EVIDENCE BRIEF

Enhancing the delivery of comprehensive abortion care in humanitarian settings, Ethiopia

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Citation

Homeless due to the conflict

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Key Messages

What is the health system challenge?

- The ongoing war in northern Ethiopia has caused many deaths and forced millions of people to leave their homes, significantly impacting access to essential sexual reproductive healthcare.
- Women and girls are disproportionately impacted by the problem, lacking access to contraceptives and quality of comprehensive abortion care services.

What is the purpose of this evidence brief?

- This evidence brief presents critical insights from four context-specific research studies aimed at improving access to contraceptive counselling and safe abortion services in Ethiopia.
- The brief has been developed to inform a stakeholder dialogue and to guide health policy decisions that address urgent sexual and reproductive healthcare needs among internally displaced women and girls living in humanitarian settings.

What did the research identify as the main challenge?

- The rate of incomplete abortion was high (64%), requiring post-abortion care (PAC).
- Most women (71%) seeking abortion services did not receive the care at the first facility they visited.
- Stigma, distance to the facility, economic barriers, lack of privacy and respectful care from healthcare providers were factors preventing women from accessing abortion services.
- There is a large unmet need for contraceptive counselling and safe abortion services defined as comprehensive abortion care (CAC) services.
- One third of women (28%) had to cover costs for medical supplies (medication) at the facility.

What are the proposed elements of a solution to address the challenge?

- We present a midwifery model of abortion care in humanitarian settings, which is evidence-informed and considers the main components of an enabling environment that, when combined, create conditions for midwives to provide CAC in humanitarian settings.

What implementation considerations should be kept in mind?

- Over the past five years, the Ethiopian Midwives Association, the Federal Ministry of Health, and other humanitarian partners have deployed midwives in conflict settings. We recommend further integrating the midwifery approach to enhance collaborative interprofessional care that is respectful and responsive, aligns with patient preferences, and improves the overall quality of and access to CAC in humanitarian settings.

The Context

The ongoing conflict in northern Ethiopia has caused many deaths and forced millions of people to leave their homes, with many of them being women and girls. There is an overall lack of access to essential healthcare due to security issues, displacement, and economic instability. Access to contraceptives is challenging, and war-related sexual violence contributes to a high incidence of unintended pregnancies.[5] There is also limited access to safe abortions, leading many women to seek unsafe methods, resulting in incomplete abortions, which require post-abortion care to treat infections and bleeding.

As of 2005, under article 551 of the penal code of the Federal Democratic Republic of Ethiopia (FDRE), termination of pregnancy is allowed in the following circumstances: rape or incest; when the pregnancy endangers the woman's life or health; fetal abnormalities; if the woman is physically or mentally disabled; and if the woman is physically or psychologically unprepared to raise a child due to young age.[6]

In response to the problem of unsafe abortion and recognition of the need for an integrated approach to reducing maternal morbidity and mortality, the Federal Ministry of Health developed the first edition of the national technical and procedural guideline for safe abortion services in 2006. This initiative has contributed to a reduction in maternal death due to unsafe abortion from 32% to 10%.[7]

Abortion-related complications continue to be a leading cause of maternal mortality and morbidity globally. Strengthening midwives' role in delivering comprehensive abortion care (CAC), including safe abortion care, post-abortion care (PAC) and post-abortion contraception, is essential to achieving universal health coverage and ending preventable maternal deaths and morbidity.[1-3]

Midwives' skills and capacity to empower women and girls and provide services with a life course approach make them key providers of comprehensive sexual and reproductive health and crucial for ensuring access to quality CAC.[4]

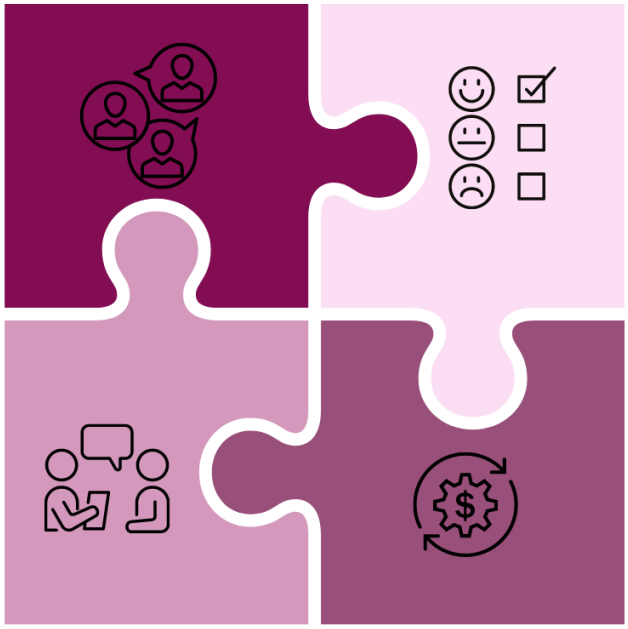
The *Lancet Series on Midwifery* reported that midwife-led care in pregnancy, antenatal care, labour, birth, post-partum care and contraception could avert 83% of all maternal deaths globally. Recent estimates indicate that even a minimal increase in midwife-delivered interventions compared to current coverage could prevent 22% of maternal deaths, while a significant increase could avert 41%, and universal coverage could avert 67%, especially in low and middle-income countries with the highest mortality rates.[3] In these projections, midwife-delivered contraception interventions would contribute to over 50% of deaths averted.[3]

