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“Don’t do it, but do it”

Exploring a legal window of opportunity for safe abortion and the role of healthcare practitioners in implementing the right to health in Ethiopia

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Abstract

Unsafe abortion is a major contributing factor to maternal mortality with 47,000 largely avoidable deaths occurring globally every year, the majority in the global south. Ethiopia has taken a unique approach to addressing maternal mortality impacted by unsafe abortion through a 2005 reform of the abortion legislation in which abortion is illegal but available under a range of exceptions. The purpose of this thesis is to bridge health and human rights perspectives by approaching abortion through a right-based perspective and investigates how healthcare workers work towards the fulfilment of the right to health through safe abortion implementation in Ethiopia. Through a thematic analysis of 10 semi-structured interviews and Lipsky's theory of street-level bureaucracy, the results reveal that views on abortion sit on a spectrum which reflect the 2005 legislation and that healthcare workers play a key role as gatekeepers for abortion access. Further, the analysis shows the importance of civil society actors for the fulfilment of the right to health. The study concludes that abortion is still stigmatised both by health providers and users but the argument of abortion as a life saving procedure is increasing acceptability.

Key words: SDG3, SDG4, safe abortion, SRHR, human rights, HRBA, street-level bureaucracy

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List of Abbreviations

AAAQ	Availability, Accessibility, Acceptability and Quality
CESCR	Committee on Economic, Social and Cultural Rights
CO	Conscientious Objection
GBV	Gender Based Violence
HRBA	Human Rights-Based Approach
ICESCR	International Convention on Economic, Social and Cultural Rights
LMIC	Lower and Middle Income Countries
LUMID	Lund University MSc in International Development and Management
MOH	Ministry of Health
NGO	Non-governmental organisation
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
UN	United Nations
UNFPA	United Nations Population Fund
UNGA	United Nations General Assembly
VAW	Violence Against Women
VCAT	Value Clarification and Attitude Training
WHO	World Health Organisation

Key Concepts and Definitions

Comprehensive Abortion Care	Services related to the provision of information about abortion, abortion services, post-abortion care.
Conscientious objection/refusal	The practice of healthcare practitioners refusing to provide abortion care based on personal conscience or religious belief.
Health	A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, as defined by the World Health Organization.
Incomplete abortion	A state where the cervix is open, and bleeding occurs but where all products of conception have not been expelled. Incomplete abortion can occur for a spontaneous (miscarriage) or induced abortion.
Induced abortion	A deliberate termination of a pregnancy.
Medical abortion	The use of pharmaceutical drugs to terminate a pregnancy.
Misoprostol; Mifepristone	The medications used in a medical abortion.
Miscarriage (spontaneous abortion)	Spontaneous loss of pregnancy before 24 gestational weeks.
Policy	A law, regulation, guideline or similar of governments and institutions.
Safe abortion	A termination of pregnancy using a method recommended by WHO appropriate to the pregnancy duration, and by someone with the necessary skills.
Surgical abortion	Use of transcervical methods of terminating a pregnancy such as manual or electronic vacuum aspiration.

Adapted from "Abortion Care Guideline". *Geneva: World Health Organization*; 2022. Licence: CC BY-NC-SA 3.0 IGO.

“When women put their trust in the health profession, they expect more than fixing diseased organs and delivering babies. They expect a profession that stands beside them and behind them, as they claim their human rights, including their right to health.”

- Fathalla (2020)

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1. Introduction

Maternal mortality can be considered the most sensitive indicator of health and development between low and high income countries as the effects of maternal mortality impact children and other family members (Tessema *et al.,* 2017). The United Nations Sustainable Development Goal 3.1 calls for a reduction of global maternal mortality to 70 per 100 000 and, by 2030, no country shall have a rate higher than 130 per 100 000 (UN General Assembly, 2015). One factor that affects maternal mortality on a global level is unsafe abortion. Globally, 4.7% to 13.2% of all maternal deaths can be attributed to unsafe abortion. This translates to 47,000 unavoidable, unnecessary deaths every year, the majority of which occurs in the global south (Fathalla, 2020). Research shows that the frequency of abortion is not affected by its legal status, but that in countries with restrictive abortion laws, abortions are less safe (Fathalla, 2020; Wada 2008; Berak *et al*., 2020). The World Health Organization (WHO) describes that abortion is a common health intervention that is safe "when carried out using a method recommended by WHO, appropriate to the pregnancy duration and by someone with the necessary skills." (WHO, 2021).

WHO, together with other agencies and scholars, point to the fact that undergoing an unsafe abortion violates human rights such as the right to life, health, privacy, and information (WHO, 2021). However, due to its sensitive nature, there is no global consensus on whether abortion itself is a human right. The most prominent international document on sexual and reproductive health and rights (SRHR), of which abortion is a significant part, is the International Conference on Population and Development's Programme of Action. Paragraph 8.25 of this document stipulates that abortion is a public health concern, but not a human right (UN, 1994:61-62). Rather, it says that where abortion is legal, it should be safe. This was further reiterated in the Maputo Protocol of Women's Human Rights which is the only human rights treaty to explicitly mention abortion (Ngwena, 2010). By speaking of abortion in terms of health, international human rights law has sought to avoid political conflict by using "the pragmatism of public health" (Erdman, 2016). This means that within the UN human rights system, abortion is not seen as an issue regarding women's reproductive justice, but of reducing death and suffering. Through this, the system has been able

to create legal obligations on states to reduce death and suffering in relation to unsafe abortion through the right to health (*ibid*). The right to health is articulated in the WHO constitution which stipulates that "…the highest attainable standard of health [is] a fundamental right of every human being" (WHO, 1946). In 1966, the right to health became a legally binding commitment through article 12 in the International Covenant on Economic, Social and Cultural Rights (UN General Assembly, 1966).

A country that has made astounding progress in the matter of abortion associated with maternal mortality is Ethiopia. Located on the Horn of Africa, it is the continent's second most populous country. Maternal mortality has been halved in Ethiopia between the years 2000 and 2017, dropping from 871 to 401 per 100 000 live births (WHO, 2019; DeMaria, Smith and Berhane, 2022). At the turn of the millennium, politicians, professional groups and international expertise combined forces to tackle the high rates of maternal mortality. The healthcare system experienced an overhaul, and more importantly, the country's abortion legislation was reformed (Holcombe and Kidanemariam Gebru, 2022). Since 2005, abortion is illegal but permissible under a range of exceptions, such as rape, if the mother is a minor, foetal deforms et cetera. What distinguishes the law in Ethiopia is that a woman's word is enough evidence of rape or incest. This makes the law arguably the most liberal abortion policy in Africa, as in practice, anyone is eligible for an abortion (Magelssen and Ewnetu, 2021).

The 2005 legal reform was not born out of a human rights argument, but rather that the public health impact of unsafe abortion was costly in many ways. In order to combat this in a conservative setting, the legislation is a compromise of an antagonistic view of abortion often framed as "pro-life" and "pro-choice" (Wada, 2008). Despite this, the technical and procedural guidelines that accompany the law use a rights-based frame by promoting a women-centred approach that stresses a woman's choice in terminating a pregnancy (Tadele *et al.*, 2019). In this way, the legislation is not only a compromise between "pro-life and "pro-choice" but also a compromise between a public health perspective and a human rights-based perspective. This thesis investigates how these compromises play out in practice by studying those who work at the front-line of the policy implementation in this sensitive matter: the healthcare workers.

1.1 Purpose and Aim

Using Michael Lipsky's theory on street-level bureaucracy, this thesis aims to investigate how key healthcare staff in Ethiopia work towards safe abortion implementation, and by extension the right to health. Stemming from sociological research in the United States, the theory argues that the individuals who work in public services not only implement policy but create it (Erasmus, 2014). According to Lipsky, regardless of how much policy-making institutions attempt to standardise and control these bureaucrats' behaviours, their practices will divert from policy through workers' use of "discretion" (Lipsky, 2010). In this way, healthcare professionals become "gatekeepers" to healthcare access (McLean *et al.*, 2019).

In a world where abortion debates are antagonistic and polarised, Ethiopia sits in a unique position. The law is restrictive, yet open, and thus appeals (or settles conflict) both with those opposed and those in favour of abortions (McLean *et al.*, 2019). The dual focus on public health and human rights caused by a combination of perspectives constitutes a compromise between human rights and public health perspectives. This warrants an analysis into both health and human rights. The purpose of this thesis is to bridge the silos between human rights studies and public health that have long existed between these two fields (Montel *et al.*, 2022) whilst shedding light on how a human rights-based approach to development, specifically the WHO framework on availability, accessibility, acceptability and quality (AAAQ), can be used as an analytical tool.

1.2 Research Questions

In order for development to be successful, changes must be recognised as constructed by actors in all parts of society, and not merely the result of efforts funded by international actors. The type of local realities that civil service staff experience can have both positive, negative and even contradictory effects. This makes determining the success or failure of development projects challenging, or even impossible, since the interventions are inevitably transformed by so-called "recipients" (Beck, 2017). The same goes for policy implementation, which can never be implemented exactly the way policymakers intended (Lipsky, 1969). In fact, it is those closest to everyday human interaction that decide on when and how policies are used on the ground. The goal of this thesis is not to assign responsibility to any particular health workforce category, nor to investigate the moral permissibility of abortion, but rather to discuss the complexities of rights and

health in matters deemed sensitive in certain contexts. The overall research question for this thesis is:

I. How can we understand the role of healthcare practitioners in securing the right to health through the provision of safe abortions in Ethiopia?

In doing so, the thesis further uses the following subquestions:

II. How can we understand the essential elements for safe abortions from a rights-based approach?
III. How can we understand the role of practitioners in fulfilling the essential elements for safe abortions?

1.3 Outline of the thesis

The next section provides more detail on the issue at stake, namely abortion as a public health issue in the context of Ethiopia. After this the literature review attempts to set the scene of current research findings on the topic. Then, the theoretical framework is presented, followed by the methodology, explaining data collections methods as well as ethical considerations. The analysis is presented in chapter 6, according to the AAAQ framework and Lipsky. In the discussion, I summarise the findings using a human rights-based approach to health. Lastly, some conclusions are made in regard to the research question along with implications and suggestions for future research.

