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Original article

Playing it Safe: Legal and Clandestine Abortions Among Adolescents in Ethiopia

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A B S T R A C T

Purpose: The 2005 expansion of the Ethiopian abortion law provided minors access to legal abortions, yet little is known about abortion among adolescents. This paper estimates the incidence of legal and clandestine abortions and the severity of abortion-related complications among adolescent and nonadolescent women in Ethiopia in 2014.
Methods: This paper uses data from three surveys: a Health Facility Survey (n = 822) to collect data on legal abortions and postabortion complications, a Health Professionals Survey (n = 82) to estimate the share of clandestine abortions that resulted in treated complications, and a Prospective Data Survey (n = 5,604) to collect data on abortion care clients. An age-specific variant of the Abortion Incidence Complications Method was used to estimate abortions by age-group.
Results: Adolescents have the lowest abortion rate among all women below age 35 (19.6 per 1,000 women). After adjusting for lower levels of sexual activity among adolescents however, we find that adolescents have the highest abortion rate among all age-groups. Adolescents also have the highest proportion (64%) of legal abortions compared with other age-groups. We find no differences in the severity of abortion-related complications between adolescent and nonadolescent women.
Conclusions: We find no evidence that adolescents are more likely than older women to have clandestine abortions. However, the higher abortion and pregnancy rates among sexually active adolescents suggest that they face barriers in access to and use of contraceptive services. Further work is needed to address the persistence of clandestine abortions among adolescents in a context where safe and legal abortion is available.

IMPLICATIONS AND CONTRIBUTION

This assessment of legal and clandestine abortion among Ethiopian adolescents shows that adolescents have the highest proportion of legal abortions, suggesting a benefit to acknowledging adolescents in reproductive health policies. The high rate of abortion among sexually active adolescents indicates a need for promoting adolescent-targeted family planning services.

Abortion is one of the leading causes of maternal mortality worldwide [1,2]. The Government of Ethiopia has made considerable efforts to decrease abortion-related morbidity and mortality. In 2005, the abortion law was expanded to permit abortion in cases of rape, incest, and fetal impairment, to save the life of the woman, if the woman has a physical or mental disability, or if she is *under 18 years of age* [3]. Ethiopia is one of the few countries that explicitly acknowledge the difficulties young pregnant

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women face and the need to decrease barriers to accessing abortion services among this age-group. Minors seeking abortions need neither parental consent nor any proof of age [3]. In 2006, the Ethiopian government made further efforts to expand the provision of legal and safe abortion services by developing and disseminating national guidelines for the provision of abortion care [3]. Under the law, legal abortions have increased from 27% of all abortions in 2008 to 53% in 2014 [4,5].

Despite the change in the law and expansion of services, young women in Ethiopia report uncertainty about the legality of abortion [6–8], and explicit knowledge that abortion is legal for minors is low [8,9]. Beyond gaps in knowledge, concerns about cost, privacy, and judgment from providers may create barriers in adolescents' access to formalized services, leaving them particularly vulnerable to clandestine, and potentially unsafe, abortion [10,11]. Adolescents also confront the same barriers as older women to accessing safe abortion, including lack of information about location and availability of services, pressure from families and communities, poorly equipped facilities, absent providers, and a weak referral system [12,13]. Similar barriers have been identified as potentially limiting adolescents' access to family planning services [14–16]. One-fifth of married adolescents and 40% of unmarried adolescents had an unmet need for family planning in Ethiopia in 2016 [17].

Research conducted in Ethiopia and elsewhere indicates that when adolescents pursue abortions, they often resort to unsafe methods or seek out abortion services at later gestations [10,18,19]. A study of abortion patients in one hospital in Ethiopia found that women under the age of 19 were twice as likely to have a second trimester abortion than older women [19]. Obtaining abortions at later gestations, and using less safe methods, may result in more severe abortion-related morbidities among adolescents [10].

Ethiopian adolescents are unique compared with other young women in the region in that they have official avenues available for legal and safe abortion. This paper assesses whether adolescents in fact benefit from the legal and service environment established to provide them with access to safe abortion. We evaluate this through five research questions: (1) What is the incidence of abortion among adolescents in Ethiopia? (2) What percentage of abortions among adolescents is legal as compared with nonadolescent women? (3) What percentage of unintended pregnancies ends in abortion among adolescents? (4) Are abortion-related complications more severe among adolescents than among nonadolescent women? And (5) What is the demographic and social profile of adolescents receiving legal abortion services compared with adolescents receiving treatment for abortion complications? Understanding adolescents' use of legal abortion services under the current law is essential for determining how to reduce clandestine abortion and its health consequences among adolescents in Ethiopia.

Methods

Terminology

In this study, an adolescent is defined as someone between 15 and 19 years of age. We use the term legal abortion to refer to abortions that occur in health facilities, and clandestine for abortions outside of health facilities. Abortion safety is determined by the skills of the person performing the abortion and the medical standards of the environment, rather than the outcome of the abortion (such as whether the abortion resulted in complications) [20]. Three categories of abortion safety have been identified: (1) "safe" abortions, provided by health care workers with methods recommended by the World Health Organizations; (2) "less safe" abortions, performed by trained providers using nonrecommended methods or performed using recommended methods but without adequate information or support; and (3) "least safe" abortions, provided by untrained providers using dangerous methods [21]. A clandestine abortion can therefore be safe, less safe, or least safe depending on who performed the abortion and the method used. Legal abortions are mostly safe, with a small proportion being less safe with the use of nonrecommended methods. Complications may occur with both legal and clandestine abortions, but the largest share comes from clandestine procedures [20]. Still, clandestine abortions can be performed without complications, particularly with the availability of medical abortion outside of the formal health system [20]. We use the term abortion care to refer to both legal abortion and postabortion care (PAC) services.

Data

This paper estimates abortion incidence indirectly using the Abortion Incidence Complications Method (AICM) [22]. We use data from three surveys conducted in Ethiopia in 2014: a Health Facilities Survey (HFS) and a Prospective Data Survey (PDS), nationally representative surveys that provide data on the number of legal abortions and postabortion care (PAC) cases in health facilities; and a Health Professionals Survey (HPS), used to estimate the proportion of all abortions likely represented by PAC patients. The HFS was conducted in 822 public, private, and nongovernmental organization (NGO) facilities and the PDS took place in 594 facilities [5,23]. The HPS was conducted among 82 knowledgeable experts that were purposefully selected to ensure rural and urban representation across all regions [5]. The PDS also gathered information from providers on the characteristics and reproductive and clinical history of women obtaining abortion care. Detailed study protocols are described in Moore et al. and Gebrehiwot et al. [5,23]. Ethical approval was received for research on human subjects from the Ethiopian Ministry of Science and Technology and the Guttmacher Institute's institutional review board.

The PDS included data on the age of abortion care clients in public and private facilities. Additional age-distribution data were provided from the two NGOs providing abortion services in the country, which together provide services to 36% of women receiving facility-based postabortion care or legal abortions [23]. We calculated the age distributions for legal abortion clients and PAC patients separately, weighting the facility type age-distributions by the caseloads for each type of abortion service. For the NGO data, we weighted each NGO's caseloads separately by their own age-distribution data.

Abortion and pregnancy rates were calculated by dividing the estimated number of abortions and pregnancies by the number of women in each five-year age-group from 15–49 using data from the Central Statistical Agency's population prospects [24]. We used age-specific fertility rates [25] to calculate the number of live births in 2014 within each age-group.