MEDICAL SOCIETIES AND CONTENTIOUS POLICY REFORM: THE ETHIOPIAN SOCIETY FOR OBSTETRICIANS & GYNECOLOGISTS (ESOG) AND ETHIOPIA'S 2005 REFORM OF ITS PENAL CODE ON ABORTION

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ABSTRACT

Unsafe abortion is one of the three leading causes of maternal mortality in low-income countries; however, few countries have reformed their laws to permit safer, legal abortion, and professional medical associations have not tended to spearhead this type of reform. To the contrary, theory predicts and the empirical record largely reveals that medical associations shy from engagement in conflictual policy-making such as on abortion, except when professional income or autonomy is at stake. Using interviews with obstetrician-gynecologists (10) and others familiar with the reproductive health policy context in Ethiopia (44) and other primary data, this research examines why, counter to theoretical expectations and experience elsewhere, the Ethiopian Society of Obstetricians & Gynecologists (ESOG) actively supported reform of national law on abortion. We find that ESOG leadership's participation was motivated by both their professional experience as obstetrician-gynecologists and their personal and ESOG's organizational commitments to reducing maternal mortality. ESOG policy contributions were also associated with circumstances that relaxed or removed negative repercussions to medical society involvement in policymaking, including those related to organizational structure and experience and to the political environment. This study can inform efforts to facilitate medical society participation in policy reform to improve women's reproductive health elsewhere in the region.

Keywords: Ethiopia; policy reform; abortion; maternal mortality; obstetrician-gynecologists; medical societies; task-shifting

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INTRODUCTION

What underlies the willingness of a professional medical society to actively support policy reform, particularly reform of a socially contentious nature? In 2005, Ethiopia enacted a broad reform of its Penal Code, resulting among other things in a liberalized law on abortion. The Ethiopian Society of Obstetricians-Gynecologists (ESOG) publicly worked in support of this reform. Second only to South Africa, Ethiopia arguably now has the most liberal law on abortion in Sub-Saharan Africa (SSA).[1] This reform took place in the context of Ethiopia's dauntingly high levels of maternal mortality which are higher than those in the rest of Eastern Africa, the region with the higher rates of the continent (WHO, 2007; WHO, Bank, UNICEF, & Activities, 2010). Unsafe abortion is one of the three leading causes of maternal mortality in the country (Abdella, 2010; Central Statistical Agency (CSA) & International, 2012). The active public role that ESOG leadership played in support of liberalization of Ethiopian abortion law runs counter to theoretical predictions and empirical evidence from other settings that professional societies actively engage in policy making only when it relates to their professional self-interest or when it does not threaten to generate conflict among members (Aries, 2003; Gasman, Blandon, & Crane, 2006; Joffe, Weitz, & Stacey, 2004; McKay, Rogo, & Dixon, 2001; Parsons, 1951). Obstetrician-gynecologists (ob-gyns) are nonetheless often influential in policy and program design. Rather than absenting themselves from policy engagement, ESOG members researched and articulated the problem of abortion-related maternal mortality, conveyed it to the elite public and to government policy makers, proposed policies, and later helped develop regulations that further expanded access by making new categories of health professionals eligible to provide services.[2]

What explains this surprising finding? This study argues that there are three sets of reasons, the first stemming from personal and organizational values, the second from ESOG's organizational structure and experience, and the third from the overall political context in which reform took place. First, both individual ob-gyns and ESOG as an organization had strong, almost definitional commitment to maternal mortality prevention. Second, typical constraints on medical society involvement in controversial policymaking were absent or relaxed at the time of the reform. To start, several features of ESOG's organizational structure and history gave ESOG leaders the latitude to be more publicly active in reform. Its lean organizational structure, reliant on volunteer leaders whose participation is motivated primarily by their philosophical commitments; the absence of experience that would limit deep public policy engagement; the relatively limited formal contact between leadership and membership that resulted in reduced accountability; and finally, the organization's limited funding base and allied lack of funder constraints all enabled ESOG's leaders

[1] The Center for Reproductive Rights has assessed the relative restrictiveness of abortion laws worldwide using four categories of permitted access to legal abortion: to save the woman's life or prohibited altogether; to preserve the health of the woman; on socio-economic grounds; and without restriction as to reason. The only country in SSA where abortion is permitted without restriction is South Africa, and Zambia is described as the only country where abortion is permitted on socio-economic grounds (Center for Reproductive Rights, 2014). However, I would argue that both the language of Ethiopia's law, as well as the way it has been implemented, permit legal abortion on socio-economic grounds. Legal abortion is far more accessible in Ethiopia than in Zambia, where the administrative requirements (consent of 3 medical practitioners, performance in a hospital by a physician) serve to bar access to most women. In Ethiopia, the woman's own testimony as to whether rape or incest has occurred is sufficient (FHD, 2006).

[2] The Technical and Procedural Guidelines for Safe Abortion Services in Ethiopia state that,

> In order to make safe abortion services as permitted by law accessible to all eligible women, the role of midlevel providers such as nurses and midwives should be expanded to include providing comprehensive abortion services, including uterine evacuation using MVA and medical abortion. Pre-service and in-service training for midlevel providers should reflect this expanded role. ((FHD, 2006), p.41).

to be heavily involved in reform. The political environment also encouraged ESOG's policy engagement. The ruling party's receptiveness to reform and expectation that ESOG would contribute, the democratic opening for civil society participation, and finally, the belief among other civil society actors that ESOG and ob-gyns were necessary contributors for reform, all reduced or removed constraints on ESOG engagement in policy.

Drawing chiefly on key informant interviews with prominent obstetrician-gynecologists and other leaders in the reproductive health and women's rights fields, this study examines how this Ethiopian case of professional society engagement in a contentious policy reform diverges from the predictions of theory and past history. It also provides a snapshot of the perspectives of obstetrician-gynecologists on their rationale for, and the nature of, their involvement in supporting reform. Four sections follow. The next section provides background on the Ethiopian context and the theory related to professional society engagement in policy making. The second section describes the research methodology. Findings as to how professional society behavior accorded with the predictions from theory and experience are outlined in the third section. I review conclusions and implications in the final section.

BACKGROUND

In Ethiopia, a nation of over 92 million, the urban and educated are a narrow sliver of its overwhelmingly rural (84%) population (Central Statistical Agency, 2012). It is one of the world's poorest countries, ranking 169th of 177, and does not fare well on markers of social welfare, with high maternal and under-five mortality and low literacy, particularly among women (UN Data, 2010). The philosophy and values of Ethiopia's population would not lead one to expect the liberalization of law on abortion. Ethiopia is a highly religious and traditional society; all major religious groups (Ethiopian Orthodox Christians, Muslims, Protestants and followers of traditional religious beliefs) proscribe abortion except to save the life of the woman.[3] Opposition to abortion among Ethiopians is strong, as is common in SSA and in non-industrialized, less secular country settings in general. Over 63% of the Ethiopian population views abortion as 'never justifiable' (World Values Survey, 2007). However, as is also typical globally, there is a gulf in Ethiopia between views on abortion and women's actual practices (Dixon-Mueller, 1995; Reagan, 1996). Ethiopia has one of the world's higher rates of maternal mortality: 676 women die for every 100,000 live births, constituting 21% of all deaths to women ages 15-49 (Central Statistical Agency, 2012; de Waal, 2013; WHO, 2007; WHO et al., 2010),[4] and unsafe abortion has been identified as one of the leading causes of maternal mortality over the past several decades (Abdella, 2010; Abdella et al., 2013; Berhan & Abdela, 2004; Kwast et al., 1986; Singh et al., 2010; Yoseph & Kifle, 1988; Yoseph, Adane, & Eyob, 1993).[5,6] Recent estimates of abortion incidence place the rate among women in

[3] Ethiopian press coverage of abortion law reform, as well as the responses of all interviewees, indicated that all major religious groups (Ethiopian Orthodox Christian, Muslim, Protestant/Evangelical) were officially opposed to abortion except in case of threat to the life of the mother.
[4] In developing country settings, the risk and reality of death during pregnancy and birth remain grimly persistent features of women's lives (Conde-Agudelo, 2000; M. C. Hogan et al., 2010).
[5] The World Health Organization defines unsafe abortion as "a procedure for terminating an unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking the minimal medical standards, or both" (WHO, 1995).
[6] Induced abortion, both safe and unsafe, has grown in incidence over the past four decades, particularly in urban areas where women are more educated and their desire to limit family size has increased most, but where contraceptive use, although increasing, is still below levels necessary to meet women's desired levels of fertility (Lindstrom & Berhanu,

Addis Ababa, the capital, at 49 per 1000 women ages 15-44, substantially higher than the national rate (29/1000), or even that of the rest of East Africa (39/100), the region with the world's highest incidence of unsafe abortion (Gebreselassie et al., 2010; Singh et al., 2010; WHO, 2007).[7]

Politically, Ethiopia has had little experience with democracy or non-governmental organizations (NGOs), and the current ruling party has viewed NGO advocacy warily, leaving them limited space. Nonetheless, the 1991 advent to power of the current government brought stability, economic growth, increasingly democratic elections, and a gradual emergence and blossoming of civil society, at least until a deadly post-election crackdown in 2005 (Abbink, 2006; Arriola, 2008; Clapham, 2009). NGOs in the health sector proliferated during this period, many of them receiving foreign financing. Ethiopia's health sector has been distinctive for the high degree of overlap between government and NGO aims, and for the low likelihood of any disagreement threatening government stability and control.[8] Nonetheless, even during this period of democratic openness prior to 2005, the ruling party kept a firm grip on power, permitting independent organizations to engage in policy advocacy only so long as their work was 'harmonized' with the government's development agenda and posed no threat to its political control (de Waal, 2013; Segers et al., 2008; Vaughan, 2011). The advocacy and reform examined here took place within this democratic opening.

ESOG AND THE OBSTETRICIAN-GYNECOLOGIST PROFESSION IN ETHIOPIA

The profession of obstetrics and gynecology globally has great influence over national policy development and standards of care in the reproductive health sector (Contreras, van Dijk, Sanchez, & Smith, 2011; Gasman et al., 2006; Hessini, 2005; Hessini, Brookman-Amissah, & Crane, 2006; Sheth, 2003). Due to their high levels of education, social linkages, and male gender, Ethiopian obstetrician-gynecologists are almost by definition prominent. They play at least a triple role: they provide medical care, train other providers, and are called on to contribute to government policymaking and program design related to reproductive health. They are the providers to whom the most difficult cases come, including those of women with severe complications of unsafe abortion who make it to medical facilities. ESOG and obstetrician-gynecologists' contributions to national reproductive health policy have largely been to executive branch administrative policy requiring little public input or support, unlike the more open and public Penal Code reform process. The Ministry of Health tends to be staffed by generalists, and to rely on obstetrician-gynecologists for technical advice and policy input.

Ethiopian-trained ob-gyns are a nascent group in Ethiopia; the first graduate training program was only established in 1980 (Gaym, 2010). Prior to this, Ethiopians received ob-gyn related training on an ad hoc basis from foreign obstetrician-gynecologists. Between 1974 and 1990, many Ethiopians went to Eastern Bloc countries for graduate medical education (Gaym, 2010). Thus their training was in health systems where abortion services are integrated into the national health systems and

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1999; Sibanda, Woubalem, Hogan, & Lindstrom, 2003; Woubalem, 2000). The proportion due to unsafe abortion in Ethiopia appears to have begun declining prior to the 2005 reform (Abdella, 2010).

[7] However, a significant proportion of the services in the capital, Addis Ababa, are safe abortion services, as a number of providers, including those at Balcha Hospital and Marie Stopes International, Ethiopia, have provided safe abortion services since at least the late 1980s (Mgbako et al., 2010).

[8] This may in part be due to the overlap between those who work in government and in NGOs: people often cycle from government to NGOs in the health sector, and some, particularly more highly trained medical professionals, provide services in medical facilities, teach in government educational institutions as well as work with NGOs.

where a Marxist, and more receptive, perspective on abortion and contraception has prevailed (Berman, 1946; David, 1974; Frejka, 1985; Potts, 1967; Savage, 1988; Tietze, 1961).[9] The obstetrician-gynecologist professional society – ESOG – is also recent, founded in 1992 with an explicit mission to address Ethiopia's elevated maternal mortality. ESOG is Ethiopia's first medical specialty society. ESOG members previously were in the Ethiopian Medical Association (EMA), which represents all trained modern medical professionals in Ethiopia and serves as the mechanism through which the government interacts with health professionals.[10] Although ESOG has grown from 75 founding members to the current membership of 234 (ESOG, 2012), it remains a small organization with leadership serving on a volunteer basis.

Obstetrician-gynecologists in Ethiopia also remain few. At most 700 work in a country of over 88 million (ESOG, 2013). One might argue that the scarcity of ob-gyns in Ethiopia explains their willingness to cede scope of practice to other categories of providers. However, features in Ethiopia (relative shortages of ob-gyns, as well as high maternal mortality related to abortion and fledgling ob-gyn societies) are also present in most Sub-Saharan African countries that have not liberalized their laws or authorized mid-level providers such as midwives to offer abortion services. In most countries, ob-gyn societies have neither been willing to work to expand legal provision of abortion services by ob-gyns nor to permit other classes of medical professionals to provide such services. Medical practitioners have jealously guarded their scope of practice, and so ESOG's promotion of midwives' scope of practice *vis*–à–*vis* their own is anomalous (Taylor, Safriet, & Weitz, 2009; Wagner, 1995).

ETHIOPIA'S 2005 PENAL CODE REFORM

Liberalization of national abortion law, with its promise of access to legal and safer services, remains an infrequent event. Nonetheless, the global trend has been one of liberalization, even in Sub-Saharan Africa (SSA) where laws have started from a more restrictive baseline.[11] In SSA, seventeen countries liberalized their laws between 1977 and 2007, although most on more limited grounds - to permit abortion to save the life of the woman, in cases of rape or incest, or to preserve the physical health of the woman (Boland & Katzive, 2008; Cook, 2000; Cook & Dickens, 1988; Cook, Dickens, & Bliss, 1999; A. Rahman, Katzive, & Henshaw, 1998).[12] This leaves the continent with the highest proportion of countries permitting legal abortion only to save the life of the woman (Center for

[9] "It goes without saying that this does not by any means prevent us from demanding the unconditional annulment of all laws against abortions or against the distribution of medical literature on contraceptive measures, etc. Such laws are nothing but the hypocrisy of the ruling classes. These laws do not heal the ulcers of capitalism, they merely turn them into malignant ulcers that are especially painful for the oppressed masses." (Lenin, 1977), p. 232.

[10] Although private sector provision has grown significantly over the past decade, the public sector provides an estimated 90% of modern health services, and the government still employs most medical professionals (Bank, 2004). Ethiopia's public health system structure begins with health extension workers at the community level; primary health care units, with a health center and five satellite health posts at the woreda (district) and kebele (township) levels; primary hospitals; general hospitals; and finally specialized referral hospitals in urban catchment populations of at least 5 million where most ob-gyns are based.

[11] Sub-Saharan African nations' laws related to abortion are often largely inheritances from colonial rulers or replicas of European laws of the 1960s or earlier (Cook & Dickens, 1981).

[12] These countries include: Comoros, Liberia and Rwanda between 1977 and 1988 (Cook & Dickens, 1988); Botswana, Burkina Faso, Ghana and South Africa (A. Rahman et al., 1998), as well as Equatorial Guinea and the Sudan between 1985 and 1997 (Cook, 2000); and Benin, Chad, Ethiopia, Guinea, Mali, Niger, Swaziland and Togo between 1998 and 2007 (Boland & Katzive, 2008); (M. Rahman & Daniel, 2010).

