Author’s response to reviews

Title: When the law makes doors slightly open: ethical dilemmas among abortion service providers in Addis Ababa, Ethiopia

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Author’s response to reviews:

Thank you to all reviewers who have taken their time to thoroughly read our paper and to provide many good and important inputs to improve the paper. We truly appreciate this. Below we respond to the comments which can be identified by this mark: **

Reviewer 1

This is a well written paper about an interesting and important topic. It is often imagined that simply changing abortion laws to allow liberal access to abortion will solve the problem of maternal mortality and morbidity related to abortion. It is, sadly, not true and this paper does a good job of illustrating the problem that arises with reluctant providers and laws which have restrictions. I have only a few rather minor comments.

1. The paper is a little bit long, it could be shortened somewhat by careful editing particularly of all the background information at the beginning.

** Thank you for the comment, we agree that the paper is on the long side, but since reviewer 3 asks for the addition of information, the total length of the paper is despite cuts unfortunately not shorter in its present version. We have however done some cutting;

- We have cut the following paragraph in the background section: “Indeed, providing abortion services has been difficult and controversial for centuries [9]. Requests for abortions touch upon ethical values and existential questions of what defines life, personhood, and responsibility [10]. The key stakeholders who grapple with these challenges are the abortion seekers and the providers of abortion services”
We have also re-phrased sentences and paragraphs to shorten the text. These include; “A key innovation, which makes the Ethiopian law unique among African countries, is that health-care providers are obliged to accept without question a woman’s word regarding rape, incest and her age” (line 170 – 172), and “abortion can either be done medically using Misoprostol and Mifepristone or surgically where manual vacuum aspiration (MVA) is the preferred method” (line 184 – 185).

2. Line 143 the mortality rate of 968 in the 1990s - this requires a denominator for readers who are not experts in the field.

** Thank you for this comment. We have added the denominator “per 100,000 live births” (line 167) and have specified that this refers to the maternal mortality ratio.

3. I find figure 1 unnecessary, why not simply state the indications for which abortion is legal. Figures interrupt the flow of a paper and in this case is not helpful.

** Thank you for the feedback. We see that a table may interfere with the flow of the argument, but in this case we do think the table provides a useful way to present the abortion law with its exact wording. Also the most interesting part of the law: namely that the woman’s word is sufficient to get an abortion is explicitly stated in the paper and the figure.

4. Line 182 in which the authors state that Addis has the highest registered abortion rate. How are abortions registered and is registration accurate?

** The study we are referring to was conducted by the Guttmacher Institute, a leading research institution in reproductive health research, not the least pertaining to abortion figures. As there is no official registration of abortions in Ethiopia the Guttmacher Institute use models in combination with key informants to estimate the abortion rates. The numbers remain mere estimates, but are nonetheless the best source of information regarding abortion numbers in Ethiopia. We have added in the paper that this number is an estimate; “Addis Ababa also has the highest registered abortion rate in the country estimated at 92 per 1000 women aged 14–49 years” (line 230 – 231).

5. I do not understand the meaning of the final sentence of the paper (line 572).

** We agree that the final sentence of the paper was not clear. It now reads; “Further research on abortion service providers roles and influence on abortion service provision should be conducted to inform policy aiming to reduce unsafe abortion and resultant deaths” (line 867 – 869).

6. Finally in the list of things to do which might help providers with their difficulties I would suggest that clinical support or mentorship would be helpful as these providers are clearly isolated.

** This is a good point. We have added the following sentence; “(…) and support mechanisms and mentoring should be provided” in the conclusion (line 866 - 867). We have also added the
Acknowledgement of the challenges the abortion service providers experience is vital. Support and mentoring should be continuously provided to the service providers by their leaders and colleagues, and leaders should be made responsible for their crucial role in hindering bullying and distress among their employers.”

