

Addis Ababa University
School of Public Health

**Assessment of health providers' perception and
preparedness of health facilities towards safe abortion
at selected health facilities in Addis Ababa**

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**A thesis submitted to the School of Graduate Studies, Addis
Ababa University for Partial fulfillment of the requirements
for the Degree of Master of Public Health**

June, 2008

Addis Ababa, Ethiopia

ACKNOWLEDGEMENT

First and most, I would like to thank my advisor Dr Mulugeta Beter for his availability, encouragement and necessary guidance and support through out the study.

My acknowledgement also goes to Dr Yilma Melkamu for his valuable comment during topic selection and for providing me with important materials.

I wish to express my deep appreciation to the medical directors, department heads, head nurses and other staff of the health facilities for their cooperation and the entire participant without whom the study would have not been a reality. All data collectors and the supervisors are highly acknowledged for the at most effort they put to the quality of data.

I would like to extend my appreciation to the staffs of Addis Ababa University School of Public Health.

I am deeply grateful to my family members who gave me continuous support and inspiration to finish this study. Specially my husband Ato Anteneh Tilahun without whom this work would have not been possible. He played a marvelous role for the success of my course.

I am also grateful to everyone else that contributed for completion of my study.

Last but not least I would like to express my acknowledgement to the University of Gondar (UoG) for covering all my expenses during my stay in Addis Ababa.

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LIST OF ABBREVIATION

<i>CSA</i>	<i>Central Statistics Agency</i>
D&C	Dilatation and curettage
E&C	Evacuation and curettage
ESOG	Ethiopia Society of Obstetrics and Gynecologists
FMOH	Federal Ministry of Health
FP	Family Planning
HIV	Human Immuno Deficiency Virus
ICPD	International Conference on Population and Development
IEC	Information Education and Communication
IPPF	International Planned Parenthood Federation
IUD	Intra Uterine Device
KAP	Knowledge, Attitude and Practice
MDG	Millennium Development Goal
MVA	Manual Vacuum Aspiration
NGO	Non Governmental Organization
OPD	Out Patient Department
OR	Odds Ratio
PAC	Post Abortion Care
RH	Reproductive Health

SAC Safe Abortion Care

SPSS Statistical Package for social Science

STI Sexual Transmitted Infection

UNFPA United Nation Fund for population Activity

WHO World Health Organization

ABSTRACT

Back ground: Each year an estimated 36 million to 53 million abortions are performed worldwide. Of those, as many as 20 million are considered unsafe. In Ethiopia the maternal mortality rate is 673/ 100,000 LB of which unsafe abortion accounts up to 32% of all maternal deaths in the country.

Objective: The objective of this study was to assess the perception of health providers and the preparedness of health institutions towards safe abortion at selected health facilities in Addis Ababa, Ethiopia.

Method: A descriptive cross sectional study was conducted from March 25-April15/2008 using structured self-administered questionnaire and observation checklist. A total of 419 health providers at the selected hospitals and health centers were included. Epi info 2000 and SPSS version 15 were used for data entry, cleaning and analysis. The results were interpreted by employing frequency table, percentage, means, Odds ratio and 95% confidence limit.

Result: - Of 419 health providers involved 54% were Nurses, 55.8% were Female, 68.8% were Orthodox and 52% were married. The great majority believed that unsafe abortion was a serious health problem. Only 37.0% of respondent health providers were actually willing to participate in pregnancy termination. Only 41.8% of the respondents were pro-legalization. Actual practice (OR 2.571 with 95% CI 1.490-4.436) and

knowledge about the law governing abortion (OR 1.765 with 95% CI 1.119-2.783) were significantly associated with attitude towards safe abortion. Of the 33 sampled health facilities, only 21 of them provide SAC/PAC.

Conclusion and Recommendation: - Although the great majority of respondent health providers believed that unsafe abortion was a serious health problem only a third of respondent health providers were actually willing to participate in pregnancy termination and only few facilities provide SAC/PAC. Therefore, sensitizing health providers about the essential nature of safe abortion services and the Law governing abortion and equipping health facilities with trained manpower, essential supplies, equipments and material important for safe termination of pregnancy is an important step forward to ensure the availability and accessibility of safe and legal termination of pregnancy.

CHAPTER ONE

INTRODUCTION

1.1 BACKGROUND

Each year an estimated 36 million to 53 million abortions are performed worldwide. Of those, as many as 20 million are considered unsafe that is, they take place outside health care systems, are performed by unskilled providers under unsanitary conditions, or both. Most unsafe abortions take place in developing countries where abortion is limited by law (1).

In developing countries complications of unsafe abortion cause between 50,000 and 100,000 women's deaths annually. WHO estimates that the proportion of maternal mortality due to abortion complications ranges from 8% in Western Asia to 26% in South America, with a worldwide average of 13%. In some settings complications of unsafe abortion cause most maternal deaths, and in a few they may even be the leading cause of death for women of reproductive age (1,2).

In Ethiopia statistical return from health facilities across the country and from hospital based studies show that unsafe abortion is one of the top 10 causes of hospital admission among women (3). Unsafe abortion accounts for nearly 60% of all gynecologic admissions and almost 30% of all obstetric and gynecology admissions (4). The maternal mortality rate in Ethiopia is 673/ 100,000 LB of which unsafe abortion accounts up to 32% of all maternal deaths in the country (4, 5).

Institution based studies have shown that the cost of care to the health system for abortion complication is enormous (6). In addition the loss of productivity due to absence from work and her attending family members can affect the overall economy of the country (6).

There is a general consensus among various bodies that legalization of abortion is central in preventing the suffering and death of women. Restrictive abortion laws violate

women's human rights according to agreements made at the UN International Conference on population and Development in Cairo (7), the Fourth World Conference on Women in Beijing and the Universal Declaration of Human Rights. The United Nations General Assembly review and appraisal of the implementation of ICPD in 1999 (ICPD + 5) further agreed that

“...in circumstances where abortion is not against the law, health systems should train and equip health-service providers and should take other measures to ensure that such abortion is safe and accessible”. Additional measures should be taken to safeguard women's health (8).

In Africa, a particular significant step was the adoption by the African union in July 2003 of the optional protocol on women's rights to the African charter on human and people's rights. The protocol entered into force in November 2005 and has now been ratified by nineteen countries in the region. It is the first among human rights treaties to include wording that explicitly recognizes a right to abortion:

“...States parties shall take all appropriate measures to: protect the reproductive rights of women by authorizing medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the fetus.”(9).

Sources on the history of abortion law indicate that prior to the beginning of the 19th century there were no abortion laws in existence. It is only around the late 19th century some restrictive legislation on abortion begins to emerge. Between 1950 and 1985 almost all developed countries liberalized their abortion laws for reasons of human rights and safety. Despite this, in developing countries mostly in Africa, Asia, and Latin America the restrictive legislation on abortion still persists (10).

Ethiopia has ratified all international law and conventions pertaining to abortion. However, until recently safe abortion services were not available. The 1957 Penal Code

allowed abortion only to save the life or health of the woman (11). This restrictive Law coupled with contraceptive shortages, low usage of available methods, and high rate of sexual violence had led the country to be among the leading developing countries in abortion related mortality (12).

In 2005, in response to a need for intervention the old criminal code was replaced by proclamation NO.414/2004 (Article 551). The new abortion Law clearly specifies cases where terminating pregnancy is allowed by law (13, 14).

“... Termination of pregnancy by recognized medical institution within the period permitted by the profession is not punishable where pregnancy is the result of rape or incest; or if the continuance of the pregnancy endangers the life of the mother or the child ..., or if the child has an incurable and serious deformity, or if the pregnant woman...unfit to bring up the child...”

A number of studies have indicated that legislation governing conditions under which a woman has the right to terminate an unwanted pregnancy is an important foundation for providing safe abortion service. However, it is not the only determinant of access to and quality of safe abortion service.

In RH service frameworks quality of care is generally defined by elements such as choice of method, information given to client, technical competence of providers, interpersonal relations, continuity of care and appropriateness and acceptability of services. Similarly, the International Planned Parenthood Federation (IPPF) framework of client right and provider needs, take these same elements into account in defining quality of care and adds a focus on access as an important element of quality. These frameworks suggest both the perspective of client and providers are very important in determining the quality of services. If there are any service that restrict or stigmatize provider perspectives then these practice are very likely to impact quality of services and also provider might be reluctant to offer any abortion service and/or unaware of the legal parameters for doing so in restricted setting (8, 15).

1.2 STATEMENT OF THE PROBLEM

Death from unsafe abortion accounts a significant proportion of global maternal mortality. Almost all of these unsafe abortion related deaths occur among women in developing countries, where additionally untreated complications of unsafe abortions can also leave women at risk of long term disability, and place tremendous strain on the over burden developing country health care (15).

Where some services are available, limited resources, lack of adequate provider training and stigma surrounding abortion further limits women's access to quality care. In such environment providers may also have little training and experience with methods of termination of pregnancy, further contributing to misinformation and stigma, which can translate into poor quality information, and counseling. Provider attitude is a major barrier to women's access to care. Stigma and passive resistance remain insidious barriers to the full realization of reproductive equality. Many individual remain unaware that termination of pregnancy is permitted under certain condition (16).

The infrastructure to provide legal and safe abortion lags behind in some developing countries, and many women still resort to abortion outside approved facilities or rely on unskilled providers when faced with an unwanted pregnancy (2). Some women particularly adolescents cannot access quality services. This could be due to woman's lack of knowledge about conditions under which abortion is permitted, lack of information about or access to health care service, financial constraints, inability to recognize the sign of pregnancy, irregular menses, initial ambivalence about having an abortion, health concern that arise after the first trimester, family conflict or a change in life circumference that makes a previously wanted pregnancy no longer feasible (17).

Ethiopia is not an exception. The 2004 liberalization of abortion has not brought the change that the country hoped for (13). Intuition tells us that this could be due to lack of infrastructure and partly due to the perception of providers. It is; however, bold to make this assertion without undergoing any empirical work. Yet, more to do with the fact that liberalization of abortion (with certain condition) is a recent development in the country,

to the best of the authors knowledge, no research has been done on the perception of health providers and the capacity of health institutions in performing safe abortion in the country during the post liberalization period. As a result, little is known about the perception of health providers and the availability of infrastructures to perform abortion. Therefore, a research on this issue is timely.

Thus, the present study will try to fill the gap in this area by giving emphasis on the perception of health provider and capacity of health facility towards safe abortion. In doing this the study will try to answer the following research questions:

- What does perceptions on safe abortion look like among health care service providers?
- What are the factors which affect the perception of health providers to safe abortion?
- Do health facilities have the capacity to perform safe abortion? (In terms of trained health provider, equipment and other infrastructure)

1.3 RATIONALE OF THE STUDY

Unsafe abortion is an important social and public health problem in large parts of the world. In Ethiopia every year 2,800,000 birth, 500,000 maternal disabilities, and 118,000 new born death 25,000 maternal deaths occur (3, 14). Hospital based studies showed that the major causes of maternal mortality are abortion (32%), obstructed labor (22%), sepsis (12%), hemorrhage (10%) and pregnancy induce hypertension (9%) (18,19). Studies showed that there are undergoing efforts to halt maternal mortality attributed to theses causes. However, it is also clear that in the wake of the new legislation, which gives a room for legal abortion under certain circumstances, the Country has achieved little, compared to what was hoped for, in reducing maternal mortality related to abortion (12, 20).

When abortion decisions become a matter to be resolved by a woman and a health care provider, the attitude of the health provider towards abortion is very crucial. Beside this, the capacity of health institution is very important for the accessibility and availability of safe abortion services. In the absence of this institutional capacity, even if the provider is ready to give the service, women who are in need of this service may not get it.

Therefore, apart from changing the proclamation, there is a need to work on the perception of health professionals and the capacity of health facilities if the country wishes to see a meaningful reduction in abortion related maternal mortality and morbidity. The author strongly believes that a research on this issue can be an important step forward in providing concerning authorities with an input in developing their policies.

CHAPTER 2

LITRATURE REVIEW

Abortions performed under unsafe conditions claim the lives of tens of thousands of women around the world every year, leave many times that number with chronic and often irreversible health problems, and drain the resources of public health system. Of the 210 million pregnancies that occur each year, about 46 million (22 per cent) end in induced abortion and, globally, the vast majority of women are likely to have at least one abortion by the time they are 45 (20). Where effective contraceptive methods are available and widely used, the total abortion rate declines sharply, but has no where declined to zero for several reasons:-

- First, millions of women and men either do not have access to appropriate contraceptive methods, or do not have adequate information and support to use them effectively.
- Second, no contraceptive method is 100 per cent effective.
- Third, high rates of violence against women including in the home and in war lead to unwanted pregnancies.
- Fourth, changing circumstances, such as divorce or other crisis, can result in a wanted pregnancy becoming unwanted (20).

WHO estimates show that 10% to 50% of women undergoing unsafe abortions in developing countries need subsequent medical care. Four factors, along with the overall health of the woman, determine the risk that a woman undergoing an abortion will experience medical complications or die from the procedure:-

- (1) The abortion method used,
- (2) The provider's skill,
- (3) The length of gestation, and
- (4) The accessibility and quality of medical facilities to treat complications if they Occur (21).

2.1 Perception of health provider for safe abortion

Despite the legalization of abortion in a number of countries women still face barriers to obtaining abortion services. Research conducted in these countries identified lack of health practitioners willing and able to perform abortion as a major obstacle.

The literature on the perception of health providers towards safe abortion is thin and fragmented. Despite this fact, in the present paper attempt is made to provide exhaustive review of the existing literature and whenever appropriate their findings are compared with ours in the discussion part of the paper.

In Great Britain women may obtain abortions only if they meet certain criteria and two physicians approve the procedure. This fact triggered a study aimed at investigating doctors' attitudes about abortion and the British Abortion Act. The study covered a sample of 702 general practitioners who gave their view through mailed questionnaire. Four in five practitioners considered themselves broadly pro choice, and three in five believed that the current law should be liberalized to give women the right to obtain an abortion without regard as to reason. Three-quarters of doctors favored government provision of free abortions, and one-quarter thought that the current law places an unreasonable burden on general practitioners. Physicians' response to whether the abortion decision should be the women's alone, however, depended on the pregnancy gestation. Among doctors who were broadly antiabortion, one-fifth favored women's right to choose, and two-third supported the current British Abortion Act, however, nearly half opposed government funding of abortion services (23).

A similar study conducted in Sweden tried to show professionals' attitude and experience of legal abortion. The study covered 258 midwives and 269 gynecologists with 84% response rate. The majority supported the legislation, which stipulates that a woman desiring an abortion may terminate her pregnancy before the 18th week without giving any grounds for the decision. This study has also revealed that there were smaller differences among views of female and male gynecologists than among views of female gynecologists and female midwives. A great majority also believed that abortion was not

used as a form of contraception. According to this study, the most important determinants of difference in view were, among others, the extent to which the staff had been working with legal abortion, especially during the last year, and type of profession (24).

A paper in Argentina also tried to examine the reaction of health professionals to the reform of the National Constitution in 1994. The study covered the views of 467 obstetrician-gynecologists from public hospitals. The method implemented was group discussion and interview with heads of department from 36 of the hospitals. The great majority believed that abortion was a serious public health issue. Among those who recognized the seriousness of the problem the majority had the view that physicians should provide abortions which are not illegal, abortion should not be penalized if it is to save the women's life or in case of rape or fetal malformations, and women having illegal abortions and abortion providers should not be imprisoned. Some 40% thought that abortion should not be penalized if it is a woman's autonomous decision. This study also revealed that those who had better disposed de-penalization of abortion cited a combination of public health reasons and the need for social equity (25).

A research done in Latin America and Caribbean countries showed that eight in ten providers characterized complications of unsafe abortion, including mortality as a "very serious" health problem in their setting. The vast majority (83%) of providers also agreed that greater access to abortion services could reduce maternal mortality. Providers' perception of the appropriateness and acceptability of abortion services as part of the continuum of reproductive health services reveals support for broader access to safe voluntary termination of pregnancy but some reluctance and personal opposition to offering abortion services. While most providers (67%) agreed that expansion of access to quality abortion services was a key step to reducing the toll of unsafe abortion only half of providers believed that their association should be directly involved in the provision of safe abortion services to meet that need. A considerable proportion of providers (44%) said that they personally would not feel comfortable working in a site that performed terminations of pregnancy (15).

There were also studies which tried to examine the attitude of health professionals in some developing countries. For example there was a study in Bangladesh which involved 376 physicians in different health centers including family planning centers. Nearly all physicians supported the use of abortion to preserve the health of the woman, where as the current Bangladesh Law permits abortion only to save a woman's life. More than 75% approved abortion if pregnancy resulted from rape, while more than 60% were in favor if the woman was unmarried (including widowed) or already had a large family. About 60 percent approved abortion for a woman who became pregnant while breastfeeding without resuming menses. Only 12% approved abortion when the husband had not given his consent (26).

A similar study tried to assess physician willingness to perform legal abortion in Ghana. The study utilized self administered questionnaire in which 73 randomly selected physicians expressed their view on whether abortion unit should be established with in national health facilities and what role they would like to play in these facilities. The finding revealed that 59(80%) favored establishment of health abortion units of which 27(36%) indicated a willingness to take part in counseling only, 33(45%) were prepared to carry out abortions, and 14(19%) said they would play no role in these units. (27)

Another study done in Nigeria identifies the most important and the least important reasons why health providers would not terminate unwanted pregnancies when requested to do so by women. The most important reason mentioned by private health providers were religious consideration followed by moral obligations and the perception that abortion is against their professional ethical code of conduct. Only 29% of the doctors mentioned obedience to the Nigerian abortion law as the most important reason and only 6% referred to the fear of police harassment (28).

A study done in Ethiopia by ESOG showed that, 18.2 % of all the health workers were able to provide or assist in the termination of pregnancy on the basis of the legal provision. Having negative attitude towards abortion (55.6%) lack of skill and knowledge for termination (26.0 %) and difficult legal procedural requirements (30%) were the commonest reasons for not providing legal abortion according to the then abortion law.