Reproductive Rights, 2013). Only one country, South Africa, allows women access to first trimester abortion without restrictions.[13]

Although the toll of maternal mortality from unsafe abortion was present in Ethiopia during the 1980s, there were no related policy initiatives under the ruling Marxist 'Derg' government. Nonetheless, the 1991 accession of a new political regime (the Ethiopian People's Revolutionary Democratic Front (EPRDF), a coalition of groups led by the Marxist Tigray People's Liberation Front (TPLF)) brought a government receptive to reforms to improve women's status and initially opened political space for civil society emergence and action. The ruling party's track record of policies to improve women's status both before and after coming to power in 1991, as well as specific senior leadership guidance during the Penal Code reform process (Wada, 2008), Holcombe, 2014), shaped a political environment friendly to reform of the law on abortion.

Public efforts to reform the law on abortion sprang from two civil society sources. The first was women's organizations, most notably the Ethiopian Women Lawyers' Association (EWLA), championing a broad set of reforms to improve women's social and economic status. The second was a network of reproductive health NGOs seeking to limit maternal mortality, particularly that due to unsafe abortion, and to expand women's access to reproductive health services. ESOG's involvement was with this second group; they had a shared focus on reproductive health and liberalizing Penal Code provisions related to abortion and contraception. Civil society engagement in the reform process took the form of educating the informed public (and policy makers) about the severity of the problem of maternal mortality and unsafe abortion and about the consequences of women's disadvantaged status, as well as reminding policy makers of the need for reform when progress stalled. After producing draft legislation, the government formally drew on civil society by convening the Reproductive Health Working Group (RHWG) in 2002 to educate and mobilize support for reform and later to help develop the law's regulations. Through public forums, many of which were televised, testimony to Parliament and informal feedback on draft Penal Code language, civil society organizations articulated the policy problem, voiced support and maintained momentum for reform. However, it is important to note that public awareness of the reform process was largely confined to more educated people in Ethiopia's urban areas.

THE REFORMED LAW

Prior to the 2005 reform, abortion in Ethiopia was permitted only to "save the pregnant woman from grave and permanent danger to life or health," required the assent of two doctors (Ethiopia, 1957), and was similar to European law of the time (Cook & Dickens, 1981; Wada, 2008). In 2003, senior government leaders had decided that the appropriate policy change was to decriminalize abortion (Minutes of the Justice System Reform Program Coordinating Committee, cited by (Wada, 2008). However, the final version of the Penal Code issued in June 2005 was not the complete decriminalization of abortion law initially proposed in Parliament, due to the late-breaking

[13] In Sub-Saharan Africa, South Africa and Ethiopia stand out for their combination of more expansive laws and of actual access to services. The laws shift responsibility for care from ob-gyns and physicians to other categories of (more numerous) medical providers, thus opening up greater access to services. Both sets of laws also go further than is the case elsewhere in Sub-Saharan Africa in enabling women to decide whether they will have an abortion, rather than leaving authority over the decision to physicians. The new laws have notably expanded access to services in South Africa (Althaus, 2000; Benson, Andersen, & Samandari, 2011; Blanchard, Fonn, & Xaba, 2003; Harrison, Montgomery, Lurie, & Wilkinson, 2000; Mhlanga, 2003) and in Ethiopia (FDRE, 2010; 2011; Otsea, Benson, Alemayehu, Pearson, & Healy, 2011; Singh et al., 2010).

emergence of formal opposition from a small religiously-inspired group of medical professionals that held two unprecedented public demonstrations in opposition to reform, and from the Patriarch of the Ethiopian Orthodox Church (Wada, 2008).[14] However, it did include a lengthy list of the exceptions permitting legal abortion in the cases of rape, incest or fetal impairment; if pregnancy continuation or birth would endanger the health or life of the woman or fetus; if the woman had physical or mental disabilities; or if the woman was a minor (under 18) who was physically or mentally unprepared for childbirth.[15] This compromise was undertaken to defuse opposition while still opening broad access to abortion services. Perhaps the most significant feature of the legislation was buried in the subsequent article: the evidence requirement for eligibility for legal abortion in case of rape or incest is "mere statement from the woman," with no requirement for authorization by a doctor, judge or police official (FDRE, 2005; FHD, 2006). This has proved to be the most common route by which women in Ethiopia now access abortion services. For providers, an important feature of the reform was the removal of penalties on medical professionals offering legal abortion services.

The law's regulations further expanded access. The Ministry of Health, tasked with developing a related regulation, drew on NGO members of the RHWG to draft it. The 2006 regulations authorized additional categories of clinicians (midwives, nurses and health officers) to provide services, a key to expanding access in a country where the ratios of doctors and of obstetrician-gynecologists to the population are among the world's lowest.[16] Ethiopia's reform has been followed by an increase in legal (and safer) abortion services: Ministry of Health service statistics also show increasing incidence of legal abortion (Abdella et al., 2013; FDRE, 2011; Singh et al., 2010). However, three years after legal reform, it was estimated that still only 27% of all induced abortions were performed in safe and legal conditions, and almost half of all abortions resulted in moderate to severe medical complications (Gebreselassie et al., 2010; Singh et al., 2010).[17]

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[14] The only instances discussed where abortion would have been criminalized were when a person profited from women's bodies or when a non-medical provider offered unsafe abortion services.

[15] 42 Proclamation Number 414/2004 (Penal Code of the Federal Democratic Republic of Ethiopia, 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.

[16] Due to political and military conflict and poverty, Ethiopia has suffered one of the world's most acute exoduses of trained professionals, particularly medical providers, to more affluent countries . Ethiopia's physician to patient ratio (1:53,642) is over 3.5 times worse than the Sub-Saharan African average for physicians and 5 times worse than the WHO recommended ratio . In contrast, in the United States in 2009, there was 1 physician for 417 people (Satiani, Williams, Landon, Ellison, & Gabbe, 2011).

[17] The continued high prevalence of unsafe abortion even after legal reform is unfortunately not surprising. This is a phenomenon in other low-income countries that have liberalized their laws (e.g., Nepal and South Africa), and as Ethiopia's health infrastructure does not yet reach all of its population ((FDRE, 2009), access to all health services remains a challenge. The proportion of safe legal services would certainly be lower but for the work of organizations such as Marie Stopes International, Ethiopia, which had offered safe abortion services in Ethiopia since the early 1990s.

THEORY AND EMPIRICAL RESEARCH

Globally, individual physicians and obstetrician-gynecologists have been prominent and influential contributors to health policy generally, and more particularly, some have been strong and effective voices in national efforts to liberalize laws on abortion (Aries, 2003; Gasman, Blandon, & Crane, 2006; Halfmann, 2003; Joffe, 1999; Joffe, Weitz, & Stacey, 2004). As such, they have faced stigma and censure from colleagues or from vocal and powerful religious institutions. Internationally, studies indicate that the more highly trained the medical professionals are, the more supportive they are of liberal abortion laws, with ob-gyns the most supportive (Abdi, 2008; Hammarstedt, Jacobsson, Wulff, & Lalos, 2005; Hammarstedt, Lalos, & Wulff, 2006; Lindström, Jacobsson, Wulff, & Lalos, 2007; Lindström, Wulff, Dahlgren, & Lalos, 2011). As well-educated, affluent, socially connected and most often male health professionals, obstetrician-gynecologists and their professional associations in low-income countries have significant social capital, equipping them to be influential in policymaking (Gasman et al., 2006; McKay, Rogo, & Dixon, 2001; Shaw & Faúndes, 2006). However, the theory and the empirical experience are at best equivocal toward, and more often unsupportive of, the proposition that their medical societies are likely to be prominent actors working to advance legal reform of a socially contentious nature.

THEORY ON MEDICAL SOCIETY ENGAGEMENT IN POLICY

Sociological study of the professions describes them as having a monopoly on a technical body of knowledge that then accords them professional autonomy, public respect and authority (Parsons, 1939; 1951; Weber, 1978). In a happy, functionalist characterization, the medical profession is understood to be distinguished by its collective (as opposed to self-interested) orientation, manifesting as an explicit professional commitment to prioritize patient well-being over personal gain (Parsons, 1939). This professional commitment is seen as creating trust and legitimizing physician authority over patient treatment.[18] Haug and others note that the greater the differential between provider knowledge and expertise and that held by patients, the greater the scope of professional power (Haug, 1976) – an observation pertinent to Ethiopia where the education gap is especially large. Parsons briefly distinguishes between individual provider activities and those of medical societies: the latter are seen as having an incentive to *avoid* engaging in policy work even on medical issues for which physicians have direct expertise if it will cause conflict among members (Parsons, 1951). However, more contemporary work has focused less on the medical profession's collective social contract orientation and predicts rather that organized medicine will pursue professional self-interest through public policy. Professional self-interest is defined as providers' economic interests, as well clinical autonomy, including control over how, when and if services are delivered, and as a consequence, control over patients (Harrison & Pollitt, 1994).[19,20] Ethiopian

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[18] However, Parsons does note that professional self-regulation can conflict with patient well-being, although his focus is on doctor-patient relations rather than on medical associations and public policy-making (Parsons, 1939).

[19] In the U.S. and other OECD countries, the organized medical profession has used its standing to protect its economic position and prerogatives through influence over broader national health policy, at times at the expense of policy efforts intended to aid (potential) patients, such as U.S. health system reform (Marmor & Thomas, 2009; Mohr, 1979; Peterson, 2001; Starr, 1982). More recently, however, the literature in the U.S. has emphasized the change in the structure of health care systems in industrialized societies and how it threatens the values of medical professionalism, including the primacy of patient care (Sox et al., 2002).

[20] Another approach to understanding professional medical society behavior emerges from more affluent countries, and emphasizes the struggle for institutional recognition between medical specialty societies as the motivator for their public policy activity (Harrison & Pollitt, 1994; Smelser & Reed, 2012). However, this model of inter-specialty competition

obstetrician-gynecologists have high clinical autonomy not only due to their relatively high levels of education and training, but also perhaps to the shortages of medical professionals of all types, and particularly ob-gyns. Organizational theorists would describe Ethiopian obstetrician-gynecologists as having both expert and informational power, due to their training and profession as well as to their research (French & Raven, 1959; Raven & French, 1958).

The literatures described above largely ignore the influence of government over organized medical societies and physician behavior. Remedying this oversight, a handful of comparative theorists focus on the state-physician relationship and its implications for the profession's power over policy. Most see the extent of state control over the production of medical services and the basis of eligibility for public health services as shaping physician profession power: more state ownership and consolidated administration of the health system (both present in Ethiopia) would each predict less profession power, and broader eligibility for government health services would predict greater profession power (Frenk & Donabedian, 1987). Others emphasize the impacts of democracy and of civil society: physician power over policy is seen to be greatest where there is democratic government and a flourishing civil society (Duran-Arenas & Kennedy, 1991). The latter in nascent form, but not the former, was present in Ethiopia. Some see the power of organized medicine as even greater during legislative rule-making than legislative enactment, due to its near monopoly on technical expertise (Marmor, 1970). However, this body of work emphasizes how the profession exerts its power to protect its autonomy and economic interests through policy; it does not speak to professional society behavior when the policy conflict is over values and is oriented toward promoting a greater social good rather than the economic self-interest of the profession. If the profession's economic security or professional autonomy is not threatened, then medical societies likely have greater latitude to actively support policy to improve patients' well-being.

Historically, the extent of broader public participation in policy has also differed by political system. In more democratic systems in affluent countries, public awareness of and influence on policy tend to be greater. In more traditional and politically restrictive contexts such as that of Ethiopia, to the extent that there is public engagement, it most often comes from more educated urban elite actors (Grindle & Thomas, 1989; Thomas & Grindle, 1994). Further, when most of a country's population is culturally conservative, more restrictive political contexts where policymaking is confined to elite actors may even increase the chances of reform. If there are influential civil society groups and a responsive government supportive of reform, it may be more possible to liberalize laws without rousing traditional opposition.[21]

EMPIRICAL RESEARCH ON MEDICAL SOCIETY POLICY ENGAGEMENT

Empirical research does not show national medical or ob-gyn societies to be at the forefront of abortion law reform efforts.[22] In affluent country settings, doctors view liberalization of abortion law

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seems ill-suited to Ethiopia, as there are few specialty societies, and as ESOG essentially has no rivals, especially in the realm of maternal and reproductive health.

[21] Finally, where the decision is made (e.g., within the Ministry of Health on a regulatory basis; in Parliament on a legislative basis; by the courts) also shapes whether a policy change can be made in a quiet and closely held manner (Engeli, Green-Pedersen, & Larsen, 2012; Studlar, Cagossi, & Duval, 2013).

[22] However, at the global level, the Federation International of Gynecologists and Obstetricians (FIGO) has issued statements, guidelines and codes over the past decade or so to encourage ob-gyn and ob-gyn society action to promote the sexual and reproductive health rights of women, including in the areas of provision of safe abortion services and advocacy for safe abortion (FIGO, 2014; Schenker & Cain, 1999; Serour, 2006). Progressive members of the profession

as having the potential to shift discretion over whether abortion services are to be provided by doctors to women. This shift occurs when abortion is decriminalized without restrictions in the first trimester, rather than requiring physician determination of the medical need, as is the case for therapeutic abortions (Halfmann, 2003). Of the wave of abortion law reforms that took place in OECD countries starting in the late 1960s, individual obstetrician-gynecologists, but not professional medical associations, were among the reformers. Few medical societies either publicly called for legal reform or were prominent reform actors (Aries, 2003; Gasman et al., 2006; Halfmann, 2003; Joffe et al., 2004; Reagan, 1996). If medical associations entered into the policy debates, they did so at later stages after recognizing the inevitability of reform, and then engaged in order to preserve physician discretion over services.[23] Research in the US and UK contexts examining medical society behavior with respect to abortion law reform has stressed reform's challenge to physician power (Aries, 2003; Halfmann, 2003; Joffe, 1999; Joffe et al., 2004; Mohr, 1979). In the UK, the Royal College of Obstetricians and Gynecologists opposed decriminalization of abortion (M, Potts, personal communication, May 1, 2014).[24] In the U.S., Aries finds that the American College of Obstetricians and Gynecologists' (ACOG) positions on abortion leading up to the 1973 liberalization of abortion law were aimed at preserving physician autonomy as well as consensus among members (Aries, 2003).[25] In Brazil and Poland, the medical societies remained outside organized efforts to liberalize abortion law, in the latter case due both to a desire to avoid conflict with church and governmental organizations, as well as to not forfeit revenue from provision of illegal abortion services (De Zordo & Mishtal, 2011; Faúndes, Duarte, Neto, & de Sousa, 2004; Zielinska, 1993).

Even in settings with high maternal mortality due to unsafe abortion, obstetrician-gynecologist societies have largely remained outside or on the sidelines of policy discussions in support of reform. In South Africa, civil society groups, particularly those working to advance women's status, were those that led the advocacy for passage of decriminalized abortion in the first trimester . The ruling party initiated reform in Guyana, and the medical association only publicly engaged in its own right when it came time to comment on the law's regulations . In Nigeria, while three obstetrician-gynecologists and a lawyer launched advocacy for reduction of maternal mortality due to unsafe abortion (and eventually for abortion law reform), the obstetrician-gynecologist society did not formally engage, and there was also support from the Minister of Health for reform (Oye-Adeniran, Long, & Adewole, 2004). Otherwise, inaction among ob/gyn societies on policy reform related to abortion is widespread across Sub-Saharan Africa, and stands in contrast to advocacy work of individual providers (F. Okonofua and N. Prata, personal communication, November 15, 2013 and

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have also increasingly voiced the obligation for ob-gyns to work to promote patients' sexual and reproductive rights, including increased access to safe abortion (Briozzo & Faúndes, 2008; Cain, 2000; Chamberlain, McDonagh, Lalonde, & Arulkumaran, 2003; de Gil, 2014; Faúndes, Duarte, & Osis, 2013; Fiol, Briozzo, Labandera, Recchi, & Piñeyro, 2012; Gasman et al., 2006; McKay et al., 2001).