Reviewer 2

This is a well planned and conducted qualitative study around an important topic, abortion provision in a LMIC (low/middle income country) where the law is relatively liberal. The findings have application to the provision of safe legal accessible abortion elsewhere in Ethiopia and in other LMIC. Study limitations as to the nationality of the interviewers and the restriction of the study to the Ethiopian capital, are noted but the in-depth nature of the interviews and the detailed content analysis lead to significant results and a layered discussion of the findings. References are appropriate, I recommend acceptance; there are two typos that need correcting: line 474 'ineligibility' and line 534, 'compassionate' rather than 'passionate' I think.

** Thank you very much. We have corrected the two typos you pointed out.

Reviewer 3

** Thank you for the thorough read of our paper. We appreciate your detailed feedback, and have tried to address them to the best of our knowledge.

Using qualitative data from a sample of abortion service providers in Addis Ababa, Ethiopia, this manuscript highlights important issues – related to wording, interpretation, and application – that apply to grounds-based abortion laws around the world. The legal innovation that makes Ethiopia unique among African countries is that the law requires service providers to accept without question a woman’s word regarding rape/incest and her age, both of which are grounds for lawful abortion. The authors might consider being more explicit and expansive about this important innovation. For example, an important question that is raised but not addressed by the paper is the extent to which the requirement of accepting a woman’s word was purposefully designed to improve access to a culturally stigmatised public health intervention.

** Thank you for this important feedback. We have added the following sentences “A key innovation, which makes the Ethiopian law unique in an African context, is that health-care providers are obliged to accept without question a woman’s word regarding rape, incest and her age” in the background section (line 170 - 172 ). We have also added the following sentence; “With the unique phrasing in the Ethiopian abortion law of a woman’s word being sufficient to gain abortion, many countries (…)” in the background section (line 214 – 215).

In the second paragraph of the discussion we start with the following sentences; “The Ethiopian law is unique in the way it opens up for abortion if certain criteria are fulfilled, and that the women’s word is enough to ensure an abortion. Although the law remains within the country’s
Penal Code, it has nevertheless left “the door slightly open” as a participant phrased it. Our study shows that also the variations found among service provider discretion relating to a woman’s eligibility for abortion under a particular legal ground, influence if the door is indeed open or not” (line 688 – 691).

Along these lines, it is unclear from the beginning whether the phrase “When the law makes doors slightly open” refers to the innovation of accepting a woman’s word or to the variations in service provider discretion about the woman’s eligibility for abortion under a particular legal ground. This is an important distinction that should frame the whole paper.

** Thank you for this important comment. We have modified the first sentence in the result part of the abstract to read as follows; “When working in a context where the law has slightly opened the door for abortion seeking women…” (line 45 – 46). Confer also to modifications described in the comment above referring to changes made in line 170 – 172, 214 – 215, 688 – 691. We would however like to suggest that we retain the ambiguity inherent in the title which, as you note, may point to both the innovation of accepting a woman’s word and to the variations in service provider discretion related to the woman’s eligibility for abortion.

Use of the term ‘ethical’, both in the title and throughout the manuscript, is unclear and potentially confusing and often appears to be conflated with (or even a synonym for) morals and personal values that are either derived from or are affected by a broad range of context-specific social determinants. If the authors choose to stick with the ethics theme, it would be important to differentiate between medical/public health ethics and personal values by providing a working definition for both, with relevant published literature cited accordingly. Authors could also consider noting, if not exploring, the broader public health ethics issues related to grounds-based abortion laws in general, address in more detail the social determinants in play in Ethiopia and explain how these relate to the qualitative data analysis and findings.

** Thank you for this important comment. We have reviewed the manuscript to detect where the employment of the term ‘ethical’ emerges as confusing. We would for several reasons like to retain the use of the term “ethics” (rather than replacing it with moral or personal values). We explicitly asked the participants what ethical dilemmas they faced. Their responses implied dilemmas linked to a) whether an abortion should be provided or not b) whether or not they should accept lies and c) whether or not to accept all kinds of reasons provided by the woman seeking an abortion. In our view these are ethical dilemmas (beneficence vs non-maleficence, autonomy vs beneficence/non-maleficence and so on). The informants’ responses to such dilemmas are - as you importantly point out - influenced by their personal and societal moral values.