Our research project aims to support internally displaced women in Ethiopia through improved access to CAC services. We have conducted four context-specific research studies to understand the problem better and inform relevant health policy decision-making. This evidence brief has been created to inform a stakeholder dialogue focused on enhancing the delivery of CAC in humanitarian settings in Ethiopia. The stakeholder dialogue approach is informed by the McMaster Health Forum's methods for participatory deliberations.[8] This evidence brief provides an overview of the context, a summary of our research findings to help understand the challenge, elements of a comprehensive approach to address the challenge, and implementation considerations.

Understanding the Challenge

We used qualitative and quantitative research to understand the main challenges associated with enhancing the delivery of CAC among internally displaced women and girls in Ethiopia's humanitarian settings. Figure 1 provides an overview of the research studies, and Table 1 summarizes the findings.

Figure 1. Overview of research studies



Focus group discussions

To help explore the needs, preferences, and decision-making pathways for seeking CAC in a humanitarian setting, we conducted six focus group discussions and 12 individual interviews with women and girls in refugee camps.

Survey

To better understand women's experiences, clinical outcomes, contraceptive uptake, and the costs associated with CAC, we surveyed 1,669 women.

In-depth interviews

We conducted in-depth interviews with 14 women and 12 midwives to explore their experiences, challenges, and options related to abortion care services in health facilities.

Associated costs

Using the survey data, we calculated the direct and indirect costs for women and their caregivers associated with CAC.

Table 1. Summary of findings

Design and methods	Study population	Key findings
Qualitative • Focus group discussions	Women and girls living in internally displaced person (IDP) camps	• High need for CAC services • CAC services not available in the IDP camps • High abortion-related stigma • Fear of discrimination and stigma leading to unsafe abortion • Gender based violence, including rape and unwanted pregnancy, reported as common
Quantitative • Cross sectional survey	Women receiving abortion care services	• 64% were admitted for treatment of incomplete abortion and 32 % for safely induced abortion • 71 % of those seeking abortion services did not receive care at the first facility they visited. • 24% of women rated the quality of CAC level as low • 39% did not receive post abortion contraceptive counselling • 73% were not using a contraceptive method post-abortion
Qualitative In-depth interviews	Women receiving abortion care services at the health facility	• Women reported absence of informed consent when receiving abortion care services • Sexual violence (rape) and economic barriers were described as common reasons for abortion • Distance to the facility, economic barriers, and lack of respectful care from healthcare providers were factors preventing women from accessing abortion services • Women experienced lack of medications and abortion supplies in the facility • Women expressed that abortion services were not a priority area of the government
Qualitative In-depth interviews	Abortion care providers Midwives	• Abortion services require special attention similar to other maternity care services • There was an overall poor attitude from healthcare providers towards abortion care • The main challenges in implementing CAC included poor infrastructure, lack of adequate supplies, lack of a separate and private room, high caseload, lack of trained healthcare providers, scarcity of medications and equipment for uterine evacuation • Training in safely induced abortion, post abortion care and contraceptive counselling was needed for all healthcare providers

Design and methods	Study population	Key findings
Quantitative • Economic modelling	Women receiving abortion care services	• The total expenditure on abortion care amounted to an average cost of 9392.80ETB(78.3USD) per woman • **Direct cost:** Women experiencing all stages of CAC and their caregivers spent about 7365.40 ETB(61.4USD) • **Indirect costs**: Indirect costs associated with the inability to carry out normal activities or work for women during all stages of CAC and their caregivers accounted for up to 2027.40 ETB of income lost • One third of women (28%) had to cover costs for medical supplies (medication) at the facility.

Description of study participants

A total of 1,669 participated in the cross-sectional survey and received CAC during the study period in a humanitarian setting.