2. Background

2.1 Abortion as a matter of global public health

The case for studying abortion as an issue for development can be made by looking at global statistics related to pregnancy and abortion. These statistics distinguish spontaneous abortion (miscarriage) from induced abortion which can be described as a deliberate termination of a pregnancy (WHO, 2022). 29% of all pregnancies end in induced abortion (Bearak *et al.*, 2020). Estimates show that approximately 73 million induced abortions occur globally every year (*ibid*). The main cause for seeking an abortion is unintended pregnancy, and almost two thirds (61%) of all unintended pregnancies result in abortion (*ibid*). An induced abortion, however, does not entail that it is safe. In fact, 45% of all induced abortions are unsafe (Ganatra *et al.*, 2017). Most of these cases (97%), and thus the health burden, fall onto developing countries. In Africa, the situation is particularly dire, with nearly 50% of all abortions happening in the least safe circumstances (*ibid*). The physical health risks stemming from unsafe abortion are plenty and include incomplete abortion, heavy bleeding or infection (WHO, 2022). Research shows that restricting access to abortion services does not reduce the number of abortion (Bearak *et al.*, 2020). Rather, evidence shows that it makes them unsafe: in countries where abortion is highly restricted, there is a higher proportion of unsafe abortions (Ganatra *et al.*, 2017). Estimates say that 4.7-13.2% of all maternal deaths every year can be attributed to unsafe abortion (Say *et al.*, 2014).

2.2 Maternal mortality and abortion in Ethiopia

Rates of maternal mortality in Ethiopia remain high, despite the progress that has been noted. According to the Ministry of Health (MoH), in the 2000s, maternal mortality was at a staggering rate of 871 per 100 000 live births (WHO, 2019; DeMaria, Smith and Berhane, 2022). In 2017, the rates of maternal deaths per 100 000 stood at 401 in Ethiopia. Between 1980 and 1999, unsafe abortion was the number one cause (31%) of maternal mortality in Ethiopia (Berhan and Berhan, 2014). Healthcare professionals described hospital wards and waiting rooms filled with women with serious unsafe abortion complications (Berhan and Berhan, 2014; McLean *et al.*, 2019). In 2008, the summary of national hospitals estimated a drop to 6% of unsafe abortion related maternal deaths, and complications from unsafe abortion are not a major cause for seeking treatment

(Berhan and Berhan, 2014). Nevertheless, the improvements differ in terms of geography as rural and regional areas report much higher rates of maternal mortality and morbidity than urban areas, albeit the situation has improved over all (Gebreselassie *et al.*, 2010).

2.3 The 2005 Reform of the Ethiopian Criminal Code

The astounding improvement of abortion related maternal mortality can in part be attributed to commitment to change by the Ethiopian government, fuelled by civil society organisations such as the Ethiopian Society for Obstetrics and Gynaecology (Holcombe and Kidanemariam Gebru, 2022). Firstly, much effort has been made into improving the healthcare system, for example by increasing the number of midwives. A campaign was launched to showcase the role of midwives and birth attendants in the quest of lowering maternal mortality (Holcombe, Berhe and Cherie, 2015). Secondly, the new, more liberal abortion law from 2005 meant women received increased access to safe abortion services (Berhan and Berhan, 2014). The makings and content of this legal reform is outlined below.

In Ethiopia, following reform of the Criminal Code in 2005, abortion is illegal but the exceptions are broad and apply to instances of rape, incest, if the life of the mother or foetus is at risk, or if the mother is a minor, and other reasons (Blystad *et al*., 2019). The distinguishing features of the legislation can also be found in article 552 (2.1.a) which states that "the mere statement by the woman is adequate to prove that her pregnancy is the result of rape or incest" (*Ethiopia: Criminal Code*, Proclamation No. 414/2004). This stands in sharp contrast to the previous legislation where women were required to produce a police report documenting the alleged rape in order to be eligible for an abortion (Tadele *et al.*, 2019). Similarly, a woman does not have to show proof of age to show that she is a minor as specified in the technical guidelines (Bridgman-Packer and Kidanemariam, 2018).

Article 551. - Cases where Terminating Pregnancy is Allowed by Law.

(1) Termination of pregnancy by a recognized medical institution within the period permitted by the profession is not punishable where:

a) the pregnancy is the result of rape or incest; or

b) the continuance of the pregnancy endangers the life of the mother or the child or the health of the mother or where the birth of the child is a risk to the life or health of the mother; or

c) where the child has an incurable and serious deformity; or

d) where the pregnant woman, owing to a physical or mental deficiency she suffers from or her minority, is physically as well as mentally unfit to bring up the child.

(2) In the case of grave and imminent danger which can be averted only by an immediate intervention, an act of terminating pregnancy in accordance with the provision of Article 75 of this Code is not punishable.

Article 552.- Procedure of Terminating Pregnancy and the penalty of Violating the Procedure.

(1) The Ministry of Health shall shortly issue a directive whereby pregnancy may be terminated under the conditions specified in Article 551 above, in a manner which does not affect the interest of pregnant women.

(2) In the case of terminating pregnancy in accordance with subarticle (1) (a) of Article 551 the mere statement by the woman is adequate to prove that her pregnancy is the result of rape or incest.

(3) Any person who violated the directive mentioned in sub-article (1) above, is punishable with fine not exceeding one thousand Birr, or simple imprisonment not exceeding three months.

Figure 1: Ethiopian Criminal Code, Article 551.

2.3.1 The procedural and technical guidelines

The new legal reform was also accompanied with technical and procedural guidelines for implementation. It provides information for health care professionals on what their legal duties are, how to assess the request for an abortion, and how to perform it. Interestingly, this guideline is framed in language about rights and gender (Tadele *et al*, 2019). The goal of the guideline is to "ensure that women obtain standard, consistent, safe termination of pregnancy services regardless of the level of care of the health institution or the qualification of the service provider." (MoH., 2014). It stipulates that the abortion care should be "women-centred" and take into account her

mental and physical health needs as well as personal circumstances. The women-centred approach includes three key elements:

1. Choice - includes the right to decide if and when to become pregnant, to continue or terminate the pregnancy, and the right to select between options, and a right to accurate information.
2. Access - having abortion services by trained professionals with modern technology, easy-to-reach services at a reasonable cost and non-discriminatory approach.
3. Quality - respectful, confidential, and tailored services according to accepted standards and referral processes (MoH., 2014).

Furthermore, the document explains the role of the healthcare provider, stating that knowledge of the law is essential both for them to know what is expected from them and to "inform and educate women and community at large." (MoH., 2014) According to the guidelines, it is the responsibility of the healthcare practitioner to assess and determine if the pregnancy is a threat to the woman's or foetus' life (*ibid*). Further, healthcare practitioners are obliged to perform abortions: conscientious objection, meaning the refusal of services on moral or religious grounds, is not permitted in the legislation, something which is unique in the African context (Magelssen and Ewnetu, 2021).

As this section has demonstrated, substantial efforts have been made to improve the maternal mortality rate in Ethiopia. The legal reform from 2005 played an important role in addressing the high death rate of deaths caused by unsafe abortions. Although abortion is still criminalised, the generous exceptions have vastly changed the way that abortion is provided in the healthcare system. Nevertheless, in order to answer the research questions, the role of healthcare actors and their practices needs further attention. In the next section, I outline the previous research conducted in this space.

3. Literature review

3.1 Safe abortion implementation: lessons learned from other countries

To understand common challenges for abortion implementation, and the relationship between actors, looking at other countries is a useful exercise. A few countries have gone down a similar route to legal change on abortion to Ethiopia. Chavkin *et al.'s* (2018a) comparative study highlighted the similarities in challenges to safe abortion implementation. The study is composed of case studies from five different countries that have undergone changes in abortion related law since 2003. The largest divide between countries was the argument for advocating for legal change. In Ghana, Portugal, Ethiopia and Uruguay, the impact of unsafe abortion on public health and maternal mortality was seen as the key evidence for safe abortion implementation (Stifani, Couto and Lopez Gomez, 2018a). In both Ghana and Ethiopia, professional societies for obstetrician gynaecologists and other health professions played an important role in advocating for reform (Bridgman-Packer and Kidanemariam, 2018; Chavkin, Baffoe and Awoonor-Williams, 2018b). In Ethiopia, these providers were often influenced by their own experiences from working with abortion related complications, some stating that the majority of obstetric ward beds at hospitals taken up by women with complications from unsafe abortion (Bridgman-Packer and Kidanemariam, 2018).

Effective implementation further hinges upon an organisational and institutional ability and capacity for collaboration. Chavkin *et al.* (2018a) highlight the variety of actors involved in improving effective implementation, ranging from ministries of health, health service providers, community leaders and country-based and international non-governmental organisations (NGOs). The case of Ghana showed that international NGOs like Marie Stopes International and Ipas contributed with technical and value clarification training, although there was a concern about community backlash if an NGO proceeded too aggressively (Chavkin, Baffoe and Awoonor-Williams, 2018b). Such a relationship relies on genuine political leadership, ownership and will as was visible in Favier, Greenberg and Stevens (2018), who told the story of abortion rights organisation Ipas leaving South Africa because the government did not want to engage with the organisation. The fluctuation in political leadership further poses challenges for the continuity and consistency of care which was noted in Colombia by Stifani *et al.* (2018b). Even in countries that

have successfully advocated and achieved legal reform in the abortion space, stigma is still considered a prevailing barrier for comprehensive abortion care. As such, the studies indicate the importance of multi-actor involvement in abortion service implementation, with state and NGOs working hand in glove towards common goals.

3.2 Healthcare practitioners as implementers of policy

Implementation of any policy is highly reliant on those who work on the "front-line", the people who face and interact with the public on a daily basis. Despite having rules and guidelines of how to conduct their work, such a workforce is also affected by societal and individual understandings of what is right and wrong (Röhrs, 2017). Although the level of knowledge of the Ethiopian abortion legislation among healthcare practitioners is higher than the general population, its full extent is not always clear (Assefa, 2019). For example, almost a third claim that women should provide evidence as to why she is seeking an abortion even though this is not necessary (*ibid*).