Rather than making a distinction between ethics and moral, which is done less in daily language/communication and to an increasing extent used interchangeably in the literature, we have tried to make clear when the informants’ responses to the ethical dilemmas are connected to their personal values and/or their religion or culture. We have explained what we imply by ‘ethical dilemmas’ in the text (line 720 – 722) reading as following; “In ethical dilemmas, ethical principles or values are at stake and will conflict with each other in a manner such that people may disagree on how to balance the principles and the final decision”. We have therefore not
included more information on this point under the heading “Religious and ethical justification” in the discussion. We hope the reviewer finds this reasoning acceptable.

The feedback about ‘the public health ethics’ dimension is interesting, and is clearly interwoven in the bedside dilemmas. Due to our word limitation and reviewer 1 suggestion to shorten the paper, we have however not been able to follow up on this point in the present article.

The methodology section needs expansion and additional detail. Consider putting some of the details in a table. How were the sites and interviewees selected (random or purposive sampling, if the latter, based on what criteria)? Describe characteristics of the study sites (size; number of abortions provided per month/year; number and cadre of health-care providers involved in provision of abortion services; division between induced abortion and treatment of complications from spontaneous or unsafe abortion, etc.). Describe characteristics of the interviewees (gender, age, education, cultural and religious affiliation, role in provision of abortion care, etc.) by type of interview (individual and focus group). Describe qualities of the individual interviews and focus group discussions (who conducted/facilitated the interviews; location of the interviews; how confidentiality of data was protected; size and composition of the focus group discussions; etc.). Were interviews open-ended or semi-structured?

** Thank you for the feedback on our methods section. We agree that we have left out some important methodological details and below we have tried to address your concerns. Though we have not been able to include all the information as some of it is lacking due to the nature of our study. For example, the exact number of abortions performed at each clinic was information that was very uncertain as there did not exist a central statistical database for this. The numbers are therefore referred to more generally based on what our participants said and numbers seen at some health centers, but only for the previous two – three months and one statistical sheet shown to us at one NGO which we were not allowed to refer to specifically instead just stating that they performed the most abortion compared to public institutions. We have also left out some descriptive information about the study sites in order to not reveal their identity as this was something particularly the NGOs participating in the study requested from us. Regarding the question of adding a table in the methods section we are a bit reluctant as to whether this would be useful. As abortion is such a sensitive topic also for health-care workers to talk about, we did not systematically ask about the health workers’ age, education and religious affiliation and so we do not have this information about all of our participants. Though we have decided to make a table that we have placed in supplementary files and can be seen further down in this response.

In accordance to the reviewers’ suggestion we have made these changes to the methods section.

- We have included a statement on the recruitment method which reads as follows: “At the initial stage of the recruitment purposive sampling was used to ensure the inclusion of participants from different abortion service providing institutions and from different cadres of health workers. Later snowballing was employed to identify new participants” (line 286 - 289).

- We have added the purpose for redoing some of the interviews; "A total of 31 in-depth interviews (IDs) were conducted, of which three were follow-up interviews
made to clarify important emerging topics. One interview took place with two people as the attendance of them both was requested by the participants.” (line 289 – 292).

- Regarding the size of the focus groups the following information is added; “(…) with two groups of five and one group of three” (line 293 - 294).

- We have addressed how the confidentiality of data was protected by adding the following point; “all the recordings were kept safe on a closed file in the authors computer” (line 375 - 384).

- We have included where the interviews were conducted by adding the following sentence; “The interviews took place in separate rooms at the health institution during breaks or after working hour. Two interviews were conducted at a restaurant following the participants request” (line 325 – 327).