Higher proportion of health workers with incorrect abortion law knowledge (23.3%) than those without correct knowledge (20.3%) provided legal abortion (29).

2.2 Factors impacting providers' perception

Various studies identified a wide range of factors impacting the perception of health professionals towards abortion. The majority of these studies have indicated that those who oppose abortion claim to have religion, tradition and law on their side. However, if abortion is a key to women's reproductive health, it is necessary to talk about the ethics of abortion from a women-centered perspective. On the basis of widely accepted medical principles, it is unethical to withhold a medical procedure that can save lives and protect health. This includes safe abortion. Some of these studies further argued that those who oppose abortion might fear or wish to restrict the autonomy that women gain with the legal right to abortion. Others may believe that if a woman becomes pregnant, she should accept and welcome the pregnancy, no matter what (30).

A number of studies have revealed that quite a larger proportion of health professionals lack sufficient knowledge of current legislative of their respective country. Other factors which need consideration are sex of the professional, year of graduation from medical school, type of institution, type of practice, or whether they have performed abortion in the past year.

In a study conducted in Sweden, for instance, profession (gynecologist versus midwives) and work experience of the provider (whether or not performed abortion during the 'last year') were found to be the most important determinants of differing views. Views were not, however, influenced by private experience of legal abortion. This study concluded that in Sweden the more experience of working with legal abortion the less restrictive gynecologists and midwives are in their views (24).

A survey in United States identified the level of training as an important variable in determining the perception of physicians towards abortion. This study demonstrated that the likelihood of abortion provision might correlate with the type of abortion training that

a doctor undergoes during residency. It further noted that nurses were significantly less likely than doctors or social workers to support the legalization of abortion (31). Explanations given by the literature, for why nurses become conservative, are diverse. One possible explanation suggested by the literature is that nurses often disapprove some abortion client's sexual behavior and their failure to guard against pregnancy successfully. Feeling among nurses about preserving life also frequently led to disapproval of abortion (32).

A study (31) goes beyond these factors and showed that in United States nursing students' opinion on abortion were largely dependent on gestational duration of pregnancy, the woman's reason for seeking an abortion and the religious orientation of the nursing student.

Considerable number of literature had suggested that social workers are generally liberal compared to other groups. This is because they have had intimate and prolonged contact with the negative consequences of unwanted pregnancy. Also, their professional orientation is toward social reform to bring about long-range solutions to the problem of their clients, as well as toward advocacy for the disadvantaged.

Consistent with this anticipation, a survey in United States indicated that the smallest proportion of those with favorable attitudes toward abortion generally was found among nursing professionals, while social work professionals tended to be most favorably disposed toward abortion. A slightly smaller proportion of medical than social work professionals had favorable attitudes (32).

A number of studies have also recognized the role of religion in shaping the attitude of health practitioners. The attitude toward abortion associated with occupational role has been moderated by religious role. Member of churches that had taken a position in opposition to abortion would be generally less positive toward abortion-Law liberalization than the rest of a given profession group. In a study conducted in the United States only a smaller proportion of Catholic health professionals were in favor of abortion

on demand than was true for non Catholic health professionals. This was less true of Protestants, however, than it was of other non-Catholic, especially Jews and those with no religious affiliation (32).

A similar survey in Northern Ireland strengthens this finding. Due to the fact that the Catholic Church officially opposes all forms of “artificial” birth control, most of the Catholic health practitioners tend to be less favorable to abortion compared to other non-Catholic practitioners in the same group (33).

2.3 Capacity of health institution to give safe abortion

Deaths related to unsafe abortion in developing regions are estimated as high as 100 deaths per 100,000 abortions in Latin America, 400 deaths per 100,000 abortions in Asia, and 600 deaths per 100,000 abortions in Africa. In contrast, the aggregate mortality rate from complications of legal abortions in 13 countries, most of them developed, for which accurate data are available are 0.6 deaths per 100,000 abortions. The mortality rate is low because in these countries abortions are performed largely by skilled providers using appropriate equipment under aseptic conditions (11).

In India abortion is legal, and yet many women seek abortions outside the formal health system because medical facilities equipped to provide safe abortion are few. Even where services are available in India, problems with confidentiality, quality, and cost deter women from using them. Also, many people are unaware that abortion is legal (15).

Evidence from South Africa shows that liberalizing the abortion Law resulted in a decrease in abortion mortality of more than 90% between 1996 and 2000. And a strong correlation was found globally between more liberal abortion laws and policies, safer abortion, and lower maternal mortality (34).

A study conducted in Nigeria tried to identify the method used by health providers in the first and second trimesters of pregnancy. The most common method used in the first trimester was manual vacuum aspiration (MVA), reported by 46% of the doctors in the

overall sample. Another 28% indicated that they use MVA followed by dilatation and curettage (D&C), as they were often not satisfied with the results of MVA alone. Only 25% in the overall sample reported that they used D&C alone, citing the lack of knowledge of MVA as the most important reason for non-use of the procedure (28).

A study in Mozambique, asked the heads of uterine evacuation services about which abortion methods were used in the facility and the care of provider that was primarily responsible for abortions using each of the methods. While most heads of uterine evacuation services (98%) in the 41 study facilities reported that dilatation and curettage were performed, fewer reported the use of manual or electric vacuum aspiration or medical abortion (51%, 20% and 46%, respectively) in their facility. Few head staff (10%) said that their facility had written guidelines and protocols for treatment of abortion complications. Less than half (49%) stated that they had a systematic process for reviewing major abortion-related complications, including deaths. However, among those who were familiar with a review process, 25% reported that the process was rarely used (35). Seventy-six per cent of heads of contraceptive services from the 38 facilities reported that women presenting with incomplete abortion received contraceptive counseling after the evacuation procedure, and 31% of head staff members reported that contraceptive methods were always or frequently supplied to these women. Most providers (83%) reported that the facility had a mechanism for referring women with incomplete abortion to contraceptive services (35).

Among the 99 mid-level providers, 43% reported that they had received in-service training on emergency obstetric care such as manual vacuum aspiration clinical procedures (15%), communication between abortion patients and staff (23%), aspiration equipment cleaning and maintenance (27%), universal precautions for infection prevention (26%) and post-abortion contraceptive counseling and referral (23%) (35).

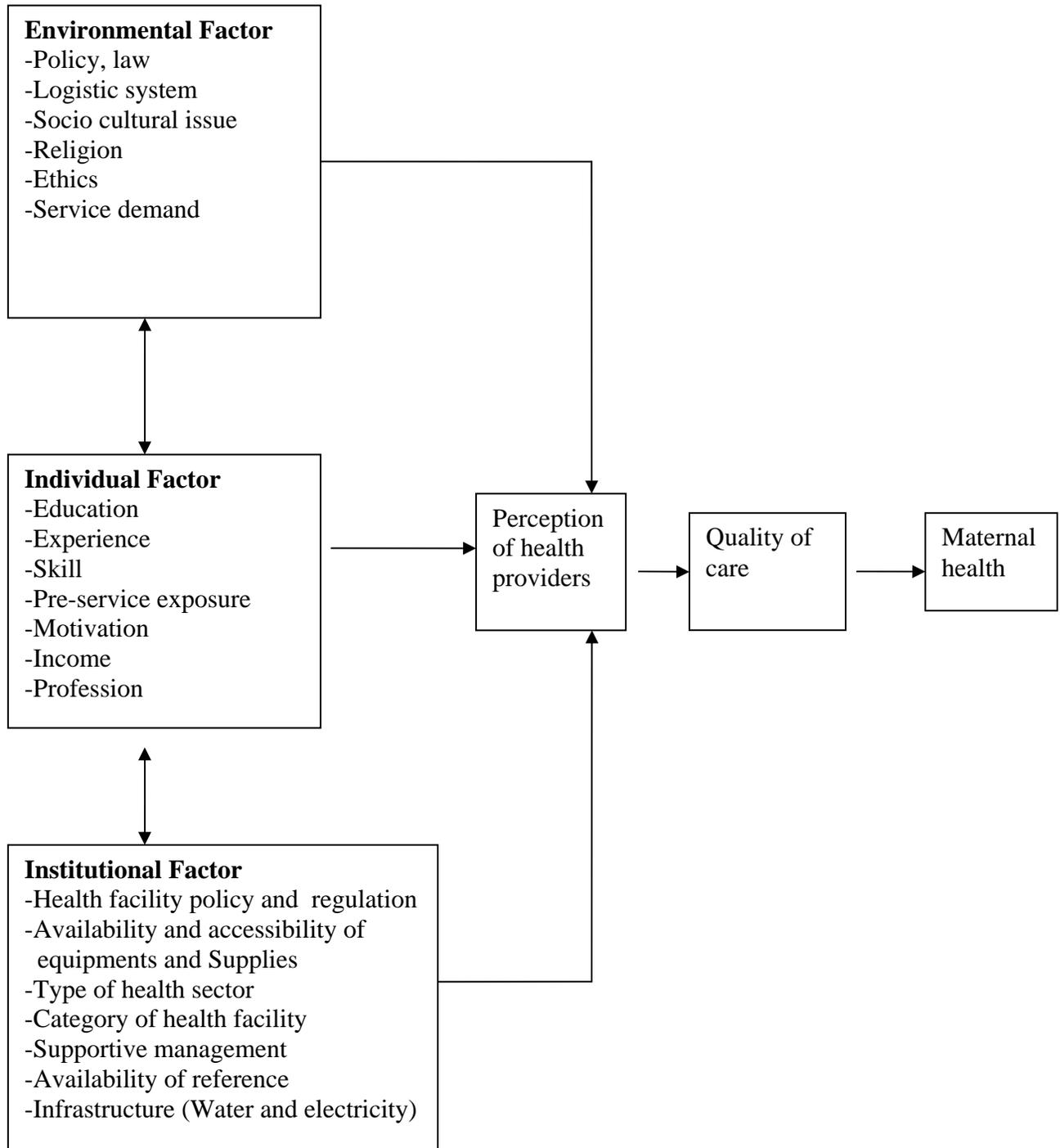
A study in Ethiopia tried to assess the availability of equipments and supplies, at selected public hospitals in Addis Ababa, to give PAC. The study found that all hospitals, included in the study, had fulfilled all the basic equipments required by MOH. The study

also found that facilities such as toilets, sinks and running water were absent in some of the departments of the sampled facilities. Vital equipments such as ambubags, oral airways, suction apparatus and oxygen apparatus were absent in most of the departments. But they all were available in the major operating theaters that are not always near to where PAC is provided (36).

The present study has a conceptual framework which helps to identify factors shaping the perception of health providers regarding safe and legal abortion which would in turn affect maternal health. The components of this framework are taken from the literature discussed so far. The presumption is that the environment surrounding health workers as captured by factors such as the Law governing abortion, policies introduced by concerned authorities, the religion of the provider, and the culture through which the provider passed through, inter alia, would shape the attitude of the provider regarding safe and legal abortion. Another important factor which would affect the perception of health providers, and hence seek attention in the study, is individual factor which, in general, encompasses the experience and education of the provider. The other factor which would somehow be believed to shape the perception of health providers is the institutional factor that may include the preparedness of health facilities, which in turn is influenced by availability and accessibility of resources and the regulation of the facility at which the provider is employed .

Having this in mind, in the present study attempt is made to, empirically; analyze the role of these factors in shaping the attitude of health providers and the preparedness of health facilities to provide safe and legal abortion.

Conceptual Framework



CHAPTER THREE

OBJECTIVES

General Objective

To assess the perception of health providers and preparedness of health institutions towards safe abortion service at selected health facilities in Addis Ababa, 2008

Specific Objectives

- To determine the knowledge and attitudes of health providers about safe abortion service in Addis Ababa
- To describe the determinants of health providers perception on safe abortion practice in Addis Ababa
- To describe the preparedness of selected health facilities towards provision of safe abortion services in Addis Ababa

CHAPTER FOUR

METHOD AND MATERIAL

4.1 Study design

A descriptive cross-sectional study was conducted from March 25, 2008-April 15, 2008 by using a structured self administer questionnaire coupled with observation of health facilities.

4.2 Study area

Addis Ababa is the capital city of the Federal Democratic Republic of Ethiopia. It is located in the central part of the country. According to the 1994 census by Central Statistic Authority (CSA) the city has a projected population of 2,646,000, of these 1, 273,000 (48.1%) were estimated to be males while 1,373,000 (51.9%) were females.

In Addis Ababa there are 37 hospitals (two NGO, twelve governmental, and twenty three private hospital), 29 Health center, 116 private not for profit and 357 private for profit clinics.

4.3 Population

4.3.1 Source of population: all health providers who are working under the sampled health facility in Addis Ababa.

4.3.2 Study Population: a sample of 33 health facilities and 431 eligible health providers who were working in these health facilities were included in the study.

4.4 Sampling techniques

The sampling method used was stratified sampling technique. Four strata was taken namely; private hospital, private higher clinic, government hospital and government health center. From each stratum a sample of study health facilities were selected by simple random sampling. In this study, a total of 33 health facilities were included. After taking in to account the staff differential between hospitals and health centers & private higher clinics, which favors the former, different weight was attached to the strata.

Accordingly, 50% of the hospitals and 10 % of the health centers & private higher clinics were included in the study (see annex I).

4.4 Sample size

The following sample size formula was used to determine the minimum sample size: 95% confidence interval with a margin of error 5 % and 44% prevalence of positive attitude of health providers towards safe abortion will be used to consider minimum sample size. The prevalence was taken from a research done by Ethiopian Society of Obstetrics and Gynecology on KAP among Ethiopian health worker in 2002, a period in which the old Penal Code govern abortion (29).

$$n = \frac{(Z_{\alpha/2})^2 p \cdot (1-p)}{d^2}$$

Where

P= an estimate of prevalence

n= minimum sample size

d= margin of error tolerated

Z= the confidence interval (95%)

$$n = \frac{(1.96)^2 0.44 (1-0.44)}{(0.05)^2}$$

= 375 *15% non response rate

431 were the final sample size.

4.5 Data collection instruments and procedures

This study used self administered questioner and observation of health facilities. The questionnaire was prepared in such a way that it captures all the variables that are desirable to meet the objective of the study. Checklists were used to observe health facilities. The data collection was fulfilled by the principal investigator, supervisor and four data collectors. The data collectors were nurses and midwives, and they had training lasting three days on how to collect the data. The questionnaire was pre tested prior to data collection to ensure the data quality.

4.6 Data analysis

Epi info 2000 and SPSS version 15 were used for data entry, cleaning and analysis. The results were interpreted by employing frequency tables, percentages, means, odds ratio and 95% confidence limit. Moreover, to appreciate the association between variables, logistic regressions were fitted.

4.7 Data quality management

Pre-test was done on similar professional groups with different facility location. Depending on the result of the pre test, correction and modification was made on the questionnaire and the check list before applied on the study population. One trained midwife and the principal investigator supervised data collection processes and check for completeness of the data and correctness of the data collection procedure and as necessary correction was done.

4.8 Variable

Dependent variables

- Perception of Health provider
- Readiness and preparedness of Health institution

Independent variables

Institutional Factor

- Health facility policy and regulation
- Availability and accessibility of equipments and supplies
- Type of health sector by ownership and level of activity
- Availability of reference
- Infrastructure (water and electricity)

- Individual Factor

- Education
- Experience
- Skill

- Environmental Factor
 - Law, Policy
 - Socio cultural issue
 - Religion
 - Ethics

4.9 Operational Definition

1. **Unsafe abortion** is a procedure for terminating an un-wanted pregnancy less than 28 weeks of gestation either by persons lacking the necessary skills or in an environment lacking the minimal medical safety standards or both.
2. **Safe abortion** is termination of pregnancy less than 28 weeks of gestation by qualified and skilled persons using correct techniques in sanitary conditions.
3. **Perception** is one's feeling towards a subject or an issue.
4. **Mean attitude score** is the average of response on the attitudinal questions.

4.10 Ethical consideration

After getting ethical clearance from Addis Ababa University and Addis Ababa health bureau, support letter was written to each sampled health facilities.

Permission of the health facilities was secured to participate in the study, each provider in selected health institution was given a written consent form for willingness of the health providers to participate in the study. Health workers who were unwilling to participate were excluded from the study. Finally confidential, anonymous, aggregate analysis and reporting system was put in place.

4.11 Dissemination of the result

Final document of the study will be given to medical faculty of Addis Ababa University, Addis Ababa health bureau and MOH. The thesis will be presented to school of public health as it is a partial fulfillment of master of public health and at Ethiopian public health association annual conference. Attempt will be made for publication of the research on reputable Journal.

CHAPTER FIVE

RESULTS

Socio-demographic

The aim was to interview 431 Health practitioners in 18 hospitals, 12 private higher clinics and 3 public health centers. However, after repeated visit 12 practitioners either could not be contacted or they were not willing to participate in the interview for various reasons. Thus, of 431 questionnaires distributed 419 were completed and returned, giving a response rate of 97.2 %.

Table 1 gives an overview of selected socio demographic characteristics of sampled health providers. Of the 419 health practitioners who had participated 228(54.4%) were nurses, 103(24.6%) midwives, 18 (4.3%) health officers, and 70 (16.7%) physicians. Among physicians, 45(10.7%) were general practitioners, 13(3.1%) obstetrics-gynecologist and the rest 12(2.9%) of other specialization. More than half (55.8%) of the respondents were female. Overall, 58% were younger than 30 years of old, 39% between 31 and 45 years, and 3% aged 46 or older with the median age 29.3yrs. Two-third (68.8%) were Orthodox, 7.6% were Muslims, 20.5% were Protestants, and the remaining 3.6% were of other religion. Nearly half (52.0%) of the respondents were married while 45.3% reported never married and the remaining 1.5% reported either divorced or widowed. The majority (48.0%) of the respondents indicated government hospitals as their primary work place. The majority (90.0%) of the respondents had more than one year of experience, of which 24.3% reported experience of 10 years or above .