[23] At earlier stages, physicians as a profession have actively sought to restrict access to abortion. Starting in 1859, the founders of the American Medical Association worked to criminalize abortion in order to eliminate professional competition from midwives. Their efforts to institute legal restrictions and bans on abortion served as a tool to build the strength and credibility of their fledgling profession and professional association (Mohr, 1979; Starr, 2009).

[24] Similar resistance to yielding authority was expressed during the abortion law reform process in the United Kingdom. The head of the Royal College of Obstetricians and Gynecologists, Sir John Peel, put an end to an impassioned member's appeal for College support for decriminalization of abortion by responding, "I don't like being told what to do by the patient" (personal communication, Dr. Malcolm Potts, 2014). This is archetypal evidence of physician desire to maintain professional control over care, not necessarily resistance to women making reproductive decisions.

[25] Aries also describes medical society strategies to preserve consensus, including adoption of more hierarchical/abrogated decision-making procedures as a coping strategy when member consensus is absent.

January, 5 2012, and (Kulczycki, 1999).

In the few cases where obstetrician-gynecologist societies have publicly supported reform, there has been government support for reform and/or the reform has left authority over the procedure in the hands of physicians. In India, it was the government that launched abortion law reform processes by convening medical associations and other groups to discuss unsafe abortion. The liberalized law, however, classified the procedure as therapeutic and thus under provider control, not a woman's right, and had strict limitations on the types of facilities where services could be offered leaving access to services limited (Bandewar, 2001; Hirve, 2004; Jesani & Iyer, 1993; Mavalankar & Rosenfield, 2005). Even in this case,, India's obstetrician-gynecologist society (the Federation of Obstetrician Gynecologists of India) was not particularly active in support of reform (Bandewar, 2001; Hirve, 2004; Jesani & Iyer, 1993). There are a few exceptions to this pattern of obstetrician-gynecologist society inaction in the context of reform. Kenya's obstetrician-gynecologist society (Kenya Obstetrical and Gynaecological Society, KOGS) took a public position urging liberalization of the law. However, its participation was sparked by the 2004 imprisonment of a senior obstetrician-gynecologist in a maximum security prison for a year on charges that would have resulted in his execution, but were later tossed out (Fjerstad, 2012; Mbugua, 2004).[26] Uruguay is the exception that proves the rule. Here, the obstetrician-gynecologist society played a central role in advancing reform, although there was clear ruling party support for legal reform and providers retain authority, as the law requires approval of three medical professionals (Briozzo, 2013).

Historical experience and the theoretical literature lead to contradictory predictions as to how medical societies might engage with abortion law reform. On balance, the prediction would be disengagement. On the one hand, a collective, social contract understanding of medical profession behavior would suggest that a medical society would support a reform that has demonstrated potential to save lives and reduce morbidity, particularly in high maternal mortality settings such as Ethiopia (Parsons, 1951; 1975; WHO, 2014). Conversely, theory emphasizing more self-interested behavior by medical societies, as well as the observed experience in most national settings, might lead one to expect silence or even opposition to reform from ob-gyn societies. Liberalization of abortion laws can reduce physician discretion and cede scope of medical practice to other classes of providers. Related reform processes can embroil a medical society and its membership in divisive internal and/or public debate, and could potentially weaken its negotiating position in other policy contexts. Finally, theory emphasizing the physician-government nexus would emphasize the role of government approval and permission in facilitating obstetrician-gynecologist policy engagement, particularly in health systems where the public sector is dominant, as is the case in Ethiopia. The empirical evidence on abortion law reform does not reveal many cases of formal and leading participation from obstetrician-gynecologist societies. However, in the few cases where there has been formal and public obstetrician-gynecologist society involvement, it has often been when there is overt or tacit government support for reform, where the reform does not threaten the clinical authority and/or scope of work of physicians, or where there has been a direct attack on a member of the profession in good standing (as in Kenya).

Overall the experience and theory touching on medical society involvement in socially and politically sensitive policy reforms such as abortion suggests that they would not be involved, often due to a desire to protect professional and economic interests and standing. This study is aimed at examining

[26] The 2004 arrest of a prominent obstetrician-gynecologist (one of only approximately 250 in Kenya) provoked intense media coverage (Fjerstad, 2012; Mbugua, 2004).

the conditions under which a medical society focused its efforts on improving women's well-being rather than on the profession's status.

DATA AND METHODS

This is a retrospective case study of the involvement of a professional medical society in abortion law reform in Ethiopia, undertaken in an exploratory mode with the goal of supporting causal inference by identifying key independent variables and uncovering causal mechanisms and routes by which they affect the outcome of reform (Trochim, 1989). In the longer term, the aim is to have the findings here contribute to developing a causal model of abortion law reform to enable generalization to a larger population of country-cases in Sub-Saharan Africa.

The study looks at the outcome of policy advocacy by the Ethiopian professional medical society during Ethiopia's reform of its Penal Code with respect of abortion, and offers the opportunity to extend theory to accommodate a case that appears not to fit current paradigms.

DATA

This study draws on observational data (in-depth interviews), as well as ESOG policy and programmatic documents, government policies plans and evaluations, donor reports, opinion data and secondary research.

The fifty-two interviews with fifty-four people result from a purposive sampling of individuals familiar with the 2005 reform of the Penal Code in Ethiopia. Interviewees worked with government, media, Ethiopian NGOs (including ESOG), as well as research institutions, international reproductive health organizations, and donor agencies. All but two interviews were conducted by the author in Addis Ababa, Ethiopia in February and March of 2012 (seven years post reform). No other screening criteria were used. These interviews were conducted in English, as all interviewees had tertiary-level education for which English is the medium of instruction. In addition, this research uses two interviews conducted in 2007 just after reform with religious leaders (from the Ethiopian Orthodox Tewahedo Church and from the Supreme Council of Islamic Affairs) that explored the views of their respective faiths and institutions on contraception and abortion. They were conducted in Amharic and summarized in English (Ferede Alemu, 2010).

At the 2012 interviews, I explained the scope and purpose of the study and obtained signed consent for the interview and for linkage of interviewees' professional affiliations and responses. Ethical approval was obtained from the University of California, Berkeley Committee for Protection of Human Subjects (CPHS) (Protocol ID: 2011-03-3010; approved May 2011, amended April 2014). The key interview data is from ten Ethiopian obstetrician-gynecologists, including six of ESOG's ten past and current Presidents (60%) and five of ESOG's nine Secretaries (56%). All potential obstetrician-gynecologist interviewees contacted were interviewed. All are men affiliated with maternity or university hospitals, Ethiopian and international NGOs, and/or the Ethiopian federal government. In addition, forty-one interviews referencing ESOG with informants from Ethiopian reproductive health and women's NGOs and international reproductive health NGOs and donors provide comparative perspectives. Men were 60% of the informants, and interviewee ages ranged from the mid-30s to the mid-70s, with the oldest being those educated and starting work in the early

1970s. All but two of the informants were still working and were Ethiopian nationals. Table 1 above lists interviewee affiliations.

Table 2-1
Interviewee background (2012 and 2007)

	(*Primary affiliation only***)**
Government	6
Women's rights NGOs	4
Ethiopian (reproductive) health NGOs	9
Reproductive health medical professionals	10
Researchers	6
International NGOs	12
Media	1
Donors	4
Religious leaders (*Ethiopian Orthodox Church, Supreme Council of Islamic Affairs*)*	2

*Fifty-two (52) individuals interviewed in 2012 in 51 interviews (one person twice; two interviews with two people each). Two (2) people interviewed in 2007 (Ferede).**

All but two interviews were recorded and transcribed verbatim. Interviews averaged 55 minutes in length, with a range from 20 minutes to four hours. All but ten were recorded and transcribed verbatim. Unrecorded interviews were summarized shortly after the interview concluded. Quotations are from obstetrician-gynecologists unless otherwise noted; all are from Ethiopians.

The semi-structured interviews from 2012 included questions concerning the reform sequence and actors; the framing of the debate; the understanding of the reform roles and actions of the informant's organization; and summative questions on perceived causes of reform. The phenomena of interest are ESOG's position on liberalization of the law on abortion, its motivations, actions and roles related to reform, the timing of key events, as well as the factors reducing the predicted constraints on medical society involvement in reform. All interview transcripts or write-ups were then coded using HyperRESEARCH 3.5.2 qualitative data analysis software ((Researchware, 2013)). All transcripts were first descriptively coded for professional affiliation and gender, then to identify actors, interests, roles and timing of key events.

METHODS

As the argument here is that the Ethiopian case accords poorly with theoretical predictions and empirical evidence of the behavior of medical professional societies, it is key first to outline what ESOG's observed contributions to reform of the Penal Code on abortion were, and how ESOG leadership understood the rationale for and nature of the profession's involvement in reform efforts. The analytic strategy is to contrast reform events, in particular the actions of ESOG, with what theory and historical experience would have predicted. The first step produced a chronology of the reform with special attention to the contributions of the ob-gyn society (ESOG), and then a

description of the motivations of ESOG reform actors. Next, we looked for factors predicted by theory and historical experience that might mitigate the pressures discouraging ESOG from acting in support of reform. The secondary and other data sources helped to validate or crosscheck statements made by interviewees and fill in any missing areas. If events were described in similar ways by multiple respondents from diverse types of organizations, all involved in the reform, saturation was deemed to have been reached.

LIMITATIONS

As with any retrospective research, this study has limitations, primarily recall and social desirability bias. The prominence of this reform may reduce recall bias. Social desirability bias could take several forms, including desire to claim personal or organizational credit as well as, conversely, discomfort with abortion and resultant inclination to downplay their own and others' roles in reform or the scope of the reform. Social desirability bias is likely less present here as interviewees are in leadership positions in their field and part of Ethiopia's educated elite. Such interviewees were able to ignore questions and redirect discussion when so inclined (Berry, 2002; Tansey, 2007; Welch, Marschan-Piekkari, Penttinen, & Tahvanainen, 2002). To the extent it is present, this bias may also be managed by comparing individuals' statements with what they might have an institutional or reputational incentive to say, by recognizing that people's desire to claim credit for reform is likely counterbalanced by discomfort with the idea of 'abortion upon request' and desire to avoid broader public attention around abortion, as well as by triangulating data sources. Finally, the author used a series of interviewing strategies to help manage bias: knowing the topic area; interviewing a wide variety of informants; asking about the roles of other actors; asking the informant to critique their own assessments; and saving questions about impact for a later stage (Berry, 2002; Dexter, 1970; Lilleker, 2003; Williams, 2012).

FINDINGS AND ANALYSIS

This section starts with a description of ESOG's involvement in the reform process, including ESOG leadership's explanation of the organization's rationale for engagement in reform and of its roles, comparing them with non-ob-gyn informants' perspectives. As this involvement is at odds with predictions from relevant theory and empirical experience, we then identify how predicted or expected constraints on medical society involvement were lower or made lower in the Ethiopian context. In particular, we describe how features of ESOG's internal organizational structure and dynamics, the government's attitudes and approach toward Penal Code reform, and the expectations of ESOG allies all facilitated its contributions to reform.

ESOG INVOLVEMENT IN REFORM

ESOG and its member obstetrician-gynecologists undertook a range of activities long preceding the actual reform that brought maternal mortality and unsafe abortion to the attention of policymakers and the elite public. Their involvement continued in new forms as policy attention to the problem of unsafe abortion grew. Work included policy-related research, discussion and presentations at ESOG annual meetings, presentations in public forums including on the radio and television in Addis Ababa and elsewhere, testimony before national and regional government bodies, and participation in government task forces.

Ethiopian obstetrician-gynecologists' first related work was research on the prevalence of maternal mortality and of unsafe abortion. In the late 1980s, senior obstetrician-gynecologists, among them many of ESOG's later founders and leaders, began carrying out research on maternal mortality and the contribution of unsafe abortion. This growing body of research, initially hospital and community-based studies and eventually nationally representative work, served as the base for future advocacy efforts.

From the start, ESOG's annual meetings served as a venue for discussion of reproductive health problems and responses for influential figures in the reproductive health and related fields. Its second (1993) and seventh (1999) annual meetings focused specifically on unsafe abortion. At the second meeting, the first at which research was discussed, not only did ESOG leadership speak (ESOG's third president and leader of the pioneering 1988 study of maternal mortality and unsafe abortion in Addis), but also the Minister of the Office of Women's Affairs in the Office of the Prime Minister, and one of the more prominent Ethiopian advocates for women's rights. This meeting's aim was to have "Addressed the issue thoroughly and created awareness on the magnitude of the problem and the maternal mortality and morbidity caused by unsafe abortion in Ethiopia" (ESOG website). A presentation by an obstetrician-gynecologist who would later become ESOG's president in the run-up to reform asked directly about what changes were needed to address illegal and unsafe abortion.

The 1999 Annual Meeting was a watershed both for ESOG and for policy attention to unsafe abortion in the country. It effectively broke the prevailing taboo on public discussion of unsafe abortion and policy, and launched explicit commitment of ESOG for work on policy in this area. It culminated with ten resolutions recommending increased access to family planning and directly addressing unsafe abortion. Resolutions called for a degree of liberalization of the country's law on abortion, ESOG engagement in research to inform policy change, and authorization of ESOG's Executive Committee to follow up on these recommendations:

- Provisions in the Penal law pertaining to abortion should be revised to accommodate safe abortion services for vulnerable groups at selected institutions.
- Until the current abortion law is liberalized, strategies should be devised to enhance the provision of safe abortion services.
- There is an urgent need to conduct research on abortion issues.
- ESOG should take a leadership role in the enactment of provisions for legal abortion as well as in the delivery of safe abortion services.

(ESOG, 1999))

As a result of this meeting, ESOG convened a subcommittee, composed largely of senior ESOG members, to focus on reform of law on abortion. Members of this committee went on to speak publicly and to aid with subsequent design of the related regulation. Other outgrowths of the meeting were nationally representative surveys central to ESOG's later policy work: one a survey of provider knowledge, attitudes and practices related to abortion care and abortion law, and the other a facility-based survey revealing the incidence and prevalence of unsafe abortion (ESOG, 2002b; 2002a; Lakew, Asres, Gebre, & Abdella, 2002). Both reports explicitly recommended liberalization of the law and ESOG collaboration with the Ministry of Health and other policymakers to liberalize laws on abortion. The conclusion from the report on the provider survey concluded with a specific call for liberalization of Ethiopia's law on abortion:

> Abortion law needs to be liberalized to accommodate termination of pregnancy on certain circumstances like rape, contraceptive method failure, maternal indication and others. Efforts need to be strengthened to increase the knowledge of health workers about the existing law as well as functioning policies in the country regularly to improve the health care provision of abortion services within the existing law (Lakew et al., 2002).

The reports helped consolidate consensus among ESOG members about the scope and nature of the problem, position ESOG as an authority, and further equip them to speak to government officials and the public.

ESOG also gradually became more public in revealing its support for reform of the law. ESOG's President from 2000-2002 and the lead author of the provider survey articulated the Society's position in 2001 to the media. She urged that "pregnancies which occur through rape, inefficacy of contraceptives as well as pregnancies that endanger the life of the mother should be given free access to safe abortion," (Walta Information Center, Nov. 29, 2001, as reported in (German Ethiopian Association Informationsblatter, 2002). The second criterion she identifies, contraceptive failure, is one that would have significantly increased the number of women legally eligible for abortion as well as women's ability to autonomously access safe abortion services. At the height of public reform discussions between 2001 and 2004, ESOG members were key speakers in numerous public forums, many of which were televised, on maternal mortality and its links to unsafe abortion.