Many studies discuss that while the law is clear, reality is not, and the implementation of the law hinges upon the healthcare practitioners' willingness to perform an abortion or not. McLean *et al.* (2019) showed that it is these individual "gatekeepers" who determine whether a woman's request for abortion is reasonable or not, and that the degree of acceptance of this was determined by their own personal convictions that influenced their willingness. Aniteye and Mayhew (2013) study on healthcare practitioners working with abortion in Ghana demonstrated this as well: the workers often used their own discretion to decide which woman was genuinely seeking an abortion. In doing this, some reasons for seeking the service were considered more serious than others, something that a study by Harrison *et al.* (2000) from South Africa labelled a "hierarchy of support". Victims of rape, incest, or a woman with life threatening complications would not be rejected by staff as they were deemed worthy to receive treatment despite moral convictions of the healthcare practitioners. Such supporting notions could not be found for young women, or women with low socioeconomic status (Harrison *et al.*, 2000).

Tadele *et al.* (2019) argues that this type of discretionary practice is also present in the case of Ethiopia where healthcare practitioners claim that women are lying above sexual assault in order to deny them access to abortion services. In fact, Blystad *et al.*, (2019) state that healthcare workers

can become trapped between providing services according to the guideline and expectations of the police to report all instances of rape. According to Tadele *et al.* (2019), discretion can happen in multiple directions: while some use the illegal but available "greyzone" to limit access to abortion, others may interpret the conditions liberally, to the extent that abortion is, in practice, available to everyone. Further, there is a general silence on the issue due to stigma. For example, despite governmental support for legislative reform, there is no public strategy to increase demand and in order to avoid confrontation, awareness raising efforts are often integrated into other SRH services. The authors further state that abortion is more available than ever, as public actors are also involved in abortion provision, but that the geographic spread is unequal and follows an urban bias (Tadele *et al.*, 2019).

3.2.1 Conscientious objection

An important concept in abortion related research is 'conscientious objection' (CO). This refers to the practice of refusing services based on personal beliefs or convictions (WHO, 2022). Research on this often discusses the legality of CO, or how it is written in policy. Yet, according to Harris *et al.*, (2018) research has been limited on how CO is enacted in practice, or its effects on patients, clinicians or health systems. This is also true for the case of Ethiopia, especially in light of human rights arguments. Studies do not get conclusive answers on whether or not abortion healthcare practitioners thought it was a woman's right and if they should have the right to refuse services on their own religious grounds, something that is currently not permitted in Ethiopia (Holcombe, Berhe and Cherie, 2015). However, many healthcare practitioners feel that carrying out an abortion is difficult and induce feelings of shame, especially considering personal religious beliefs (McLean *et al.* (2019). In Tadele *et al.*, (2019) it was demonstrated that some health workers in Ethiopia use discretion to deny abortion services, and that they claim to have a right to conscientious objection. Nevertheless, Holcombe, Berhe and Cherie (2015) indicate that there is strong support for midwives to provide abortion. In Magelssen and Ewnetu's study (2021), it was found that willingness to provide abortion was more common in private than public clinics. In the public sector, many healthcare practitioners said they were not willing to provide abortions unless it was an emergency, and argued that respect of individual consciousness is a right (Magelssen and Ewnetu, 2021).

3.3 Human rights-based approach to Health

HRBAs have quickly become a key tool in development which is used to translate law into principles that can be applied in programming and implementation, and can refer to both the outcomes and processes of development. HRBA to development has grown out the movement for a 'right to development'. Uvin (2007) describes that this was driven by lower-middle income countries (LMIC) during the 1970s who used their numerical majority to push for global financial reforms and redistribution of resources, something that rich countries vehemently opposed. In 1986, a Declaration of the Right to Development was introduced (*ibid*). This further built the connection between human rights and development. In the early 2000s, the justifications of the HRBA to development were further informed by Amartya Sen's *Development as Freedom* (1999). Sen argued for a redefinition of development in which human rights were constituted both as outcomes and processes of development. Such a view of development claimed that major factors that limit freedom (poverty, social deprivation and neglect of public facilities) must be removed so that human beings have "the capacity to lead the kind of life he or she has reason to value" (Sen, 1999:87).

Since Sen's pioneering work on human development, the notion of a HRBA has had a large impact on development. A HRBA to development entails incorporating principles of human rights law into development projects and programming (Uvin, 2004). This includes principles of participation, equality, non-discrimination, legality, and accountability. Gready (2008) argues that the benefit of HRBA is that it reframes development as entitlement instead of charity, moving from citizens' needs to claims. The rights-based approach sees its objectives to 1) increase capacity of duty-bearers, who in most cases work for the state, and 2) empower 'right-holders', citizens, to claim their rights (Cornwall and Nyamu-Musembi, 2004).

Hunt (2016) differentiates between the right to health and RBA. Though general comments created in international agreements are a way to bridge legal practice to implementation (like the AAAQ), often the comments are not detailed enough to provide enough guidance on "the front-line" (*ibid*). Similar views are shared by Gruskin *et al.*, (2012), who believe that the AAAQ answers *what* should be implemented but not *how*. In contrast to Hunt (2016) however, Gruskin *et al.* (2012) argue that the right to health is "an obvious place to start when determining the human rights

concepts most relevant to health systems" (Gruskin *et al.,* 2012) making the AAAQ framework a natural departure point for analysis. According to them, AAAQ should primarily be understood as key elements that outline state responsibility. Building on this, Gruskin, Bogecho and Ferguson, (2010) outlines a plan for assessing the right to health which includes the AAAQ along with principles of participant, non-discrimination, transparency and accountability in order to create a "minimal checklist" for implementing a rights-based approach to health. In this way, the authors encourage states to use human rights principles as a method of assessment rather than only looking at public health data (Gruskin *et al.,* 2012).

Most existing studies using the AAAQ as a framework for analysis are recent and apply the framework in a multitude of ways. For example, Homer *et al.*, (2018) used the AAAQ framework to analyse barriers to care in sexual, reproductive, maternal, neonatal and adolescent health. Health worker scarcity and disproportionality was explained to be major problems with availability since the low number of healthcare workers lived in urban areas, whereas the majority of the population lived in rural areas (*ibid*). Hällström, Ranjbar and Ascher's (2017) study on adolescent health access in Sweden, in which AAAQ also was used, showed that confidentiality emerged as a key aspect of accessibility. The perceived lack of confidentiality was a common reason for adolescents to not seek health services, particularly for girls seeking abortion services (*ibid*). Homer *et al*. (2018) showed that harsh, judgemental and unfriendly health staff is a serious problem for acceptability across in all the 36 investigated countries. Adding to this Mselle *et al.*'s (2011) analysis into obstetric fistula and birth in Tanzania argued that to ensure acceptability and quality, the level of professional ethics must be increased in the training of healthcare providers. These studies all provide insight into how the AAAQ framework can be applied as means of analysis whilst also drawing conclusions applicable in this study.

4. Theoretical framework

In this section, the theoretical framework of the thesis is presented. This study uses a human rights-based approach to development, more specifically the AAAQ framework on the right to goods and services in combination with Lipsky's theory of street-level bureaucracy in order to shed light on the practices of healthcare workers. Lipsky's theory informs my own focus on practitioners because of their discretion, and the AAAQ helps theorise participants' role in securing the right to health through safe abortions.

4.1 Human rights-based approach to development and health

The overarching theoretical framework of this thesis is a human rights-based approach (HRBA) to development and health. A HBRA to health can be understood in many ways, using a myriad of frameworks and concepts. In this thesis, it is used as the process with which the human right to health (as stated by the WHO) is achieved. London (2008) describes three aspects of the right to health that must underpin a HRBA to health. Firstly, understanding the indivisibility of civil and political rights and socio-economic rights is core to developing health policies that fulfil the right to health on many fronts. Secondly, rights will not move from paper to action unless there is an active civil society that is able to advance citizens' agency and claims on their entitlements. Lastly, London argues, ethical standards should be accompanied by human rights criteria that defines who is a rights-holder, duty-bearer, and the nature of obligations. Such criteria will assist in establishing accountability, something that is particularly necessary for healthcare workers as it is currently not clear how a rights-based approach applies to the *responsibilities* of individual healthcare providers in realising human rights. London describes that such criteria is important to avoid healthcare workers becoming a vehicle for human rights violation where they are trapped in "dual loyalty" towards their patients and the state.

4.1.1 Availability, Accessibility, Acceptability and Quality of healthcare services

To better understand the implementation aspect of the right to health in the case of safe abortion in Ethiopia, the AAAQ outlining essential elements of healthcare is used as a complementary framework. Developed in 2000, the framework was set out in General Comment 14 to the International Convention on Economic, Social and Cultural Rights (ICESCR) and was developed by the WHO and human rights treaty bodies (Hällström, Ranjbar and Ascher, 2017). To provide

some background, after social and cultural rights had been in held in the dark by Western countries in favour of civil and political rights, the WHO, together human rights treaty bodies aimed to create a common ground of an understanding of the right to health as a set of arrangements which would enable an environment to secure good health (Nygren-Krug, 2013:41). The UN Committee on Economic, Social and Cultural Rights (CESCR) General Comment 22 (2016) on the right to sexual and reproductive health describes these essential elements in relation to SRHR (CESCR, 2016). Under 'Availability' the Comment stipulates that the unavailability of services due to ideologically or conscience based refusal of services "must not be a barrier to accessing services" (*ibid*). As described earlier, previous research in human rights and global public health has mostly been conducted in silos where concepts of human rights do not seem to translate to public health experts (Montel *et al.*, 2022). The theoretical aim of this thesis is to bridge this effect and provide a suggestion of how this type of analysis can be conducted.

The AAAQ framework on rights-based approaches to health services

- Availability - there shall be a sufficient quantity of functioning health facilities, services, and goods. The nature of these facilities will vary upon developmental state but should include basic determinants of health like safe, potable drinking water, adequate sanitation, trained medical staff with competitive salaries and essential drugs.
- Accessibility - health facilities, goods and services must be accessible for everyone without discrimination.
    - Non-discrimination: health facilities, services and goods must be accessible to all, particularly the most vulnerable, both *de jure* and *de facto*.
    - Physical accessibility - health facilities, services and goods must be within safe reach, especially for the most vulnerable and marginalised. This further includes access to safe water, drugs etcetera.
    - Economic accessibility - health facilities, services and goods must be affordable, for all and payment shall be based on equity.