Table1. Selected socio demographic characteristics of respondent health providers, Addis Ababa, April 2008

Characteristics	No (%)
Sex	
Male	185 (44.2)
Female	234 (55.8)
Age	
20-25	96 (22.9)
26-30	148 (35.3)
31-35	77 (18.4)
36-40	47 (11.2)
41-45	39 (9.3)
46-50	12 (2.9)
	Median age=29.3
Marital Status	
Never Married	190 (45.3)
Married	223 (52.9)
Divorced	4 (1.0)
Windowed	2 (0.5)
Religion	
Orthodox	286 (68.3)
Muslim	32 (7.6)
Protestant	86 (20.5)
Other	15 (3.6)
Type of provider	
Physician(ob-gyn)	13 (3.1)
Physician(other spec)	12 (2.9)
Physician(GP)	45 (10.9)

Health officer	18 (4.3)
Midwives	103 (24.6)
Nurse	228 (54.4)

Table 1. Continued...

<i>Years of experience</i>	39 (9.3)
Less than one year	93 (22.2)
1-2 years	92 (22.0)
3- 5 years	93 (22.2)
6- 10 years	102 (24.3)
More than 10 years	
<i>Primary work place</i>	201 (48.0)
Government hospital	65 (15.5)
Private hospital	134 (32.0)
Government health center	19 (4.5)
Private higher clinic	

Knowledge about safe abortion

Table 2 provides detailed information on the state of knowledge of health practitioners about safe abortion and its procedures. The first question that the study asked was whether or not health practitioners have the right understanding of "safe abortion". Three-quarter (74.7%) of the respondents said they knew what safe abortion means. Furthermore, as providers were likely to have different views they were asked to explicitly define what safe abortion means. One hundred seventeen (37.9%) had defined safe abortion as done by trained person and sterile technique, 45(14.4%) as abortion performed by sterile technique, 35 (11.2%) as abortion performed by trained person, and 34 (10.9%) as abortion performed at a health facility by trained person.

Regarding the pregnancy termination procedures, more than three-quarter of the respondents were familiar with D&C (78.5%), E&C (74%), and MVA (84.7%), while

less than half were familiar with other types of procedures such as oxytocin (48%), prostaglandin's (35.6%), misoprostol (21.2%), and surprisingly about 6.0% of the respondents did not know anyone of these procedures. Asked whether or not they had formal training on procedures to terminate pregnancy, only 29.4% said they had. When respondents were asked about what type of procedure they were trained on, the majority of them reported MVA (85.4%), while 37.4% reported D&C, 38.2% E&C, 23.6% oxytocin, 24.4% prostaglandins, and similarly 24.4% misoprostol.

Table 2. Knowledge of respondents regarding safe abortion, procedure of abortion and training on the method of termination of pregnancy, Addis Ababa, April 2008

Characteristics	No (%)
Do you know what safe abortion means	
Yes	313 (74.7)
No	106 (25.3)
Description of safe abortion	
Trained person and sterile technique	117 (37.9)
Sterile technique	45 (14.4)
Trained person	35 (11.2)
At health facility by trained person	34 (10.9)
Trained person, sterile technique before 12wk	25 (8.0)
Trained person, sterile technique at health facility	23 (7.3)
To save mothers life	19 (6.1)
Abortion performed at health facility	13 (4.2)
Health facility using sterile technique	2 (0.6)

Knowledge of available abortion procedures	
D&C	329 (78.5)
E&C	310 (74.0)
MVA	355 (84.7)
Oxytocin	201 (48.0)
Prostaglandins	149 (35.6)
Misopristol	89 (21.2)
I don't know	25 (6.0)
Ever trained on pregnancy termination procedure	
Yes	123 (29.4)
No	296 (70.6)

Table 2 continued...

Trained on the abortion procedure	
D&C	46 (37.4)
E&C	47 (38.2)
MVA	105 (85.4)
Oxytocin	29 (23.6)
Prostaglandins	30 (24.4)
Misopristol	30 (24.4)

Regarding the provision of abortion services by the respondents

Less than a third, 33.0% male and 26.9% female, of respondents had the experience of terminating pregnancy. Forty five percent of those who said they had performed pregnancy termination reported at least one termination within the last six months while 30% reported before two years.

On further analysis of the views of the practitioners who said they never performed pregnancy termination, 13.6% indicated that the facility in which they are employed did not provide safe termination, and 3.6% mentioned lack of equipments. Nearly a third of respondents, 35.5% male and 31.0% female, reported that the employer did not allow

them to perform termination of pregnancy. Of all respondents, 11% mentioned overload from other tasks. A sizable proportion of respondents, 46.0% male and 47.4% female, put forward personal reason as the main factor.

Respondents were asked about their views on pregnancy termination before and after 12 weeks' gestation. The vast majority (96.9%) of respondents favor termination in the first 12 weeks. After 12 weeks health practitioners took a more restrictive line. Only 3.1% did not object termination after 12 weeks.

Table 3. Respondent health providers' practice of safe abortion and their opinion on the best time for termination of pregnancy, Addis Ababa, April 2008

Characteristics	Male	Female	Total (%)
Ever performed abortion procedure (n=419)			
Yes	61(33.0)	63(26.9)	124 (29.6)
No	124(67.0)	171(73.1)	295 (70.4)
When did you perform (n=124)			
Before two years	18 (29.5)	20 (31.7)	38 (30.6)
Between the last one and two years	17 (27.9)	13 (20.6)	30 (24.2)
Within the last six months	26 (42.6)	30 (47.6)	56 (45.2)
Reason for not performing* (n=295)			
Facility does not provide safe termination	26 (21.0)	31 (18.1)	57 (13.6)
Lack of equipment and supply	9 (7.3)	6 (3.5)	15 (3.6)
The facility not allow us to perform	44 (35.5)	53 (31.0)	97 (23.2)
Over load of work	16 (12.9)	30 (17.5)	46 (11.0)
Personal reason	57 (46.0)	81(47.4)	138 (32.9)
Not trained on abortion procedure	13 (10.5)	16 (9.3)	29 (6.9)
Not my duty	6 (4.8)	4 (2.3)	10 (2.4)

Other	8 (6.4)	14 (8.3)	6 (1.3)
Best time for termination (n=419)			
Less than 12 wks	179(96.8)	227(97.0)	406 (96.9)
Between 12-24weeks	3(1.6)	6(2.6)	9 (2.1)
Greater than 24 weeks	3(1.6)	1(0.4)	4 (1.0)

*total do not add to 100 because of multiple response

Views on unsafe abortion related complications

Health providers were asked about their views on major complications inflicted by unsafe abortion. The vast majority of the health provider identified bleeding (95.9%), and infection (90.7%) as the main complication of abortion. Other complications mentioned by health providers were uterine perforation (77.1%), death (73.7%), infertility (73.0%), pelvic pain (67.1%), psychological trauma (65.2%) and other including HIV/STI accounts 2.6 %.

Health providers were asked to suggest possible response when complications arise due to unsafe abortion. The majority identified taking vital sign (87.2%), securing IV line (90.2%), and consulting senior (80.0%) as the best reply.

The study asked respondents to state their agreements or disagreements on the possible solutions to halt the incidence of unsafe abortion. The majority (87.4%) of respondents agreed with using modern contraceptive and another sizable portion (76.8%) further agreed on giving health education on pregnancy, complication and prevention of abortion. Only few (10.5%) of the respondents support the idea of abortion legalization as a sustainable solution to solve the problem of unsafe abortion (Table 4).

Table 4. Respondent health providers' views on complications and solutions to prevent unsafe abortion, Addis Ababa, April 2008

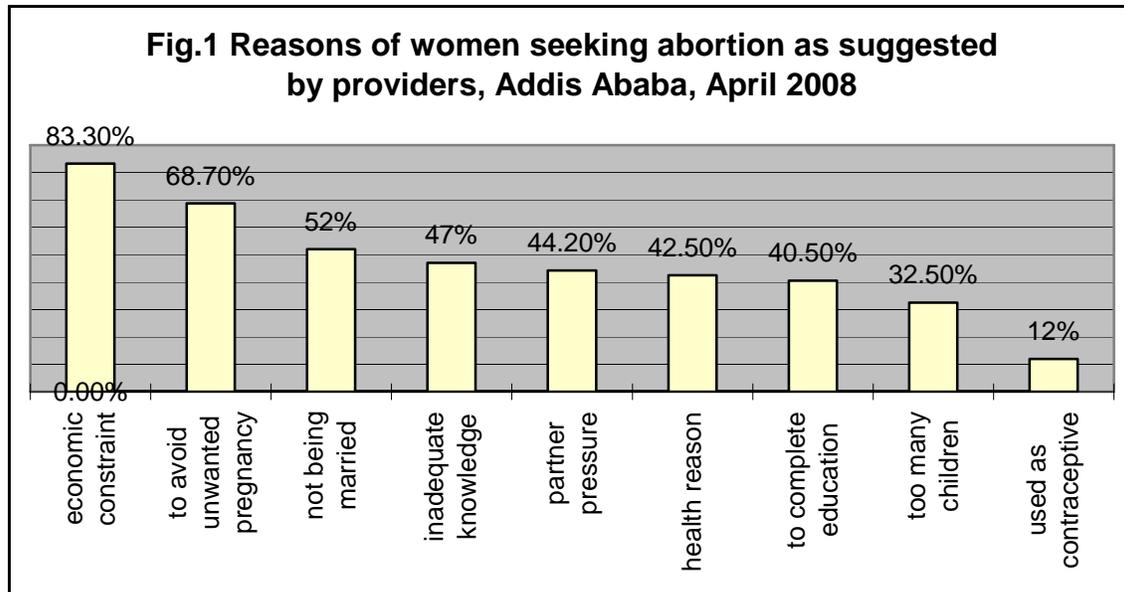
Characteristics	No (%)
Problem due to unsafe abortion*	
Bleeding	402 (95.9)
Infection	380 (90.7)
Uterine perforation	323 (77.1)
Infertility	306 (73.0)
Pelvic pain	281 (67.0)
Psychological trauma	273 (65.2)
Death	309 (73.7)
Other	11 (2.6)
I don't know	2 (0.2)

Suggestion as a solution*	
Use of modern contraceptives	366 (87.4)
Use of traditional/natural method	92 (22.0)
Avoiding sex if unmarried	184 (43.9)
Give birth once pregnant	90 (21.5)
Health education	322 (76.8)
Use of safe abortion service	131 (31.3)
Abortion legalization	44 (10.5)
Other	6 (1.4)

*total do not add to 100 because of multiple response

Views of health providers on why women seek abortion

Respondents were asked to forward reasons for why women seek abortion. Accordingly, providers suggested several reasons for which women seek abortion (see figure 1). These include economical constraint (83.3%), to avoid unwanted pregnancy (68.7), not being married (52.0%), inadequate knowledge (47.0%), partner pressure (44.2%), health reason (42.5%), to complete their education (40.5%), too many and too close children (32.5%) and 12.0% of the providers believed that women use abortion as contraceptive.



Willingness of respondent health providers to participate in abortion

When asked whether or not they would participate in performing abortion procedures, 37.0% of the respondents said they would participate. Also, when respondent health providers were asked which activity they would prefer to perform, 35.5% said they would take part in D&C, 39.6% said they would participate in providing E&C, and nearly half (48.9%) said they would participate in MVA. When asked in what type of care they would like to participate, 41.5% said psychological screening, 47.5% said psychological preparation, 56.3% said care during abortion, and 56.3% said care after abortion.

When asked about the type of counseling they would prefer to provide for a woman seeking abortion the majority (86.2%) said they would like to give contraceptive counseling, 37.2% said on means of abortion, and 12.4% said on encouraging abortion.

Table 5. Respondent health providers' willingness to participate in activities involving abortion, Addis Ababa, April 2008

Characteristics	Would participate	Wouldn't participate
	No (%)	No (%)
Procedure*		
D&C	148 (35.5)	271 (64.7)
	166 (39.6)	253 (60.4)

E&C	205 (48.9)	214 (51.1)
MVA		
Caring for patient*		
Psychological Screening	174 (41.5)	245 (58.5)
Psychological preparation	199 (47.5)	220 (52.5)
Care during abortion	236 (56.3)	183 (43.7)
Care in immediate PAC period	248 (59.2)	171 (40.8)
Counseling and teaching patient*		
Means of abortion	156 (37.2)	263 (62.8)
Encourage termination of pregnancy	52 (12.4)	367 (87.6)
Abortion service seeking	155 (37.0)	264 (63.0)
Contraception counseling and offering	361 (86.2)	58 (13.8)

*total do not add to 100 because of multiple response

View of respondents' not comfortable working in a site where abortion is done

Those respondents, who said would not be comfortable working in a site where termination of pregnancy is performed, were asked their reasons. Among the 306 health providers, the majority of them said abortion is against my religion, followed by personal value, and not trained on abortion procedure which, respectively, accounted for 204 (66.6%), 122 (39.8%) and 80 (19.0%). The rest of them said (9.6%) it was out of their scope (figure 2).

Method of counseling for women who came for abortion service

All the respondents were asked about the methods of counseling they gave for women who came for safe termination of pregnancy (Table 6). The majority of the providers (44.2%) counseled the women who came for abortion about the benefits and risks of termination of pregnancy, followed by counseling on the risk of abortion and recommend to continue the pregnancy (32.7%). The other methods suggested by provider were referral of the woman to a site where safe termination of pregnancy is given (32.2%), inform that abortion is illegal (28.9%), inform abortion is legal (15.3%), counsel only the risk (12.6%), counsel only the benefit (7.9%) and advice the woman to speak to a religious cleric (5.5%).

Views of respondent health providers on the components of PAC

The study carried out analysis of whether or not respondents knew the components of post abortion care (PAC). Among the total 419 health providers, more than half 245 (58.5%) of them said that they knew at least one component and of which, the majority of them 208 (84.9%) were familiar with counseling, 142 (58.0%) had treated incomplete abortion and complication of unsafe abortion, 207 (84.5%) of them had given contraceptive and FP service, 102 (41.6%) reported referral from the community to service and 125 (29.8%) knew about linkage to other reproductive health service.

All health providers were asked whether or not they do counsel and offer FP method after giving or assisting abortion care. Of all, 392 (90.2%) health providers reported

counseling about FP after abortion care and among which 378 (90.2%) of them offered FP method. Frequently offered FP methods were oral contraceptives, injectables, condoms and IUD which accounted for 327 (86.5%), 307 (81.2%), 276 (73.0%) and 185 (48.9%), respectively. Few of the respondents said depending on the choice of the woman.

Views of respondent health providers regarding the nature of the law

Given the central role of health providers in providing abortion, their knowledge on the very existence of the law and its provisions, their attitude toward the law that governs abortion in Ethiopia are very important. With this understanding the first question asked was whether or not respondents knew the current law on abortion. Two-third of the respondents, 68.6% male and 67.5% female, respondents said they are familiar with the current abortion law (proclamation NO. 414/2004). Of these, 26.3% knew the law by reading the FMOH guidelines, 17.7% heard about it from their friends and only 8.6 % of them directly read the proclamation.

When respondents were asked whether termination of pregnancy occurred due to incest is unpunishable, more than two-third, 66.7% male and 70.1% female, were aware that it is unpunishable. The majority (92.6%) were aware that termination of pregnancy caused by rape is permitted and nearly two-third (65.0%) was aware that termination is unpunishable if the baby is recognized to be malformed. Slightly more males (77.1%) than females (68.5%) said abortion is unpunishable if the mother and the baby are at risk. On the other hand, of the sampled health provider respondents 54.6% and 51.9%, respectively, thought that it is unpunishable if the mother is physically or psychologically not capable and in the case of emergency.

Respondents were also asked what additional evidence is needed to terminate a pregnancy. Nearly two-third of the respondents, 66.7% male and 67.9% female, believed that the mother's word should be enough. On the other hand, about 58 (17.8%), and 45 (13.4%) said that at least three witnesses, and police evidence, respectively (Table 6).

Table 6. Respondent health providers' knowledge regarding the current law and conditions under which termination is unpunishable according to Ethiopian law, Addis Ababa, April 2008

Characteristics	Male	Female	Total (%)
Familiar with current law	127 (68.6)	158 (67.5)	285 (68.0)
From where you hear	48 (38.1)	62 (39.5)	110 (38.9)
Reading FMOH guidelines	36 (28.6)	38 (24.2)	74 (26.1)
From friends	16 (12.7)	20 (12.7)	36 (12.7)
Read Penal Code	9 (7.1)	15 (9.6)	24 (8.5)
Television	12 (9.5)	19 (12.1)	31 (11.0)
Radio	5 (4.0)	3 (1.9)	8 (2.8)
Others			
Knew unpunishable conditions	153 (82.7)	184 (78.6)	337 (80.4)
Incent	102 (66.7)	129 (70.1)	231 (68.5)
Rape	141 (92.2)	171 (92.9)	312 (92.6)
Malformed baby	104 (68.0)	115 (62.5)	219 (65.0)
Mother and baby condition is at risk	118 (77.1)	126 (68.5)	244 (72.4)
If mother is Physically or Psychologically unable to raise	86 (46.5)	98 (41.9)	184 (54.6)
Emergency Condition	88 (57.5)	87 (47.3)	175 (51.9)
Additional evidence	102 (66.7)	125 (67.9)	227 (67.4)
Mothers word only	23 (15.0)	22 (12.0)	45 (13.4)
Police evidence	24 (15.7)	34 (18.5)	58 (17.8)
Three witness	4 (2.6)	3 (1.6)	7 (2.1)
Other			

The study further analyzed how health providers label the current abortion law of the country. In line with this, respondents were asked to reflect their opinion about the status of the current abortion law. Nearly two-third of the respondents, 67.0% male and 68.4% female, said abortion is legal under certain condition. A handful of respondents, 3.8% male and 2.1% female respondents, labeled it as liberalized while 8.8% thought it is legalized and a sizeable portion (19.8%) thought it is illegal (Table 7).