ESOG representatives also participated in the RHWG, a group convened by government in 2002 to educate the public and policymakers about maternal mortality and unsafe abortion and to offer technical assistance to government leaders. Members of this group, including ESOG representatives, did not shy away from presentations in public forums, on the radio and at national and regional level meetings. ESOG's leadership also testified at hearings held in most regions of the country on the proposed Penal Code reforms. A current and a future ESOG president presented at the 2003 Parliamentary hearings on Penal Code reform on maternal mortality, unsafe abortion and reproductive health. ESOG leaders also educated medical professionals and medical society members, including the Ethiopian Midwives Association, about the reform and its rationale. Subsequently, ESOG representatives were also central actors in developing the law's even more progressive 2006 regulations, which increased the categories of medical providers authorized to provide abortion services.

If theories of the professions hold, a medical society would both resist expansion of the scope of practice of other medical professions and try to retain authority over whether and when to provide abortion services to women (Aries, 2003; Mohr, 1979; Starr, 1982). In the case of abortion, theories and experience would also predict that ESOG would work to require that medical necessity be the condition for women's eligibility for services (therapeutic abortions), rather than supporting availability of services in the first trimester or allowing the woman to decide whether she is eligible for services. Empirical experience in most countries suggests the same incentives at work. In many countries, obstetrician-gynecologist societies have both failed to participate in expanding access to legal abortion services, and have also blocked other categories of providers (such as midwives) from doing so. However, ESOG leaders did quite the opposite. They were among those proposing the final regulatory guidance that made mid-level providers such as nurses and midwives eligible to provide abortion services. Further, ESOG's behavior on physician versus women's decision-making on when abortion could be legally provided was also contrary to predictions from theory. In many countries where liberalization of abortion law has occurred, abortion is still only permitted on

therapeutic grounds. This type of law preserves physician (or medical provider) authority over whether and when women should be able to access abortion services. However, ESOG also supported the feature of the law that authorized legal abortion for rape on the basis of women's testimony alone. In addition, as noted above, ESOG had proposed that abortion be permissible in cases of contraceptive failure, which would have resulted in women being able to decide when they wanted an abortion (Aries, 2003; Lakew et al., 2002)..

ESOG AND OB-GYN MOTIVATIONS AND CONTRIBUTIONS TO REFORM

This section reviews the motivations behind obstetrician-gynecologists' and ESOG support for reform, largely stemming from concern about high maternal mortality and professional responsibility. It then goes on to describe their and other actors' understanding of ESOG contributions to reform in the areas of research, evidence-based outreach and the framing and presentation of the policy issue to best connect with the broadest audiences.

Obstetrician-gynecologists' experience with maternal mortality

The motivations of individual obstetrician-gynecologists sprang from their work experience with women dying from unsafe abortions and their allied sense that they and their profession were the ones with the knowledge, skills and experience to make improvements. Maternal mortality and unsafe abortion have been an inescapable part of obstetrician-gynecologists' work environment in Ethiopia, as well as that of the reproductive health sector more generally. Their perspectives, particularly those of senior obstetrician-gynecologists practicing in the 1980s and early 1990s, are grounded in their direct medical experience of caring for women, particularly young women, dying from unsafe, illegal abortions (Masho, 1997).

> The magnitude and the mortality, the mortality. And that it's affecting mainly the young people. You see, the eyes of these young people remain in your eyes, when they are almost dying. They see you, they say, "please save me." This is almost a daily practice in our Gyne ward when we are residents, in the so-called 'septic room.' There are three or four people, going into septic shock, very eager to survive. But you can't save them, because they came so late. And there were no proper antibiotics at that time. For an ob-gyn, it was the kind of thing that you start to hate the … We used to operate at least one patient a day, at least every day, with abortion complications. *Interview 12*

Several ESOG informants described this experience of being unable to save young women with their lives ahead of them as underpinning their support for legal reform. Obstetrician-gynecologists generally were well aware of the impacts of unsafe abortion due to their work, but also as a result of their research on maternal mortality and its causes in Ethiopia, which was shared at ESOG and other meetings. ESOG's second president, Dr. Seyoum Yoseph, had done the pioneering 1988 research that brought the problem of maternal mortality and unsafe abortion to the attention of national policy makers. Informants also spoke of the responsibility and obligation of those who best knew the scope and nature of the impacts of unsafe abortion to speak for policy change.

> These (obstetrician-gynecologists) are the learned people […] They know the problem, they know much of the causes of the problem, and they know the solutions. […] So again, crossing their arms and sitting cannot be a way out, they have to do something, right? These

people have a conscience. If they don't do it for women who are suffering or dying …. There is this moral issue, right? *Interview 14*

Maternal mortality prevention became an almost definitional feature of the work of individual obstetrician-gynecologists and of the profession. Due to their status and expertise, they had what has been described as 'problem ownership' (Gusfield, 1981).

Overall, the obstetrician-gynecologist profession in Ethiopia was deeply concerned about maternal mortality and broadly supportive of liberalization of the law on abortion. ESOG's nationally representative survey of medical providers in 2000 prior to reform revealed near unanimous agreement among obstetrician-gynecologists, as well as among other medical professionals, on the seriousness of the problem of maternal mortality due to unsafe abortion, as did a survey two years post-reform.[27] It showed that 80% of obstetrician-gynecologists viewed the 1957 law as too restrictive, and that over three quarters believed that preventing the interruption of schooling was an acceptable rationale for legal abortion (Lakew et al., 2002). These were provisions that were far more liberal than those of the existing 1957 law. Table 2-2 below contains further data on obstetrician-gynecologists' and other medical professionals' attitudes and experience related to abortion and the law.

Obstetrician-gynecologists were the ones who saw the worst complications and deaths from unsafe abortion. At the same time, they also knew of safe alternatives to the unsafe abortions that sent injured women to the overflowing labor and delivery wards of the capital's hospitals. Through the training of many senior obstetrician-gynecologists in Soviet bloc countries and their contact with providers of safe abortion services in Addis,[28] ESOG leaders knew this maternal mortality could be reduced through access to safe abortion services. Further, much of ESOG's leadership, including at least three ESOG Presidents, had been key movers in the introduction of post-abortion care (PAC), a comprehensive set of clinical and health interventions to preserve the life and health of women presenting with complications of unsafe abortion. The introduction of PAC not only brought clinical skills to save lives (the same used for safe abortion services), it offered an opportunity for providers to clarify and articulate their values and also their roles and professional responsibilities regarding unsafe abortion and abortion more generally (Turner, Hyman, & Gabriel, 2008).

> The introduction of postabortion care (PAC) services here in Ethiopia […] has given us actually the competence to familiarize everybody with the topic and with the quality of care. So if that was not there, definitely the groundwork would have been missing, so it would have been difficult to jump from nowhere to policy formulation, no way! *Interview 33*

The way that obstetrician-gynecologists discussed the rationale for post-abortion care in terms of saving women's lives foreshadowed the frame ESOG leaders used later during the 2005 reform process.

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[27] In 2000 and 2008, 98% and 97% of ob-gyns surveyed agreed that "abortion related mortality and morbidity is a significant public health problem" (Abdi, 2008; Lakew et al., 2002).

[28] It was well known to both medical professionals and national health policymakers that the Dedjazmatch Balcha Hospital, founded by the Russian Red Cross, and the clinics of Marie Stopes International–Ethiopia provided abortion services.

Table 2-2 Ethiopian medical provider attitudes and experience related to abortion (2000, 2008, 2013)*

	ESOG (2000)	Abdi (2008)	EMA (2013)
	Percent Agreeing		
Abortion related mortality and morbidity is a significant public health problem	0.98	0.97	0.95
Access to safe abortion would reduce maternal death/If abortion is illegal, ------------women will die of unsafe abortions	-	0.82	0.86
Pre-2005 law is too restrictive			
Obgyns	0.80	-	-
Nurses (including Midwives)	0.44	-	-
Support liberalization of the law to accommodate termination of pregnancy on certain conditions			
Obgyns	0.89	-	-
Nurses (including Midwives)	0.79	-	-
Abortion should be legally permitted for economic reasons			
Obgyns	0.78	-	-
Nurses (including Midwives)	0.51	-	0.56
Abortion should be legally permitted to prevent interruption of schooling			
Obgyns	0.77	-	-
Nurses (including Midwives)	0.44	-	0.56
A woman has the right to terminate her pregnancy if she wishes.	-	0.41	0.49
Termination of unwanted pregnancy is a sinful act	-	0.61	
Clinical experience and views on who should provide abortion services:			
Ever encountered a woman with an incomplete abortion?	0.97	-	0.91
Ever had anyone request an abortion?	0.72	-	0.72
Ever had abortion training?/Ever had training in first trimester abortion?	-	0.29	0.49
Ever terminated a pregnancy?/ Ever terminated a pregnancy? / Ever recommended medical abortion?	0.35 (priv) 0.15 (public)	0.30	0.63
Willing to provide MVA abortion/Definitely willing to provide abortion	-	0.37	0.55
Only MDs should provide abortions/Midlevel providers are able to provide surgical abortions/ Midwives should be allowed to provide surgical abortion services in the first trimester	0.75	0.30	0.84
Understanding of the law:			
Views self as familiar with the law/(very or somewhat)	-	0.68	0.80
Correctly understand that only the woman's word is required for legal services	-	0.67	0.64

**2000 data is nationally representative; 2008 data is from a survey of medical professionals at four health facilities in Addis; 2013 data is from a survey of midwives at the Ethiopian Midwives Association (EMA) annual meeting. Unless otherwise noted, ESOG's and Abdi's respondents are of all provider types; EMA respondents are midwives.*

ESOG founding rationale and mission

When discussing ESOG's involvement in reform, obstetrician-gynecologist interviewees first explained that ESOG's founding motivation and explicit mission was to address Ethiopia's elevated

levels of maternal morbidity and mortality (Gaym, 2010; E. S. O. O. A. Gynecologists, 2012). This mission, as well as the research and practice of ESOG's founders, were directly consonant with support for reform of the country's laws on abortion.

Obstetrician-gynecologists and other interviewees almost unanimously viewed ESOG as having taken a clear position in support of reform of the law. Several referenced the organization's 2000 nationally representative provider survey as revealing the profession's strong support for liberalization of the law. The one dissenting obstetrician-gynecologist interviewed did express concern about ESOG focusing excessively on advocacy rather than on other activities to strengthen the profession. Otherwise, obstetrician-gynecologist informants viewed internal opposition as absent or muted. A former President explained that while there might be discomfort among some ESOG members about the reform or about ESOG's public stance, they would not voice opposition explicitly or publicly due to loyalty to the profession. An informant who did acknowledge the existence of some ESOG member opposition to ESOG's focus on abortion law reform emphasized the organization's consistent public position in support of reform.

> Yes, ESOG has always been positive, I mean even if there are people who are opposed to [abortion reform …] probably they know that they are not many, or probably they don't want as a person to be included, but as an institution, it is okay. I don't know how they see it, but there has never been, or I have never witnessed, anybody who has raised his or her hand and said this is immoral, this is negative, this is … you know. I have never heard that in the meetings of ESOG that I have attended. *Interview 14*

At the same time, some of the same ESOG members stressed that ESOG was a professional association rather than an advocacy group with a specific policy platform. They also noted that ESOG did not have the clout of a trade union and the strength to pressure government or other organizations into changing their policies or behaviors. They emphasized ESOG's collaborative rather than adversarial relationship with government.

> This is just a professional society, it's not like a labor union whereby it imposes a new policy. But we closely cooperate and collaborate with the Ministry of Health in terms of formulating policies or act as resource person for whatever activities the Federal Ministry of Health undertakes. *Interview 33*

ESOG contributions to reform efforts

The ten ob-gyns interviewed, as well as other civil society actors, described ESOG as having made three chief contributions to reform: building a research base on the problem of maternal mortality due to unsafe abortion, conducting evidence-based public outreach to the public and policy makers, and describing (framing) the policy issue in the way that would appeal to the broadest number of supporters among the public and throughout government.

Development of a research base

Most centrally, ESOG leaders saw the development of a research base on maternal mortality and unsafe abortion in Ethiopia as key to saving lives and reforming the law, as well as to effective ESOG participation in public education. They typically began their discussion of the reform by pointing to several decades of Ethiopian research, much of it by individual ob-gyns, on the extent

and impacts of maternal mortality. Almost all the ob-gyns interviewed mentioned the combination of Ethiopia's high levels of maternal mortality plus research data on the phenomenon as important factors behind the reform and as a central part of ESOG involvement in reform. In talking about factors behind reform, most spoke functionally about how obstetrician-gynecologists and ESOG identified the problem and produced a body of research on it, and that this combination was key to reform.

> Synergy. It was quite obvious that there was a need to change, there was information on how we needed to change. This brought about modifications in the law. *Interview 22*

Evidence-based advocacy

The ob-gyns stressed the importance not only of the research, but also of how ESOG members and leadership shared these findings with policy makers and the elite public. They saw evidence-based advocacy, particularly around the incidence and impacts of maternal mortality due to unsafe abortion, as ESOG's characteristic strategy.

> The main thing is the evidence-based advocacy. The main thing there was this study by Seyoum Yoseph and his colleagues that has shown that women are dying. There was also this study by Barbara Kwast, a community-based study on maternal mortality. Yes, it showed a long time before, that abortion is really a killer in this country. *Interview 14*

A former ESOG president who testified in Parliament and on television was very clear on the appropriate way to discuss the issue:

> That is not the place for playing emotional stuff. You have to convince people with hard facts. The other side is playing with emotions. As long as I've known, we've based it on research. *Interview 22*

Other ob-gyns and civil society actors did not see this 'just the facts, ma'am' approach as fully explaining either how ESOG members operated or ESOG's credibility and weight. In both their interviews here and in their own public presentations, several ob-gyn interviewees shared their own experiences with caring for women dying of unsafe abortions, as well as research evidence. They rather felt that the sharing of both stories and research evidence were complementary strategies. One informant felt that ESOG was most persuasive not because of its command of statistics and research, but because it sent respected senior ob-gyns to share their experience, noting that the testimony of younger professionals would not have carried as much weight.

> Q: What arguments are most effective with people in government?
> A: You send a person who is very prominent. These are people who were very popular with the public, the Parliamentarians. They were very much respected. So I think that works more than the message that they passed on. (*laughter*) This is what I was saying, this is what they shared, the personal experience, instead of the field, this is the strongest things that they can do. You can just talk, from twenty-five years of experience… *Interview 15*

They were nuanced in explaining the synergy resulting from having an evidence base, credibility and the self-confidence to speak publicly on this controversial topic. Several viewed these factors as inextricably linked.

> That's what advocacy is. I mean how do you tell whether they were listening to the figures or whether they were listening to the person? How do you know whether that person would be able to talk like that devoid of evidence? You can stand up, head up, and talk when you are confident, when you have something to respond to, when you are well-equipped. That's when you are confident. *Interview 14*

Framing the debate and delivering the message

How abortion and legal reform are discussed can significantly influence how much support a proposed reform attracts. Framing is a tool used by political elites to depict a policy issue in order to shape political opinion and to gain support (Schattschneider, 1960; Stone, 1988). How the problem to be solved is defined not only shapes what support can be gained, but also can prevent certain avenues of attack. The predominant frame used by supporters of abortion law liberalization was one of public health and maternal mortality prevention, and ESOG led in articulating this perspective. This focus on preventing unnecessary deaths made it more difficult for opponents to object.

ESOG members were central to successfully framing abortion law reform as a critical public health response to the country's extraordinarily high rates of maternal mortality. Their frame and that of other health providers was grounded in their identity and professional experience as health professionals trying to save women's lives, as well as from their research on maternal mortality due to unsafe abortion. ESOG interviewees described their approach to explaining the need for reform of the law on abortion as grounded in a public health perspective, one of preventing maternal mortality.