- 71% were from urban settings
- Of those who received abortion care, 30% were displaced women primarily due to conflicts or war, and the rest were from the host community
- 97% did not live in camps and were either renting houses or staying with relatives
- 39% received medication abortion
- 84% received abortion care at hospitals and were referred from a lower-level health facility

Access to abortion services

Study participants reported that they sought safe termination of pregnancy due to different reasons. Our data show that there are numerous barriers to accessing abortion services, including distance to the facility, economic barriers such as the cost of the service, unavailability of the service in the camp, and societal stigma.

The quantitative findings support that women did not receive the service at the facility where they primarily visited.

- 71% did not receive abortion services at the first visited facility

> "Gossip and stigmatization of women who had an abortion are common in the society. This is because most of our society is uneducated and does not know about abortion services." FGD 6

> "The women who need abortion service could not access the service easily because of the cost of the transport, the cost of the service some facilities, and lack of information of where the service is available since the service is not available in the IDP camp." FGD 5

Quality of abortion care

The quality of abortion care was measured in the cross-sectional survey.

Among participants who received abortion care:

- 24% rated the quality of care as low
- 55% felt their privacy and confidentiality were not maintained during their care
- 28% felt they were not involved in decision-making regarding their care
- 30% rated the communication between them and healthcare providers as poor
- 30% rated the supportive care from healthcare providers as poor
- 28% felt they did not receive respectful care
- 32% felt the waiting time was long

Among participants who rated the quality of care as low:

- 42% received care at primary hospitals, and 32% at general hospitals
- 78% experienced incomplete abortions, and 17% had safe terminations

> "Due to the lack of healthcare providers, high caseloads, and poor infrastructure (e.g., private rooms), we lack time and favorable conditions to counsel the women adequately. This lack of proper communication often results in women not taking the prescribed medication correctly, which delays the evacuation process and causes unnecessary hospital stays. This is common among women managed with medication abortions, where we often have to repeat the dose, leading to extended hospital stays."
> In-depth interview

Respectful care, support, and communication during abortion are essential to ensure a positive experience and uphold the dignity and rights of individuals seeking abortion services. This includes a non-judgmental approach, protecting confidentiality and privacy, providing clear information, and empowering autonomy. Women who received abortion care reported not having a clear understanding of why their healthcare provider decided to terminate the pregnancy. One participant shared, *"I came to the health facility for antenatal follow-up, but the healthcare provider said that this pregnancy is not healthy, and it will harm you, so it's better to terminate it. I was unclear about the problem, but I had no choice but to follow the provider's decision."*

Providing adequate information about signs of complications and the proper use of prescribed medications is another aspect of CAC. Participants described receiving enough information about pain severity, medication use, and how to monitor for signs of complications. One participant described this, *"The provider explained the severity of pain as low, moderate, and severe, described signs of complications, and instructed me to return after a week once I finished the prescribed drugs."*

Contraceptive counselling and utilization

Among women who received abortion care, 39% did not receive contraceptive counseling, and 73% were not using postabortion contraceptives at 2-4 weeks follow-up. However, the qualitative study findings showed that healthcare providers reported that they deliver contraceptive counseling. They said that detailed information was given to every woman about each method and then they chose what was most preferable. Depo-Provera is the method that most women normally want.

One midwife participant shared, "Before we perform the abortion procedure, we give detailed counseling about contraceptive methods. After the procedure, we provide the method they choose. Since I mainly work with abortion clients, I provide post-abortion contraception. The injectable method (Depo Provera) is the most commonly preferred, but we counsel about the advantages of all methods."

Post-abortion contraceptive counselling varied according to the level of health facility, the level of quality of CAC, the type of abortion, the kind of abortion procedure, and the presence of abortion complications.

- Women who received care at health centres (89%) were more likely to receive contraceptive counselling than those at hospitals (Primary: 47%, General: 59%, and Referral hospitals: 59%)
- Women who rated the quality of CAC as low were less likely to receive contraceptive counseling (41%) compared to those who rated it as high (76%)
- The proportion of women who received contraceptive counseling was higher among those who came for safe termination (74%) compared to those with incomplete abortions (56%)
- Contraceptive counselling was also more frequently given to women who underwent medication abortion (71%) compared to those who had manual vacuum aspiration (54%)
- Women who experienced abortion complications were more likely to not receive contraceptive counselling (56%) compared to those without complications (36%)

Costs associated with CAC among women living in conflict setting

The mixed study also highlights the significant financial burden on women seeking abortion care, both in terms of direct and indirect costs, as well as the challenges posed by the unavailability of necessary medications at health facilities.