Respondents were asked about their preference to the legalization of abortion and slightly more male (46.5% male to 38.0% female) favored legalization. When asked why they opted for legalization, the majority (82.3%) of the respondents said because it reduces mortality and morbidity due to unsafe abortion, whereas nearly half (48.6%) said because abortion is a major health problem, 52.0% said legalization helps to facilitate availability of service in safe area and trained provider, 62.0% said legalization helps to solve the problem inflicted by unwanted pregnancy, and 25.2% said it helps to reduce the cost of inducing abortion. Those who opposed the idea of legalization, on the other hand, presented various reasons. The majority (85.9%) presented their religion as a defense for their stance, while 34.5% said it is not culturally acceptable, 54.9% described abortion as a homicide, 51.0% tried to justify their position by saying it encourages unwanted pregnancy, and 39.8% said it may lead to pre marital sex.

Table 7: Respondent health providers according to their awareness on current legal status of abortion and their attitude towards legalization, Addis Ababa, April 2008

Characteristics	Male	Female	Total
	No (%)	No (%)	No (%)

<i>Current legal status of safe abortion in Ethiopia</i>	21 (11.4)	16 (6.8)	37 (8.8)
Legal	33 (17.8)	50 (21.4)	83 (19.8)
Illegal	7 (3.8)	5 (2.1)	12 (2.9)
Liberalized	124 (67.0)	160 (68.4)	284 (67.8)
Legal with certain condition	-	3 (1.3)	3 (0.7)
Other			
<i>Preference to full legalization of safe abortion in Ethiopia</i>	86 (46.5)	89 (38.0)	175 (41.8)
Prefer to be legal	99 (53.5)	145(62.0)	244 (58.2)
Prefer not to be legal			
<i>Reason for preference of legalization of safe abortion (n=175)*</i>	43 (50.6)	42 (46.7)	85 (48.6)
Abortion is a health problem in our area	47 (55.3)	44 (48.9)	91(52.0)
Facilitate to get service in safe area and trained provider	74 (87.1)	70 (77.8)	144 (82.3)
Reduce mortality and morbidity due to unsafe abortion	57 (67.1)	52 (57.8)	109 (62.3)
Solve problems of unwanted pregnancy	23 (27.1)	21 (23.3)	44 (25.1)
Reduce cost for inducing abortion			
<i>When do you wish it to be fully legalized (n=175)</i>	44 (51.2)	43 (48.3)	87 (49.7)
Now	21 (24.4)	20 (22.5)	41 (23.4)
Near future	5 (5.8)	5 (5.6)	10 (5.7)
Late Future	16 (18.7)	21 (23.6)	37 (21.1)
At any time			
<i>Reason for not opting to a full legalization*(n=244)</i>	69 (82.1)	108 (88.5)	177 (85.9)
My religion does not allow	28 (33.3)	43 (35.2)	71 (34.5)
Culturally not accepted	49 (58.3)	64 (52.5)	113 (54.9)
Homicide	45 (53.6)	60 (49.2)	105 (51.0)

Encourage to have unwanted pregnancies	38 (45.2)	44 (36.1)	82 (39.8)
Encourage pre/extra marital sex			

* multiple responses were allowed

Respondents were also asked to put forward their anticipation about the reaction of different segments of the public if abortion is legalized. The majority (87.8%) anticipated opposition from religious group; a quarter anticipated oppositions from section of the community, 40.3% expected opposition from part of the community. From resource perspective, 53.9% said lack of trained manpower will pose a problem, while 52.3% and 32.7% anticipated lack of adequate facilities and lack of fund as possible bottlenecks, respectively (Table 8).

Respondents were further asked to suggest precondition that must be satisfied before the introduction of safe legal abortion. The majority (81.9%) proposed training of manpower, 62.0% of the respondents recommended establishing additional facilities, while 44.9% suggested securing fund. To deal with the problem that may arise from the public, 52.0% suggested obtaining approval from the community and 62.0% suggested approval from religious leaders before the legalization of abortion.

Table 8. Distribution of respondents by their perception on anticipated problems if abortion is legalized, suggested preconditions to legalize induced abortion and possible reason not to legalized abortion on demand, Addis Ababa, April 2008

<i>Characteristics</i>	No (%)
<i>Anticipated problem if abortion is legalized*</i>	
	368 (87.8)
Opposition from religious group	106 (25.3)
Opposition from the whole community	169 (40.3)
Opposition from the part community	226 (53.9)
Lack of trained man power	219 (52.3)
Lack of adequate service provision facilities	137 (32.7)
Shortage of fund	6 (1.4)
Do not know	11(2.6)
Other	
<i>Precondition suggestion by provider*</i>	
	343 (81.9)
Training of providers	262 (62.5)
Establishing of service provision facilities	188 (44.9)
Securing fund	218 (52.0)
Obtaining approval from community	165 (63.2)
Obtaining approval from religious leaders	9 (2.1)
Do not know	5 (1.2)
Other	
<i>Reason for not legalized*</i>	
	380 (90.7)
Religion	267 (63.7)
Culture	159 (37.9)
Lack of facility/provider	99 (23.6)
Poverty	

* multiple responses were allowed.

Views of respondent health providers on conditions under which abortion should be denied

All respondents were asked to suggest conditions under which women should not be allowed to terminate their pregnancies. Table 9 provides a more detailed examination of the results. Of all, 19.8% thought the services of abortion should not be available to any women. Nearly a quarter (27.2%) of the respondents believed that the service should not be rendered if there is no medical indication. Almost half (48.4%) are against abortion for married women, while only 15.5% object abortion for unmarried woman. Respondents are less likely to object abortion for groups such as student (30.5%), victim of rape (23.9%), victim of incest (14.1%), and very young women (14.6%). When asked whether all pregnant mothers should be allowed only 16.0% agreed.

All respondents were asked to forward their agreement or disagreement on whether or not the woman herself should decide to have a legal abortion. Of the total, only 123 (29.4%) agreed, whereas the majority 231 (55.1%) disagreed. Those health providers who disagreed on the sole decision of the women were asked to suggest who else should be involved in the decision making. Of all, 138 (59.7%) said partners, 73 (31.6%) said health professionals, and only 9 (3.9%) suggested her family.

Table 9. Respondent health providers according to their views on conditions under which abortion should be denied and parties to be involved in the decision, Addis Ababa, April 2008

Characteristics	No (%)
<i>Women Not allowed</i> *	83 (19.8)
All women	114 (27.2)
With no medical indication	203 (48.4)
Married women	65 (15.5)
Unmarried woman	128 (30.5)
Student	100 (23.9)
Victims of rape	59 (14.1)
Victims of incest	61 (14.6)
Very young women	67 (16.0)
All should be allowed	16 (3.8)
I do not know	9 (1.9)
Other	
<i>Women herself should decide</i>	123 (29.4)
Agree	65 (15.5)
Neutral	231 (55.1)
Disagree	
<i>Who else should decide</i>	138 (59.7)
Partner/man	73 (31.6)
Health worker	9 (3.9)
Family	11 (4.8)
Other	

*total do not add to 100 because of multiple responses

Factors impacting health providers' attitude

The present study employs binary regression in order to appreciate the relationship of various variables taken from the literature. The result from the fitted regression shows that those who took training on abortion (64.2%) tend to have above the mean attitude score and it is statistically significant at crude OR 2.056 (1.332-3.172). However, the same variable turned out statistically insignificant after adjustment; it was found that the adjusted OR 1.023 (0.592-1.768). Similarly, those who were able to identify the unpunishable provisions of the law (54.9%) seem to have attitude above the mean score with crude OR 1.902 (1.162-3.113). The same variable, however, appeared statistically insignificant after adjustment; it was found that the adjusted OR 1.401 (0.824-2.383). Practice and familiarity with the law were also found statistically significant at crude OR 2.984 (1.907-4.672) and 2.984 (1.907-4.672), respectively and it was also found significant after adjustment. Another finding is that, all socio-demographic variables entered into the regression seem statistically insignificant in explaining changes in mean attitude score.

Table 10. Factoring of selected characteristics by mean attitude of health provider for safe abortion, Addis Ababa, April 2008

Characteristics	Mean attitude score		Crude OR CI	Adjusted OR CI
	<10.6	>10.6		
Sex				
Male	87 (47.0)	98 (53.0)	0.919 (0.624-1.351)	0.913 (0.615-1.353)
Female	115 (49.1)	119 (50.9)		
Age				
Greater than 30	80 (45.7)	95 (45.3)	0.842 (0.571-1.243)	0.743 (0.440-1.253)
Less than 30	122 (50.0)	122 (50.0)		
Religion				
Muslim	11 (34.4)	21 (65.6)	1.860 (0.873-3.963)	1.863 (0.857-4.048)
Christian	191 (49.4)	158 (40.8)		
Marital Status				
Currently married	104 (47.1)	117 (52.9)	0.907 (0.618-1.332)	0.940 (0.582-1.518)
Currently not married	98 (49.5)	100 (50.5)		
Profession				
Nurse/midwife	160 (48.3)	171 (51.7)	1.025 (0.640-1.641)	0.990 (0.608-1.612)
Physician/Ho	42 (47.7)	46 (52.3)		
Experience				
Greater than 5	98 (50.3)	97 (49.7)	1.166 (0.794-1.712)	1.409 (0.887-2.240)
Less than 5	104 (46.4)	120 (53.6)		
Owner				
Government	140 (48.6)	148 (52.7)	1.053 (0.696-1.592)	0.909 (0.582-1.418)
Private	62 (47.3)	69 (52.7)		
Did you train on abortion procedure				
No	158 (53.4)	138 (46.6)	2.056 (1.332-3.172)	1.023 (0.592-1.768)
Yes	44 (35.8)	79 (64.2)		
Ever performed abortion procedure				
No	165 (55.9)	130 (44.1)	2.984 (1.907-4.672)	2.571 (1.490-4.436)
Yes	37 (29.8)	87 (70.2)		

Familiar with current Law				
No	83 (61.9)	51 (38.1)		
Yes	119 (41.8)	166 (58.1)	2.984 (1.907-4.672)	1.765 (1.119-2.783)
Know unpunishable condition				
No	50 (61.0)	32 (39.0)		
Yes	152 (45.1)	185 (54.9)	1.902 (1.162-3.113)	1.401 (0.824-2.383)

Binary regression was fitted by taking preference to full legalization as the dependent variable. The result from the fitted regression shows similar result with the one which uses mean attitude score as the outcome variable. Those who took training on abortion tend to be pro-legalization of abortion (62.2%) and it is statistically significant at crude OR 1.725 (1.128-2.637). However, the same variable turned out statistically insignificant after adjustment. The adjusted OR was found 1.023 (0.592-1.768). Another finding is that those who performed abortion tend to be pro-legalization (65.8%) and it is found statistically significant at crude OR 2.843 (1.846-4.379) and it was also found significant after adjustment with adjusted OR 2.955 (1.726-5.062). As in the previous regression socio-demography characteristics found statistically insignificant.

Table 11. Factoring of selected characteristics of respondent health providers towards preference of full legalization of safe abortion, Addis Ababa, April 2008

Characteristics	Preference to legalization		Crude OR (CI)	Adjusted OR (CI)
	Prefer	Not prefer		
Sex				
Male	88 (47.8)	96 (52.2)	0.707 (0.478-1.045)	0.733 (0.492-1.093)
Female	87 (37.0)	148 (63.0)		
Age				
Greater than 30	72 (41.1)	103 (58.9)	1.045 (0.705-1.550)	0.870 (0.511-1.480)
Less than 30	103 (42.2)	141 (57.8)		
Religion				
Muslim	15 (46.9)	17 (53.1)	1.252 (0.607-2.58)	1.0471(0.694-3.119)
Christian	160 (41.3)	227 (58.7)		
Marital Status				
Currently married	86 (43.3)	112 (56.6)	1.139 (0.772-1.680)	1.042 (0.641-1.696)
Currently not married	89 (40.3)	132 (59.7)		
Profession				
Nurse/midwife	134 (40.5)	197 (59.5)	1.282 (0.799-2.058)	1.145 (0.700-1.872)
Physician/Ho	41 (46.6)	47 (53.4)		
Experience				
Greater than 5	77 (39.5)	118 (60.5)	1.192 (0.807-1.761)	1.319 (0.824-2.112)
Less than 5	126 (56.3)	98 (43.8)		
Owner				
Government	128 (44.4)	160 (55.6)	0.699 (0.457-1.071)	0.674 (0.426-1.069)
Private	47 (35.9)	84 (64.1)		
Did you train on abortion procedure				
No	63 (51.2)	60 (48.8)	1.725 (1.128-2.637)	0.881(0.509-1.524)
Yes	112 (37.8)	184 (62.2)		

Ever performed abortion procedure				
No	74 (59.7)	50 (40.3)		
Yes	101 (34.2)	194 (65.8)	2.843 (1.846-4.379)	2.955 (1.726-5.062)
Familiar with current Law				
No	49 (36.6)	85 (63.4)		
Yes	126 (44.2)	159 (55.8)	1.375 (0.901-2.097)	1.087 (0.683-1.730)
Know unpunishable condition				
No	29 (35.4)	53 (64.6)		
Yes	146 (43.3)	191 (56.7)	0.716 (0.434-1.182)	1.198 (0.699-2.053)

Finally, a logistics regression was fitted by taking preference to full legalization of abortion as the outcome variable and all other attitude characteristics as explanatory variables. Accordingly, preference to full legalization was found to be higher among; those who opted elective abortion to be legal and accessible (adjusted OR 2.218 with 95% CI 1.344-3.662), those who believed that access to safe abortion would reduce maternal death (adjusted OR 2.950 with 95% CI 1.652-5.570), and those who thought that access to safe abortion is a key step to reduce unsafe abortion (adjusted OR 2.406 with 95% CI 1.059-4.180). On the other hand preference to full legalization was found to be lower among those who described termination as a sinful act (adjusted OR 0.576 with 95% CI 0.345-0.962) and those who opted for regulation of institutions on abortion (adjusted OR 0.502 with 95% CI 0.316-0.800).

Another finding is that, those who objected penalization if the woman makes an autonomous decision tend to be pro-legalization (adjusted OR 2.386 with 95% CI 1.396-4.076). Preference to full legalization was also found to be higher among those who believed that a woman has the right to terminate her pregnancy if she wishes (adjusted OR 2.240 with CI 1.381-3.632) and those who would like to participate in termination if the woman wishes to do so (adjusted OR 2.550 with 95% CI 1.563-4.160). Similarly, those who agreed that the woman should give her baby for adoption instead of abortion (adjusted OR 2.165 with 95% CI 1.299-3.610) and those who suggested that every

program which address maternal health should include SAC/PAC (adjusted OR 1.890 with 95% CI 1.158-3.084), tend to be pro legalization of abortion.

Table 12. Factoring of selected perceived attitudes of respondent health providers towards preference of full legalization of safe abortion Addis Ababa, April 2008

Characteristics	Preference to legalization		Crude OR (CI)	Adjusted OR (CI)
	Prefer	Not prefer		
Feel comfortable working in a site abortion is performed				
Yes	55 (71.4)	22 (28.6)	4.625 (2.69-7.952)	0.360 (0.187-0.693)
No	120 (35.1)	222 (64.9)		
Elective abortion legal and accessible				
Agree	105 (59.7)	71 (40.3)	3.655 (2.427-5.502)	2.218 (1.344-3.662)
Disagree	70 (28.8)	173 (71.2)		
Do you agree on regulation of institution on abortion				
Yes	118 (53.6)	102 (46.4)	2.882 (1.921-4.324)	0.502 (0.316-0.800)
No	57 (28.6)	142 (71.4)		
Access to safe abortion would reduce maternal death				
Yes	155 (51.0)	149 (49.0)	4.941 (2.903-8.412)	2.950 (1.562-5.570)
No	20 (17.4)	95 (82.6)		
Unsafe abortion is a very serious health problem				
Yes	172 (42.5)	233 (57.5)	2.707(0.744-9.85)	0.920 (0.204-4.149)
No	3 (21.4)	11 (78.6)		

Access to quality abortion service is a key step to reduce unsafe abortion				
Yes	159 (49.8)	160 (50.2)	5.217(2.927-9.299)	2.406 (1.059-4.180)
No	16 (16.0)	84 (84.0)		
Termination of unwanted pregnancy is a sinful act				
Yes	92 (35.9)	164 (64.1)	0.541 (0.363-0.806)	0.576 (0.345-0.962)
No	83 (50.9)	80 (49.1)		
Support friend or relatives to terminate pregnancy				
Yes	90 (70.3)	38 (29.7)	5.74 (3.639-9.053)	2.871 (1.696-4.860)
No	85 (29.2)	206 (70.8)		
Abortion used as contraceptive				
Disagree	64 (51.2)	61 (48.8)	1.73 (1.134-2.639)	1.217 (0.717-2.065)
Agree	111 (37.8)	183 (62.2)		
Not penalize if the women makes an autonomous decision				
Agree	82 (64.1)	46 (35.9)	3.795 (2.451-5.876)	2.386 (1.396-4.076)
Disagree	93 (32.0)	198 (68.0)		

Table 12 continued...