> It was never about rights in Ethiopia. It was about preventable deaths and that women are not only [dying], but also suffering. That women and families have been going through illicit abortion. So that's, that's the whole issue. I mean, most hospital beds were occupied by septic abortions and women were dying right and left like flies. So I think that it is more of like from a medical-oriented perspective of preventing deaths, especially among teenagers and young women. *Interview 26*

They described the deaths of very young women, and the need to choose the lesser evil of losing one life rather than two. They started from a place where there could be no reasoned disagreement (avoidable deaths of young women and girls), and moved to discussion of the need for policy change to address the problem.

Women's advocates concurred with ESOG members' descriptions of how ESOG framed the rationale for legal reform. They saw ESOG as using a health and mortality prevention narrative, and women's organizations as voicing a rights-based narrative, albeit the most basic of women's rights: the right to life. As described earlier, they saw these narratives as complementary.

> Well, that is a difference, for example, in the role of ESOG and the Women Lawyers' Association. We approach it from a rights-based approach, you know, this is an entitlement, of the integrity, of women's right to life, and freedom of choice and so on. On the other hand, ESOG and other more health-oriented institutions, talk about, you know, the health risks and so on. *Interview 37* (Women's rights group leader)

This focus on averting needless maternal mortality was not only rooted in obstetrician-gynecologists' experience, it was also closer to the perspectives of most Ethiopians. ESOG's frame matched more closely to the traditional national context, but also aligned with the agendas of women's groups and the focus of government and party leaders who sought to ensure women's health as a necessary step toward advancing national development (Holcombe, 2014a).

The messenger also matters. Obstetrician-gynecologists in Ethiopia, as is the case globally, began with significant social capital due to their high levels of education, male gender and age, in addition to their specific expertise in reproductive health. Political leaders and the public were predisposed to be willing to hear from them.

REMOVAL OR RELAXATION OF CONSTRAINTS ON ESOG'S ENGAGEMENT IN POLICY

Ethiopia's conservative cultural context, especially with regard to abortion, only made conflict over abortion policy (either among members or with the public) more foreseeable, especially as ESOG leaders became increasingly visible during the reform process. Theories related to professional society behavior would predict that ESOG would avoid divisive issues and work to maintain organizational harmony, and would defend obstetrician-gynecologists authority and scope of practice vis-à-vis other health care professionals and patients. However, this is not what we see. Key organizational features as well as broader environmental factors helped shield ESOG from repercussions of its participation in reform. This section describes how ESOG faced fewer organizational constraints to participation in policy making than medical societies would be predicted to face. ESOG's newer and lean organizational structure, the receptiveness of government to reform and the high value other reform supporters placed on ESOG's contributions all facilitated ESOG's active role in reform.

ESOG's organizational structure/development

Several features of ESOG's organizational structure gave more latitude to its leadership to engage in policymaking than might otherwise have been expected. The Society was at an early stage of organizational development, one where it was highly motivated by mission, but relatively lacking in systems and resources (Aghion & Tirole, 1997; Bailey & Grochau, 1993; Kimberly & Miles, 1980; Quinn & Cameron, 1983; Walsh & Dewar, 1987; Whetten, 1987). While there were certainly management and governance systems in place, they remained relatively minimal and flexible, allowing volunteer leadership to pursue the policy goals in which they believed with fewer impediments. As ESOG's formal leadership worked on a volunteer basis, it tended to attract those motivated to work on topics and activities to which they were personally committed (Andrews, Ganz, Baggetta, Han, & Lim, 2010). ESOG's leaders during this period of reform included several who had been particularly active in research and training related to maternal mortality prevention, and who, as noted earlier, had been in the vanguard of the introduction of post-abortion care to

Ethiopia and the region. They were thus more accustomed to dealing with the negative societal views on abortion.

ESOG leadership also had further latitude because of how responsibility for work was allocated. At ESOG's annual meeting, the General Assembly of members typically delegated broad responsibility for project implementation during the following year to ESOG's President and Executive Board or, for example, to the sub-committee working on reform. This allowed those working on a particular project or policy reform to operate with substantial autonomy. The limited formal contact between leaders and membership also reduced potential obstacles for ESOG leaders' public contributions to reform. Members, unless they had official positions (e.g., were an officer or other Executive Committee member) or attended ESOG's one annual conference, might have little to no formal interaction with ESOG's leadership outside of the annual meeting.

Finally, ESOG's organizational youth also meant that it lacked a track record prescribing or proscribing particular types of activity. Otherwise, activities producing public controversy might well have been stopped before they started. Previous ESOG policy work had neither been on issues with the same potential for contention as abortion law, nor been in the context of broader public policy making processes such as that of comprehensive Penal Code reform. In the past, ESOG leaders and obstetrician-gynecologists had only contributed to Executive Branch creation of national policies on reproductive health. If ESOG had previously established an organizational position, for example, forbidding the organization to take a position on legal policy without a two-thirds majority vote in support by the membership at the annual meeting, this would have hampered ESOG advocacy. In contrast, leading up to the 1973 Roe v. Wade decision in the U.S., when both the American College of Obstetricians' and Gynecologists and the American Medical Association were crafting their organizational positions on state legal reform, they had already weathered several bouts of internal debate over previous policy positions which constrained how liberal a subsequent stance they could take (Aries, 2003; Halfmann, 2003). Given the absence of any precedent, ESOG leaders had more room to contribute actively and publicly to policymaking.

ESOG was also relatively free of pressure from funders, and from the U.S. in particular. It had few external sources of financial support up through 2006 (when the final Ministry of Health regulation on abortion was issued), making it less susceptible to donor demands (see Table 3 below). Significantly, ESOG had no direct U.S. government funding, and thus could ignore the U.S. government's Mexico City policy (known by opponents as the "Global Gag Rule") that barred non-U.S. organizations from receiving U.S. assistance if they provided abortion services or referrals or advocated for legal reform related to abortion.[29] Since 1982, the Mexico City policy has governed US foreign assistance during Republican administrations, and did so during the 2000-2008 period.

> There was the Gag Rule and so on at that time. Even ESOG didn't have, didn't get a lot of support in terms of projects at that time, because ESOG was considered as an institution which promotes abortion. At that time, we were having very much difficulty in getting

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[29] During the period of Penal Code reform, U.S. foreign assistance was governed by the Mexico City Policy (also known as the "Global Gag Rule"). This policy, and an Executive Order instituted in 1984 under President Reagan and in effect under all subsequent Republican administrations, prohibited the funding of any non-U.S. NGO that provides abortion services or engages in activities which could be construed as reform of national laws or policies on abortion, even if such activity were financed by other sources (Cohen, 2000; USAID, 1982). Further, it required all non-U.S. NGOs receiving U.S. support to sign a pledge attesting to their compliance with the policy.

projects and so on, research support. Because USAID and everybody considered it as an abortion organization. *Interview 12*

Table 2-3 ESOG's externally-funded projects and consultancies (1992-2012)

Period	Number of projects & consultancies	Number with US government funding
1992-1994	-	-
1994-1996	-	-
1996-1998	1	-
1998-2000	3	-
2000-2002	-	-
2002-2004	1	1 (indirectly)
2004-2006	-	-
2006-2008	10	2 (1 direct; 1 indirectly)
2008-2010	12	1 (direct)
2010-2012	14	1 (direct)

**Indirect US government assistance is channeled through a US international NGO {Gynecologists:vg}. Periods correspond to ESOG Presidencies; 2006 on is the post-reform.*

However, if ESOG had operated in a narrow, financially self-interested manner rather than pursuing its larger social mission, it would have avoided activities related to abortion. The U.S. Agency for International Development (USAID) is the largest donor in Ethiopia, particularly in the health and reproductive health sectors, and is also the donor most likely to channel support through national NGOs rather than only to the national government (Alemu, 2009). As the country's premier professional association in the reproductive health field, and with ob-gyns the primary medical trainers, ESOG was virtually assured of being able to get support from any donor in the field. By involving the organization in policy on abortion during the 2000-2008 period, ESOG's leaders knew they were forgoing potential U.S. government support.[30,31] Thus ESOG's policy work occurred despite U.S. government pressure.[32] Table 2-4 shows ESOG's external funding sources, revealing the absence of direct U.S. funding until after the reform.

[30] Ethiopia is notable for being one of the few countries where (two) NGOs chose to forgo U.S. funding because of the requirement to avoid any activities related to abortion – the Family Guidance Association of Ethiopia and Marie Stopes International, Ethiopia (Bogecho & Upreti, 2006).

[31] ESOG was in a position of forgoing funding it did not (yet) have but had the potential of getting, rather than actually giving up support they already possessed. Common sense and prospect theory suggest that the latter would have been a more difficult decision to make (Kahneman & Tversky, 1979; Samuelson & Zeckhauser, 1988).

[32] ESOG had also resisted external funder pressure in 1998. At the start of a project to prevent maternal mortality funded by the Swedish Society of Obstetrics and Gynecology (SSOG) through the International Federation of Obstetricians & Gynecologists (FIGO), ESOG rejected the project director selected by the Swedish Society of Obstetricians & Gynecologists (SSOG) and appointed its own.

Table 2-4 Overseas development assistance (ODA) as a proportion of Ethiopian government expenditures (2003-2006)

Year	ODA as a proportion of total government expenditures	Health aid as proportion of government health expenditures
2003	.63	.57
2004	.63	.67
2005	.60	.62
2006	.59	.70

Alamo, 2009, citing NBE Quarterly Bulletin, Third Quarter 2007/08, Vol. 23, No.3 (for public expenditure) and Moffed (External Economic Cooperation Section), various bulletins of external economic cooperation (for health aid).

ESOG's behavior also diverged from the predictions of theory in another way. ESOG devoted its resources to supporting national policymaking rather than to strengthening the profession and organization. ESOG did not add a focus on professional development until after completion of the Penal Code reform and its allied regulation in 2006. It was only with adoption of its 2011 strategic plan that ESOG diversified and expanded its funding sources and turned attention to obstetrician-gynecologist training and accreditation, membership development and organizational capacity building (ESOGs, 2010).

Ruling party receptiveness to reform

The government's receptiveness to reform also eased and encouraged ESOG participation. In particular, the ruling party's well-known ideological predisposition to improve women's status, its enactment of progressive policies that served as foundations for later reform and the opening for a time of a democratic space for civil society made ESOG's reform participation less risky. Senior government leaders would likely expect ESOG's participation as the pre-eminent medical practitioners in the field.

The government's progressive ideology and policy track record

Reforming the law on abortion was in keeping with the government policy orientation. Virtually all interviewees were quick to mention the importance of the government's openness to reform. Senior government leadership, especially from the Tigray People's Liberation Front (TPLF), the leading force in the governing Ethiopian People's Revolutionary Democratic Front (EPRDF), had a well-known track record of seeking to improve women's status and of being avowedly secular and insusceptible to traditional religious influences (EPRDF, 2006; Haustein & Ostebo, 2013). Women were as much as 30% of the TPLF's fighters, and the TPLF has seen improving women's status as a necessary step toward improving economic conditions for the rural majority (EPRDF, 2006; Veale, 2003b; Zenawi, 1992). Interviewees saw the TPLF's progressive ideology, its experience incorporating women into its armed forces, and its governing in rural regions where it was exposed to the second-class status of women as promising for further reforms related to women and reproductive health.

> The government has a good and strong position on promoting women's rights, starting right from the bush. There were many women soldiers involved in the fighting. *Interview 44*

Progressive legal antecedents

Both before and after it came to power, the government leadership had enacted policies to improve women's socio-economic status and wellbeing. During its 17 years of fighting while governing much of rural Tigray, the TPLF instituted policies to raise the minimum age of marriage, make dowry voluntary, confer equal right to divorce, increase women's access to education and ensure gender equity in land distribution, ownership and inheritance rights. The TPLF successfully carried out these reforms despite resistance from rural Ethiopian Orthodox Church and male traditional leaders (Berhe Gebrelibanos, 1999; Berhe, 2009; Hammond, 1990; Veale, 2003b).[33] After the 1991 overthrow of the previous regime, the new Civil Code of Tigray Region (1991) formalized these reforms, making it nearly as progressive as the (national) Federal Family Code of almost a decade later (Veale, 2003a).

Further, government leadership had come to power with an agenda to reform and update national policy, and continued instituting progressive policies related to women. The swift adoption of a progressive National Women's Policy (1993), a National Population Policy (1993) and particularly the new Constitution (1995) made it clear there would be a complete overhaul of the 1957 Penal Code, with an explicit eye for expanding the "democratic rights and freedoms" of women, as well as reducing the "grave injuries and sufferings caused to women and children by reason of harmful traditional practices" (FDRE, 1995; TGE, 1993). ESOG leaders and other reform supporters often started their explanation about the context for reform by referring to the Constitution and other national government policies.

> The Constitution was very specific on the importance of protecting and promoting women's rights, and against harmful traditional practices. With a favorable constitution, it is very likely that there would be reforms aligning policy with the Constitution. *Interview 22*

Although interviewees saw the TPLF's progressive ideology and track record as promising for reform of existing laws related to women, including abortion, they noted that high-level political leaders did not want to take action without public demonstration of support. The government saw it as the responsibility of civil society to educate the public and galvanize support. This approach to policy change grew from the ruling party's experience as an insurgency movement fostering social change in rural Tigray. They saw substantial and lasting social change as requiring public engagement, understanding and support (Ab Barnabas & Zwi, 1997; Berhe, 2009; Hammond, 1990; Segers et al., 2008). Both obstetrician-gynecologists and women's advocates emphasized the importance of senior government receptiveness, but noted that it did not guarantee reform.

> Ok, you bring it forward, he [the government] is not going to cook it and finish everything and give it to you. But you have to bring it up. You need initiators to take it up to the top of

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[33] The TPLF's commitment to improving women's status had immediate pragmatic as well as longer-term yields. Its early reforms furthering gender equality (education, later marriage) proved a strong recruiting device for rural girls and women – important as over a third of the TPLF fighters were women (Berhe Gebrelibanos, 1999; Berhe, 2004; Veale, 2003b; Young, 1994).

> the ladder, to make sure it'll be blessed by them. It's progressive, they have been for it, and they were for it and they encouraged the movement to take its course, they facilitated everything, took it up to the Parliament and had it passed through. Who else could do it for you, unless you have got a government that is very cooperative and progressive? *Interview 33*

Further, not all government leaders welcomed reform, and reform of the law on abortion was not high on the list of priorities even among those leaders who did support it (Arriola, 2008; Vaughan, 2011).

Broader space for civil society engagement

Finally, the country's democratic opening for civil society growth and participation prior to the 2005 crackdown, as well as the government's expectation that NGOs would contribute their expertise to policy, made ESOG participation easier. Assessing the evolution of the political system in Ethiopia, several advocates pointed to the more favorable environment for advocates, particularly as compared with the closed and unstable political context under the previous Communist Derg regime. During the Penal Code reform, the national government left open space for NGOs to present their experience, research and perspectives and to inform policymakers and the elite public.

> Yes, that period was a very good time for civil society, for blooming of civil society, for creation of new NGOs and everything. I think it was very conducive for bringing about new ideas and for supporting family planning and a lot of different issues. So in terms of environment, not in terms of the issue, it was more conducive than what we have now. Because it has a lot of space. *Interview 25* (Women's rights leader)

The Ethiopian government was generally wary of NGOs and their engagement in policy advocacy, viewing them as a potential threat to power. However, NGO participation and advocacy around the Penal Code reform was unlikely to result in surprises, as the government had formally organized and channeled NGO participation through the RHWG. It encompassed both government representatives (from the National Office of Population and the Family Health Department), as well as those from civil society (the Ethiopian Women Lawyers Association, ESOG, Ipas, the Family Guidance Association, and others). Given the responsiveness from government, the progressive policy foundations and the vehicle of the Penal Code reform, ESOG faced few barriers to publicly supporting this policy reform.