- We have moreover added a sentence about how abortion consent was obtained which reads as follows; “Before the abortion was conducted the doctor or nurse and the woman wishing to obtain safe abortion signed a consent form” (line 262 – 263). We have added some more specific details to the description of the study participants which reads as follows; “Of the abortion service providers, 19 were male and 23 were female. The majority, 24 participants, worked as nurses with nine having additional training in midwifery, five worked as doctors, three as health officers, three as medical students that had training in induced abortion and one pharmacist. The majority, 16 participants, considered themselves Orthodox Ethiopian Christian, three as Protestant, five as Christian, two as Muslims and six were religious without further specification. It must be noted that information about age, profession, years of working experience and religion was not obtained from all the participants as abortion is a sensitive topic and it was not always appropriate to ask about this. An additional file with more details about the characteristics of the study participants is provided [see additional file 1].” (line 308 – 318)

- We have also added some more details to the general description of the study site that we already had written which reads as follows; “The various health facilities provided abortion services in different ways. At the public health centers, abortion was provided free of charge and was open Monday to Friday. At the NGO clinics the price varied with some providing abortion to a reduced price to poor women. They were also open Monday – Friday. The hospitals also provided free abortion services, but there women could seek an abortion by going to the gynecological emergency room which was open 24 hours all days. There were commonly one or two nurses working as abortion service providers, although at the hospitals and NGO clinics a doctor often worked alongside the nurses with providing abortion services or would be called for when encountering challenging cases, such as second trimester abortions which only the doctors could perform. Commonly, the head nurse or doctor assessed the woman’s eligibility through a consultation
where they would either accept or reject her request for an abortion. Before the abortion was conducted the doctor or nurse and the woman wishing to obtain safe abortion signed a consent form. The size of the study sites varied, at the public hospitals induced abortions were performed at the minor gynecological emergency room which consisted of three to four beds, while the health centers only had one small private room with one bed used for the procedure. The NGOs either had a whole department only for abortion services or it was mixed with general gynecological services. They always had several private rooms to perform the procedure. No official statistics on the abortion caseload per clinic was available but through the interviews we got to understand that the health centers performed the least abortions with three to ten per month, the hospitals seemed to perform more especially since second trimester abortions all had to be performed here. Though most abortions seemed to be performed at the NGO clinics who stated that they performed several hundred abortions per month. All clinics at times experienced a lack of staff and medicines. At all the clinics visited during the study, surgical abortion was reported to be more common than medical abortion, though this picture was reported to be changing.” (line 251 – 279)

Some of the information the reviewer asks for is - we believe - is already presented in the paper. These point include:

1) who conducted and facilitated the interviews is explained as follows in the original version; “The majority of the interviews were conducted in English by the first author (EM). The focus group discussions and seven individual interviews were conducted in Amharic by a research assistant trained in qualitative methodology (with EM present)” (line 322 – 325).

2) whether the interviews were open ended or semi-structured which is explained as follows; “A semi-structured interview guide was employed. To ensure that the questions were as relevant as possible to the context, adaptations to the guide were made during the course of the fieldwork to incorporate emerging issues” (line 320 – 322).

We have decide to add a supplementary file with a table showing the study participants characteristics based on type of interview as the reviewer requested. We have added the table in supplementary files and referred to it in the text by adding as follows; “An additional file with more details about the characteristics of the study participants is provided [see additional file 1].” (line 317 – 318)

A style note: it is a potentially stigmatizing colloquialism to refer to ‘abortion providers’, ‘abortion provision’, ‘providers’, and ‘abortion seekers’, rather than referring to abortion service providers, service provision, and women wishing to obtain safe abortion.

** Thank you for pointing out this important issue. We have now changed the wording to ‘abortion service providers’, ‘abortion service provision’ and ‘women wishing to obtain safe abortion’.
Line-by-line comments/suggested revisions

35: under 18 years of age.
** Thank you, the correction has been made.

44: Content rather than Concept analysis…
** Thank you, the correction has been made.

46: …ambiguity concerning how to interpret and implement…
** Thank you, the words have been added.

97-98: According to the World Health Organization (WHO), each year between 4.7% - 13.2% of maternal deaths can be attributed to unsafe abortion.¹

** Thank you for the updated information on deaths due to unsafe abortions. The text now reads; “(…) each year between 4.7% - 13.2% of maternal deaths can be attributed to unsafe abortion” (line 99 – 100).