Law should permitted even women felt fetal movement				
Agree	55 (61.8)	349 (38.2)	2.831 (1.747-4.588)	1.223 (0.683-2.191)
Disagree	120 (36.4)	210 (63.6)		
A woman has the right to terminate her pregnancy if she wishes.				
Yes	103 (60.6)	67 (39.4)	3.779 (2.503-5.706)	2.240 (1.381-3.632)
No	72 (28.9)	177 (71.1)		
Do you agree to terminate, If people decide to terminate				
Agree	100 (64.9)	54 (35.1)	4.691(3.066-7.179)	2.550 (1.563-4.160)
Disagree	75 (28.3)	190 (71.7)		
Instead of abortion women should give her baby for adoption				
Disagree	66 (61.1)	42 (38.9)	2.912 (1.854-4.574)	2.165 (1.299-3.610)
Agree	109 (35.0)	202 (65.0)		
Women should decide to have an abortion				
Agree	70 (56.9)	53 (43.1)	2.403 (1.564-3.69)	1.566 (0.940-2.607)
Disagree	105 (35.5)	191(64.5)		

More comfortable with medical abortion Agree Disagree	78 (51.0) 97 (36.5)	75 (49.0) 169 (63.5)	1.812 (1.21-2.713)	1.181 (0.732-1.907)
Abortion is acceptable if it is due fetal anomaly Agree Disagree	144 (43.2) 31 (36.0)	189 (56.8) 55 (64.0)	1.352 (0.828-2.208)	1.223 (0.683-2.191)
Mid level health provider able to provide medical abortion Agree Disagree	66 (55.0) 109 (36.5)	54 (45.0) 190 (63.5)	2.13 (1.386-3.275)	1.309 (0.760-2.257)
Mid level health provider able to provide Surgical abortion Agree Disagree	64 (51.6) 111 (37.6)	60 (48.4) 184 (62.4)	1.768 (1.157-2.701)	1.469 (0.852-2.532)
Every program that address women health should include SAC/PAC Agree Disagree	132 (49.9) 43 (28.1)	134 (50.4) 110 (71.9)	2.52 (1.645-3.861)	1.890 (1.158-3.084)

Views regarding the capacity of facilities to offer abortion service

The study explored the capacity of sampled health facilities to perform safe abortion and to provide treatment of incomplete abortion. Table 13 provides information pertaining to the view of providers about the capacity of their respective facility (in which they were working in at the time of data collection) to offer safe abortion. Overall, health providers seem to agree that their facility lacked the necessary equipment and supplies to perform safe abortion. Less than half of the professionals of each category, namely only 45.3% of physicians, 42.1% nurses, and 48.6% of midwives, believed that their respective facility had adequate and functional equipment to perform safe abortion. A slightly larger proportion of physicians (55.8%) and midwives (53.3%) than nurses (46.5%) believed that their respective facility had sufficient trained manpower. On the subject of essential supplies and drugs, nearly one third of physicians (34.9%) and nurses (33.8%) compared to slightly larger proportion of midwives (42.9%) thought that their facility was capable. In order to obtain a clearer understanding about their overall evaluation of their facility, in terms of readiness to give safe abortion, respondents were asked whether or not their

facility was ready to give safe abortion. Forty five percent of sampled midwives, 37.7% of nurses and 31.4% of physicians believed that their facility was ready to give abortion.

Table 13. Percentage distribution of health providers' attitude towards the capacity of their respective facility, Addis Ababa, April 2008

Characteristics	Physician/Ho (n=86)			Nurse (n=228)			Midwife (n=105)		
	Agr	Neu	Dis	Agr	Neu	Dis	Agr	Neu	Dis
Facility has adequate and functional equipment	39 (45.3)	22 (25.6)	25 (29.1)	96 (42.1)	49 (21.5)	83 (36.4)	51 (48.6)	22 (21.0)	32 (30.5)
Well trained staff	48 (55.8)	21 (24.4)	17 (19.8)	106 (46.5)	50 (21.9)	72 (31.6)	56 (53.3)	20 (19.0)	29 (27.6)
Essential supplies and drugs	30 (34.9)	22 (25.6)	34 (39.5)	77 (33.8)	75 (32.9)	76 (33.3)	45 (42.9)	26 (24.8)	34 (32.4)
Ready to give safe abortion	27 (31.4)	31 (36.0)	28 (32.6)	86 (37.7)	67 (29.4)	75 (32.9)	48 (45.7)	23 (21.9)	34 (32.4)

Observation on the capacity of health facilities

The study analyzed the capacity of a sample of 6 government hospitals, 12 private hospitals, 3 health centers and 12 private higher clinics. Only 21 of them provide SAC/PAC. The Head Nurse of Gynecology OPD, of each of the health facilities, which usually do not give the actual service, was asked why they were not providing this service. They gave different reasons. Two facilities said it is illegal, the remaining Head Nurses reported one or a combination of the following reasons: physicians are not interested to perform, service only during emergency, provide the service at delivery room to save women life, refer to other hospital facilities, and one facility reported that it is a religious medical care facility.

Table.14 shows the availability of abortion services at the sampled health facilities. Among the 33 health facilities included in the study, 2 of them never gave any abortion service, and 10 of them provide abortion service only in case of emergency. Given this

fact, these facilities were assessed for availabilities of essential equipment and supplies only. The remaining 21 facilities that provide safe/post abortion care were assessed with respect to their preparedness.

For the three month period prior to the study (January-March), the reported number of incomplete abortion service rendered by these 21 facilities had ranged from 0 to 137, with mean 23.9 and median 16.5. Only 10 of the health facilities reported that they did provide safe abortion services. The number of safe abortions delivered for the same period in the facilities had ranged from 0 to 37, with mean 7.7 and median of 10. Of those that provide SAC/PAC, 17 of them had standard logbook. However, the study had encountered problem to differentiate at what gestational age the service was provided. The highest number of abortion service was given at Gandhi memorial hospital Moreover this facility had a complete registration book including gestational age.

The majority (31) of the facilities had FP service and of which 19 of them were engaged in post abortion family planning service. Twelve facilities had all type of FP method including permanent method, 7 of them had pills, condom, injectable and IUD. The study further asked where FP services were provided in these facilities and it was found that 11 of them provide the service at FP unit, 5 of them in the abortion treatment room and in 3 of them in other places such as nursing office and EPI room.

Table 14. Sampled facilities by safe/post abortion care service characteristics, Addis Ababa, April 2008

Characteristics	No (%)
Provide PAC/SAC	21 (63.6)
Facility provide FP method	30 (90.9)
Standard log book	17 (51.5)
Perform induced abortion <12 wks	12 (36.4)
Perform induced abortion >12 wks	4 (12.1)
Remove retained product < 12 wks	20 (60.6)

Remove retained product >12 wks	17 (51.5)
Post abortion FP	19 (57.6)
Blood transfusion	18 (54.5)
Administer Antibiotic	31 (93.9)
Administer IV fluid	31 (93.9)
Administer Oxytocin	31 (93.9)
Separate room	16 (51.6)

Availability of basic facilities

Table 15 provides an overview of the availability and adequacy of infrastructure. Of all the sampled facilities, 29 had examination table, 30 of the facilities had beds. Stretchers were available in 27 of the facilities but those in 3 of the facilities were not functional. Moreover, the head nurses in 5 of these health facilities reported that the number of stretchers at their disposal is not adequate. Almost all health facilities have public toilet for patients and in some of the facilities it was observed that both abortion care room and Gyn ward. Twenty-nine health facilities had no problem with water, but in three of the facilities it was observed that either there was a problem with the sink or with the supply of water from the provider. All the health facilities had electricity and adequate room light.

The study also assessed the availability of reusable equipment and supplies. In 28 of the health facilities, examination gloves and clean gloves were available and in 25 of them had reusable masks, 22/31 had goggles and 29/31 had aprons. Among the 31 health facilities, 29 of them have sterilizers and adjustable lighting. One non-functional sterilizer and adjustable lighting were observed.

We further analyzed the availability and adequacy of materials for prevention of infection that may occur during abortion. Sharp disposal containers were available in 30/31 of the sampled health facilities. It was also observed that disposable containers; contaminated trash and decontamination buckets were available in 29/31, 30/31 and 30/31 of the health facilities, respectively.

In this study attempt was also made to assess the availability of equipment for vital sign and it was found that Sthetscope and BP cuff were available at 30 health facilities and in one of these health facilities it was not adequate because it was used for all Gyn ward patients. Twenty-eight of the facilities had thermometer.

SAC/PAC service specific equipment and supplies

Regarding the availability and adequacy of equipment for PAC/SAC, the study found that only 25 facilities had MVA and of those 4 were not functional and didn't provide SAC/PAC. Twenty-five health facilities had MVA cannula, of which those in 5 of the facilities were not functional and at 8 of the facilities MVA cannula are not available especially number 5 and 6.

All the sampled health facilities were assessed for availability, functionality and adequacy of speculum, uterine sound, tenaculum, sponge forceps, curret and dilators. The study found that 31 had speculum, 27 had uterine sound, 28 had tenaculum, 30 had sponge forceps, 24 had currets, and 26 had dilators. Guauze, cotton, alcohol, disinfectant, antiseptic solution were sufficiently available in all health facilities.

Table 15. Material and supply distribution of selected health facilities, Addis Ababa, April 2008

Characteristics	Available	Functional	Adequate
Equipment for abortion			
MVA	25 (80.6)	21(67.7)	19 (61.2)
MVA cannula	26 (83.8)	21(67.7)	18 (58.1)
Dilators	26 (83.8)	25(80.6)	24 (77.4)
Currete	24 (77.4)	19 (61.2)	18 (58.1)
Speculum	31 (100)	31(100)	28 (90.3)
Tenaculem	28 (90.3)	25 (80.6)	25 (80.6)
Uterine sound	27 (87.1)	25 (80.6)	23 (74.1)

Sponge forceps	30 (96.7)	29(93.5)	28 (90.3)
For Vital sign			
Stetscope	31 (100)	31 (100)	29 (93.5)
BP cuff	31 (100)	31 (100)	29 (93.5)
Thermometer	29 (93.5)	28 (90.3)	25 (80.6)
For infection prevention			
Sterile glove	28 (90.3)	28 (90.3)	28 (90.3)
Examination glove	28 (90.3)	28 (90.3)	28 (90.3)
Clean glove	29 (93.5)	28 (90.3)	28 (90.3)
Goggle	22 (70.9)	22 (70.9)	16 (51.6)
Apron	29 (93.5)	28 (90.3)	25 (80.6)
Mask	25 (80.6)	28 (90.3)	23 (74.1)
Sterilizer	29 (93.5)	28 (90.3)	28 (90.3)
Storage for sterile equipment	31 (100)	28 (90.3)	30 (96.7)
Sharp disposal	30 (96.7)	30 (96.7)	30 (96.7)
Disposing container	29 (93.5)	29 (93.5)	28 (90.3)
Contaminated trash	30 (96.7)	30 (96.7)	29 (93.5)
Decontamination bucket	30 (96.7)	30 (96.7)	28 (90.3)
Chlorine	30 (96.7)	28 (90.3)	30 (96.7)
Syringe and needle	30 (96.7)	28 (90.3)	29 (93.5)

Table15 continued...

Medication			
General anesthesia	16 (51.6)	16 (51.6)	16 (51.6)
Local anesthesia	31 (100)	31 (100)	31 (100)
Antibiotics	30 (96.7)	30 (96.7)	30 (96.7)
Analgesics	30 (96.7)	30 (96.7)	30 (96.7)
Oxytocin	29 (93.5)	29 (93.5)	29 (93.5)
IV fluid	30 (96.7)	30 (96.7)	30 (96.7)
Adjustable light	29 (93.5)	28 (90.3)	28 (90.3)
Oxygen tank with set	27 (87.1)	18 (58.1)	18 (58.1)
Ambu bag	27 (87.1)	25 (80.6)	24 (77.4)

Suction machine	26 (83.8)	24 (77.4)	24 (77.4)
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Finally, attempt was made to analyze the preparedness of the 21 health facilities that claimed providing PAC/SAC. Accordingly, the finding shows that all facilities had MVA, MVA cannula, speculum, and sponge forceps. However, only 20 of the facilities had tenaculum and uterine sound. It was also found that only 19 of the facilities were equipped with dilators and curette.

CHAPTER SIX

DISCUSSION

Unplanned and unwanted pregnancies and unsafe abortions are serious public health problems in the developing world. National laws and policies directly affect women's access to safe abortion. Restrictive national laws, particularly in developing countries, result in inequitable access to safe abortion, large number of maternal deaths and injuries, and violations women's sexual and reproductive rights. Even in countries where abortion is allowed by Law safe public sector services are commonly not available even for eligible women (37, 38). Ethiopia falls under this latter category. In Ethiopia, despite the introduction of the new proclamation in 2004, which amends the 1997 Penal Code in such a way, that abortion is allowed in a relatively larger number of cases; the incidence of unsafe abortion still remains high. Studies that have addressed similar scenarios in other developing countries stressed. In addition to the law, which allows safe abortion,

the importance of the perception of health, providers and the capacity of health facilities in reducing abortion related maternal mortality were looked into consideration.

Provider attitudes would have potential consequences for women's already with scarce access to safe abortion services. Women's access to safe abortion services is dependent on providers' willingness to offer service, offer a choice of methods, and provide clients with quality services. One must understand how individual, socio-cultural, and institutional barriers can be addressed in order to provide women with higher quality services (39).

The investigator was not able to find similar studies in Ethiopia during the post liberalization period, perhaps because the topic is thought to be sensitive issue, and because it has not been long since the new Law supplanted the old Penal Code. Therefore, the present study tries to assess, the perception and willingness of health providers to participate in safe abortion service, their views about the Law governing abortion in the Country, the factors shaping their views and finally preparedness of health facilities to provide safe abortion.

Given these objectives, the first task of the study was to analyze the understanding about safe abortion among health providers. Although three-quarter of the respondents said they knew what safe abortion means the finding from the follow up questions shows that the knowledge of the providers were diverse and in a number of cases inconsistent with the standard definition, which describes safe abortion as "*the termination of pregnancy by qualified and skilled persons using correct techniques in sanitary conditions*" (21).

The other important finding that emerges from the study is that, although the vast majority of the respondents claimed that they knew the procedures for termination of pregnancy, namely, MVA, D&C, and E&C, only few knew about oxytocin, prostaglandins, and misoprostol. This could be due to the fact that, in Ethiopia so far, only few had access to up to date trainings pertaining to pregnancy termination. This proposition can be evidenced by the result from this study; among the sampled health

providers, only 123 (29.4%) reported that they had training on pregnancy termination. This, unequivocally, suggests the need to introduce procedures of pregnancy termination during health service providers' pre-service training. With this regard, there are ongoing efforts on the part of non-governmental organizations such as Ipas, which is currently working with MOH to give training on safe termination of pregnancy. It, mainly, focuses on how to use MVA and, partly, this may be the reason on why slightly more health providers are aware of MVA.

Another interesting pattern emerges when one looks at the finding (Table3) on the percentage of health practitioners who had performed pregnancy termination. That is, the number of respondents who had the experience of terminating pregnancy is slightly larger than those who had training on termination procedure. One possible explanation for this discrepancy could be the increase in the number of pregnant women who seek abortion in the face of limited number of professionals capable of undertaking the task.

In line with the guideline for safe termination for abortion service, the respondents unanimously indicated that the ideal gestation period for termination of pregnancy is until 12 weeks. Another encouraging result is that almost all respondents were well aware of the complications of unsafe abortion and subsequent measures to be taken.

The finding that only a quarter of respondents were willing to participate in pregnancy termination is striking and shows the challenge posed by lack of awareness among professionals. The majority preferred the provision of MVA followed by E&C. It seems that providers' willingness to participate in pregnancy termination is largely influenced by their previous training experience. However, it is encouraging that the majority of the respondents were willing to participate in contraception counseling and provision of the service. Those respondents who said they would not participate in pregnancy termination were asked to reveal their reasons and the majority put religion and personal value on defense. A likely explanation for this is that religion and personal value outweigh professional ethics in shaping the perception and actual practice of health professionals in the country.

Results also suggest that nearly 12% of the providers believed that women use abortion as contraceptive. This raises concern because the view of these respondents is contrary to what governments agreed during the 1994-ICPD program of action that ‘abortion should not be promoted as a method of family planning’ (7).

Another intriguing finding is that only half of the respondents knew at least one component of PAC. Of those who reported at least one component, the majority indicated counseling and contraceptive and FP services and only few mentioned linkage with other reproductive health service and referral from community to service provider. A likely explanation for this is that earlier PAC components were three and most of the respondents had probably got trained in that context. With this respect, our finding is similar with what was found in a study by ESOG (29).

WHO guidance for safe abortion clearly indicated that women should receive information on post-abortion contraception and FP method and similar researches on the issue has also shown the effectiveness of contraceptive services in reducing unplanned pregnancies (20). The finding from this study reiterates these arguments. The majority (87.4%) of the respondents said modern contraceptive is important to prevent unsafe abortion. Furthermore, nearly all respondents reported that they had offered oral contraceptive and injectable.

Given the central role of health providers in providing abortion, their knowledge on the very existence of the Law and its provisions, their attitude toward the Law that governs abortion in Ethiopia are very important. With this understanding, the first question asked in relation to the abortion Law of the Country was whether or not respondents knew the current Law of abortion. The majority (68%) of the respondents said they are familiar with the current abortion Law (Proclamation NO. 414/2004) (13).

The current Law governing access to abortion clearly indicates that termination of pregnancy by a professional is not punishable where pregnancy is the result of rape or

incest; or if the continuance of the pregnancy endangers the life of the mother or the child or if the child has an incurable and serious deformity, or if the pregnant woman is unfit to bring up the child (13, 14). Despite this fact, only two third of the respondents were aware that pregnancy occurred due to incest is unpunishable, only half of the respondents were aware that abortion is unpunishable if the mother is physically or psychologically not capable and if in the case of emergency. However, it is encouraging that the majority (92.6%) was aware that termination of pregnancy caused by rape is permitted and nearly two-third was aware that termination is unpunishable if the baby is recognized to be malformed. Slightly more than seventy two percent of the respondents said unpunishable if the mother and the baby are at risk. According to the result, it seems that when it comes to specific cases in which abortion is allowed a sizeable portion of respondents, including those who initially thought they knew the Law, misunderstood the true spirit of the Law.

According to the old Penal Code (11) abortion was allowed under very limited conditions and it further required police evidence, witness or medical evidence and the signature of three physicians indicating that the pregnancy has a problem if continued. According to the new proclamation, however, the words of the woman are sufficient to perform termination. Given this fact respondents were asked whether or not mother's words suffice to perform abortion and the finding shows that only slightly more than half of the respondents got it right (14). A likely explanation for this is the appropriateness of the source of information on which the respondents relied on. This can be evidenced by the fact that only 8.6% knew about the law from own reading.

The ability to decide on personal matter is essential towards the fulfillment of women's human rights with a direct implication on the achievement of the MDG 3 on gender equality (40). From a human rights perspective, compelling a woman to serve others by bearing unwanted child is a clear denial of her human dignity and autonomy and an abuse of her reproductive rights and capacities. Application of human right to sexual and reproductive health emphasized the right to be free from all forms of discrimination including "*Discrimination with regard to access to sexual and reproductive health service and right to information and education*". Moreover it "...discourages programs

which do not give full information on the relative benefits, risks and effectiveness of all methods of fertility regulation” (7). With this general understanding, respondents were asked whether or not a woman should decide to have legal abortion. Contrary to our expectation, the majority of the respondents 231 (55.1%) were against the idea that women herself should decide whether or not to have a legal abortion.