- Home termination attempts: About 3% of women in the survey tried to terminate their pregnancy at home. Most women paid these attempt costs out of pocket, with an average cost of 1611ETB(13.5USD).
- Direct costs: Women experiencing all stages of CAC (*attempts of pregnancy termination, visit to the health facility, recovery, re-admission for complications*) and their caregivers spent about 7365.40 ETB(61.4 USD). This cost included 1219.30 (10.16 USD)for medical expenses (e.g., medications, and lab tests) and 3159.50 ETB(26.4USD) for non-medical costs (e.g., transportation, food, and sanitary products), and other direct costs 2986.60ETB(25USD)
- Indirect costs: Indirect costs associated with the inability to carry out normal activities or work for women during all stages of CAC and their caregivers accounted for up to 2027.400 ETB (17 USD) of income lost. This includes (1) the cost of inability to carry out normal activities during attempts for pregnancy termination, amounting to 279.20ETB(2.4USD); (2) costs of inability to work for a woman, amounting to 136.90 ETB(1.14USD) and caregiver, amounting to 496.6 ETB(4.13USD) during a stay at the health facility; (3) cost of the inability to work for the woman after the procedure, amounting to 802.40ETB(7USD); (4) cost of inability to work for women, amounting to 109.60ETB 0.91UD) and caregiver, amounting to 202.70ETB (1.7USD) during re-admission for complications
- Overall costs: The total expenditure on abortion care amounted to an average cost of 9392.80ETB(78.3 USD) per woman.
- Challenges with the availability of medications: Despite government exemptions for abortion services at public services, 28% of the total direct costs spent by women and their caregivers at the facility were medical expenses, likely due to the unavailability of medications at the health facilities, forcing women to purchase them externally at high costs. During qualitative interviews, women reported significant difficulties in affording these medications, often reporting borrowing money to cover their expenses and this acted as a barrier to women's access to CAC.

Elements of a Comprehensive Approach to Address the Challenge

A range of approaches can be taken to address the challenge of enhancing the delivery of CAC in humanitarian settings in Ethiopia. We are presenting a framework to guide the discussion about the pros and cons of potential approaches (see Figure 2). In early 2024, the Canadian Association of Midwives developed a "*National Strategy for Midwife-led Abortion Care in Canada.*"[9] As part of this project, they developed a framework for the midwifery model of abortion care, which is informed by the World Health Organization's abortion care guidelines. We have adapted the framework the Canadian Association of Midwives created to better address humanitarian contexts in low-resource settings (see Figure 2).

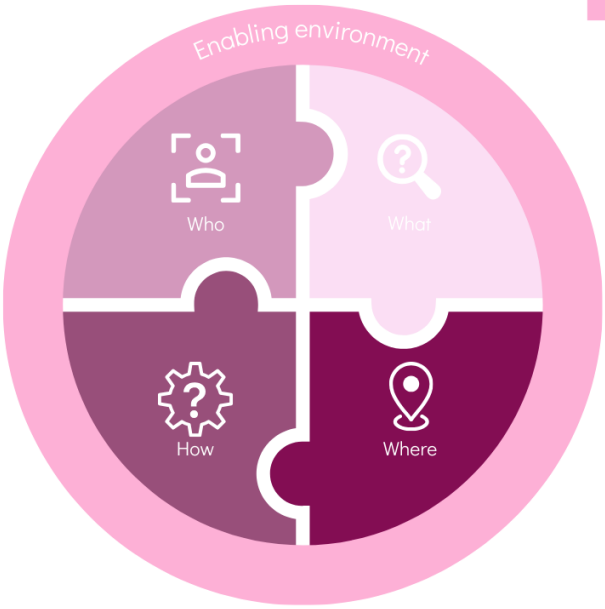
The framework focuses on the delivery of CAC in humanitarian settings by midwives. It outlines the main components of an enabling environment that, when combined, creates conditions for midwives to provide CAC in humanitarian settings. The framework then considers four key implementation areas:

1. Who, which focuses on the healthcare provider that delivers abortion care
2. What, which includes the range of abortion care services that are delivered
3. Where the abortion care services are delivered
4. How, which includes details on how abortion care services are delivered

Figure 2. The midwifery model of abortion care in humanitarian settings*

WHY

61% of maternal deaths worldwide occur in countries affected by fragility and crisis, and unsafe abortion is one of the leading causes of death