- Information accessibility - the right to seek, receive and impart information without infringement on confidentiality.

- Acceptability - health facilities, services and goods must be respect of medical ethics, culturally appropriate as well as be designed to respect confidentiality.
- Quality - health facilities, services and goods must be scientifically and medically appropriate with skilled personnel, appropriate drugs and equipment, adequate water and sanitation.

Figure 2 adapted from CESCR, 2000.

4.2 Street-level bureaucracy

To understand the practices of healthcare workers, this thesis further uses Lipsky's theory of street-level bureaucracy. Although mostly used in studies on social work, Lipsky's theory has also been used within the field of SRHR, for example Shukla and McCoyd's (2019) study on healthcare providers working with HIV patients in India or Zulu *et al*., (2019) on teachers' views of the implementation of comprehensive abortion policy in Zambia. This theory stipulates that public services workers, street-level bureaucrats, are people who interact directly with citizens (Hupe and Hill, 2007). This can be police officers, teachers, social workers or healthcare practitioners to name a few. Because of their status as "public", the citizens, especially the poor, are dependent on and influenced by street-level bureaucrats (Lipsky, 1969). In this way, the clients are largely nonvoluntary, as they are not able to seek services from elsewhere, most often due to the cost of private services (Shukla and McCoyd, 2019). Additionally, the potential impact of street-level bureaucrats on clients is great, and the interactions are immediate and personal (Lipsky, 2010). However, Lipsky (1969) writes that clients can overestimate bureaucrats' influence or impact.

Street-level bureaucrats sit on a substantial amount of *discretion* when conducting their work (Zulu *et al.,* 2019). A police officer, for example, cannot be expected to infringe on every crime they observe but they decide who to arrest and who to overlook (Lipsky, 1969). Such situations are by nature very complicated and it is not possible to carry around a guideline or policy to refer to when decisions have to be made, forcing the employee to rely on discretion. This is also because citizens expect street-level bureaucrats to make decisions grounded in humanity and show sensitivity to

the individual's situation, rather than acting like a policy-implementing automaton (Lipsky, 2010). In fact, Lipsky argues that some rules are complex, and some situations so complicated, that rules can only be applied selectively. This kind of 'slippage' from the written policy is assumed by policy makers to occur in practice, even though most street-level bureaucrats do accept formal structures (Lipsky, 2010).

4.2.1 Conscientious Objection

For this thesis, the concept 'conscientious objection' (CO) is seen as a part of what Lipsky describes as discretion. The WHO defines this as "the practice of health-care professionals refusing to provide abortion care on the basis of personal conscience or religious belief" (WHO, 2022). Ethiopia is the only country in Africa which has explicitly forbidden CO and the guidelines stipulate that practitioners may not refuse services based on personal beliefs (Magelssen and Ewnetu, 2021). On an international policy level, there is no consensus on whether CO should be considered a right for healthcare workers, but the WHO argues that where it is legally allowed, it should be regulated. This is based on a concern that in the majority religious communities, there could be a lack of available healthcare professionals if conscientious objection was widely allowed (Ortiz-Millán, 2017).

4.3 Critique

Critics of HRBA argue that the approach adds more difficulties to implementation as it is resource demanding and ambiguous. A great variation of interpretations exists, making it a difficult tool to apply as a theoretical lens (Cornwall and Nyamu-Musembi, 2004). In the end, I chose to use the AAAQ due to its solid connection to the right to health. At times, this felt like a blunt instrument for analysis since many of the dimensions intersect and affect each other. For example, the concept of conscientious objection both has an impact on accessibility and availability of services. Lipsky's theory made this process easier by finding relevant themes within the AAAQ categories pertaining to the conditions of those working in safe abortion implementation in Ethiopia.

Street-level bureaucracy has made a significant impact on public policy research and is a valuable tool to understand the gaps between policy and implementation, and the unintended consequences that can arise from policies (Erasmus, 2014). However, in the past, Lipsky has been criticised as

somewhat outdated due to his categorisation of street-level bureaucrats as a contrast to managers. To Lipsky, these two belong to different professions and experience different environments. In modern workplaces, managers often have the same educational or professional background as the street-level bureaucrats but have extended training (Evans, 2011). This was evident in this study, as many of the participants were physicians who had later studied or entered the public health field. Using Lipsky's understanding proved to be difficult during the data coding process, as it stipulated that the managers in this perspective were not able to comment as street-level bureaucrats. Here, the theoretical basis in a HRBA to health that stresses the role of civil society actors was able to explain how non-medical professionals (who Lipsky would not classify as street-level bureaucrats) still have a function in promoting the right to health similar to those with a clinical, medical background.

5. Methodology

5. 1. Research Design

This thesis is based on a constructivist ontological perspective, meaning that it sees the knowledge produced in the study as constructed by the observers which means that the knowledge created thus differs depending on who is involved and at what time (Moses and Knutsen, 2012:169). The accounts from the participants hence represent subjective perspectives of abortion services. The thesis further uses an interpretivist epistemological view: the research is seen as a dialogical process between researcher and researched, where the latter can transform the research through its input (England, 1994). As such, the knowledge produced from this study is co-produced between myself and the participants (*ibid*). The results are then further interpreted by me as a researcher, and, as a consequence, through my own objectives and experiences (Hammett, Twyman and Graham, 2015:21).

The thesis uses inductive qualitative research methods and analysis. It is a single instrumental case study approach (Creswell, 2007:74) where the legal and cultural context of Ethiopia constitutes the borders of the case. Bryman (2012:36) describes that this is the preferred research strategy when investigating how individuals interpret their social world. Considering the complex nature of abortion in Ethiopia, the study uses interviews as these are best used to capture people's thoughts, feelings and behaviours - aspects that people keep private or personal and do not generally broadcast to the public (Scheyvens, 2016:60). This enabled me to centre the thesis around the participants' perspectives of abortion services. To determine the actual practices of healthcare workers, both observations and focus group discussion could have been used. However, due to the sensitivity of the topic and limited resources, interviews were deemed the most appropriate method for investigation. The interviews in the thesis followed a semi-structured model. An interview guide (see Appendix I) was constructed to follow themes rather than a sequence of questions (Kvale, 1996:127). The interview guide explored a range of themes as there was no theory to guide the questions at this stage. This was to allow aspects that were important to the participants that I may not have thought of, to come forth (Bryman, 2012:403).

5.2 Sampling and Data Collection

The study consists of 10 semi-structured online in-depth interviews in English with people who work or have worked with abortion services. The participants worked in public hospitals, private clinics, and NGOs such as Ipas, Population Services International, UNFPA and Marie Stopes International. Their roles included but were not limited to physician/medical doctor, obstetrician-gynaecologist, programme specialist and programme coordinator. A number of the participants were trained in the medical field and had direct experience of providing abortions but had retrained to work in public health.

The interviews were conducted in February and March 2023. The time for the interview was decided together with the participant and occurred during the morning, day, evening and occasionally on weekends. The interviews lasted from 30 to 45 minutes and were transcribed shortly thereafter. In the transcription, repetitions and grammatical errors were adjusted to improve fluency of quotes. The data collection took place over the video conferencing tool Zoom. It was chosen since it does not require third-party software for recording, and because of its relative user-friendliness (Archibald *et al.*, 2019). Participants were encouraged to conduct the interview somewhere they felt comfortable and safe, using headphones to ensure privacy and improve the audio quality. The participants were not required to display their name on Zoom as to ensure anonymity. Consent for the recording of the interview and of participation was asked at the very beginning of the interview. One interview was not recorded as the participant was not able to connect to the sound on Zoom. As a result, the interview was conducted via video call on Whatsapp. Here, the recording malfunctioned and so diligent notes were taken and analysed instead. All the recordings were stored offline to ensure anonymity.

The study uses a mix of purposive and snowballing sampling methods, something which aptly melds with qualitative interview studies (Bryman, 2012:416). The participants were recruited in two cohorts. The first cohort consisted of healthcare practitioners approached directly through LinkedIn. The second cohort was recruited through a network I had worked with during the LUMID field semester. To ensure the anonymity of the participants, the name of the network will not be disclosed. A recruitment flyer (see Appendix II) was emailed to around 60 Ethiopian members outlining the objectives and background of the study, and the rights of the potential

participants along with my contact details. Interested participants were directed to my email, where a meeting was set up. From this, further contacts were found using snowball sampling. Bryman (2012:424) writes that snowball sampling is an appropriate method to use when the topic of study is sensitive or covert, in this case, abortion service provision.

5.3 Data Analysis

The transcripts were read through multiple times during the transcription phase. Nvivo was used to code and categorise the data in this study. The main categories were developed using the AAAQ framework. Several attempts were made during the coding phase to investigate what categorisation mostly clearly described the data results. In the end, the transcripts were coded using thematic analysis to systematically distinguish patterns (Bryman, 2012) based on a broad understanding of the AAAQ framework. After this, the selected nodes were further thematised in relation to Lipsky's theory on street-level bureaucracy.

5.4 Ethical considerations

A proposal for the study was submitted to the LUMID Ethics board in October 2022 and approved with recommendations a few weeks later. The recommendations have been applied in the study, such as using multiple sources for recruitment, and the anonymisation of the recruitment network. To secure ethical approval for the study, as well as to get access to the community, a collaboration with a local researcher was necessary. This was especially true considering the sensitivity of the topic, and so a gatekeeper could make participants more willing to speak to me (Hammett, Twyman and Graham, 2015:78). Through my internship, I had an Ethiopian contact who managed to find a suitable researcher at the University of Addis Ababa. Creswell (2007: 125) writes that a gatekeeper needs information about the motivations, aims and background for the study. During an initial meeting, I presented the information to him and he then agreed to assist me with the study. In December 2022 and January 2023, a research proposal was prepared and submitted to the departmental ethical review committee. The proposal was approved on the departmental level in the first week of February 2023.