The present study tried to obtain information on which type of abortion Law health providers would prefer. Attitude favoring abortion to be legal was found only in 41.8% of the respondents. However, it is encouraging that about 82.3% of those who would prefer abortion to be legal justified their choice by saying that legalization reduces mortality and morbidity due to unsafe abortion. Perhaps the most interesting result is that, although only less than half of the respondents opted for legalization nearly all (96.7%) health providers identified unsafe abortion as a very serious health problem. Apparently, while those health providers are not, personally, in favor of legalization for various reasons including religion and culture they are well aware of the consequences of unsafe abortion.

Even though, almost all health providers believed that abortion is a very serious health problem and nearly half of them acknowledge abortion should be legal and accessible to all women, in actual practice only 37% were willing to give abortion service and only 29% of them are involved in actual practice. The result of this study is similar with what was found in Argentina and Ghana (25, 27). In such a situation trainings intended towards improving the attitude of health providers are fundamental.

A research conducted by ESOG prior to liberalization suggested that *‘the secrecy surrounding abortion forces women to use any available method of abortion irrespective of its safety’ (29).* The study further noticed that complications of the unsafe abortions are compounded by the legal restrictions prevailed at that time. However, the findings of this study shows that even after liberalization women’s access to safe abortion are limited partly due to provider’s unfavorable attitude towards abortion. A similar study conducted in South Africa also shows that after liberalization only few facilities are providing safe

termination of pregnancy and still women have limited access to safe abortion services (34).

Despite the limited number of high-level health professionals in the Country which entails the need for mid-level providers participation, only less than one-third of the respondents thought that mid-level health practitioners could perform medical and surgical abortion. The Technical Guideline also permits that midlevel health provider can perform except sharp metal curette to access and avail quality safe abortion service (14). This finding is also in line with a research done in Mozambique (35).

The present study tried to fit logistic regression, by taking mean attitude score as the outcome variable, in order to disentangle the factors shaping the attitude of health practitioners included in the study. The finding from the regression shows that those who already performed abortion were more likely (OR 2.984 with CI, 1.907-4.672) to be pro-abortion than those who had never performed termination. As expected, those who had claimed to be familiar with the Law were more likely (OR 2.270 with CI, 1.491-3.458) to favor safe abortion compared to those with limited knowledge about the Law governing abortion. When a similar logistic regression was fitted for the same explanatory variables but with 'preference to legalization' as the outcome variable, the significance association was maintained for those who already performed abortion while the significance disappeared for those who were familiar with the Law. Perhaps the most interesting finding obtained from these regressions is that all socio demographic variables were not statistically significant in explaining providers' attitude toward safe abortion. This finding is consistent with the result obtained by a study done in Tigray, Ethiopia (41). Thus, as far as the study's sample is concerned, actual practice and knowledge of the provider about the Law governing abortion in the Country seem more important in moderating provider's attitude towards abortion. Unequivocally, this implies that efforts to enhance providers' knowledge about the current abortion Law and increasing their involvement in actual practices would improve the perception of health providers toward safe abortion.

A logistic regression was also fitted by taking preference to full legalization of abortion as the outcome variable and all other attitude characteristics as explanatory variables. In line with expectation, almost all attitudinal characteristics were significantly associated with preference to full legalization. A possible explanation for this finding is that respondent health providers were consistent in their response regarding attitudinal issues.

There is a consensus that introduction of abortion Law that allows termination of pregnancy alone would not guarantee access to safe and legal abortion. In developing countries such as Ethiopia, where abortion is partially liberalized, women's access to safe abortion has long been limited by the availability of facilities capable of providing the service. The present study tried to assess the readiness and preparedness of 33 health facilities in the study area.

Of all, one NGO hospital and one higher clinic reported absence of abortion related services. Moreover, although one hospital reported that it did not give abortion service it was later found that it actually had performed 8 removal retained product during the 3 month period before data collection. The explanation given by the head nurse was that since the facility belongs to a certain religious group it performs abortion only if there is emergency case.

Among those health facilities that provide abortion care service in one-way or another, only 21 of them provide PAC/SAC. This shows that only 2/3 of the facilities provide abortion service, and among these only 16 of had separate room for abortion service and only 17 had standard logbook. Perhaps the most interesting finding is that only 12 of the health facilities perform induced abortion with a gestation of less than 12 weeks. Among others, the most frequent reasons given by the head nurses were; the facility perform only incomplete abortion care, the facility gives only post abortion care, lack of trained person, hospital regulation/administration, induced abortion not yet started and not legal. The

finding partly would speak about the lack of commitment in the part of the facilities (28, 35). Furthermore, especially, the last reason in the list (abortion is illegal) shows that the problem of awareness extends to the directors of sampled facilities.

This study has also analyzed the availability and adequacy of MVA in the sample health facilities. The finding shows that MVA was available in 25 of the health facilities but those in 4 of the facilities were not functional. Other important supplies and equipment, including equipment necessary for D&C, were available in almost all health facilities.

Another encouraging finding is that nearly all health facilities provide different method of contraceptive. However, only 19 health facilities provide post abortion FP methods. This result raises concern because post abortion FP is arguably the most important component of safe abortion.

The findings of this study are consistent with the findings of the study done in South Africa which showed that of the 248 public health facilities designated by the minister of health to provide abortion services, only 73 were doing so and 99% of these facilities were hospitals and the reason was unwillingness of providers to be involved in abortion service (34).

The findings of this research provide valuable information intended to guide efforts to the quality of and access to abortion services in the country. However, since the findings are based on responses, attitudes, and practices of health providers from selected facilities and on observing the availability of some equipment and supplies in the sample facilities rather than directly evaluating quality of care, caution is needed in using the results of the study. It is clear that despite these limitations the findings of the study will serve as a valuable source of information for future studies on the issue.

CHAPTER SEVEN

STRENGTH AND LIMITATIONS

Strength

1. It included both private and public health facilities
2. Use of random sampling method
3. Quality of data was maintained by training and pretest

Limitation

1. Courtesy bias because of the professional data collectors
2. Unavailability of similar study in the country after the revision of the law

CHAPTER EIGHT

CONCLUSION AND RECOMMENDATION

Conclusion

- Although the great majority believed that unsafe abortion was a serious health problem only a quarter of respondent health providers were actually willing to participate in pregnancy termination. The result also suggests that a considerable proportion (12%) of the respondents believed that women use abortion as contraceptives.
- The majority of the respondents claimed that they knew about the current abortion Law although it turned out that a sizable proportion of respondents, including those who initially thought they knew the Law, failed to understand the specific provision of the Law.
- Another intriguing finding is that slightly above half of the respondents were against the idea of that women herself should decide whether or not to have legal abortion.
- Only one-third of the respondents thought that mid-level practitioners could perform medical and surgical abortion.
- Only less than half of the respondents were pro-legalization and these respondents justified their choice by putting that legalization reduces mortality and morbidity attributable to unsafe abortion.
- The finding from the logistic regressions reveal that socio-demographic variables were not important in explaining providers' attitude toward safe abortion, while actual practice and knowledge about the Law governing abortion appeared significantly associated with providers' attitude.
- Majority of the attitudinal characteristics were significantly associated with the outcome variable "preference to full legalization of abortion".
- Health providers' assessment of their respective health facilities and observations from the study indicate that only few facilities have well trained manpower and functional and adequate equipment.
- Despite the fact that basic supplies that are necessary for abortion services would seem available in all health facilities, in some of them it seems inadequate.

Recommendations

- Sensitizing health care providers to the essential nature of safe abortion services and the Law governing abortion is an important step forward in order to ensure the availability and accessibility of safe and legal termination of pregnancy.

- Training of health providers about different type of procedures, reproductive right as well as their sense of ethical obligation to provide safe termination of pregnancy is very crucial.
- Mid-level health providers should be practically involved in termination of pregnancy to make safe abortion services available and accessible.
- Health facilities should revise regulation according to the revised Law of abortion and inform the changes to health providers as well.
- Facilities' should be equipped with essential supplies, equipments and material important for safe termination of pregnancy.

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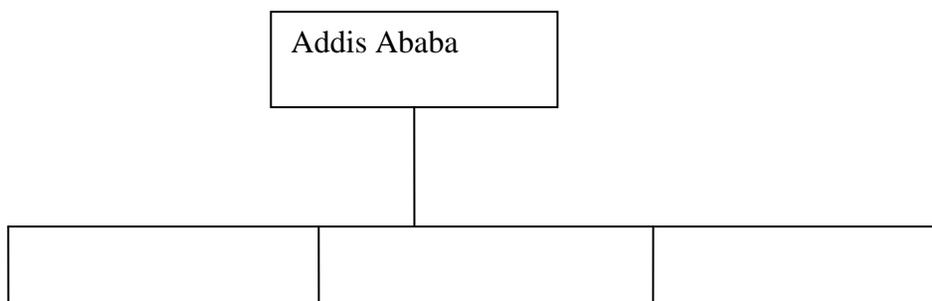
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ANNEX I
SAMPLING PROCEDURE



ANNEX II
CONSENT FORM

How are you, I am _____. This is an interview to be done with you for a study that is being conducted by Addis Ababa University, School of Public Health. I would like to ask you few questions and your willingness in the study. This study is prepared to

obtain relevant information about the perception of health providers and the readiness and preparedness of health facilities towards safe abortion service in selected health facilities at AA. Your participation in the study is very important in reducing the maternal morbidity and mortality rate, which is caused by unsafe abortion and its complication. Your name & address will not be written in this form and will never be used in connection with any information you tell us. All the information given by you will be kept strictly confidential and only used for this study. Your participation is voluntary and you are not obligated to answer any question which you do not wish to answer. If you feel discomfort to respond to any of the question, please feel free to drop it any time you wish to do so. Thank you in advance for your participation in the study.

I have read all the process and the objective of the study and I have understood the same as written. I understand that the research imposes no risk and no compensation would be provided to me.

Could I have your permission to continue?

1. Yes
2. No Stop the interview and thank the respondent.

Witness's signature certifying that the informed consent has been given.

Witness: Signature _____ Dated _____

Data collector: Name _____
Signature _____ Dated _____

Result: Questionnaire completed _____
Questionnaire partially completed _____
Participant refused _____
Others (please Specify) _____

Checked by Supervisor: Name _____

Supervisor's Signature _____ Date _____

Title: Assessment of health provider perception and readiness and preparedness of health institution towards safe abortion at selected health facility in Addis Ababa

INDIVIDUAL QUESTIONNAIRE

Identification

Ser. No	Question	Response	Code	Skip to:
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001	Date of Data Collection	dd / mm/ 2008 -----	
002	Questionnaire Number	XXX -----	
003	Identification Number of Interviewer	XX -----	
004	Name of Health Facility	-----	
005	Health Facility Code	XX -----	
006	Type of Health Facility	1. Central/ specialized Hospital 2. Regional/Zonal Hospital 3. Private Hospital 4. Health Center 99. Other (specify) ----- -----	
007	Ownership of Health Facility	1. Government 2. Private (profit Driven) 3. Other (specify) -----	

PART I: BACKGROUND INFORMATION OF HEALTH PROVIDERS

S.no	Question	Responses	Code	skip to
101	Sex	1. Female 2. Male	/___/	

102	Age in completed year (enter number)	1. _____ year	/____/	
103	Marital status	1.Never married 2.Married 3.Divorced 4.Cohabiting 4.Separated 5.Widowed	/____/	
104	Religion	1.Orthodox 2.Muslim 3.Protestant 4.Catholic 5.Other (Specify) _____	/____/	
105	Profession	1.Oby&Gyn specialist 2.Other Specialist 3.Physician(GP) 2.Midwifery 3.Health officer 4.Nurse 5.Other (Specify) _____	/____/	
106	Years of Professional Experience	1.Less than one year 2.one-three years 3. three -five years 4. five-ten years 5.More than 10 years	/____/	
107	For how long have you been working in this health facility?	_____ year		
108	Primary work place	1.Gov't Hospital 2.Private Hospital 3.Gov't Health center 4.private Higher Clinic	/____/	
109	Employment status at the primary work place	1. full time 2. part time		

PART II: KNOWLEDGE OF HEALTH PROFFESIONALS IN RELATED WITH ABORTION

S.no	Question	Responses	Code	skip to
201	Do you know safe abortion?	1. Yes 2. No	/____/	203

202	Could you describe it?	_____	/____/	
203	What type of abortion procedure do you know? (circle all mentioned)	1. D&C 2. E&C 3. MVA 4. Using Oxytocin 5. Using prostaglandins 6. Using Misopristol 99.other,Specify _____ 88. I don't know	/____/	
204	Do you have a formal training to perform termination of pregnancy?	1.Yes 2.No	/____/	206
205	Which method?	1. D&C 2. E&C 3. MVA 4. Using Oxytocin 5. Using prostaglandins 6. Using Misopristol 99.Other specify _____ 88. I don't know	/____/	
206	Did you ever perform safe termination of pregnancy?	1.Yes 2.Not at all		208
207	When did you perform?	1.before two years 2.b/n the last one and two years 3.within the last six months		
208	If your answer is No, why didn't you perform safe termination of pregnancy? (circle all mentioned)	1.The facility does not provide safe termination of pregnancy 2.Lack of equipment and Supply 3.The facility does not allow us to provide safe termination of pregnancy 4.Over load of work 5.personal reasons 99.Other specify _____ 88. I don't know		
209	When do you think the best time for safe termination of pregnancy?	1.Less than 12 weeks o 2.between 12-24 weeks 3.Greater than 24 99.OtherSpecify _____	/____/	
210	What are the complications of abortion? (circle all mentioned)	1.Bleeding 2.Infection 3.Utrine perforation 4.Infertility 5.Pelivic pain 6.Psycological trauma		

		7.Death 99.Other(Specify)_____		
211	If any complication arises, what would be your responses? (circle all mentioned)	1.Take vital signs 2.Secure IV line 3.Start antibiotics 4.Consult Seniors 5.Counsel the woman 99.other Specify _____ 88.I don't know	/____/	
212	Do you know the components of PAC/SAC?	1.yes 2.no	/____/	214
213	Which components do you know? (circle all mentioned)	1.Community and service provider partnership 2.counseling 3.Treatment of incomplete and complication of unsafe abortion 4.Contraceptive and FP service 5.Integration of Reproductive and other health Service	/____/	
214	How do you counsel a woman who comes for safe termination of pregnancy? (circle all mentioned)	1.Inform abortion is legal 2.Inform abortion is illegal 3.Counsel only on the benefit of the procedure and perform termination of pregnancy 4.Counsel only on the risk of the procedure and perform termination of pregnancy 5.Counsel both the benefit and risk of the procedure and perform termination of pregnancy 6.Refer the woman to a site where you know that she could have a safe abortion 7.Counsel her on the risk of abortion and recommend continuing with the pregnancy 8.Advise the woman to speak to a religious cleric 99.other(specify)_____ 88.I don't Know	/____/	
215	Are you familiar with the revised law of abortion care?	1.yes 2.No	/____/	217
216	From where did you hear about it?	1.Friend 2.Radio 3.TV 4.FMOH Guidelines 5.Read the revised penal code 99.Other(specify)_____	/____/	

217	What type of information do you have on abortion legislation?	1.Abortion is legalized 2.Abortion is not legalized 3.Abortion is liberalized 4.Abortion is legal in certain circumstances 99.Other(specify)_____	/____/	
218	Do you know the condition currently abortion is unpunishable according to Ethiopia criminal law?	1.Yes 2.No	/____/	221
219	What are they? (circle all mentioned)	1.The pregnancy is due to incest 2.Rape 3.Congenital malformed baby 4.If mother or baby condition is at risk due to the pregnancy 5.If mother is physically or psychologically unable to raise the child 6.In emergency condition 99.other Specify_____	/____	
220	If your answer is choice one and two, what additional evidences are required?	1.At least 3 witnesses 2.Police evidence 3.Mothers word only 99.other specify_____	/____	
221	Did you council about Family Planning after abortion care?	1.yes 2.sometimes 3.not at all	/____	224
222	After counseling, Did you offer FP method?	1.yes 2.sometimes 3.not at all	/____/	
223	If yes, which method? (circle all mentioned)	1. Condom 2. Spermicidal 3. Diaphragm or Cervical Cap 4. Oral Contraceptives 5. Injectables 6. Implant (Norplant) 7. IUD 8. Female Sterilization 9. Male Sterilization 10.Periodic Abstinence (Rhythm,Temp(T ⁰),Cervical mucus) 11. Withdrawal 12.Other(specify)_____	/____	
224	If No, why?	Mention_____	/____	

PART III: ATTITUDES OF HEALTH PROFFESTIONALS IN RELATED WITH ABORTION

S.no	Question	Responses	Code	skip to
------	----------	-----------	------	---------

301	Why do you think women seek abortion? (you can have more than one answer)	1.Inadequate Knowledge 2.Economical constraint 3. Used as a Contraceptive 4.To avoid unwanted pregnancy 5. Health reasons 6. Partner pressure 7. Too many and too close pregnancies 8. To complete their education 9. Not being married 99.Other(specify)_____ 88.Dont know	/____/	
302	Do you feel comfortable working in a site where termination of pregnancy is being performed?	1.Yes 2.No 88.Do not know	/____/	303
303	If your answer is No, What are your reasons?	1.Out side of the scope of my practice 2.Against my religious practice 3.Against my Personal value 4.I didn't have the opportunity to be trained in abortion technique 99.Other(specify)_____	/____/	
304	Do you agree on the current legislation and institutional regulation of termination of pregnancy?	1.yes 2.no 88.Don't know	/____/	
305	Elective abortion should be legal and accessible under any circumstance	1.Agree 2.Neutral 3.Disagree 99.Other Specify _____	/____/	
306	Do you think access to safe termination on demand based on the guideline would reduce maternal death?	1.yes 2.no 88.Don't know	/____/	
307	Do you think complication of unsafe abortion including mortality is a very serious health problem in Ethiopia?	1.yes 2.no 88.Don't know	/____/	
308	Do you think expansion of access to quality abortion services is a key step to reduce unsafe abortion?	1.yes 2.no 88.Don't know	/____/	
309	Do you think termination of unwanted pregnancy is a sinful act?	1.yes 2.no 88.Don't know	/____/	
310	Do you think, you would support your friend or relatives to terminate an unwanted pregnancy?	1.yes 2.no 88.Don't know	/____/	
311	Legal abortion is used as a form of contraception.	1.Agree 2.Neutral 3.Disagree	/____/	
312	The law should not penalize abortion when the woman makes an autonomous decision.	1.Agree 2.Neutral 3.Disagree	/____/	