ENABLING ENVIRONMENT

Ensuring the security and safety of midwives and women in the conflict setting

Involving midwives before, during, and after the emergency crisis

Integrating the role of midwives in the health system

Strengthening midwifery leadership
Strong midwifery association

Supportive regulatory structure

Incentivizing and appropriately paying midwives for their work

Engaging humanitarian partners with flexible funding arrangements

Community engagement to address stigma and normalize abortion as routine care

WHO

Midwives are frontline providers of CAC in humanitarian settings
Intra-professional peer support and collaboration among midwives
Inter-professional collaboration and consultation of midwives with physicians and other healthcare providers

WHAT

Pre-abortion - information, GBV, clinical assessment, options counselling, and shared decision-making
Abortion - pain management, manual vacuum aspiration, medication abortion
Post-abortion - follow-up care, assessing and managing complications, and family planning counselling and provision
Post-abortion care - diagnosis and treatment of incomplete abortion using medication abortion or manual vacuum aspiration

HOW

Person centered care includes dignity, autonomy, privacy, communication, social support, and trust
Universal access to conception and abortion care in all settings, including in refugee camps and mobile clinics
Improving to access abortion options (medication abortion and manual vacuum aspiration)

WHERE

Home, telemedicine, refugee camps, mobile clinics
Primary health care level: Health post
Secondary health care level: Primary and general hospitals
Tertiary health care level: Referral and specialized hospitals

*Adapted from: Canadian Association of Midwives. National strategy for midwife-led abortion care in Canada. Montreal: CAM; 2024.

Implementation Considerations

The research presented in this evidence brief provides important, context-specific insights into women's needs, experiences, and barriers to accessing CAC in humanitarian settings. After discussing how these challenges might be addressed, the next step is to identify implementation barriers as well as potential windows of opportunity that can be harnessed to enhance access to CAC in humanitarian settings. Outlined below are implementation barriers across the health system levels (see Table 2) and windows of opportunity for implementation (see Table 3).

Table 2. Overview of potential implementation barriers

System level	Implementation consideration
Community level	Stigma and lack of information • Community stigma and a lack of understanding about abortion services prevent women from seeking care. Many women prefer to terminate pregnancies unsafely due to fear of societal judgment
Healthcare provider level	• There is a shortage of healthcare providers trained in CAC, leading to inadequate service delivery • There is poor willingness of midwives who are already trained in CAC to provide the service • Healthcare providers often face conflicts between their personal beliefs and professional responsibilities, impacting their ability to deliver non-judgmental care
Health-system level	• **Poor infrastructure**: Many health facilities lack the necessary infrastructure, such as private rooms, which is a barrier to CAC • **High caseloads**: Overwhelmed healthcare facilities struggle to manage high patient volumes, leading to rushed services and insufficient patient counselling • **Medications and equipment shortages**: Health facilities often face shortages of essential medications and equipment needed for safe abortion procedures, forcing patients to purchase supplies at high costs • **Lack of access:** Many women do not receive abortion services on their first visit to health facilities due to various barriers, including the unavailability of services in certain areas including at refugee camps
External factors	• The ongoing and escalating war in the community leads to complete blockage of healthcare services in some areas in the Amhara Region

Table 3. Overview of potential implementation windows of opportunity

Opportunity	Implementation consideration
Integrating the midwifery model of abortion care in humanitarian settings	• Integration of a midwife-led approach will support midwives to play a key role in the provision of respectful and response care to better support individual patient preferences, needs, and values, and can significantly improve the quality of abortion care in a humanitarian context • The Ethiopian Midwives Association and the Federal Ministry of Health have actively deployed midwives in conflict settings over the last 5 years • They engage midwives and other healthcare providers in continuous training to enhance their ability to deliver CAC
Supporting stakeholder collaboration	• Active participation and collaboration between CAC providers, healthcare institution administrators, researchers, and policymakers are crucial for the successful implementation of abortion care services • Participatory stakeholder dialogues can help create a shared understanding of the local challenges and facilitate the development of tailored implementation strategies
Investing in infrastructure and resources	• Investing in better infrastructure, such as private rooms for consultations to enhance patient confidentiality, privacy, and comfort • Ensuring a consistent supply of essential drugs and equipment will reduce the financial burden on patients and improve the quality of care • Strengthening healthcare insurance in the health system
Improving community education and awareness	• Increasing community awareness and education SRHR will help to reduce stigma and improve understanding that abortion services are a routine and normal part of healthcare • Implementing comprehensive SRHR education programs in communities and camps to address misconceptions and promote safer health practices
Expanding CAC access	• Expanding CAC services in all levels of healthcare including in refugee camps and mobile clinics • Introducing self-managed medication abortion for women living in hard-to-reach areas • Aligning with evidence-base which includes the diagnosis and treatment of incomplete abortion with misoprostol by midwives[10] and the provision of post-abortion care by midwives for women in the second trimester[11]

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