5.4.1. Positionality and reflexivity

According to Acker, Barry and Esseveld (1983) the assumption of objectivity must be criticised, as individual experiences inevitably have an impact on what, how and why something is studied. It is of utmost importance that the researcher recognises their own position in the research and how previous experiences, opinions and ideologies affect the research process and results (Hammett, Twyman and Graham, 2015:21). These aspects affect how the research is planned as well as the interpretations of the results (*ibid*). Being a white, female academic from a global north country means that I sit in positions of power in relation to the participants of the study, and the topic itself. Similarly, I am not a healthcare practitioner and have no experience from working in a clinical environment which means I cannot fully understand what it is like to work in this environment and making the decisions that I am inquiring about in the study. Having done my field semester within global health and interacting with people with different health backgrounds and views on sensitive topics was helpful in navigating the complexities of SRHR work.

As previously mentioned, the researcher will inevitably bring their personal ideological standpoints into the research (Hammett, Twyman and Graham, 2015). For me, having grown up in an environment and social groups where the moral debate on abortion is non-existent and its support assumed, putting my own preconceived notions about anti-abortion or pro-life sentiments has been a challenging but very useful experience. Scholars like Spivak argue that learning to learn is the only way to improve development practice and research (Kapoor, 2004). This means attempting to suspend the belief that the researcher is indispensable or culturally superior, or that they sit on the solutions for "troubles" in the Global South (*ibid*). I chose to focus on abortion specifically because I wanted to be challenged on my views and to improve my understanding of complex or controversial topics. The thesis process has been a great learning experience in unpacking my own stance and assumptions regarding abortion and its debate.

5.5 Trustworthiness

Trustworthiness, according to Bryman (2012:390) is made up of 4 criteria: credibility, transferability, dependability, and confirmability. This thesis uses these four categories as its starting point for thinking about trustworthiness. Credibility means that the study has been done

according to good practice and that the findings have been confirmed by members of the social world where the study was conducted (*ibid*). Transferability is a complicated criteria to fulfil in qualitative research where much is context-dependent and the results are therefore rarely generalizable (Bryman, 2012:392). In this study, I consider parts of the results transferable, as the moral aspects of performing abortions in conservative contexts exist across borders. However, the legal situation surrounding abortion is unique in Ethiopia, and the findings thus cannot be lifted into a separate context. The last criteria, confirmability, is concerned with how the actor has worked in good faith, avoiding personal or theoretical biases to sway the process and its results (Bryman, 2012:392). Here, I consulted my Ethiopian contacts on what terminology best to use, and the departmental ethical review board at the Addis Ababa University also provided recommendations on how best to formulate the research questions to reduce bias.

5.6 Limitations

Because the participants' recruitment was reliant on other people, there is a risk of data domination by some gatekeepers (Mclennan, Storey and Leslie, 2016). Since I as a researcher was not present, I do not know how or why participants from snowballing recruitment were contacted. Some participants may want to use the opportunity to entertain contacts for their own benefit, rather than to improve the results of the study. To mitigate this, recruitment occurred from two separate sources. Getting an email from a Scandinavian researcher inquiring about such a sensitive topic as abortion may also have deterred some from participating. This is especially true for those who do not support it who may not want to be associated at all. Some could have refrained from partaking in the study because they do not support abortion. Rather than interpreting this silence as disinterest or ignorance, silence should be seen as an action or a sign of agency or resistance (Kapoor, 2004). Since most of the participants in this study have some form of university education, medical or other, the vast majority have a degree or diploma. Consequently, all the participants had good or excellent command of English. In general, language was not a major barrier in this study although some aspects will have been lost in translation.

Because the interviews were conducted online, some of the natural interaction between researcher and participants was lost. To mitigate this, the introductory questions were quite open-ended to allow for the participant to share about themselves should they want to. Having enough privacy

and time to do a Zoom interview can be challenging. Lobe, Morgan and Hoffman (2020) write that digital interviews require participants to have knowledge about technology as well as good enough quality internet. The latter can be a major disadvantage when conducting interviews as delays, lags or glitches may cause frustration (Archibald *et al.*, 2019). Glitches were at times a problem during interviews but the connection never failed completely.

6. Data analysis

The overall research question in this thesis: *How can we understand the role of healthcare practitioners in securing the right to health through the provision of safe abortions in Ethiopia?* In the following section, the data is presented according to the categories in the AAAQ framework and then analysed through key concepts in Lipsky's theory of street-level bureaucracy. This section answers the two sub-questions:

II. How can we understand the essential elements for safe abortions from a rights-based approach?

III. How can we understand the role of practitioners in fulfilling the essential elements for safe abortion?

6.1. Availability

The AAAQ framework stipulates that 'availability' refers to the quantity of health facilities, services and goods (CESCR, 2000). In this section, findings related to the availability of abortion services are analysed, focusing on the availability of healthcare practitioners. A fundamental aspect of Lipsky's theory is that workers will inevitably divert from policy. When decision-makers create new policy, some "slippage" between wording and implementation is expected (Lipsky, 2010). These types of changes occur due to implementers' "discretion", where their own judgement of situations has an impact on the provision of services. The findings in this study indicate that discretion from the abortion legislation in Ethiopia goes in two directions: some health workers refrain from asking a lot of questions about the woman's case if she had just disclosed one of the indicators making her eligible for an induced abortion. Others spoke of discretion by not providing abortion, and referring the patient to a colleague, even though this form of conscientious objection is not allowed in Ethiopia - something that is discussed in more detail in the 'Accessibility' section. The interviews uncovered a range of views on healthcare workers' professional requirements. Similar results have also been found by Holcombe, Berhe and Cherie (2015). Many participants stated that there was a lack of understanding among healthcare providers in terms of the legality of conscientious objection:

> "I read one under exchange, that one health provider, if one health provider receives the training, he must provide the services for any girl seeking services. But not all the professionals understood this." *Participant 6*

> "Physicians and other professionals do not understand that they are obligated to perform abortions." *Participant 10*

Others explained that conscientious objection was a widely practised phenomenon but saw no issue with this (Participant 8), as referral between colleagues was easy. One participant went further, claiming it was their right to not perform abortions, with exception of clinical practise during studies:

> "Sometimes it might be difficult because as an intern, even if it's an induced abortion, you're obliged to do all the procedures whether you want it or you don't want it. But after I have graduated, you have a right to decide if you want to work on it or if you don't want to work on it." *Participant 7*

The statement indicates how rights language is interpreted among different people when it comes to abortion. The participant above articulates that conscientious objection is not just a practice, but a right for physicians. However, whether or not conscientious objection can be considered a human right in a legal sense is debatable, since it is not protected in Ethiopian or international law (Magelssen and Ewnetu, 2021). Many participants invoked rights to support their stance, regardless of if they were in favour or opposed to abortion as a phenomenon. One participant claimed that abortion was a right for the pregnant woman, but that *"doctors also have a right to cross-check"* (Participant 10) her answers in deeming her eligible for an induced abortion or not - something which further highlights the gatekeeping role of healthcare practitioners. For some of the participants, it was not the choice of terminating a pregnancy that was a human right, but healthcare services access, even if this entails abortion services:

> "If you ask about the abortion, most of the leaders deny giving an abortion because it says it's the opposite of the culture and religion. But the law and the medical professional is aware of the rights of the woman and rights of this pregnant mother, so they will give abortion care because it is the right to get healthcare service in Ethiopia." *Participant 8*

The variety of views highlights the importance of guidelines not only including descriptions of practices, but also of what the rights and duties are of the clinicians (London, 2008). Presently, the lack of knowledge about what the law requires from healthcare providers means that multiple understandings and interpretations coexist. This type of environment further gives space to the existence of conscientious objection. This is dependent on contextual factors, such as the availability of services: if other doctors or centres are available, discretion in the form of conscientious objection can be tolerated as referrals are more likely to be considered viable options among healthcare practitioners (Harris *et al.*, 2018). Consequently, the practice of conscientious objection is more likely to have an impact on health service provision in areas where access to health services is scarce (Ortiz-Millán, 2017). Although the urban-rural divide was not a factor intently investigated in the study, participants themselves mentioned how the situation differs between urban and rural areas in the country (Tadele *et al.* 2019). In major cities such as Addis Ababa, women are more likely to be able to reach out to a number of providers (Participant 4, 8), meaning that conscientious objection may have less of an impact in terms of availability. Nevertheless, a participant who had completed her mandatory graduate service in a very rural area described how abortion services were consistently refused to women regardless of the legal requirements, and that staff with more open views became singled out and perceived as the only available person to administer abortions:

> "These women talk amongst themselves. So they received… two of them, maybe one or two of them received care from me. And eventually that word spread and so whenever somebody wants to seek abortion services they used to wait for me to come to the OPD[1] and ask to be seen by me, because they know that you would provide the services regardless, and I wouldn't ask questions about it. As compared to you know, if they face another physician, you know, proof that they deserve that abortion service and even risk that they might be rejected. So it was interesting, even after I got shifted from that adult outpatient department and when I was assigned at the Paediatrics unit, you know, women and girls, they used to come to the outpatient department and seek the female physician...." *Participant 4*

Such stories bear witness to the concerning effects of conscientious objection on service provision warned by those critical of CO, namely, that a general application of the practice leads to unavailability of services (Ortiz-Millán, 2017) which in turn can affect women's human right to

[1] Out-patient department.

health. Especially in rural areas, the concern about a lack of staff thus seems to be legitimate in this case, but more research is needed to better understand the picture.

The findings point to the importance of holistically improving healthcare systems on many fronts and levels. Many participants described that the demand for safe abortion services is great, especially after awareness raising interventions have been introduced in communities. Women, both old and young, want safe abortion services to be available, confidential and of high quality (Participant 2, 5). Several interviewees noted, from their experience, that if women were refused access to safe abortion services, they were likely to seek to terminate the pregnancy with dangerous means, often using traditional medicine (Participant 3, 4, 8, 9). This is in line with international statistics on abortion which indicate that the abortion frequency rates are not affected by the legal status, rather banning abortion services will make abortion services clandestine and unsafe (Ganatra *et al.*, 2017).

