics, symptoms and severity of abortion complications and clinical management among patients seeking care for a recent unsafe or spontaneous abortion; and

3. estimate the financial cost to the overall health system of treating abortion complications.

These data will also be used to establish a baseline for determining the impact of any future interventions to reduce maternal morbidity and mortality from abortion-related causes.

* Abortion case record extraction form (PDF)
* Health Professional Survey questionaire (PDF)
* Health Facilities Survey questionnaire (PDF)
* Abortion Costing Forms_Facility costs (PDF)
* Abortion Costing Forms_Health system costs (PDF)

Summary

In response in part to mounting evidence on abortion-related maternal mortality, the Ethiopian Parliament amended the penal code on abortion in 2004. The new law states that abortion can be performed legally in cases of rape or incest, if the woman has physical or mental disabilities, if it is needed to preserve the woman's life or her physical health, or if she is a minor who is physically or mentally unprepared for childbirth. Although there is strong consensus that unsafe abortion contributes substantially to Ethiopia's high maternal mortality ratio, previous investigations have been unable to quantify this factor because of limitations in the studies' scope and breadth. Although legal reforms have been made to prevent unsafe abortions, social norms regarding elective abortion have only just begun to change and the expansion of elective abortion services throughout the health care system has progressed at a slow pace. The penal code changes provide the mandate to carefully document the extent and consequences of unsafe abortion, and to use this evidence to advocate for the resources needed to make universal access to safe elective-abortion care a public-health priority.

Routine monitoring of abortion-related morbidity and mortality is poor in Ethiopia. With the adoption of the penal code reform of 2004, safe abortion has been legally allowed in the case of rape or incest, if the woman has physical or mental disabilities, if serious fetal deformity is present, if the procedure is needed to preserve the woman's life or health, or if the pregnant girl is physically or mentally unprepared for childbearing and childrearing because of her age. Yet the standards and guidelines for provision of abortion care in the public sector were only recently distributed, in 2006, and the training of health care providers in comprehensive abortion care is merely beginning. However, since the legal reform, there is some speculation that elective abortion is becoming more common in the private sector, but high-quality services are probably still limited to women living in urban areas. Even with changes to the penal code, many women remain unaware of their rights or whether their unintended pregnancy would

meet the legal criteria for a safe abortion. Rural and poor women, in particular, face great difficulty accessing safe, legal elective-abortion care, in part because of high, unregulated fees for abortion services in the private sector and a dearth of private-sector providers outside of urban areas.

In this study, researchers use an adapted version of a methodology developed by the WHO, which has been used in South Africa, Kenya, Cambodia and elsewhere to collect prospective, descriptive data on abortions and abortion-related morbidity. This study estimates the annual abortion rate and ratio, and the rates of abortion-related morbidity and hospitalizations. An additional component of the work uses an indirect estimation methodology that has been applied in a number of countries worldwide, requiring interviews of health facility administrators and a range of health professionals, in order to estimate the national level of abortion. Another study aim is to provide a partial indicator of abortion-related mortality based on the number of women who die in hospitals and health facilities of abortion-related complications. In addition, the direct medical costs of treating unsafe abortion and the cost savings to the health system under the reformed law will also be estimated.

Data will be collected on all elective-abortion procedures performed and abortion-complication case-patients admitted during a four-week period to the universe of public and private hospitals and a nationally representative sample of health centers and private-sector facilities. To validate and refine the accuracy of our estimates, data will be collected simultaneously from the same nationally representative sample of facilities on the average numbers of women requesting an elective abortion and women presenting with complications of an unsafe or spontaneous abortion. Interviews with health professionals will allow us to estimate the number of women who have abortion complications but do not obtain care, as well as the number who have safe abortions in the private sector outside of the surveyed categories of facilities. Indirect estimation techniques will be applied to both sets of data to calculate the total number of induced abortions

occurring in the country, abortion rates and ratios, the proportion that are elective and the proportion that result in medical complications and are treated in health facilities. Separately, these new estimates of induced abortion will be combined with information on unplanned births from the Demographic and Health Survey (DHS) to calculate unintended pregnancy rates. Validating and comparing these methods and datasets, indirect estimation using provider reports and DHS data supplemented with prospective records of complications statistics will allow for the most reliable national estimates on abortion, contribute to policy and programs in Ethiopia, and advance the measurement of abortion worldwide.

Study components

- **Prospective Data Capture on Abortion Cases:** A prospective study of a national sample of health facilities with a stratified random-sampling design will be used to generate descriptive data on all women seeking elective-abortion services or care for complications of an unsafe or spontaneous abortion at participating facilities during a four-week period.

- **Health Professionals Survey**: Approximately 100 interviews will be conducted with health professionals who are very knowledgeable about abortion provision and/or postabortion care, including medical doctors, midwives, hospital administrators, researchers, policymakers and family planning program managers. The selection of health professionals will take into consideration factors such as expertise, knowledge and experience in the field of reproductive health, with a focus on abortion. A special effort will be made to include experts familiar with abortion in rural Ethiopia. The goal of interviewing knowledgeable health professionals is to obtain their expert opinions and perceptions from a sample of experts about the provision of elective-abortion services and postabortion care in Ethiopia. Each participant will have a face-to-face interview guided by a semi-structured questionnaire including characteristics of the respondent,

and estimates of abortion care-seeking behaviors, costs and complications among women in rural and urban areas.

- **Health Facilities Survey:** The health facilities survey will be carried out with one key informant, senior-level professionals knowledgeable about postabortion-care provision, from each of the health facilities selected for participation in the prospective case-capture component of the study. At large facilities such as hospitals, the key informant would be the chief of the obstetrics-gynecology service or an obstetrician-gynecologist, and at lower-level facilities, the key informant could be a health officer, nurse, midwife or other health worker in a position to provide information about abortion care provided at the site. Each key informant will be interviewed in person, using a semi-structured questionnaire to document the level of abortion service provision, identifying methods used and estimating the likelihood of experiencing complications and receiving treatment. The questionnaire is similar to that of the health professionals survey, providing more detail on abortion services, women who seek care at the facility and abortion policies.

- **Health-System Cost Estimates:** This component of the study will develop a national estimate of the direct economic cost to the health system of providing treatment for postabortion complications. It will utilize an adaptation developed by the Guttmacher Institute of a methodology that was developed by the World Health Organization for costing of maternal and child health care services, the Mother-Baby-Package. There are two key steps in this component of the project: (a) collecting original data on the costs of specific inputs, and the amount of each input that is used for treating postabortion patients; and (b) applying these unit costs to the national data on the number of women treated for abortion complications, to produce a national estimate of the direct costs of providing postabortion care.

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