102-104: Globally, there is a broad continuum of legal categories for abortion, ranging from abortion on a woman’s request with no requirement for justification, to specified grounds, to uncertain prohibition where laws prohibit unlawful abortion but do not specify any lawful grounds, to prohibition of all abortions.” ²

** Thank you for informing us about this interesting paper on abortion lawfare and your formulation on the variety of legal categories. We have added the following sentence; “Globally, there is a broad continuum of legal categories for abortion. Some countries allow abortion on a woman’s request with no requirement for justification, some claim specific grounds, while in other countries there is an uncertain prohibition where laws prohibit unlawful abortion but do not specify any lawful grounds, in a few countries abortion is prohibited on all grounds” (line 103 – 107).

107-106: Authors may also want to note South Africa, another important example of poor implementation, which is noted later in the paper.

** True and a good point. We have now have added “and South Africa” (line 110) and have moreover included a reference to this paper “Harries J, Stinson K, Orner P. Health care providers’ attitudes towards termination of pregnancy: a qualitative study in South Africa. BMC Public Health. 2009;9:11-11.” Which is the same as we refer to later in the paper.

108: Distance to health-care institutions…

** Thank you, the correction has been made.
110: health workers willing to provide abortion services may all create access barriers [6].

** We agree that access barriers is a better wording. The text has been modified.

113: Finding health workers willing to provide abortion care can be difficult…

** Thank you, the text has been modified.

115: providers are faced with stigma and discrimination [8].

** Thank you, the text has been modified.

124-125: …a better understanding of the complexities of access barriers to abortion services.

** Thank you, the text has been modified.

130: Loi et al. found that local culture and social norms…

** Thank you, the text has been modified.

143: Usually, maternal mortality is given as a ratio per 100,000 live births rather than a rate. Please double-check and if necessary provide this detail.

** Thank you. We have now corrected the information to ‘ratio’ and included per 100,000 live births (line 167).

141-148: Suggested rewrite: In sub-Saharan Africa, Ethiopia stands out in terms of its abortion law. Deaths from unsafe abortions were identified as the main reason behind Ethiopia’s high maternal mortality ratio of 968 per 100,000 live births in the 1990’s [15,16]. In an effort to curb the high number of women dying from unsafe abortions, the law was changed in 2005, expanding the number of grounds for which lawful abortion could be provided (see Figure 1). A key innovation, which makes the Ethiopia law unique among African countries, is that health-care providers are obliged to accept without question a woman’s word regarding rape/incest and her age.

** Thanks you. This is a very good suggestion for the phrasing of this point. The text has been modified (line 166 – 172).

160-162: In the guidelines there are recommended methods for medical abortion (mifepristone and misoprostol) and surgical abortion before and after 12 weeks gestational age. The guidelines do not recommend only surgical abortion prior to 12 weeks. See pages 17-19 of the guidelines.3

** Thank you for the clarification. This has now been corrected.
Many countries in Africa have liberalised their abortion laws. It is the requirement that health-care providers accept the woman’s word regarding rape and her age that makes Ethiopia unique.

** An important point. We have changed this and it now reads as follows; “With the unique phrasing in the Ethiopian abortion law of a woman’s word being sufficient to gain abortion, many (…)” (line 214 – 215).

This is more background information than methodology.

** Thank you for this input. After consideration we have decided to keep the information in the methods section as placing it in the background would make that section too long. Another reviewer has pointed out that the background should be reduced. Retaining the information in the methodology section moreover ensures a good introduction to the study setting.

Do you mean the total fertility rate? If so, please specify.

** Thank you for pointing out that this is not clear. We have now clarified the point and have written ‘total fertility rate’ which is what the number is referring to (line 227).

Is the 56% for ‘all’ contraceptive methods or ‘effective’ contraceptive methods? Please specify.

** Thank you. The 56% referred to all contraceptive methods. We have corrected it to 50,1% which is modern contraceptive methods used (line 229).

Please clarify whether women seeking abortion from the emergency room (and other locations) were presenting for induced abortion or treatment for abortion complications.

** Thank you for this comment. We have tried to clarify the point by adding “induced” to the sentence making it read as follows; “The abortion service providers met the women seeking induced abortion either through an elective appointment or at the emergency room” (line 248 - 249).