6.2 Accessibility

The accessibility category in the AAAQ framework emphasises that services should be accessible to everyone in relation to non-discrimination, physical accessibility, economic accessibility and information accessibility. Stigmatisation is of issue to plans to improve accessibility, as silence on abortion is a pervasive factor on all levels of society (Tadele *et al.*, 2019). Public health participants discussed the challenges to integrate abortion services into national health system providers. One participant explained that while advocating for the expansion of abortion services, activists wanted them to be introduced into the national government health programme flagship called the health extension task force (Participant 1). As health extension workers work with family planning counselling, extending their services to include abortion was seen as natural by the activists. Yet, the national government was worried that the health extension workforce would be viewed as "abortion workers" by their communities, and abortion was excluded. Instead, participants attempt to use this part of the health workforce in demand and awareness creation (Participant 2, 6). A participant who had successfully advocated for the inclusion of abortion services into GBV centres expressed something similar:

> "While starting this abortion care in One Stop Centres. The aim was the care... they feel it will divert to an abortion care centre. Because they fear the GBV survivors, the pure GBV survivors. cannot be treated in the center, or the women who are pregnant with for example, let's say, with GBV sexual violence, or in other cases, they will come and they will use the service as abortion care only." *Participant 8*

Even so, Lipsky (2010:189) argues that integrated services are preferable as street-level bureaucracies, as previously mentioned, constitute and are constituted by the larger society. Integrating services that are controversial will have a greater impact on quality because they cannot be neglected or ignored. Should safe abortion services only be given at a single point of service, it would most likely face resistance from the community, have issues keeping confidentiality, but it could also be more easily dismissed by funders as a "fringe issue." (2010:189). The more people that take up a service, the more power that group has on the service - something that is important in improving the access to the right to health.

When it comes to discretion for accessibility, the participants highlighted how the changed legislation had increased accessibility for all women, and not just those who fulfilled one of the indicators, something which previous studies confirm (Blystad *et al.*, 2019; McLean *et al.*, 2019; Tadele *et al.*, 2019). Participants highlighted that the reason to not require proof of age for women claiming they were younger than 18 years was since Ethiopia lacks a system to issue ID-cards. Yet, many witness that the intention of this, in practice, meant that anyone should be able to access the service.

> "We've fought so hard to remove this barrier during the guideline development because we understand this: it will open many doors. So a woman can walk in and declare, even if she's 20, that she is under 18. Nobody will ask her. It facilitates access instead of becoming a barrier." *Participant 1*

> "If she is saying 17, we can write 17. When she come to complain about an unwanted pregnancy happen, or… it's incest. If she can say incest, we can write. Then we can provide that service, but otherwise if she… [is] complaining that her unwanted pregnancy happens and she doesn't want to deliver this baby. 'I want to terminate this pregnancy, so please give me this service'. When she says that, we can't provide that service." *Participant 3*

> "if the client says 'I'm underage'... He should not kind of check, cross-check the age or whatever. For example, a 35-year-old woman comes and if she claims to be 17, he just documents like she's 17 and he or she conducts on the safe abortion services." *Participant 5*

Many participants pointed out that the law was a "window of opportunity" where false or incorrect statements by women should be overlooked and not investigated further. In urban areas in particular, participants recounted that women's awareness of the law is high and that most women who approach the services are prepared to give one of the approved reasons (Participant 4, 8). For healthcare professionals, there was a split between participants on how to approach a patient who, for example, claims to have been raped. Some felt that asking questions was necessary in order to determine that the woman was "legitimately" seeking the service, a pattern that has also been noticed by McLean *et al.*, (2019). Those who had worked with integrated gender-based violence (GBV) services expressed that it was difficult to strike the balance between not asking further questions and understanding the true needs of women, and what other needs for help they may have. In line with the concerns stated above, one participant stated that women may at first only approach centres for abortion services in cases of rape, but that they are unwilling to disclose that the rape may have occurred due to abuse, something which prevents the healthcare professional from suggesting other services (Participant 8, 9). Other healthcare professionals claim that women strategically lie about being raped in order to access the abortion services, something that caused discomfort both among healthcare providers and clients:

> "Because some people know the law, the other thing they say is like, 'I slept 2 months ago with my uncle. Or I slept with my brother two months ago'...and 'this thing happened so I don't need to have this baby'. Sometimes there are people that lie. But as a physician, no matter what they say you need to believe them first. That's why, like I don't want to perform these abortion things because people lie." *Participant 7*

> "The one who had been sexually assaulted. They come in and if after abortion is done, they may feel like they have relief. But when there is some ambiguous things, maybe they may feel that there is a guilty feeling" *Participant 9*

The first quote shows how healthcare professionals are affected by women using this window of opportunity for their own benefit. For professionals who are more sceptical about providing abortion services, such interactions feel like an invasion of their moral convictions. Lipsky (2010)

explains that framing of clients as "liars" is rarely due to a sense of moral superiority among street-level bureaucrats, but a mechanism emerged from the fact that they do not have to worry about not having enough patients: the clients at a hospital are not customers who can shop around for the best service, but most often have no choice as to where to seek help. However, none of the participants mentioned the influx of patients as something which affected their abortion service provision. Rather, they felt uneasy treating patients who were not honest about their intentions. A participant working with GBV service explained that at times women approach the centre for abortion services only, which poses a problem as the integrated service is a cross-sector collaboration with police, health and social services (Participant 9). The participant thus felt obliged to direct women to the public health centre instead.

Such stories show the tension that can emerge in client-clinician relationships in sensitive matters like abortion service. Drawing on Lipsky, Gilson (2015) writes that health systems in LMICs are strongly influenced by power relations from international and national organisations where medical professionals are seen as actors of authority in "machine-like organizations" (Gilson, 2015:10). With this mindset, guidelines that regulate behaviour and personal judgement become a centrepiece for implementation; personal convictions are not supposed to affect the way health professionals conduct their work:

> "But at the end like they insist because people will study those things and come in front of you, they know which direction that you cannot go. So it's very challenging." *Participant 7*

Likewise, when awareness is raised in the community, knowledge is transmitted to the patients who expect a certain type of service to be given in a certain type of way. One could argue that patients also expect clinicians to use discretion, provided that the patient claims to fulfil required criteria. The legislation on abortion has in this way created room for discretion among health workers, making them a type of gatekeeper for abortion service provision. On the one hand, the law and guidelines allow a flexible interpretation, where many patients may be deemed eligible for an induced abortion service. On the other hand, the lack of information and knowledge about the legal requirements for healthcare providers to administer abortion means that some healthcare professionals do not issue abortions when they should, and that women will be denied services that

they have a right to. The denial of services was not something that emerged from this study, however such results have been presented in other studies, for example in Tadele *et al.* (2019).

I believe that women approaching GBV services for abortion is rooted in the nature of the legislation. Seeking services at a GBV facility may be easier for some women who are aware that sexual assault is an approved reason to be eligible for an abortion. Their mere presence at the facility justifies the termination of pregnancy, while at a public health facility, they will more likely have to argue for their cause. Although this was not investigated in the study, such experiences can be challenging for patients due to the personal and sensitive nature of abortion. As Lipsky (2010) writes, being neglected by an impersonal organisation is one thing, but "[i]t is quite another thing to be shuffled, categorized and treated 'bureaucratically,' (in the pejorative sense), by someone to whom is directly talking and from whom one expects at least an open and sympathetic hearing." (Lipsky, 2010:9)

Accessibility in the AAAQ framework also pertains to questions of confidentiality. Many participants mentioned a desire to provide services in line with this, especially in light of the fact of how having an abortion could be seen as a cause of discrimination by the community. When asked about how healthcare professionals built trust with clients, many participants who were comfortable with providing abortion lifted the importance of confidentiality: "*They need privacy and confidentiality, no one to know - other persons, about safe abortion care services"* (Participant 3). Participants (3, 4, 5, 6) agreed though, that If healthcare practitioners guarantee that the condition of confidentiality can be fulfilled, women will start demanding abortion services.

6.3 Acceptability

In the following section, I analyse how the participants spoke of implementing culturally appropriate abortion services in conservative communities. Their navigation of human rights is emphasised, as well as health worker beliefs about abortion. Lipsky writes that street-level bureaucrats reflect the current culture from the communities in which they are situated (Lipsky, 2010:188). Although community attitudes were not the target in this study, the explanations of community attitudes are thus relevant because the practices among street-level bureaucrats establish and are established by local norms. Overall, participants identified a lack of acceptability

of abortion services in Ethiopia as a challenge to implementation. This pertained to two different groups: the community and the healthcare practitioners. When asked about the community perceptions of abortion, it was described that abortion is "forbidden" or frowned upon from a religious perspective (Participants 1, 3, 9). Many in the community believe that life is a gift from God that begins at the moment of conception. Terminating a pregnancy is thus a violation of the unborn child's right to life and an unholy practice. Requesting an abortion, whether safe or not, is associated with stigma for the woman. Nevertheless, for women to access the services at all, they need to be aware of its existence. Because of this the implementation of abortion services is not just targeting the availability of centres and doctors, but also awareness and knowledge creation among community members through outreach activities like community meetings and seminars:

> "When we do on demand creation, when they understand the way they to meet their goals or the importance of birth spacing or using family planning, they seek the services" *Participant* 6

> "Our post abortion counselling tools uses stories. So for example, there are two stories which I remember. One is: a married woman, a rural girl, her husband went to urban areas. But she's raped by her close family. So it talks about that and it pauses at the moment and it asks the couples, the main session it asks: what can you do? So that it creates an opportunity for the couples, for the girls to talk about the situations" *Participant 2*

A key to get to these target groups was to not immediately address abortion, but to speak more generally about girls and women being able to reach their goal, or by promoting family planning. Talking directly about abortion creates opportunities for backlash and critique about imposing "Western" practices (Participant 1, 2, 4). Tadele *et al.*, (2019) argues that this strategy is a type of active silence or masking used to avoid conflict with religious leaders and local communities, that also helps to protect the legislation from resistance. It is particularly visible when it comes to human rights, and participants strategically do not focus on abortion as a right, or the right to bodily autonomy for women. Because men have more social and economic power, moving too far, too quickly may have adverse consequences for the target group. Speaking explicitly about women's reproductive and sexual rights may cause backlash from husbands in terms of GBV (Participant 2).