Reform supporters' consensus about the importance of ESOG's contributions

Health professionals generally viewed ESOG as an influential organization in the reproductive health sector, and obstetrician-gynecologists as near the top of the hierarchy of medical professionals in many countries (Creed, Searle, & Rogers, 2010; Khader et al., 2008; Rosoff & Leone, 1991). In 2000, ESOG's nationally representative survey of all categories of health professionals indicated that 82% believed that ESOG could influence policy change on abortion. They saw dissemination of ESOG's experience and research (21%) and the direct engagement of ESOG in policy development (26%) as the key ways that ESOG could encourage liberalization of the law (Lakew, Asres, Gebre, & Abdella, 2002).

ESOG's reform collaborators strongly valued ESOG participation and made sure they were

prominent if not lead speakers at public events. The consensus among other organizations supporting reform that ESOG and obstetrician-gynecologists were essential contributors to policy discussions – 'their absence would have been fatal' (Interview 6, *International NGO*) – further smoothed the way for ESOG participation. ESOG's involvement was also made easier by the fact that it was a lead member of the RHWG as well as of a broader network of reproductive health organizations supporting reform. While interviewees didn't necessarily point to ESOG as the most critical or proactive reform supporter, they unanimously attested to the high value of ESOG's participation.

> It's true. We want them [obstetrician-gynecologists] on the forefront because our people look up to them on these issues. And also, you know, one voice of an ob-gyn is worth a million of ours. And it was so important to make sure that we are working with them.
>
> *Interview 6* (NGO leader)

Several advocates mentioned how ESOG and its ob-gyn leadership were in many ways the best messengers for reform. Their status as highly educated and senior male doctors lent credibility to their views, particularly in the eyes of some more traditional representatives in Parliament and the regional governments. One women's rights advocate emphasized not only the complementarity of the strategies of women's advocates and those of ESOG, but also the special value of testimony from male obstetrician-gynecologists, particularly with more conservative people.

> What really complemented our story is the involvement of the obstetrician-gynecologists because they are mostly men. There are women, but the majority of them are men. It is not westernized women shouting and saying "you have to do this and this" on television and camera. It was these doctors, men, saying that on camera and in the meetings. […] So they brought the numbers; we brought the stories. Those complemented each other very well in Parliament, for dealing with religious groups and for other reluctant people.
>
> *Interview 25* (Women's rights group leader)

ESOG member involvement legitimized and detoxified public discussion of maternal mortality, including that due to unsafe abortion, as a policy problem. Their participation lent reform and reform supporters gravitas and stature.

The members of the RHWG regarded the visible presence of obstetrician-gynecologists in advocacy work as critical, and worked to structure opportunities for ESOG to contribute at pubic meetings and other events, reducing the amount of work ESOG had to put into advocacy efforts. However, not all viewed ESOG's role favorably. Their criticism was not that ESOG opposed or did not contribute to reform, but that it was not a proactive participant. Some felt they had to cajole ESOG leadership to act. There was one interviewee who felt ESOG was not a primary force in policy because the gap between what ESOG could have done and what it actually did do in support of reform was too large.

> I have my misgivings about ESOG, because I don't think they played their roles right or used their positions to influence policies. I am very reluctant to say that they have done quite a bit to push things along. There might be some individuals that, Dr. X or Dr. Y, for that matter, who when pushed had to present. But otherwise, I don't think that they were the galvanizing voice at all for that policy or for maternal health now.
>
> *Interview 38* (International NGO leader)

However, it is important to consider this critique in light of the absence or opposition to reform of medical societies in other countries, as well as of ESOG's role as a membership organization representing a profession rather than a policy or advocacy organization.

INCREASED CONSTRAINTS AFTER 2006 ON ESOG INVOLVEMENT IN PUBLIC POLICY

ESOG's very public involvement in controversial policymaking did generate internal tensions in the profession. Although it is beyond the scope of this paper to provide great detail, some of these growing constraints included increased internal member opposition to public participation in support of reform, a public attack on ESOG from other outside medical professionals for its support for reform and an allied shift in organizational focus to strengthening of the profession and of the society itself. Further, two large shifts in ESOG's external environment – the government's restrictions on civil society advocacy after 2005, and ESOG's substantial growth in reliance on foreign funding, including that from the U.S. – would have made such ESOG advocacy efforts almost prohibitively difficult.

Toward the end of the reform process, when the revised Penal Code was undergoing public review, the politics related to abortion assumed a level of intensity that ESOG had not previously encountered. As ESOG took an increasingly public role in reform, there were a number of incidents that revealed tensions among obstetrician-gynecologists and with other medical professionals. A former senior ESOG official wrote a piece critical of ESOG's reform participation in the *Ethiopian Medical Journal*, the publication of the country's largest medical association. Several ESOG leaders mentioned the professional embarrassment resulting from the publication of an anti-abortion tract in 2003 by an ob-gyn who highlighted his position as ESOG Secretary. Further, near the end of the reform process, reform opponents in the media did not treat ESOG leaders as dispassionate experts. An ESOG president gave a recorded interview that was subsequently tampered with to include inflammatory language and views; the interview was then aired on television. Finally, organized opposition to reform emerged among physicians. Christian physicians organized the public anti-abortion law reform demonstration. ESOG interviewees spoke about the importance of preserving professional unity. These events revealed difficult tensions among medical professionals and the lack of unified support for reform.

ESOG organizational changes would also diminish ESOG's ability to engage in controversial policymaking. In 2006 after the reform, ESOG's new President launched activities that would strengthen membership, the profession and the organization, and devoted energy to increasing and diversifying funding (Gaym, 2010; ESOG, 2010). Further, in contrast to the period of the Penal Code reform, ESOG currently has higher levels and more sources of external funding than it did in the past. ESOG today often acts as a conduit from outside donors.

> But otherwise, you know, the main focus of ESOG these days is, okay, there are lots of grants from all over the world so […] You can fund any program and run it through ESOG. So ESOG is just a kind of a facilitator or organizer of such undertakings. *Interview 33*

After reform, ESOG also began receiving direct financial support from the U.S. government. This is support that ESOG would have to forgo during any future U.S. Republican administrations if it wanted to carry out any policy work or training on abortion.

Finally, after 2005, the democratic opening in Ethiopia that made civil society advocacy possible disappeared. First, the government attitude and approach to NGOs became more forbidding. Second, the government set in motion a legal process (the Civil Society Organizations Law, eventually enacted in 2009) to bar NGOs receiving foreign funding from engaging in policy advocacy (FDRE, 2009).

CONCLUSIONS

This study documents the role of a medical society and obstetrician-gynecologists in supporting the 2005 reform of Ethiopia's Penal Code with respect to abortion, as well as their understanding of how their medical society contributed to policy making. It shows how, contrary to theoretical and empirical expectations, and even within the context of a policy area that is socially contentious, a medical society can contribute to policy adoption. Contrary to predictions of economically self-interested behavior by professional societies, in Ethiopia, the obstetrician-gynecologist society pursued a socially-oriented mission to reduce maternal mortality. ESOG, a medical professional society, took a public stance supporting abortion law liberalization and was one of the more prominent public voices on the topic in Ethiopia. Drawing on their own and others' research to highlight evidence of the problem and the need for change, ESOG communicated with policy makers and the informed public. They opened and helped legitimize public discussion of maternal mortality and unsafe abortion by framing it as an issue of saving lives. In their own view, as well as that of other reform supporters, the high social status of the well-educated and mostly male obstetrician-gynecologists, as well as how they talked about abortion, made them more palatable messengers on the sensitive issues of maternal mortality, unsafe abortion and legal reform, particularly for older and more traditional leaders.

Although this research cannot provide a definitive answer to why ESOG engaged in policy making and supported what amounts to a reduction in their clinical discretion and an erosion of their scope of practice vis-à-vis midwives and other providers, it offers some promising explanations. This study finds that an explicit medical society social mission focused on maternal mortality prevention combined with relaxed organizational and political constraints to participation that are often present in other contexts left a larger space for ESOG engagement. In particular, ESOG's young and lean organizational structure with few historical precedents to bar action and few funding constraints, a government receptive to progressive reform and to civil society contributions and the high value other advocates placed on ESOG contributions all facilitated or reduced the potential costs to ESOG of participating in controversial policymaking.

However, while we see here that a combination of constraints on ESOG participation in reform were relaxed, allowing them to make notable public policy contributions, this situation was not permanent. Almost immediately after reform, several constraints reappeared: the government ceased to welcome civil society policy engagement generally. In addition, ESOG turned its attention to institutional strengthening and fundraising, including from a donor (the U.S.) that didn't support organizations doing work related to abortion. If political space for policy-making on controversial reproductive health policy issues arose again, ESOG would still likely contribute if invited by the

government. However, it would be more likely to participate in instances where their public visibility could be low, such as on executive branch policy-making efforts. Given its experience during Penal Code reform, ESOG will be more cautious in participating in highly public and visible reform processes that are socially controversial. In the end, this case does not lead us to revise or reject existing theories about the conditions deterring medical associations from participating in controversial reforms. Nonetheless, there does appear to be more latitude for newly formed medical societies such as ESOG to contribute in reform, as they may not confront the constraints faced by more established medical societies. Accordingly, motivated leaders can potentially take advantage of windows of opportunity for involving their organizations in efforts to devise policies benefiting the nation as a whole, rather than the more narrow material and other interests of the profession. Further comparative analysis could help assess whether ob-gyn societies in Sub-Saharan Africa, with their relatively tighter ties to government and often regular contributions to national administrative policy-making and training in reproductive health, are likely to be more ready to contribute to reform than is the case in other regions.

Ethiopia has features common to other countries in Sub-Saharan Africa: elevated levels of maternal mortality including that due to unsafe abortion, weak health infrastructure, small numbers and chronic shortages of ob-gyns and young ob-gyn societies. Thus by examining the ob-gyn society's contributions to reform in Ethiopia, this research can help advance understanding of the circumstances in which professional medical societies in the region can step forward in support of socially contentious yet life-saving policy reforms. One might argue that the small number of ob-gyns in Ethiopia, the stigmatized nature of abortion care and the lack of a threat to their income explain obstetrician-gynecologist willingness to cede professional responsibilities to other categories of providers. However, this is not the pattern that has been observed historically in Sub-Saharan Africa and in other settings with similar conditions. ESOG's active and successful engagement in reform suggests that even with contentious policies, medical societies can be politically relevant in part due to their scientific credibility and technical expertise (Keller, 2009). Taking advantage of political openings, and collaborating with civil society partners that value the contributions of ob-gyns and ob-gyn societies can also increase the possibilities of ob-gyn participation in reform.

REFERENCES

1. Ab Barnabas, G., & Zwi, A. (1997). Health policy development in wartime: establishing the Baito health system in Tigray, Ethiopia. *Health Policy and Planning*, *12*(1), 38–49.
2. Abbink, J. (2006). Discomfiture of democracy? The 2005 election crisis in Ethiopia and its aftermath. *African Affairs,* 105(419), 173–199. doi:10.1093/afraf/adi122
3. Abdella, A. (2010). Maternal mortality trend in Ethiopia. *Ethiopian Journal of Health Development*, 24(Special Issue 1), 115–122.
4. Abdella, A., Fetters, T., Benson, J., Pearson, E., Gebrehiwot, Y., Andersen, K., et al. (2013). Meeting the need for safe abortion care in Ethiopia: Results of a national assessment in 2008. *Global Public Health,* 8(4), 417–434. doi:10.1080/17441692.2013.778310
5. Abdi, J. (2008, June). *Assessment of health providers' perception and preparedness of health facilities towards safe abortion at selected health facilities in Addis Ababa* (unpublished master's thesis). Addis Ababa University School of Public Health, Addis Ababa, Ethiopia.
6. Aghion, P., & Tirole, J. (1997). Formal and Real Authority in Organizations. *Journal of Political Economy*, *105*(1), 1–29. doi:10.2307/2138869?ref=search-gateway:629131bb160235fc3c4edc2bec8f3955
7. Alemu, G. (2009). A case study on aid effectiveness in Ethiopia. *Analysis of the Health Sector Aid Architecture, the Brookings Global Economy and Development*. Alemu, G. (2009). *A case study on aid effectiveness in Ethiopia: analysis of the health sector aid architecture*. Wolfensohn Center for Development at the Brookings Institution, Brookings Global Economy and Development working paper 9(p. 46). Washington, D.C..
8. Althaus, F. A. (2000). Work in progress: the expansion of access to abortion services in South Africa following legalization. International Family Planning Perspectives, 84–86.
9. Andrews, K. T., Ganz, M., Baggetta, M., Han, H., & Lim, C. (2010). Leadership, Membership, and Voice: Civic Associations That Work. *American Journal of Sociology*, *115*(4), 1191–1242.
10. Aries, N. (2003). The American College of Obstetricians and Gynecologists and the evolution of abortion policy, 1951-1973: the politics of science. *American Journal of Public Health*, *93*(11), 1810–1819.
11. Arriola, L. R. (2008). Ethnicity, Economic Conditions, and Opposition Support: Evidence from Ethiopia's 2005 Elections. *Northeast African Studies*, *10*(1), 115–144.
12. Bailey, D., & Grochau, K. E. (1993). Aligning Leadership Needs to the Organizational Stage of Development:. *Administration in Social Work*, *17*(1), 23–45. doi:10.1300/J147v17n01_03
13. Bandewar, S. (2001). Abortion Legislation and Access to Safe Abortion Care Services: The Indian Experience. In B. Klugman & D. Budlender, *Advocating for Abortion Access: Eleven Country Studies, The Johannesburg Initiative* (pp. 135–156). The Women's Health Project School of Public Health University of the Witwatersrand Press: Johannesberg, South Africa.
14. World Bank. (2004). *Ethiopia A Country Status Report on Health and Poverty* (No. 28) (pp. 1–248). The World Bank: Washington, D.C.
15. Benson, J., Andersen, K., & Samandari, G. (2011). Reductions in abortion-related mortality following policy reform: evidence from Romania, South Africa and Bangladesh. *Reproductive Health,* 8(1), 39. doi:10.1186/1742-4755-8-39
16. Berhan, Y., & Abdela, A. (2004). Emergency obstetric performance with emphasis on operative delivery outcomes Does it reflect on the quality of care? *Ethiopian Journal of Health Development*, 18(2), 96–106.