Please clarify, the meaning of ‘worked with abortion services’. E.g., provision of pre-abortion information and counselling; provision of abortion pills and/or vacuum aspiration; provision of abortion aftercare.

’ Thank you for this observation. We have added the following information; “Participants were included if they worked with any aspect of induced abortion services provision at the time of the study including either provision of pre-abortion information and counselling, provision of abortion pills or MVA and post-abortion care.” (line 282 – 285)

Please clarify ‘of which three were follow-up interviews’. Why only three follow-up interviews? Was this part of the methodology or for some other reason?
** Thank you. We have added the following information; “(…) follow-up interviews made to clarify important emerging topics. One interview took place with two people as the attendance of them both was requested by the participants” (line 290 - 292).

193-194: How many participants were in each focus group discussion?

** Thank you. We have added the following information; “(…)with two groups of five and one group of three participants” (line 293 - 294)

197: ‘working with abortions’ is vague and unclear (see comment for lines 190-91).

** Thank you. We have added; “(…)working with all aspects of abortion services provision from actually inducing the abortions to taking care of women undergoing an induced abortion” (line 307 – 308).

199-200: Please provide exact numbers for disaggregation by religious status.

** Thank you. We have responded to this point in the methods section above see and can be find in the paper in line 312 - 318.

205: The focus group discussions and seven individual interviews…

** Thank you. The text has been modified.

209: Interview participants were recruited until a sense of….

Thank you. The text has been modified.

223: …generalized descriptions of the most common dilemmas…

** The text has been modified.

224-225: These were supported by specific verbatim statements from the interviews.

** Thank you. The text has been modified.

226: delete ‘material’.

** The text has been modified.

231: replace ‘at’ with from the Regional Ethical Committee of Norway…

** The text has been corrected.

232: General research ethics principles of…
** Thank you, the text has been modified.

239: Suggest deleting ‘Severe’ or replacing with Challenging.

** Thank you. The text has been modified.

244-258: Suggest moving this section to methods (study context), since it is not results.

** Thank you for this feedback. We have moved this text to the methods section (line 251 - 279).

263: Suggest replacing ‘talks’ with discussions or interviews. Also, were interviews/discussions semi-structured?

** Thank you. The text has been modified replacing talks with discussions/interviews. Yes the interviews were semi-structured (stated in the methods section line 320).

266-269: The difference between points 1 and 3 is not clear.

** Thank you for pointing this out. The section now states; ”(1) should abortion be provided or not (2) should they accept lies or not, and (3) should they accept all kinds of reasons or not” (lines 398 – 400).

272: …an abortion according to the grounds/exceptions stipulated in the law.

** Thank you. The text has been modified.

274: Suggest replacing ‘with’ with from an unskilled provider.

** Thank you. The correction has been made.

275: Suggest replacing colloquial language: …of how refusing care to a desperate woman seeking abortion could have…

** Thank you. The text has been modified.

282-283: One health worker had experienced a case where refusal led to the patient dying from unsafe abortion and recalled how the experience had a substantial transformative…

** Thank you. The modification has been made.

300-302: The sentence: According to the abortion law and guidelines… is misleading. Health- care providers are only to accept a woman’s word for rape/incest and age. A woman is disqualified if she does not meet a stipulated legal ground, not if she lies about her age or being raped.
Thank you for pointing this out. We have now modified the sentence to read as follows; “According to the abortion law and guidelines, health-care providers are to accept a woman’s word of rape, incest and age. Yet many found this unpleasant and upsetting, which in turn made them confused about the ethically correct way to handle the challenge” (line 496 – 498).

312: Our Participants revealed…

** The text has been modified.

320: It is unclear what ‘courted’ means. Suggest adding bracketed clarification.

Thank you. We have clarified the point by adding the following statement “sent to jail” in brackets (line 514).

339: Suggest replacing ‘reasonable’ with legitimate abortion seekers. This reflects the values of the interviewees.

** Thank you. We understand what you are pointing at, but since this (reasonable/unreasonable) was the wording used by the study participants we wish to keep the phrasing.