> "It's very difficult just to talk directly, especially to everyone who is living in the rural areas where the breadwinner of the household is a man and her literacy level is very low. So the economic source of the families is the man. So you can't directly say " my body, my right" or such kinds of things." *Participant 2*

> "In nations like Ethiopia where we are developing there are different misconceptions and misunderstandings pertaining to rights issues, basically on the SRH. because there are some sensitivities. When you talk about health rights,. OK, OK, that's fine. But when you zoom in and talk about SRHR rights [*sic*], when you zoom in, talk about this safe abortion right, you touch a very sensitive spot…" *Participant 5*

Instead, actors in awareness or demand creation focus on using the experiences from the community as a strategy to make abortion more acceptable. As the impact of unsafe abortion was previously very large in Ethiopia, many communities have personal stories of what happened:

> "It focuses on the impact of unsafe abortion because a lot of young women are… they are going to the traditional way of terminating a pregnancy. So they encounter a lot of challenges when you speak about that. Well, tools for that so.... the community will speak up: 'young woman died in my neighbourhood'" [...] So generally the challenge is abortion is seen as a sin or, you know, like 'I'm killing a life'. But when you speak about the impact of unsafe abortion, the community will start speaking up" *Participant 2*

> "Potentially what they talk or what I get from the tip of their mouth is this one: She gets bleeding and then she may die. They say, oh, they know the harm unsafe abortion can cause this and bleeding and may affect the things. So by communicating the impact of unsafe abortion, it's possible to convince people that safe abortion is very important." *Participant 6*

In general, the participants stated that the community is more accepting toward safe abortion in life saving instances, such as spontaneous abortion, incomplete abortion or in cases of rape or incest. Similarly to South Africa, as described by Harrison *et al*. (2000), there is a hierarchy of reasons when abortion is an appropriate measure. Those situations are perceived to be outside the woman's control, as opposed to if a woman gets pregnant "by accident". Some participants said that there is a difference between gender as, due to their lived experience of the issue, older women understand the impact of unsafe abortion to another extent than husbands. Overall, men as husbands were considered major opponents of induced abortion. However, similarly to healthcare professionals, such notions stem from wider societal beliefs regarding community, family and

power. For example, that husbands can be opposed to abortion because having a lot of children is associated with wealth and high social status:

> "A lot of children make them have that feeling of being a rich person. If many children are living in their homes, they are feeling like a rich person, OK. That's the reason. In addition, the people are compared to the neighbours. The neighbours have a lot of children and the other persons have two or three children. They are compared to the other, their neighbours houses. So there is peer influence and neighbour influence in our countries, especially in rural areas, it is a major problem for us." *Participant 3*

> "Because still we have lots of negative attitudes to unsafe abortion due to the expectation from communities like a woman needing to get married to get pregnant. These people are kind of judgmental. Like you… 'Oh, the daughter of X, she's pregnant' because the neighbours in the community, they will talk about it." *Participant 5*

Stigmatisation of women seeking safe abortion services is not limited to the community. Many participants described that healthcare providers perpetuate existing views in the community which prevents women from getting the services. Individual religious beliefs and norms cause resistance among healthcare professionals. Different views emerged from the interviews. For example, some feel that the unborn foetus has the status of personhood which the healthcare worker essentially murders, something that is a crime.

> "Some of my colleagues think that maybe she's killing a person. Maybe the unborn child is like a person, so it's maybe killing. We are participating or killing, such things." *Participant 9*

> "Some healthcare workers accept safe abortion services. Some healthcare providers are not, not accepting safe abortion care services due to different reasons, especially religion. They are feeling as it is a crime" *Participant 3*

> "I personally feel like the foetus might feel the pain. It's like doing an extra thing to the foetus, because he feels. He feels the pain." *Participant 7*

Participants (1, 2) expressed that some staff have preconceived notions about youth and sexuality and are reluctant to provide services because they believe that young people should not be sexually active. Just like in the community, several organisations are working to improve acceptability of

abortion. They lift values clarification and attitude transformation training (VCAT) as a tool to address stigma from healthcare professionals. Similarly to community awareness activities, abortion VCAT focuses on the harmful effects of unsafe abortion on individual and community levels. The aim of these types of workshops is to identify what values are most important to individuals and use the results to grow more compassion for marginalised groups (Turner *et al.*, 2018). VCAT training can be seen as a controlled "socialisation" process. In order to exercise control over street-level bureaucrats' discretion, agencies and managers attempt to improve the workers status by increasing the level of professionalisation within an organisation (Lipsky, 2010:204). Part of this is to ensure standards of practices that make outcomes consistent. Nevertheless, VCAT training can also be seen as an exercise in socialisation, rather than a measure to increase skills and knowledge. Socialisation can be a powerful tool in making sure that all workers adhere to the same standards, as socialisation makes it difficult for newcomers to have divergent opinions (Lipsky, 2010). As part of the guidelines, medical students are required to perform abortions as part of their training, and they cannot obtain a doctor's licence without administering medical and surgical abortions (MoH, 2014).

The guidelines issued by the MoH have had a breakthrough in terms of medical practice and techniques. When it comes to a broader understanding of abortion in terms of a rights-based frame like a women centred approach focusing on choice and a right to information, work is left to be done. Although abortion was considered healthcare, speaking of abortion as a woman's right was rare. Speaking from their religious point of view, Participant 9 said that:

> "If we are supporting that we are killing someone is as human right, even if there are some circumstances. But killing someone is... If you speak with us, limit other human rights because he has… or the baby has the right to live." *Participant 9*

This shows that there is great diversity when it comes to abortion support or opposition among healthcare staff. Though the participants in the study were not explicitly asked to share their personal views on abortion, many were open to share. When asked how they build trust with a patient, Participant 4 stated that they do not have a particular technique, but rather:

> “I don't judge. I don't stigmatise. I don't ask a lot of questions. Unlike other providers where they said,” why are you seeking abortion? Who did you get pregnant from?” If she says that she has been sexually assaulted. I wouldn't ask for evidence. “Who did it? When did he rape you? When did this happen? Why didn't you report to the police? Why didn't you do this or that?” I stay away from those questions. Just make sure that all the information is available for them. They make their own decisions.” *Participant 4*

Abortion is often presented as an antagonised issue, but the findings from this study indicates a much wider set of beliefs or attitudes towards abortion. Among the participants, the views were complex and at times contradictory. For example, the same participant as above self-identified as “pro-life” but had a liberal, rights-based stance towards providing abortions (Participant 4). Others were comfortable providing abortions as long as the woman was in her first trimester and had presented an approved indicator, while also stating they did not want to provide abortions to people who had circumvented the legal requirements (Participant 7). Some identified abortion as a human right that women in Ethiopia were yet to access (Participant 3). This aligns with Magelssen and Ewnetu’s (2021) findings that conscientious objection exists on a wide spectrum, and intermingles with many other ideas and preconceptions, which does not allow for a simplistic binary narrative of “pro-life” and “pro-choice”.

> "But in our country, it's not legal rights, clients' rights are not legal. Age is under 18, if the pregnancy is saying rape, incest, maternal condition, child condition, more focused area, is only this. It's all maternal right, but it is not here. Most of the clients are lying to come to our clinic, if they are 30 but she's saying 18 or 17. Because of the legal issue" *Participant 3*

6.4 Quality

The final dimension of the AAAQ framework is quality, which has a somewhat vaguer description. Previous studies using the AAAQ framework argue that even if there are available, accessible and acceptable services, a lack of quality can make health services ineffective (Homer *et al.* 2018). In theoretical application, this means that the quality dimension intersects with other dimensions in the framework.

One of the main findings of this thesis is the diversity of knowledge and beliefs currently present on the safe abortion scene in Ethiopia. Some believe that the legislation on abortion is clear, but

do not understand the prohibition of conscientious objection (Participant 8). Others, regardless of their individual beliefs of abortion, saw the legislation as contradictory due to the illegal status of abortion but wide exceptions pertaining to the clause of not asking for evidence from a woman seeking the services. Although the guidelines explain the medical and clinical technicalities of issuing abortions, the exact stipulations of rights of healthcare workers and patients are missing, causing confusion:

> "I remember in my medical training there wasn't any session about abortion training. It's just in the medical indications, complications, you know, the procedure. You know, the risks, this and that, all technical information, but nothing about the legal information about, you know, your rights as a physician or other healthcare provider that is providing abortion services and your responsibilities as well. At the same time, what are the rights of the clients who come for abortion services? What is it that we're expected to do? Nobody is clear on that, unless and otherwise you deliberately look for those answers." *Participant 4*

What this passage indicates is that healthcare professionals are requesting criteria that are founded on a HRBA and not just ethical guidelines, as explained by London (2008). From London's point of view, this type of criteria is needed to avoid healthcare workers becoming trapped in "dual loyalty" towards patient and state, with a risk of becoming a tool for human rights violations. Such a notion cannot be found in this case, as the national government and MoH have shown strong support for safe abortion implementation (Holcombe and Kidanemariam Gebru, 2022). Rather, the healthcare worker can be said to face a "dual loyalty" between their patients, and their own personal convictions. Despite abortion not having explicit protection in international human rights law, a refusal of services can result in violations of the right to life, health or privacy.

How would such a notion be explained by the theory of street-level bureaucracy? Lipsky (2010:164) writers that a lack of clarity of agency objectives often leads to a greater frequency of discretion used by workers. Agency goals can be unclear due to neglect or inertia, although that does not seem to be the case here, given the continued relevance and prioritisation by the government and its partners (Holcombe and Kidanemariam Gebru, 2022). Instead, perhaps the current state is best understood as *inherently* contradictory. The limited use of HRBA in the legislation is due to the fact that the public health argument was the foundation of advocacy for legal reform (Stifani, Couto & Lopez Gomez, 2018a). Approaching abortion from a rights-based

direction without acknowledging abortion *as a right* is difficult, or even impossible, given Ethiopia's social and political climate. Consequently, the law sits as a compromise between public health and rights which in turn has caused confusion among those at the front-line of health service provision: the healthcare workers.