17. Berhe Gebrelibanos, T. (1999). *The Tigrean Women in the Liberation Struggle and its Aftermath, 1975-1996* (p. 72). Addis Ababa: OSSREA.
18. Berhe, A. (2004). The Origins of the Tigray People's Liberation Front. *African Affairs*, *103*(413), 569–592. doi:10.1093/afraf/adh024
19. Berhe, A. (2009). *A Political History of the Tigray People's Liberation Front (1975-1991): Revolt, Ideology, and Mobilisation in Ethiopia*. Tsehai Pub and Distributors: Los Angeles,
20. Berman, H. J. (1946). Soviet Family Law in the Light of Russian History and Marxist Theory. *Yale LJ*.
21. Berry, J. M. (2002). Validity and Reliability Issues in Elite Interviewing. *PS: Political Science and Politics*, *35*(4), 679–682. doi:10.2307/1554809?ref=search-gateway:eb20e69c07715cb31a5c561962deb45b
22. Blanchard, K., Fonn, S., & Xaba, M. (2003). Abortion law in South Africa: Passage of a progressive law and challenges for implementation. *Gaceta Medica De Mexico,* 138(1), S109–S114.
23. Bogecho, D., & Upreti, M. (2006). The Global Gag Rule: An Antithesis to the Rights-Based Approach to Health. *Health and Human Rights*, *9*(1), 17. doi:10.2307/4065387
24. Boland, R., & Katzive, L. (2008). Developments in laws on induced abortion: 1998-2007. *International Family Planning Perspectives*, 34(3), 110–120.
25. Briozzo, L. (2013). La despenalización del aborto como estrategia hacia una práctica segura, accesible e infrecuente. *Revista Médica Del Uruguay*, *29*(2), 114–117.
26. Briozzo, L., & Faúndes, A. (2008). The medical profession and the defense and promotion of sexual and reproductive rights. *International Journal of Gynecology and Obstetrics*, *100*(3), 291–294. doi:10.1016/j.ijgo.2007.09.015
27. Cain, J. M. (2000). A global overview of ethical issues in women's health. *International Journal of Gynecology and Obstetrics*, *70*(2000), 165–172.
28. Center for Reproductive Rights. (n.d.). The World's Abortion Laws, 2014 (p. 1). New York: Center for Reproductive Rights. Retrieved from http://worldabortionlaws.com/map/
29. Central Statistical Agency. (2012). Ethiopia Demographic and Health Survey, 2011 (p. 452). Addis Ababa, Ethiopia amd Ca;verton, Maryland, USA: CSA, Ethiopia and ICF International, USA.
30. Chamberlain, J., McDonagh, R., Lalonde, A., & Arulkumaran, S. (2003). The role of professional associations in reducing maternal mortality worldwide. *International Journal of Gynecology and Obstetrics*, *83*(1), 94–102. doi:10.1016/S0020-7292(03)00185-1
31. Clapham, C. (2009). Post-war Ethiopia: The Trajectories of Crisis. Review of African Political Economy, 36(120), 181–192. doi:10.1080/03056240903064953
32. Cohen, S. A. (2000). Abortion Politics and U.S. Population Aid: Coping with a Complex New Law. *International Family Planning Perspectives*, *26*(3), 137–139+145. doi:10.2307/2648303?ref=search-gateway:f30e6e4311982bdc2aa670feb440cb56
33. Conde-Agudelo, A. (2000). Maternal morbidity and mortality associated with interpregnancy interval: cross sectional study. *British Medical Journal, 321*(7271), 1255–1259. doi:10.1136/bmj.321.7271.1255
34. Contreras, X., van Dijk, M. G., Sanchez, T., & Smith, P. S. (2011). Experiences and Opinions of Health-Care Professionals Regarding Legal Abortion in Mexico City: A Qualitative Study. *Studies in Family Planning*, 42(3), 183–190. doi:10.1111/j.1728-4465.2011.00280.x
35. Cook, R. J. (2000). Developments in Abortion Laws: Comparative and International Perspectives. *Annals of the New York Academy of Sciences,* 913(1), 74–87.

36. Cook, R. J., & Dickens, B. M. (1981). Abortion Laws in African Commonwealth Countries. *Journal of African Law*, 25(02), 60–79. doi:10.1017/S0021855300012559
37. Cook, R. J., & Dickens, B. M. (1981). Abortion Laws in African Commonwealth Countries. *Journal of African Law*, *25*(02), 60–79. doi:10.1017/S0021855300012559
38. Cook, R. J., & Dickens, B. M. (1988). International developments in abortion laws: 1977-88. *American Journal of Public Health*, 78(10), 1305–1311.
39. Cook, R. J., Dickens, B. M., & Bliss, L. E. (1999). International Developments in Abortion Law from 1988 to 1998. *American Journal of Public Health*, 89(4), 579–586.
40. Creed, P. A., Searle, J., & Rogers, M. E. (2010). Medical specialty prestige and lifestyle preferences for medical students. *Social Science & Medicine*, *71*(6), 1084–1088. doi:10.1016/j.socscimed.2010.06.027
41. David, H. P. (1974). Abortion and family planning in the Soviet Union: public policies and private behaviour. *Journal of Biosocial Science*, 6(4), 417–426.
42. de Gil, M. P. (2014). Contribution of the Central American and Caribbean obstetrics and gynecology societies to the prevention of unsafe abortion in the region. *International Journal of Gynecology and Obstetrics*.
43. de Waal, A. (2013). Review Article: The theory and practice of Meles Zenawi. African Affairs, 112(446), 148–155. doi:10.1093/afraf/ads081
44. De Zordo, S., & Mishtal, J. Z. (2011). Physicians and Abortion: Provision, Political Participation and Conflicts on the Ground - the Cases of Brazil and Poland. *Women's Health Issues*, *21*(S), S32–S36. doi:10.1016/j.whi.2011.01.006
45. Dejene, T. (2001, February). Women in Ethiopia. *German Ethiopian Association Informationsblatter*, pp. 36. Germany.
46. Dexter, L. A. (1970). *Elite and specialized interviewing*. Northwestern University Press.
47. Dixon-Mueller, R. (1995). Abortion Policy and Women's Health in Developing Countries. *International Journal of Health Services*, 20(2), 297–314. doi:10.2190/V08N-UE7N-TNBH-RA4P
48. Duran-Arenas, L., & Kennedy, M. (1991). The constitution of physicians' power: a theoretical framework for comparative analysis. *Social Science & Medicine*, *32*(6), 643–648.
49. Empire of Ethiopia. (2005). Proclamation No. 158/1957 (1957). Penal Code.
50. Engeli, I., Green-Pedersen, C., & Larsen, L. T. (2012). *Morality Politics in Western Europe*. Palgrave Macmillan.
51. EPRDF. *A Weekly Message No 3: We fight Fundamentalism due to its challenge against Peace and Democracy* (pp. 1–4). Addis Ababa: Ethiopian Peoples Revolutionary Democratic Front. Retrieved from http://www.eprdf.org.et/c/document_library/get_file?uuid=b4aafda9-e4f8-49b7-a397-2eeb5c310edd&groupId=10136
52. EPRDF. *EPRDF Program* (pp. 1–66). Addis Ababa, Ethiopia: Ethiopian People's Democratic Revolutionary Front.
53. Ethiopian Society of Obstetricians & Gynecologists. (1999). *Recommendations of the Seventh Annual Conference*, Based on the panel discussion: "Illegal and unsafe abortion in Ethiopia" (p. 2). Presented at the seventh annual conference of ESOG, Addis Ababa. Retrieved from http://www.esog.org.et/Recommendations%20of%20the%20seventh%20annual%20conference.htm
54. -----. (2002a). *A Data Base on Abortion Literature Review* (pp. 1–8).
55. -----. (2002b). *Survey of Unsafe Abortion in Selected Health Facilities in Ethiopia* (pp. 1–4). Addis Ababa: Ethiopian Society of Obstetricians and Gynecologists. Retrieved from http://www.esog.org.et/Survey%20of%20unsafe%20abortion.htm
56. -----. (2012). *Constitution of the Ethiopian Society of Obstetricians and Gynecologists* (pp. 1–3). Addis Ababa: Ethiopian Society of Obstetricians and Gynecologists.

57. -----. (2014). *ESOG Projects* (p. 10). Retrieved from website 6/10/14: http://www.esog.org.et/Projects.htm
58. -----. (2010). *Strategic Plan (2011-2016)* (pp. 1–19).
59. -----. (2012). *Members*. Retrieved October 23, 2012, from http://www.esog.org.et/members.htm
60. Faúndes, A., Duarte, G. A., & Osis, M. J. D. (2013). Conscientious objection or fear of social stigma and unawareness of ethical obligations. *International Journal of Gynecology and Obstetrics*, *123*, S57–S59. doi:10.1016/S0020-7292(13)60003-X
61. Faúndes, A., Duarte, G. A., Neto, J. A., & de Sousa, M. H. (2004). The Closer You Are, the Better You Understand: The Reaction of Brazilian Obstetrician–Gynaecologists to Unwanted Pregnancy. *Rhm*, *12*(24), 47–56.
62. Federal Democratic Republic of Ethiopia. (1995). *Constitution of the Federal Democratic Republic of Ethiopia (1995).* Addis Ababa, Ethiopia. Retrieved from http://www.unhcr.org/refworld/docid/3ae6b5a84.html
63. -----.(2009). Charities and Societies Proclamation 621/2009, 25 Federal Negarit Gazeta of the Federal Democratic Republic of Ethiopia 4521–4566 (2009).
64. -----. (2005). *The Criminal Code of the Federal Democratic Republic of Ethiopia, 2004 (2005).* Addis Ababa.
65. -----, Ministry of Finance and Development. (2012). *Assessing Progress toward the Millenium Development Goals*. Addis Ababa.
66. -----. Ministry of Health & WHO. (1999). *Expanding Options in Reproductive Health: Research on the Introduction and Transfer of Technologies for Fertility Regulation.* (No. WHO/RHR/HRP/ITT/99.1) (p. 68). World Health Organization: Geneva.
67. -----, Ministry of Health, Family Health Department. (2006). *Technical and Procedural Guidelines for Safe Abortion Services in Ethiopia*. 26 pp. Addis Ababa, Ethiopia.
68. -----, Ministry of Health. (2009). *Health Sector Development Programme IV, Annual Performance Report* (1st ed., pp. 1–108). Addis Ababa.
69. -----, Ministy of Health. (2010). *Health and Health Related Indicators 2002 (2010 G.C.)* (pp. 84). Addis Ababa, Ethiopia.
70. -----, Ministy of Health. (2011). *Health and Health Related Indicators 2003 (2011 G.C.)* (pp. 1–43). Addis Ababa, Ethiopia.
71. -----. Ministry of Health. (2012). *Maternal Death Surveillance and Response (MDSR) Technical Guideline.* (p. 64). Addis Ababa: FDRE.
72. -----, The Women's Affairs Office, and the World Bank. (1998). *Implementing the Ethiopian National Policy for Women*. World Bank Publications: Washington, DC.
73. Ferede Alemu, F. (2010). *Minors' Awareness About The New Abortion Law And Access To Safe Abortion Services In Ethiopia: The Case of Marie Stopes International Ethiopia Centers in Addis Ababa.* (Unpublished master's thesis). University of Amsterdam, Medical Anthropology. Amsterdam, Netherlands.
74. FIGO. (2014). *Saving Mothers & Babies: the role of professional associations*. FIGO. Italy.
75. Fiol, V., Briozzo, L., Labandera, A., Recchi, V., & Piñeyro, M. (2012). Improving care of women at risk of unsafe abortion: implementing a risk-reduction model at the Uruguayan-Brazilian border. *International Journal of Gynaecology and Obstetrics*, *118*, S21–S27.
76. Fjerstad, M. (2012, November 29). PERSPECTIVES: 'It was worth the sacrifice': Kenya's Dr. John Nyamu on why he spent a year in prison. *Medical Abortion Matters*, 1–3. Retrieved from http://www.ipas.org/~/media/Files/Ipas%20Publications/MAMattersNov2012.ashx
77. Frejka, T. (1985). Induced abortion and fertility. *International Family Planning Perspectives*.

78. French, J. R. P. J., & Raven, B. (1959). The bases of social power. In D. Cartwright, *Studies in Social Power* (7 ed., pp. 150–167). University of Michigan.
79. Frenk, J., & Donabedian, A. (1987). State intervention in medical care: types, trends and variables. *Health Policy and Planning*, *2*(1), 17–31.
80. Gasman, N., Blandon, M. M., & Crane, B. B. (2006). Abortion, social inequity, and women's health: Obstetrician-gynecologists as agents of change. *International Journal of Gynecology and Obstetrics*, *94*(3), 310–316. doi:10.1016/j.ijgo.2006.04.018
81. Gaym, A. (2010). The Ethiopian Society of Obstetricians and Gynecologists (ESOG) And The Quest for Optimal Sexual and Reproductive Health in Ethiopia. *Ethiopian Journal of Reproductive Health*, 1(1), 1–21.
82. Gebreselassie, H., Fetters, T., Singh, S., Abdella, A., Gebrehiwot, Y., Tesfaye, S., et al. (2010). Caring for women with abortion complications in Ethiopia: national estimates and future implications. *International Perspectives on Sexual and Reproductive Health*, *36*(1), 6–15.
83. German Ethiopian Association. (2002). Health. *German Ethiopian Association Informationsblatter*. Germany.
84. Grindle, M. S., & Thomas, J. W. (1989). Policy makers, policy choices, and policy outcomes: The political economy of reform in developing countries. *Policy Sciences*, *22*(3-4), 213–248. doi:10.1007/BF00136320
85. Gusfield, J. (1981). *The Culture of Public Problems*. Chicago: University of Chicago Press.
86. Halfmann, D. (2003). Historical Priorities and the Responses of Doctors' Association to Abortion Reform Proposals in Britain and the United States 1960-1973. *Social Problems*, *50*(4), 567.
87. Hammarstedt, M., Jacobsson, L., Wulff, M., & Lalos, A. (2005). Views of midwives and gynecologists on legal abortion–a population-based study. *Acta Obstetricia Et Gynecologica Scandinavica*, *84*(1), 58–64.
88. Hammarstedt, M., Lalos, A., & Wulff, M. (2006). A population-based study of Swedish gynecologists' experiences of working in abortion care. *Acta Obstetricia Et Gynecologica Scandinavica*, *85*(2), 229–235. doi:10.1080/00016340500409976
89. Hammond, J. (1990). "My revolution is like honey": Women in revolutionary Tigray. *Women: a Cultural Review*, *1*(1), 56–59. doi:10.1080/09574049008578021
90. Harrison, A., Montgomery, E. T., Lurie, M., & Wilkinson, D. (2000). Barriers to implementing South Africa's termination of pregnancy act in rural KwaZulu/Natal. *Health Policy and Planning*, 15(4), 424–431.
91. Harrison, S., & Pollitt, C. (1994). *Controlling Health Professionals*. Open University Press.
92. Haug, M. R. (1976). The erosion of professional authority: A cross-cultural inquiry in the case of the physician. *The Milbank Memorial Fund Quarterly. Health and Society*, 83–106.
93. Haustein, J., & Ostebo, T. (2013). EPRDF's Revolutionary Democracy and Religious Plurality: Islam and Christianity in post-Derg Ethiopia. In J. Abbink & T. Hagmann, *Reconfiguring Ethiopia: The Politics of Authoritarian Reform*. Routledge: London.
94. Health. (2002, August - February). Health. *German Ethiopian Association Informationsblatter*, pp. 33. Germany.
95. Hessini, L. (2005). Global Progress in Abortion Advocacy and Policy: An Assessment of the Decade since ICPD. *Reproductive Health Matters*, 13(25), 88–100. doi:10.2307/3776232?ref=search-gateway:864f70f63fcb748d7b718c1a69cc3be7
96. Hessini, L., Brookman-Amissah, E., & Crane, B. B. (2006). Global Policy Change and Women's Access to safe abortion. *African Journal of Reproductive Health*, 10(3), 14–27. doi:10.4314/ajrh.v10i3.7896