313	Legal abortion should be permitted even if the woman had felt the fetal movement.	1. Agree 2. Neutral 3. Disagree	/____/	
314	Legal abortion should be permitted under any circumstances	1. Agree 2. Neutral 3. Disagree	/____/	
315	If abortion on demand is legally allowed, what type of women do you think should not be allowed to do so? (circle all mentioned)	1. All women 2. Women with no medical indication 3. Married women 4. Unmarried women 5. Students 6. Victims of incest 7. Victims of rape 8. very young women 9. All should be allowed 88. Don't know 99. Other (specify)_____	/____/	
316	If abortion on demand is not yet legalized (not legally allowed) at present in Ethiopia, do you prefer that to be legalized?	1. I prefer it to be legalized 2. I prefer it not to be legalized 3. I don't mind 99. Other (specify)_____	/____/	319
317	Why do you prefer abortion on demand to be legalized? (circle all mentioned)	1. Abortion is a health problem in our area 2. Can facilitate to get service in safe area and by trained provider. 3. Can reduce morbidity and mortality due to unsafe abortion 4. Can solve problems of unwanted pregnancies 5. Can reduce cost for inducing abortion 88. I don't know 99. Other (specify)_____	/____/	
318	When do you wish abortion on demand would be legally allowed?	1. Now 2. Near future 3. Late future 4. I don't mind at any time 5. I do not know 99. Other (specify)_____	/____/	
319	Why do you prefer abortion on demand not to be legalized? (circle all mentioned)	1. My religion doesn't allow (abortion is against God's will) 2. Culturally not accepted 3. It is homicide on the fetus 4. Encourages to have unwanted pregnancies 5. Encourages pre/extra-marital sex 88. I don't know 99. Other (specify)_____	/____/	
320	Do you think a woman has the right to terminate her pregnancy if she wishes?	1. Yes 2. No 99. Other (specify)_____	/____/	

321	In general, if people for some reasons decide to terminate their pregnancies, do you agree or disagree to terminate those pregnancies?	1. Agree 2. Disagree 3. Don't mind 99. Other (specify) _____	/____/	
322	If abortion on demand is legally allowed, what problems do you think that could be encountered? (circle all mentioned)	1. Opposition from religious group 2. Opposition from the whole community 3. Opposition from part of the community 4. Lack of trained man power 5. Lack of adequate service provision facilities 6. Shortage of fund 88. I don't know 99. Other (specify) _____	/____/	
323	Before starting providing legal abortion services on demand, what preconditions, do you think should be fulfilled? (circle all mentioned)	1. Training of providers 2. Organizing/establishing of service provision facilities 3. Securing fund 4. Obtaining approval from community 5. Obtaining approval from religious leaders 88. Don't know 99. Other (specify) _____	/____/	
324	What measures do you think should be taken to prevent problems due to unsafe abortion (abortion in unhygienic conditions and by untrained provider)? (circle all mentioned)	1. Use of modern contraceptives to prevent unwanted pregnancies 2. Use of traditional/natural family planning methods to prevent unwanted pregnancies 3. Avoiding sex if unmarried to prevent unwanted pregnancies 4. Gave birth if once get pregnant 5. Health education on Pregnancy/complications and prevention of abortion/ family planning. 6. Use of safe abortion services 7. Abortion legalization 88. Don't know 99. Other (specify) _____	/____/	
325	What do you think the reasons could be for not legalizing abortion on demand, in Ethiopia? (More than one answer is possible).	1. Religion 2. Culture 3. Lack of facility/provider 4. Poverty 88. I do not know 99. Other (specify) _____	/____/	
326	Woman should have her baby and then give it up for adoption instead of having an abortion.	1. Agree 2. Neutral 3. Disagree	/____/	
327	The woman herself should decide whether or not to have a legal abortion.	1. Agree 2. Neutral 3. Disagree	/____/	
328	If you disagree that women should decide, who else do you think should be involved in the decision to have an	1. Phycician 2. Midwife? nurse 3. Partner/ man	/____/	

	abortion?	4.family 99. other specify_____		
329	I am more comfortable with medical abortion than surgical abortion.	1.Agree 2.Neutral 3.Disagree	/___/	
330	It's acceptable for a woman to choose abortion because of a fetal anomaly or congenital disorder.	1.Agree 2.Neutral 3.Disagree	/___/	
331	It's acceptable for a woman to choose abortion under any circumstance.	1.Agree 2.Neutral 3.Disagree	/___/	
332	Mid level health providers should be able to provide medical abortion.	1.Agree 2.Neutral 3.Disagree	/___/	
333	Mid level health providers should be able to provide surgical abortion.	1.Agree 2.Neutral 3.Disagree	/___/	
334	Every program that addresses women's health should include Safe/post abortion training.	1.Agree 2.Neutral 3.Disagree	/___/	
335	Do you think this facility has adequate and functional equipment for safe abortion service?	1.Agree 2.Neutral 3.Disagree	/___/	
336	Do you think this facility has a well trained staff to give safe abortion service?	1.Agree 2.Neutral 3.Disagree	/___/	
337	Do you think essential supplies and drugs, which are necessary for safe abortion, are adequate and available?	1.Agree 2.Neutral 3.Disagree	/___/	
338	Do you think this facility is ready to give safe abortion?	1.Agree 2.Neutral 3.Disagree	/___/	

PART IV: Intentions with Activities associated with abortion

Variable	Would participate	Wouldn't participate	Code
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401.Procedure			
401.1 D& C			/___/
401.2 E &C			/___/
401.3 MVA			/___/
402.Caring for patient			
402.1 Psychological screening			/___/
402.2 Psychological preparation			/___/
402.3 Care during abortion			/___/
402.4 Care in immediate post abortion period			/___/
403.Counseling and teaching patient			
403.1 Means of Abortion			
403.2 Encourage abortion			
403.3 Give abortion service			
403.4 Contraceptive counseling and offering different methods			

CHECKLIST FOR OBSERVATION OF HEALTH INSTITUTION

Facility review for safe abortion Checklist

Name of Facility _____

Source of information used to complete this form: _____

Form completed by: _____

Form completed on: _____

Type of facility

Hospital _____

Health center _____

higher Clinic _____

Type of operating agency

Government _____

Private _____

1. Does this facility provide SAC/PAC? Yes _____ No _____

2. If the answer for Q No 3 is No, where do you provide PAC/SAC service?

3. How many staff members/personnel that provide uterine evacuation service have received in service training in MVA clinical skill?

- Obs/ Gyne, number: _____
- Midwife, number: _____
- Health Officer, number: _____
- Nurses, number: _____
- Other members, number: _____

4. Does the health facility provide FP service?

5. Which of the following contraceptive commodities are available in the facility?

- a. Combined Pill _____
- b. Progestin only pill _____
- c. IUD _____
- d. Injectable _____
- e. Norplant _____
- f. Condom _____
- g. Diaphragm/Cervical cup _____
- h. Other Specify _____

6. Where are family planning services provided to clients?

FP unit _____

Abortion treatment room _____

Other (specify) _____

7. Do you have a standard abortion log book and reporting format? Yes _____

No _____

Service statistics

2.1 Check yes or No for each of the following items

Where the following services performed at least once during the last three month

1. Number of cases of incomplete abortion of 12 or less weeks of gestation_____
2. Number of cases of incomplete abortion of more than 12 weeks of gestation: _____
3. Number of cases of safe abortion of less than 12 weeks _____
4. Performance of induced abortion for uterine size less than 12 weeks. Yes____
No____ If not, why? _____
5. Removal of retained product for uterine size less than 12 weeks. Yes ___No___ If
not, why? _____
6. Performance of induced abortion for uterine size > 12 weeks. Yes____ No____ If
not, why? _____
7. Removal of retained products for uterine size > 12 weeks. Yes____ No____
If not, why? _____
8. Provision of safe/post abortion contraceptive methods. Yes____No____
If not, why? _____
If yes, which methods are available?_____
9. Perform blood transfusion if needed. Yes____ No____
If not, why? _____
10. Administer essential antibiotic for oby-gyn patient if needed. Yes____ No____ If not,
why? _____
11. Administer Intravenous fluid for oby-gyn patient if needed. Yes____ No____ If
not, why? _____
12. Administer oxytocin Yes____ No____
If not, why? _____
13. Is there a separate room for safe/post abortion service? Yes____ No____
If not, why? _____

Essential equipment and supplies

Equipment and Supplies	Available		Functional		Adequate	
	Yes	No	Yes	No	Yes	No
A. Facility						
Privacy						
Examination table						
Beds						
Stretchers						
Chairs or benches						
Toilet for patients						
Sink						
Running water						
Adequate room lighting						
Electricity						
B. Reusable equipment and supplies						
Examination glove						
Cleaning glove						
Reusable masks						
Eye protection (goggles)						
Surgical gowns or aprons						
Adjustable lighting						
Sterilizer						
Container (For storing sterilized instruments)						
Stethoscope						
Blood pressure gauge						
Thermometer						
Vaginal speculum						
Uterine sound						
Tenaculum						
Sponge forceps						
Sharp disposal container						
Container for disposing contaminated trash						
Decontamination bucket						
Oxygen tank with set						
Ambu bag						
Suction apparatus						
MVA						
MVA cannulae 4mm-12mm						
Curette (7mm & 12mm)						
Dilators						
IEC materials						
C. Disposable supplies						
Disposable sterile gloves						
Disposable masks						
Disposable different size syringes with needles						

Cotton swabs						
Gauze						
Cotton						
Alcohol						
Disinfectant						
Antiseptics solution to clean vagina and cervix						
Chlorine for disinfections /decontamination						
Soap						
IEC materials for patients to keep						
different types of FP methods						
D. Medication						
General Anastasia						
Local anesthesia						
Analgesics						
Antibiotics						
Pitocine						
Ergometrine						
IV fluid with its set						

ክፍል አንድ: ስለ ጤና ባለሙያው መሠረታዊ ጥያቄ

ተ.ቁ	ጥያቄ	መልስ	ኮድ
101	የታ	1 ሴት 2 ወንድ	
102	ዕድሜ በሙሉ ዓመት (እድሜዎትን በክፍት ቦታው ውስጥ ይሙሉ	1 ----- ዓመት	
103	የጋብቻ ሁኔታ	1 ያገባ/ች 2 የፈታ/ች 3 አብረው የሚኖሩ 3 ያልፈቱ (ተለያይተው የሚኖሩ 4 የሞተበት/ባት 5 ያላገባ/ች	
104	ኃይማኖት	1 ኦርቶዶክስ 2 እስላም 3 ፕሮቴስታንት 4 ካቶሊክ 5 ሌላ ይግለፁ-----	
105	ሙያዎት	1. የማህፀን ሐኪም 2. የልላ ሐኪም 3. ጠቅላላ ሐኪም 2 አዋላጅ ነርስ 3 ጤና መኮኒን 4 ነርስ 99. ሌላ ይግለፁ -----	
106	የሥራ ልምድ	1 ከአንድ ዓመት በታች 2 ከ1-3 ዓመት 3 ከ3-5 ዓመት 4 ከ5-10 ዓመት 5 ከ10ዓመት በላይ	
107	በዚህ ጤና ድርጅት ለምን ያክል ጊዜ ሰርተዋል?	-----ዓመት	
108	ተቀዳሚ የስራ ቦታዎት የት ነው?	1 የመንግስት ሆስፒታል 2. የግል ሆስፒታል 3. ጤና ጣቢያ 4. የግል ከፍተኛ ክሊኒክ	
109	ተቀዳሚ የስራ ቦታዎት ያለዎት የቅጥር ሁኔታ ምን ይመስላል?	1. ሙሉ ሰዓት 2. በትርፍ ሰዓት	

ክፍል ሁለት፡ የጤና ባለሙያዎች ጥንቃቄ ስለአለው የጽንሰ ማቋረጥ ስላላቸው እዉቀት ጥያቄ

ተ.ቁ	ጥያቄ	መልስ	ኮድ
201	ጥንቃቄ ያለው የፅንሰ ማቋረጥ ያውቃሉ?	1.አዎ 2.አላውቅም	
202	ሊገልፁልኝ ይችላሉ?	----- -----	
203	ምን አይነት የፅንሰ ማቋረጫ ዘዴ ያውቃሉ?(የተመለሰውን ያክብቡት)	1. የማህፀን በር በማስፋትና መጥረግ (D &C) 2. ማህፀን ውስጥ ያለን ነገር ማውጣትና መጥረግ(E & C) 3 MVA (ኤም ቪ ኤ) በእጅ ቫኪዩም መምጣጥ 4. አክሲቶሲን መጠቀም 5. ፕሮስቶግላንዲስ መጠቀም 6. ሚዛፕሪስቶን መፎቀም 99. ሌላ ይግለፁ ----- 88. ምንም አይነት ዘዴ አላውቅም	
204	እርግዝናን ለማቋረጥ የሚሆን ስልጠና ወስደዋል? መልስዎ አልወሰድኩም ከሆነ ወደ ጥያቄ ቁጥር 3 ይልፉ	1. አዎ 2. አልወሰድኩም	
205	ምን አይነት ዘዴ ነው ስልጠና የወሰዱት?	1. የማህፀን በር በማስፋትና መጥረግ (D &C) 2. ማህፀን ውስጥ ያለን ነገር ማውጣትና መጥረግ(E & C) 3 MVA (ኤም ቪ ኤ) በእጅ ቫኪዩም መምጣጥ 4. አክሲቶሲን መጠቀም 5. ፕሮስቶግላንዲስ መጠቀም 6. ሚዛፕሪስቶን መፎቀም 99. ሌላ ይግለፁ ----- 88. ምንም አይነት ዘዴ አላውቅም	
206	ጥንቃቄ ያለው የጽንሰ ማቋረጥ ስርተው ያውቃሉ?	1.አዎ 2.አላውቅም	
207	መቼ ነው የሰሩት?	1.ከሁለት አመት በፊት 2.ባለፉት ሁለት እና አንድ አመት መካከል 3.ባለፉት 6 ወራት ውስጥ	
208	መልስዎ አልስራሁም ከሆነ ለምን?	1.ድርጅቱ የጽንሰ ማቋረጥ አገልግሎት አይሰጥም 2.የአቅርቦትና የእቃ እጥረት 3. ድርጅቱ የጽንሰ ማቋረጥ አገልግሎት ለመስጠት አይፈቅድልንም? 4.የሥራ ጫና 5.የግል ምክንያት 99. ሌላ ይግለፁ ----- 88. አላውቅም	
209	ለጽንሰ ማቋረጥ ጥሩ ጊዜ መቼ ይመስልሃል?	1.ከ 12 ሳምንት በታች 2.በ12 እና 24 ሳምንት መካከል 3.ከ24 ሳምንት በላይ 99. ሌላ ይግለፁ -----	

210	በፅንስ ማቋረጥ ምክንያት የሚመጣው ችግር ምንድን ነው/ናቸው	<ol style="list-style-type: none"> 1. የደም መፍሰስ 2. በሰውነት ውስጥ ጀርም መግባትና መባዛት 3. የማህፀን መበሳት 4. አለመውለድ/መፀነስ ያለመቻል 5. ማህፀን አካባቢ ህመም 6. የአእምሮ መጎዳት 7. ሞት <p>99. ሌላ ይግለፅ -----</p>	
211	በፅንስ መቋረጥ ምክንያት ችግር ቢፈጠር ምን ያደርጋሉ? (ከአንድ በላይ መልስ ካለዎት ይጥቀሱ)	<ol style="list-style-type: none"> 1. ዋነኛ መመዘኛ ምልክቶችን መለካት 2. በደም ስር የሚሰጥ ንጥረ ነገር መጀመር 3. ፀረ ባክቴሪያ መጀመር 4. የበላይ ከፍተኛ ባለሙያን መጥራት 5. እናትየዋን መምከር <p>99. ሌላ ይግለፅ -----</p> <p>88. አላውቅም</p>	
212	ከጽንስ ማቋረጥ በኋላ መደረግ ያለባቸውን ነገሮች ያውቃሉ?	<ol style="list-style-type: none"> 1. አዎ 2. አላውቅም 	
213	ከፅንስ ማቋረጥ በኋላ የሚደረጉ እንክብካቤዎች ምን ምን ያካትታሉ	<ol style="list-style-type: none"> 1. የህብረተሰብና የጤና አገልግሎት አጋርነት 2. የምክር አገልግሎት 3. ያልተጠናቀቁና ጥንቃቄ የጎደለው የፅንስ ማቋረጥ 4. የወሊድ መቆጣሪያና የቤተሰብ ምጣኔ 5. ሥነ ተዋልዶና ሌላ የጤና አገልግሎት <p>99. ሌላ ይግለፅ -----</p> <p>88. አላውቅም</p>	
214	ጥንቃቄ ለተሞላበት ፅንስን ለማቋረጥ ለመጣች እናት ምን አይነት ምክክር ያደርጋሉ? (ከአንድ በላይ ከሆነ ቁጥሮችን ይክበቧቸው)	<ol style="list-style-type: none"> 1. ስለ ፅንስ ማቋረጥ ህግ እነግራታለሁ 2. ስለ ፅንስ ማቋረጥ ዘዴ ጥቅም ብቻ እነግራትና የፅንስ ማቋረጡን እሰራለሁ (አከናውናለሁ) 3. ስለፅንስ ማቋረጥ ዘዴ የሚያመጣውን ችግር ብቻ እነግራትና የፅንስ ማቋረጡን እሠራለሁ (አከናውናለሁ) 4. የፅንስ ማቋረጥ ዘዴ አሰራር ጥቅምና የሚያመጣውን ችግር እነግራትና ፅንስ ማቋረጡን እሠራለሁ 5. እናትየዋ ጥንቃቄ ያለው የፅንስ ማቋረጥ ሥራ የሚሠራበትና እሷ ወደምታውቀው ቦታ እልካታለሁ 6. ፅንስ ማቋረጥ የሚያመጣውን ችግር በምክር አገልግሎት እነግራትና በእርግዝናው እንድትቀጥል እመክራታለሁ 7. እናትየዋ የኃይማኖት አባቶችን እንድታነጋግር እመክራታለሁ <p>99. ሌላ ይግለፅ -----</p> <p>88. አላውቅም</p>	

