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Induced abortion among internally displaced women in Ethiopia: prevalence, annual incidence, and access to care during an extended crisis

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Background: Displaced women face disproportionate reproductive health risks. However, research on the burden of induced abortion in this population is limited. This mixed research, the first among displaced women in Ethiopia, attempts to determine the prevalence and incidence of induced abortion. It also highlights barriers and facilitators to safe abortion access among these women, providing useful information for humanitarian sexual and reproductive health programs.

Methods: In 2024, we conducted a mixed-methods cross-sectional study on internally displaced women in Debre Birhan, Ethiopia, including 1,863 women and 16 key informants for the quantitative and qualitative components. The quantitative component comprised reproductive-aged women, whereas the qualitative component included women who had undergone induced abortions, abortion service providers, and non-governmental organisation (NGOs) workers. The quantitative study recruited women by a random selection approach. Purposive sampling strategies were used to recruit participants for the qualitative investigation. Qualitative data were collected using the Kobo Toolbox and analyzed in SPSS 22. The prevalence of induced abortion during women's camp life was estimated by dividing the total number of women who reported induced abortion by the total number of participants. The annual induced abortion rate was computed per 1000 women. We used the self-reported and best friend approaches to determine the incidence of induced abortion. To address transmission biases, we adjusted for the best friend's incidence of induced abortion. The socio-ecological framework drove the thematic analysis of the qualitative data in Atlas.ti 8. We applied both inductive and deductive methodologies.

Results: According to our research, 3.1% of displaced women reported having an induced abortion while in the camp. The annual rates of self-reported, unadjusted, and adjusted best friend-induced abortions were 5.4, 8.8, and 42.2 per 1000 women, respectively. The most significant individual-level barriers to getting safe abortion services were a delay in seeking treatment, fear of punishment, and lack of knowledge. Inadequate social support was a significant interpersonal barrier to receiving care. Social stigma and religious opposition were the main barriers at the community level. The key organizational obstacles were camp overcrowding, poor care quality, and indirect payments. At the policy level, a vague abortion law was seen as a major barrier to providing care. Self-efficacy, the availability of free abortion services, NGOs'help, and referral networks were the most important facilitators.

Conclusions: Induced abortion is a significant yet underreported public health problem among displaced women, with true incidence rates potentially eight times higher than the self-reported estimate. Despite the presence of some facilitators, women face a variety of interrelated barriers. To address underreporting and improve access to safe abortion services, we propose three key recommendations: First, at the policy and organisation levels, there is an urgent need to clarify abortion rules and ensure that healthcare staff get comprehensive training in rights-based care. Second, programming approaches should focus on culturally relevant awareness campaigns, encouraging partnership between NGOs and health institutions to decrease stigma and improve service accessibility. Finally, future research should use more anonymous and culturally sensitive methods to identify the unreported abortion instances in displacement contexts.

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