356-369: ** No information was included here.

384: The religious teaching of that abortion being is sinful made it…. ** Thank you. The correction has been made.

445-446: Suggest including some quotes that illustrate abortion being a job that ‘brings money to the table’ and ‘is the right of a woman to decide over her own body’.

** Thank you for this suggestion, we have now included the quotes as following; “So I don’t have a chance to reject the work because I want to live and earn money (…)” (23, ID) and “The rule should support every woman’s right to get an abortion. It does not have to restrict some women's right and approve others' rights” (24, ID) (line 666 – 670)

452: Such experiences assisted helped the health workers…

** Thank you. The text has been modified.

460: Suggest replacing ‘frames’ with scope of the law.

** Thank you. The text has been modified.

461-462: Suggest deleting …follow and interpret the abortion law…
Suggest replacing ‘legal rights’ with access to safe abortion.

474: ‘illegibility’ should be corrected to ineligibility for abortion…

476-477: …implying that women asking for an abortion were denying their role as women reproductive agents.

477-481: Is this the view of the researchers or the participants? If participants, then it would be good to include some quotes.

486-487: Often, ethical dilemmas arise when professional ethics or personal ethics values require health workers to go beyond their legal duties exercise liberal interpretations of the law.

488: …and principles among our study participants; removing or taking the life of a fetus was experienced viewed by religiously and culturally grounded ideals some people as doing harm or maleficence, while others viewed assisting a vulnerable women segment of the population was experienced as doing good, or beneficence.

493: ….the woman was not legally eligible under the strictest interpretation of the law.

497: ….accepted what they deemed to be lies and thus ‘stretched’ the law. The health workers’ responsibility to accept a woman’s word regardless of their own views of the situation manoeuvre in such ambiguous landscapes imposed substantial burdens on them.
510: The health workers in the study had a gatekeeping role regarding women’s access to…

** Thank you for this suggestion. The text has been modified.

512-513: The sentence could be rewritten for clarity. Try not to use the terms ‘grounds’ (rather use situations or decisions) and ‘unfairness’ (rather use discrimination and inequities). E.g., This situation led to some decisions being based more on the service provider’s personal values and notions of the legitimacy of women’s reasons for abortion and thus to discrimination and inequities in service access.

** Thank you for these good suggestions. We have modified the sentence and it now reads as follows; “This situation led to some decisions being based more on the service provider’s personal values and notions of the legitimacy of women’s reasons for abortion, thus creating discrimination and inequality in the access to safe abortions” (line 777 - 779).

517-519: You cannot provide health workers with knowledge. You can provide them with information to build knowledge, guidance to direct it, and authority to apply it (see reference 17). Only legislative and judicial bodies (and perhaps public referenda) can determine if laws are legitimate.

** Thank you for pointing this out. The text has been modified and now reads; “However, providing health-care workers with the authority to apply the abortion law is not per definition ‘unfair’ if the law is legitimate and is properly understood and followed.” (line 783 – 785)

524: With the abortion law of 2005 and the guidelines of 2014, Ethiopian health workers were given explicit guidance for provision of safe abortion services.

** Thank you for pointing. The text has been modified and now reads; “With the abortion law of 2005 and the guidelines of 2014, Ethiopian health-care workers were given explicit guidance for provision of safe abortion services” (line 790 – 791)

554-555: Why is the principle investigator’s status as a foreigner from a country with a comparatively liberal law a study limitation? This statement needs a bit of unpacking.

** Thank you for bringing up this point. We agree that this might not really be a limitation and have therefore removed the statement.

564: Suggest using recently liberalised law rather than semi-liberalised.

** Thank you, we agree. The text has been modified.

567-568: …leads to various ethical personal dilemmas and coping…

** Thank you. The text has been modified to: “(…) leads to various personal dilemmas and coping mechanisms. “ (line 869)
573: Suggest deleting ‘female’.

** Thank you. The text has been modified.

References:

1) https://www.who.int/news-room/fact-sheets/detail/preventing-unsafe-abortion