> "The law said 'don't ask any further questions, just treat.' But maybe there are some issues which are raised after that. Is that correct or not? We don't know. Another thing on the other way around the laws is that abortion is illegal. So there is some contradiction: 'do it. But no, don't do it, but do it'. So I think it's not clear in our country, there are no clear boundaries." *Participant 9*

7. Discussion

This section discusses the results found in the analysis and is inspired by London's (2008) framework of a HRBA to health, as described in the theoretical section. It concludes with a problematisation of HRBA to health in the context of abortion. The aim of the discussion is to answer the principal research question:

I. *How can we understand the role of healthcare practitioners in securing the right to health through the provision of safe abortions in Ethiopia?*

As the analysis shows, abortion is still a highly stigmatised issue in Ethiopia, both from a user and a provider side. Many people believe that abortion constitutes a destruction of life, mostly based on religious beliefs. At the same time, the impact of unsafe abortion is widely recognised in local communities as well as among political leadership, which is why legal reform was possible (Holcombe and Kidanemariam Gebru, 2022). Civil society actors working with demand creation encounter people who remember the toll that unsafe abortion had on people before the reform in 2005. People, especially older women, understand why abortion can be necessary, but they do not want it to be used to a large extent. Conversations about abortion should be made under the disguise of other interventions, most often related to health or gender. Speaking specifically about abortion or women's rights to bodily autonomy is considered too controversial in a society where men are the principal breadwinners, and where status is associated with a large family. Confidentiality is an absolute must in order for clients to seek out abortion services.

If it becomes known that someone has terminated a pregnancy, she may be ostracised by family, neighbours or even her own husband. The necessity of abortion in life saving circumstances, as a measure of last resort, points to the interpretation of abortion as a service that is part of a woman's right to health, but not as a right in and of *itself*. By talking about safe abortion as a mechanism to save lives, actors in demand creation hoped to spread awareness while avoiding backlash and resistance from religious leaders. Seen from a human rights-based approach to health, these workers are strengthening women's agency for them to claim their entitlements when it comes to health. The arguments deployed in this work appeal to another of London's (2008) aspects,

namely, that healthcare actors attempt to underscore the indivisibility of civil and political rights (the right to life) and social, economic and cultural rights (the right to health).

The criminalised yet liberal status of abortion in Ethiopia is to an extent a reflection of these efforts and is thus well anchored in community perceptions. Nevertheless, the legislation's compromised nature creates challenges for healthcare practitioners. The criteria to avoid asking for proof of age and evidence in case of rape relies on healthcare practitioners' willingness to exercise discretion. In this way, discretion is not just an outcome of the law, but an objective: many participants explicitly describe the legislation as a "window of opportunity" for abortion service access for everyone - almost on demand. The reliance on health worker discretion produces a space for a wide range of interpretations and understandings of what the legislation requires from the healthcare practitioners, something that was evident from the participants in this study as well.

To London (2008), ethical professional standards are not enough to determine duties and obligations for healthcare practitioners but that a separate document based on human rights criteria is necessary too. From the participants' view, the guidelines, although framed in rights language, do not adequately inform healthcare practitioners about their legal requirements. The content of the guidelines is not widespread. Instead, understanding the legislation is reliant on practitioners' own interest. Though the regulations on clinical practice on abortion have been established, social and legal aspects of the guidelines are taught on an ad-hoc basis. Civil society thus plays a further role in filling the gaps by providing value clarification and attitude training, VCAT. As a consequence of these challenges, healthcare practitioners play a key role as "gatekeepers" to abortion services which can either limit or widen access to the right to health for women in Ethiopia.

Even if health workers would want guidelines that are framed in the language of rights and duties because of clarity, the sensitive nature of abortion makes this difficult. There is a fine balance (politically speaking) between framing abortion as a right, versus the right to health. At least, the more neutral public health argument for abortion has created a state where abortion is being administered, saving thousands of lives every year. In light of this, one could argue that the glass of silence surrounding abortion has been cracked. But for the conversation on abortion to be further

advanced, for services to reach more people, one can question whether or not silence will be a useful strategy. Compromises, whether legal or political, allow silences to remain unchallenged. Norms struggle to change when left unopposed or neglected. Given that the debate itself on the permissibility of abortion is less antagonistic in Ethiopia than in other places, as the diversity of opinion is big and does not necessarily fit into an antagonistic discourse of "pro-life" and "pro-choice", there is a real opportunity for more change in the future.

8. Conclusion and future research

In this section, I refrain from making policy recommendations. A study of this scope, and with my limited understanding of the context cannot draw such conclusions. What is clear is that the abortion legislation in Ethiopia which was constructed as a compromise, was both constituted by and constitutes perceptions of abortion in the community. Receiving or performing abortion care in life threatening situations is slowly becoming a more accepted notion. But stigma is still a prevailing barrier for abortion service, both from a provider and a user perspective. Such an environment increases the space for individual healthcare practitioners' beliefs and legal interpretations to influence discretion and the use of conscientious objections. A more intentional focus on a human rights-based approach may be a solution to increasing empowerment and knowledge awareness efforts. However, such an approach is difficult given the sensitive nature of abortion in Ethiopia.

This thesis has attempted to draw a nuanced image of safe abortion implementation from a provider's perspective. However, this picture cannot be complete without hearing from the users, women and girls, to fully understand how AAAQ factors impact their ability, willingness and experience to seek safe abortion services. A number of fascinating aspects were revealed during the interview stage but not explored further due to the scope and focus of the thesis. A lack of supplies was a recurring issue lifted by the participants. Even in settings where acceptability in terms of abortion had come far, implementation had stagnated due to a lack of commodities. An investigation into the supply systems could be able to indicate bottlenecks that prevent commodities from reaching users. Another aspect raised was the influence from international actors. Several participants expressed concern regarding how the US Supreme Court of Justice

overturning Roe vs Wade emboldens conservative anti-abortion groups in Ethiopia. While the fall out of this may be too soon to tell, such a study could shed light on the political struggles and their effects on services.

As a reader, the question of time is something to bear in mind in this study. Since the reform taking place in 2005, there has been enough time to develop systems and procedures for implementation. Changing attitudes though, cannot simply be done in less than two decades. I believe that the diversity of opinions on abortion in Ethiopia is best seen as an example that change is underway. Now, the challenge is to sustain and continue the development. Improving the lives of women and girls, fulfilling their right to health, is not possible without the backing of healthcare workers. If anything, the writing process of this has given me hope regarding healthcare workers' motivation and ability to advocate for women around them. Their key role ought to be recognised and used to advance reproductive rights and justice, sustainable development and the fulfilment of human rights for all.

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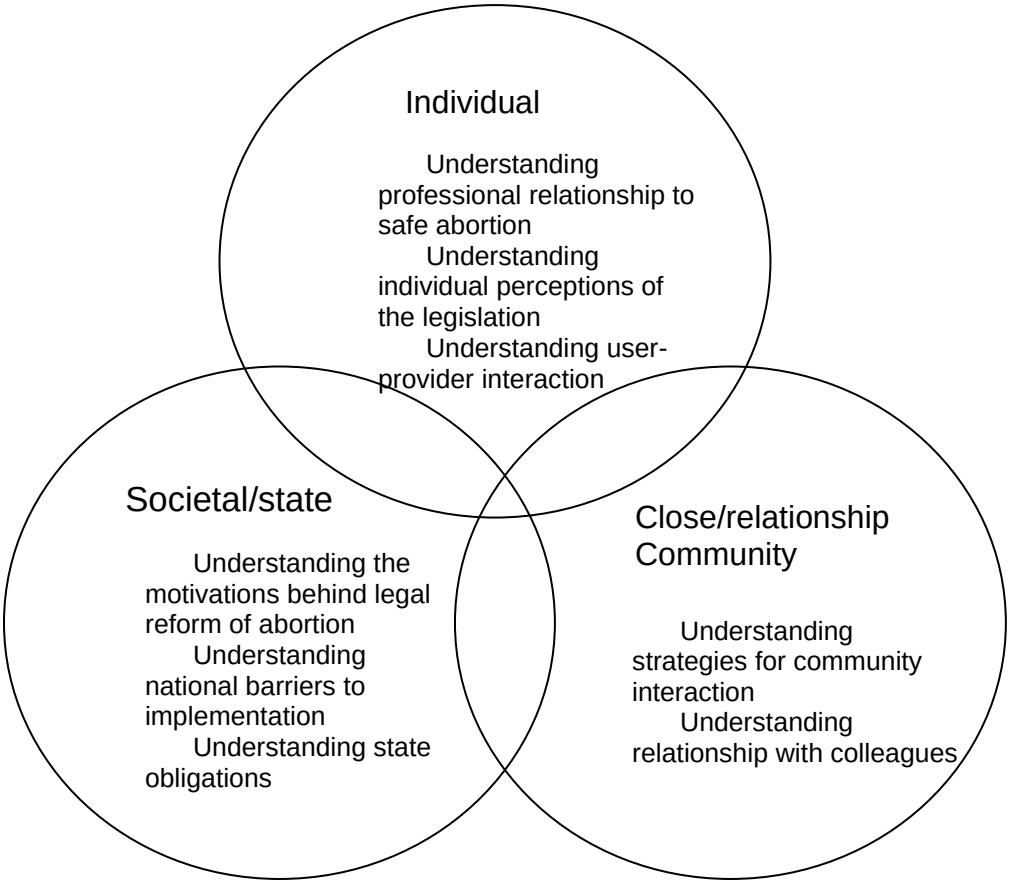
Appendix I: Interview guide



Appendix II: Letter of Invitation

Dear XXXX,

My name is Anna Ternström and I am a master student at Lund University. Since September, I have been coordinating work related to XX, and I was thrilled to meet some of you at XXX. I am currently working on a study on SRHR as part of my master's thesis at the master's programme in International Development and Management and would like to invite XXX members from Ethiopia to participate.

The purpose of the study is to examine healthcare practitioners' experiences from working with abortion services in Ethiopia. You are eligible to participate if you are a healthcare practitioner, or63 working in a management position related to abortion services for example at an NGO, hospital or at government ministries. You will be asked to take part in a 30 minute interview on Zoom. In the interview, you will be asked questions about your professional role and experience related to abortion. Your responses will be kept anonymous and confidential.

Your participation in this study is completely voluntary. If you choose to participate you may discontinue your participation at any time, and you may choose not to answer questions that you do not wish to answer.

If you want to participate, please contact me at an3668te-s@student.lu.se.

All the best,

Anna