97. Hirve, S. S. (2004). Abortion law, policy and services in India: a critical review. *Reproductive Health Matters*, *12*(24 Supplement), 114–121.
98. Hogan, M. C., Foreman, K. J., Naghavi, M., Ahn, S. Y., Wang, M., Makela, S. M., et al. (2010). Maternal mortality for 181 countries, 1980–2008: a systematic analysis of Development Goal 5. *The Lancet*, 375(9726), 1609–1623. doi:10.1016/S0140-6736(10)60518-1progress towards Millennium
99. Jesani, A., & Iyer, A. (1993). Women and abortion. *Economic and Political Weekly*, 2591–2594.
100. Joffe, C. (1999). Reactions to medical abortion among providers of surgical abortion: an early snapshot. *Family Planning Perspectives*, *31*(1), 35–38.
101. Joffe, C. E., Weitz, T. A., & Stacey, C. L. (2004). Uneasy allies: pro-choice physicians, feminist health activists and the struggle for abortion rights. Sociology of Health & Illness, 26(6), 775–796.
102. Kahneman, D., & Tversky, A. (1979). Prospect theory: An analysis of decision under risk. *Econometrica: Journal of the Econometric Society*.
103. Keller, A. C. (2009). *Science in environmental policy: the politics of objective advice.* Cambridge, MA: The MIT Press.
104. Khader, Y., Al-Zoubi, D., Amarin, Z., Alkafagei, A., Khasawneh, M., Burgan, S., et al. (2008). Factors affecting medical students in formulating their specialty preferences in Jordan. *BMC Medical Education*, *8*(1), 32. doi:10.1186/1472-6920-8-32
105. Kimberly, J. R., & Miles, R. H. (Eds.). (1980). *The organizational life cycle*. Jossey-Bass Inc.: San Francisco.
106. Kulczycki, A. (1999). *The Abortion Debate in the World Arena*. New York: Routledge.
107. Kwast, B. E., & LIFF, J. M. (1988). Factors associated with maternal mortality in Addis Ababa, Ethiopia. *International Journal of Epidemiology,* 17(1), 115–121.
108. Lakew, Z., Asres, Y., Gebre, F., & Abdella, A. (2002). *KAP Study On Abortion Among Ethiopian Health Workers* (p. 42). Addis Ababa: Ethiopian Society of Obstetricians & Gynecologists.
109. Lenin, V. I. (1977). The Working Class and NeoMalthusianism. . In G. Hanna, *Lenin Collected Works* (Vol. 19, pp. 235–237). Moscow: Progress Publishers.
110. Lilleker, D. G. (2003). Interviewing the Political Elite: Navigating a Potential Minefield. *Politics*, *23*(3), 207–214. doi:10.1111/1467-9256.00198
111. Lindstrom, D. P., & Berhanu, B. (1999). The impact of war, famine, and economic decline on marital fertility in Ethiopia. *Demography*, 36(2), 247–261.
112. Lindstrom, D. P., & Woubalem, Z. (2000). The demographic components of fertility decline in Addis Ababa, Ethiopia: a decomposition analysis. *Genus*, *59*(3/4), 147–158.
113. Lindström, M., Jacobsson, L., Wulff, M., & Lalos, A. (2007). Midwives' experiences of encountering women seeking an abortion. *Journal of Psychosomatic Obstetrics & Gynecology*, *28*(4), 231–237. doi:10.1080/01674820701343505
114. Lindström, M., Wulff, M., Dahlgren, L., & Lalos, A. (2011). Experiences of working with induced abortion: focus group discussions with gynaecologists and midwives/nurses. *Scandinavian Journal of Caring Sciences*, *25*(3), 542–548. doi:10.1111/j.1471-6712.2010.00862.x
115. Marmor, T. R. (1970). *The Politics of Medicare*. Transaction Publishers.
116. Marmor, T. R., & Thomas, D. (2009). Doctors, Politics and Pay Disputes: "Pressure Group Politics" Revisited. *British Journal of Political Science*, *2*(04), 421–442. doi:10.1017/S0007123400008796

117. Masho, S. W. (1997, Autumn). *Cost analysis and attitudinal study of abortion among health workers and women admitted to hospitals in Addis Ababa, Ethiopia* (unpublished dissertation). University of California, Berkeley: Berkeley, CA.
118. Mavalankar, D. V., & Rosenfield, A. (2005). Maternal mortality in resource-poor settings: policy barriers to care. *Journal Information*, *95*(2).
119. Mbugua, F. (2004). Murder charge for abortion doctor divides medical profession in Kenya. *British Medical Bulletin*, p. 6.
120. McKay, H. E., Rogo, K. O., & Dixon, D. B. (2001). FIGO society survey: acceptance and use of new ethical guidelines regarding induced abortion for non-medical reasons. *International Journal of Gynecology and Obstetrics*, *75*(3), 327–336.
121. Mgbako, C., Ali, T., Ashley, D., Igboeli, N., Degol, A., Gintamo, F., & Tesfaye, M. (2010). *Exporting Confusion.* Walter Leitner International Human Rights Clinic: New York.
122. Mhlanga, R. E. (2003). Abortion: developments and impact in South Africa. *British Medical Bulletin,* 67(1), 115–126. doi:10.1093/bmb/ldg006
123. Mohr, J. C. (1979). *Abortion in America: The Origins and Evolution of National Policy*. Oxford University Press.
124. Otsea, K., Benson, J., Alemayehu, T., Pearson, E., & Healy, J. (2011). Testing the Safe Abortion Care model in Ethiopia to monitor service availability, use, and quality. *International Journal of Gynecology and Obstetrics*, 115(3), 316–321. doi:10.1016/j.ijgo.2011.09.003
125. Oye-Adeniran, B. A., Long, C. M., & Adewole, I. F. (2004). Advocacy for Reform of the Abortion Law in Nigeria. *Reproductive Health Matters*, *12*(24), 209–217. doi:10.1016/S0968-8080(04)24025-3
126. Parsons, T. (1939). The professions and social structure. *Social Forces*, *17*(4), 457–467.
127. Parsons, T. (1951). Social Structure and Dynamic Process: The Case of Modern Medical Practice. In *The Social System* (pp. 429–479). The Free Press: New York.
128. Parsons, T. (1975). The sick role and the role of the physician reconsidered. *The Milbank Memorial Fund Quarterly. Health and Society*, 257–278.
129. Peterson, M. A. (2001). From trust to political power: interest groups, public choice, and health care. *Journal of Health Politics, Policy and Law*, *26*(5), 1145–1163.
130. Potts, M. (1967). Legal abortion in Eastern Europe. *The Eugenics Review,* 59(4), 232.
131. Quinn, R. E., & Cameron, K. (1983). Organizational Life Cycles and Shifting Criteria of Effectiveness: Some Preliminary Evidence. *Management Science*, *29*(1), 33–51. doi:10.1287/mnsc.29.1.33
132. Rahman, A., Katzive, L., & Henshaw, S. K. (1998). A Global Review of Laws on Induced Abortion, 1985-1997. *International Family Planning Perspectives,* 24(2), 56–64.
133. Raven, B. H., & French, J., Jr. (1958). Legitimate power coercive power, and observability in social influence. *Sociometry*.
134. Reagan, L. J. (1996). *When Abortion Was a Crime*. Univ of California Press.
135. Researchware. (2013). HyperRESEARCH 3.5.2. Randolph, MA: ResearchWare Inc. Retrieved from http://www.researchware.com/
136. Rosoff, S. M., & Leone, M. C. (1991). The public prestige of medical specialties: Overviews and undercurrents. *Social Science & Medicine*, *32*(3), 321–326. doi:10.1016/0277-9536(91)90110-X
137. Samuelson, W., & Zeckhauser, R. (1988). Status quo bias in decision-making. *Journal of Risk and Uncertainty*, *1*(1), 7–59. doi:10.1007/BF00055564
138. Satiani, B., Williams, T., Landon, M., Ellison, C. G., & Gabbe, S. (2011). A critical deficit of obgyn surgeons in the US by 2030. *Surgical Science*, *2*(2), 95–101.

139. Savage, M. (1988). The Law of Abortion in the Union of Soviet Socialist Republics and the People"s Republic of China: Women"s Rights in Two Socialist Countries. Stanford Law Review, 40(4), 1027–1117. doi:10.2307/1228777?ref=search-gateway:15fa53fc3acc4226e0dbdd7faf4d724b
140. Schattschneider, E. E. (1960). *The Semi-Sovereign People. A Realist's View of Democracy in America*.
141. Schenker, J. G., & Cain, J. M. (1999). FIGO Committee Report. FIGO Committee for the Ethical Aspects of Human Reproduction and Women's Health. International Federation of Gynecology and Obstetrics. *International Journal of Gynaecology and Obstetrics*, *64*(3), 317.
142. Segers, K., Dessein, J., Hagberg, S., Develtere, P., Haile, M., & Deckers, J. (2008). Be like bees - the politics of mobilizing farmers for development in Tigray, Ethiopia. *African Affairs*, *108*(430), 91–109. doi:10.1093/afraf/adn067
143. Serour, G. I. (2006). Ethical guidelines on conscientious objection: FIGO Committee for the Ethical Aspects of Human Reproduction and Women's Health. *International Journal of Gynecology and Obstetrics*, *92*, 333–334.
144. Shaw, D., & Faúndes, A. (2006). What is the relevance of women's sexual and reproductive rights to the practising obstetrician/gynaecologist? *Best Practice & Research Clinical Obstetrics & Gynaecology*, *20*(3), 299–309. doi:10.1016/j.bpobgyn.2006.01.013
145. Sheth, S. S. (2003). Reproductive Health and Obstetricians and Gynecologists. *Annals of the New York Academy of Sciences*, 997(1), 1–10. doi:10.1196/annals.1290.002
146. Sibanda, A., Woubalem, Z., Hogan, D. P., & Lindstrom, D. P. (2003). The Proximate Determinants of the Decline to Below-replacement Fertility in Addis Ababa, Ethiopia. *Studies in Family Planning*, 34(1), 1–7.
147. Singh, S., Fetters, T., Gebreselassie, H., Abdella, A., Gebrehiwot, Y., Kumbi, S., & Audam, S. (2010). The estimated incidence of induced abortion in Ethiopia, 2008. *International Perspectives on Sexual and Reproductive Health*, 36(1), 16–25.
148. Smelser, N. J., & Reed, J. S. (2012). Groups, Teams, Networks, Trust and Social Capital. In *Usable Social Science* (pp. 121–150). University of California Press: Berkeley, CA.
149. Sox, H. C., Blank, L., Cohen, J., Kimball, H., Smelser, N., Copeland, R., et al. (2002). Medical professionalism in the new millennium: a physician charter. *Annals of Internal Medicine*, *136*(3), 243–246.
150. Starr, P. (1982). *The Social Transformation of American Medicine*. Basic Books.
151. Starr, P. (2009). Professionalization and public health: historical legacies, continuing dilemmas. *Journal of Public Health Management and Practice*, *15*(6), S26–S30.
152. Stone, D. A. (1988). *Policy Paradox: The Art of Political Decision Making*. Scott Foresman & Co.
153. Studlar, D. T., Cagossi, A., & Duval, R. D. (2013). Is morality policy different? Institutional explanations for post-war Western Europe. *Journal of European Public Policy*, *20*(3), 353–371. doi:10.1080/13501763.2013.761503
154. Survey, W. V. (n.d.). Ethiopia World Values Survey, 2007. Madrid: World Values Survey Association. Retrieved from http://www.worldvaluessurvey.org
155. Tansey, O. (2007). Process Tracing and Elite Interviewing: A Case for Non-Probability Sampling. *PS: Political Science and Politics*, *40*(4), 765–772. doi:10.2307/20452062?ref=search-gateway:eb20e69c07715cb31a5c561962deb45b
156. Taylor, D., Safriet, B., & Weitz, T. (2009). When Politics Trumps Evidence: Legislative or Regulatory Exclusion of Abortion From Advanced Practice Clinician Scope of Practice. *Journal of Midwifery & Women's Health*, 54(1), 4–7. doi:10.1016/j.jmwh.2008.09.003

157. Thomas, J. W., & Grindle, M. S. (1994). Political leadership and policy characteristics in population policy reform. *Population and Development Review*, *20*, 51–70.
158. Tietze, C. (1961). Legal Abortion in Eastern Europe. *JAMA*, 175(13), 1149–1154. doi:10.1001/jama.1961.03040130033008
159. Transitional Government of Ethiopia. 1993. *National Policy on Ethiopian Women*. Addis Ababa.
160. Trochim, W. M. (1989). Outcome pattern matching and program theory. *Evaluation and Program Planning*, *12*(4), 355–366.
161. Turner, K. L., Hyman, A. G., & Gabriel, M. C. (2008). Clarifying Values and Transforming Attitudes to Improve Access to Second Trimester Abortion. *Reproductive Health Matters*, *16*(31), 108–116. doi:10.2307/25475408?ref=search-gateway:dd8f4f19766cfdf2a863749212823627
162. United United Nations Data 2010, Ethiopia Country Profile. United Nations. Retrieved March 15, 2014, from http://data.un.org/CountryProfile.aspx?crName=Ethiopia
163. USAID. *USAID Policy Paper:. Population Assistance* (p. 18). Washington, DC: United States Agency for International Development. Retrieved from http://www.usaid.gov/sites/default/files/documents/1864/populat.pdf
164. Vaughan, S. (2011). Revolutionary democratic state-building: party, state and people in the EPRDF's Ethiopia. *Journal of Eastern African Studies*, *5*(4), 619–640. doi:10.1080/17531055.2011.642520
165. Veale, A. (2003b). *From Child Soldier to Ex-fighter, Female Fighters: Demobilisation and Reintegration in Ethiopia*. South Africa: Institute for Security Studies (ISS). Retrieved from http://www.iss.co.za/Publications/pub_prices.html
166. Wada, T. (2008). Abortion law in Ethiopia: a comparative perspective. *Mizan Law Review*, *2*(1), 1–32.
167. Wagner, M. (1995). A global witch-hunt. *The Lancet*, 346(8981), 1020–1022.
168. Walsh, J. P., & Dewar, R. D. (1987). Formalization And The Organizational Life Cycle. *Journal of Management Studies*, *24*(3), 215–231. doi:10.1111/j.1467-6486.1987.tb00700.x
169. Welch, C., Marschan-Piekkari, R., Penttinen, H., & Tahvanainen, M. (2002). Interviewing elites in international organizations: a balancing act for the researcher. *International Business Review*.
170. Whetten, D. A. (1987). Organizational growth and decline processes. *Annual Review of Sociology*, *13*, 335–358.
171. World Health Organization. (1995). *Complications of Abortion*. World Health Organization: Geneva, Switzerland.
172. -----. (1999). *Reduction of maternal mortality: a joint WHO/UNFPA/UNICEF/World Bank statement* (p. 44). World Health Organization: Geneva, Switzerland.
173. -----. (2007). *Unsafe abortion* (5 ed., pp. 1–55). World Health Organization: Geneva, Switzerland.
174. -----. (2012). *Safe Abortion* (2nd ed.). World Health Organization: Geneva, Switzerland.
175. -----. (2012a). *Trends in Maternal Mortality*. World Health Organization, UNICEF, UNFPA, & World Bank. World Health Organization: Geneva, Switzerland.
176. -----. (2013). Maternal death surveillance and response: technical guidance information for action to prevent maternal death. World Health Organization: Geneva, Switzerland.
177. -----. (2014). *Clinical practice handbook for safe abortion* (p. 72). World Health Organization: Geneva, Switzerland.
178. Williams, C. (2012). *Researching Power, Elites and Leadership*. SAGE.
179. Yoseph, S., & Kifle, G. (1988). A six-year review of maternal mortality in a teaching hospital in Addis Ababa. *Ethiopian Medical Journal,* 26(3), 115–120.

180. Yoseph, S., Gossa, A., Tadesse, E., & Mulleta, I. (1993). A survey of illegal abortion in Addis Ababa. *Ethiopia Medical Journal*, *32*(3), 151–159.
181. Young, J. (1994). *Peasants and Revolution in Ethiopia: Tigray 1975-1989*. (unpublished dissertation). Simon Fraser University, Department of Political Science: Canada.
182. Zenawi, M. (1992). *The Development Lines of Revolutionary Democracy*. Addis Ababa.
183. Zielinska, E. (1993). Recent Trends in Abortion Legislation in Eastern Europe, with Particular Reference to Poland. *Criminal Law Forum*, 4(1), 47–93.