215	ስለ ተሻሻለው የፅንሰ ማቋረጥ ዘዴ ሠምተዎል? መልስዎ አልሠማሁም ከሆነ ወደ ጥያቄ 10 ይለፉ	1. አዎ 2. አልሠማሁም	
216	መልስዎት አዎን ከሆነ ከየት ሰሙ?	1. ከጓደኛ 2. ከፊደዮ 3. ከቴሌቪዥን 4. ከጤና ጥበቃ መመሪያ 99. ሌላ ይግለፁ-----	
217	ስለ ፅንሰ ማቋረጥ ህግ ምን አይነት መረጃ አለዎት?	1. ጽንሰ ማቋረጥ ህጋዊ ነው 2. ጽንሰ ማቋረጥ ህጋዊ አይደለም 3. ጽንሰ ማቋረጥ በአንጻራዊነት ለቀቅ/ላላ ያለ ነው 4. ጽንሰ ማቋረጥ በተወሰነ ሁኔታ ህጋዊ ነው 88. አላውቅም 99. ሌላ ይግለፁ -----	
218	በኢትዮጵያ ፍታብሄር ህግ መሰረት የማያስቀጣው የጽንሰ ማቋረጥ ሁኔታ ምን እንደሆነ ያውቃሉ?	1.አዎ 2.አላውቅም	
219	መልስዎት አዎን ከሆነ ምን ምን ናቸው?	1.እርግዝናው ከቤተሰብ ከሆነ 2.እርግዝናው በመደራር ከሆነ 3. ጽንሰ ችግር ካለበት 4.እናትየዋ ወይም ጽንሰ በእርግዝናው ምክንያት ችግር ላይ ከሆኑ 5.እናትየዋ በአካል ወይም በአእምሮ ችግር ምክንያት ልጁን ማሳደግ ካልቻለች 6.በድንገተኛ ሁኔታ 99. ሌላ ይግለፁ -----	
220	መልስዎ 1 እና 2 ከሆነ ሌላ ተጨማሪ መረጃ ምን ያስፈልገዎታል?	1.ሦስት ምስክር 2.የፖሊስ መረጃ 3.የእናትየዋ ቃል ብቻ በቂ ነው 99. ሌላ ይግለፁ -----	
221	ስለ ቤተሰብ ምጣኔ የምክር አገልግሎት ሰጥተው ያውቃሉ?	1.አዎ 2.አልፎ አልፎ 3.አላውቅም	
222	የምክር አገልግሎት ከሰጡ በኋላ የቤተሰብ ምጣኔ ሰጥተው ያውቃሉ?	1.አዎ 2.አልፎ አልፎ 3.አላውቅም	
223	የትኛውን ዘዴ ነው?	1.ኮንዶም 2.እስፐርሚሳይድ 3.የማህፀን ቆብ 4.የሚዋጥ እንክብል 5.በመርፌ 6.በክንድ ውስጥ የሚቀበር 7.ሉፕ 8.ማህጸን መቋጠር 9. ዘላቂ ቤተሰብ ምጣኔ ለወንዶች 10.ለተወሰነ ጊዜ ግንኙነት አለማድረግ(የጊዜ ሰሌዳ፣የሰውነት መቀት፣የማህፀን ፈሳሽ፣ 99.ሌላ ይግለጹ-----	

224	ካልሰጡ ምክንያቱ ምንድን ነው?	-----	
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ክፍል ሦስት: የጤና ባለሙያዎች ጥንቃቄ ስለአለው የጽንሰ ማቋረጥ ስላላቸው አመለካከት ጥያቄ

ተ.ቁ	ጥያቄ	መልስ	ኮድ
301	እናቶች ለምን ፅንሰ ማቋረጥ የሚፈልጉ ይመስልዎታል? (ከአንድ በላይ መልስ ካለዎት ይጥቀሱ)	1. የተሟላ እውቀት ባለ መኖር 2. የገንዘብ እጥረት 3. እንደ ወሊድ መቆጣጠሪያ በማየት 4. ያልተፈለገ እርግዝናን ለማስወገድ 5. በጤና ምክንያት 6. የባል ግፊት 7. በጣም ብዙ እና የተቀራረበ እርግዝና 8. ትምህርታቸውን ለመጨረስ 9. ስላላገቡ 88. አላውቅም 99. ሌላ ይግለፁ -----	
302	ፅንሰ ማቋረጥ የሚሠራበት ቦታ መሰረት ምቹት ይሠማዎታል? (መልስህ 1 እና 88 ከሆነ ወደ 304ኛ ጥያቄ ይለፉ)	1. አዎ 2. አይሠማኝም 88. አላውቅም	
303	ምቹት አይሠማኝም ከሆነ መልስዎ ምክንያቱ ምንድን ነው? (ከአንድ በላይ መልስ ካለዎት ይጥቀሱ)	1. ከስራ ድርሻዬ አቅም በላይ ስለሆነ 2. ከሃይማኖት ጋር ስለሚቃረን 3. ከራሴ አመለካከት ጋር ስለሚቃረን 4. ስለ ፅንሰ ማቋረጥ ዘዴ ስልጠና አግኝቼ ስለማላውቅ 88. አላውቅም 99. ሌላ ይግለፁ -----	
304	የፅንሰ ማቋረጥ ህግ እና የጤና ጅርጅት ደንብን በእርስዎ አመለካከት እንዴት ያዩታል?	1. እስማማለሁ 2. ምንም ማለት አልቻልኩም 3. አልስማማም	
305	በፍላጎት የሚደረግ ፅንሰ ማቋረጥ ህጋዊ ሆኖ በሁሉም ቦታና በማንኛውም ሁኔታ መገኘት አለበት	1. እስማማለሁ 2. ምንም ማለት አልቻልኩም 3. አልስማማም	
306	በእርስዎ አመለካከት ጥንቃቄ ያለው የፅንሰ ማቋረጥ በተፈለገ ጊዜ ሁሉ በከፍተኛ የእናቶችን ሞት የሚቀንስ ይመስልዎታል?	1. አዎን 2. የለም 88. አላውቀውም	
307	በእርስዎ አመለካከት ጥንቃቄ የጎደለው የፅንሰ ማቋረጥ ችግር ከፍተኛ የጤና ችግር ይመስልሃል(ሻል)?	1. አዎን 2. የለም 88. አላውቀውም	
308	ጥራት ያለው የፅንሰ ማቋረጥ አገልግሎት ቢስፋፋ ጥንቃቄ የጎደለው የፅንሰ ማቋረጥን ለመቀነስ ቁልፍ እርምጃ ነው ብለው ያስባሉ?	1. አዎን 2. የለም 88. አላውቀውም	
309	በእርስዎ አመለካከት ያልተፈለገ እርግዝናን ማቋረጥ ሃጢያት ነው ብለው ያስባሉ?	1. አዎን 2. የለም 88. አላውቀውም	
310	በእርስዎ አመለካከት ጓደኛዎችን ወይም ዘመድዎችን ያልተፈለገ እርግዝናን ለማቋረጥ የሚረዷቸው ይመስልዎታል?	1. አዎን 2. የለም 88. አላውቀውም	

311	ህጋዊ የሆነ የፅንሰ ማቋረጥ እንደ አንድ የእርግዝና ዘዴ መወሰድ አለበት	<ol style="list-style-type: none"> 1. እስማማለሁ 2. ምንም ማለት አልችልም 3. አልስማማም 	
312	አንድ እናት በእራሷና ያለምንም ተፅእኖ ፅንሰ ለማቋረጥ ከወሰነች ህጉ መቅጣት የለበትም	<ol style="list-style-type: none"> 1. እስማማለሁ 2. ምንም ማለት አልችልም 3. አልስማማም 	
313	አንድ እናት የፅንሱን እንቅስቃሴ በማህፀን ውስጥ በምትሰማበት ደረጃም ቢሆን ህጋዊ የፅንሰ ማቋረጥ መፈቀድ አለበት	<ol style="list-style-type: none"> 1. እስማማለሁ 2. ምንም ማለት አልችልም 3. አልስማማም 	
314	በማንኛውም ሁኔታ ቢሆን ህጋዊ የሆነ የፅንሰ ማቋረጥ መፈቀድ አለበት	<ol style="list-style-type: none"> 1. እስማማለሁ 2. ምንም ማለት አልችልም 3. አልስማማም 	
315	በእርስዎ አመለካከት በፍላጎት ፅንሰ ማቋረጥ ህጋዊ ቢሆን ለየትኞቹ ህጉ መፍቀድ የለበትም ብለው ያስባሉ? (ከ አንድ በላይ መልስ ይቻላል።የተጠቀሱት ብቻ ይክበቡ)	<ol style="list-style-type: none"> 1. ለሁሉም ሴቶች 2. በህክምና እንዲያቋርጡ ከታዘዘላቸው ውጭ ያሉ ሁሉም ሴቶች 3. በትዳር ላይ ያሉ ሴቶች 4. ያላገቡ ሴቶች 5. ለተማሪዎች 6. ለሁሉም መፈቀድ አለበት 88. አላውቅም 99.ሌላ(ይገለጽ)----- 	
316	በፍላጎት ጽንሰ ማቋረጥ በሃገራችን ህጋዊ ቢሆን ይመርጣሉ?	<ol style="list-style-type: none"> 1.ሙሉ በሙሉ ህጋዊ ቢሆን እመርጣለው 2. ህጋዊ ባይሆንእመርጣለው 3. ግድ የለኝም 99.ሌላ(ይገለጽ)----- 	
317	በፍላጎት ጽንሰ ማቋረጥ ሙሉ በሙሉ ህጋዊ እንዲሆን የፈለጉበት ምክንያት ምንድን ነው? (ከ አንድ በላይ መልስ ይቻላል።የተጠቀሱት ብቻ ይክበቡ)	<ol style="list-style-type: none"> 1. ጽንሰ ማቋረጥ በአካባቢያችን የጤና ችግር ስለሆነ 2. ጽንሰ ማቋረጥ በጥንቃቄና በሰለጠነ ባለሙያ እንዲሰራ ስለሚያበረታታ 3. ጥንቃቄ በጎደለው የጽንሰ ማቋረጥ ምክንያት የሚመጣውን ህመምና ሞት ስለሚቀንስ 4. ባልተፈለገ እርግዝና ምክንያት የሚመጡ ችግሮችን ለማስወገድ ስለሚጠቅም 5.ጽንሰን ለማቋረጥ የሚወጣውን ወጭ ስለሚቀንስ 88. አላውቅም 99.ሌላ(ይገለጽ)----- 	
318	በፍላጎት ጽንሰ ማቋረጥ ሙሉ-በሙሉ ህጋዊ እንዲሆን የሚፈልጉት መቼ ነው?	<ol style="list-style-type: none"> 1. አሁኑኑ 2. ወደፊት በጣም በቅርቡ 3. ወደፊት ትንሽ ቆየት ብሎ 4. መቼም ቢሆን ግድ የለኝም 	

		88. አላውቅም 99.ሌላ(ይገለጽ)-----	
319	በፍላጎት ጽንሰ ማቋረጥ ሙሉ-በሙሉ ህጋዊ እንዳይሆን የፈለጉበት ምክንያት ምንድን ነው? (ከ አንድ በላይ መልስ ይቻላል።የተጠቀሱት ብቻ ይከበቡ)	1. ሃይማኖቱ ስለማይፈቅድ(ከእግዚአብሔር ፈቃድ ውጭ ስለሆነ) 2. በባህላችን ተቀባይነት የሌለው ተግባር ስለሆነ 3. ጽንሱን እንደመግደል ስለሚቆጠር 4. ያልተፈለገ እርግዝና እንዲበራከት ስለሚያደርግ 5. ከጋብቻ በፊትና ከጋብቻ ውጭ የሚደረግ የግብረሰጋ ግንኙነትን ስለሚያበረታታ 88. አላውቅም 99.ሌላ(ይገለጽ)-----	
320	በእርስዎ አመለካከት አንድ እናት ከፈለገች እርግዝናዎን ማቋረጥ ትችላለች ብለው ያስባሉ?	1. አዎ 2. የለም 99.ሌላ(ይገለጽ)-----	
321	በእርስዎ አመለካከት በአጠቃላይ ሰዎች በራሳችው በሆነ ምክንያት እርግዝናን ማቋረጥ ቢፈልጉ ይደግፉታል?	1. እደግፈዋለሁ 2. አልደግፈውም 3. ግድ የለኝም 99.ሌላ(ይገለጽ)-----	
322	በፍላጎት ጽንሰ ማቋረጥ ሙሉ-በሙሉ ህጋዊ ቢሆን ምን አይነት ችግሮች ሊገጥሙ ይችላሉ?	1. ከሃይማኖት በድኖች ተቃዋሚ ይኖራል 2. ከሁሉም የህብረተሰብ አካላት ተቃዋሚ ይኖራል 3. ከተወሰኑ የህብረተሰብ አካላት ተቃዋሚ ይኖራል 4. የሰለጠነ የሰው ሃይል እጥረት ያጋጥማል 5. በቂ የሆኑ የአገልግሎት መስጫ ተቋማት አይኖሩም 6. የገንዘብ እጥረት ይኖራል 88. አላውቅም 99.ሌላ(ይገለጽ)-----	
323	በፍላጎት ጽንሰ ማቋረጥን ሙሉ-በሙሉ ህጋዊ አድርጎ ስራ ከመጀመር በፊት ምን ምን ቅድመ ሁኔታዎች መሟላት አለባቸው?	1. ባለሙያዎችን ማስልጠን 2. የአገልግሎት መስጫ ተቋማትን ማጠናከር/መመስረት 3. አስተማማኝ የገንዘብ አቅም እንዲኖር ማድረግ 4. ከህብረተሰቡ ተቀባይነትን ማረጋገጥ 5. ከሃይማኖት ተቀባይነትን ማረጋገጥ 88. አላውቅም 99.ሌላ(ይገለጽ)-----	

324	<p>ጥንቃቄ በጎደለው የጽንሰ ማቋረጥ ምክንያት የሚመጣውን ችግር ለመከላከል ምን አይነት እርምጃዎች መወሰድ አለባቸው? (ንጽህናው ባልተጠበቀ ሁኔታና ባልሰለጠኑ ግለሰቦች የሚካሄደውን) (ከ አንድ በላይ መልስ ይቻላል።የተጠቀሱት ብቻ ይከበቡ)</p>	<p>1.ያልተፈለገ እርግዝናን ለማስወገድ ዘመናዊ የቤተሰብ እቅድ አገልግሎት መጠቀም</p> <p>2.ያልተፈለገ እርግዝናን ለመከላከል በባህላዊ የቤተሰብ እቅድ ዘዴዎች መጠቀም</p> <p>3.ያልተፈለገ እርግዝናን ለማስወገድ ከጋብቻ ውጭ ያለን ግንኙነት መከላከል</p> <p>4.አንድ ጊዜ እርግዝና ከተከሰተ እንዲወለድ ማደረግ</p> <p>5.ስለ እርግዝና የጽንሰ ማቋረጥ ችግር መከላከያውና ቤተሰብ ምጣኔ የጤና ትምህርት መስጠት</p> <p>6.ጥንቃቄ የተሞላበት የጽንሰ ማቋረጥ አገልግሎት እንዲኖር ማድረግ</p> <p>7.የጽንሰ ማቋረጥ ህጋዊ ማድረግ</p> <p>88. አላውቅም</p> <p>99.ሌላ(ይገለጽ)-----</p>	
325	<p>በእርስዎ አመለካከት በፍላጎት ጽንሰማቋረጥ በሀገራችን ህጋዊ የማይሆንበት ምክንያት ምንድን ነው</p>	<p>1. ሃይማኖት</p> <p>2. ባህል</p> <p>3. የጤና ተቋማት ወይም ባለሙያ እጥረት</p> <p>4. ድህነት</p> <p>88. አላውቅም</p> <p>99. ሌላ(ይገለጽ)-----</p>	
326	<p>አንድ እናት ጽንሰ-ን ከማቋረት ይልቅ ልጇን ከተወለደ በኋላ ለማደግ መስጠት አለባት</p>	<p>1. እስማማለሁ</p> <p>2. ምንም ማለት አልችልም</p> <p>3. አልስማማም</p>	
327	<p>ህጋዊ የጽንሰ ማቋረጥ በተመለከተ እንዲሰራላት የመወሰን መብት የሴቷ ብቻ መሆን አለበት</p>	<p>1. እስማማለሁ</p> <p>2. ምንም ማለት አልችልም</p> <p>3. አልስማማም</p>	
328	<p>ውሳኔው የሴቷ ብቻ መኖን የለበትም ካሉ በውሳኔው ማን መሳተፍ አለበት</p>	<p>1. እስማማለሁ</p> <p>2. ምንም ማለት አልችልም</p> <p>3. አልስማማም</p>	
329	<p>በመሣሪያ ከሚደረግ የፅንሰ ማቋረጥ ይልቅ በመድኃኒት የሚደረግ የፅንሰ ማቋረጥ ይሻለኛል?</p>	<p>1. አዎን</p> <p>2. የለም</p> <p>88. አላውቀውም</p>	
330	<p>እናቶች ፅንሰ ማቋረጥን ፅንሱ ችግር ካለበት ቢመርጡት ተቀባይነት አለው?</p>	<p>1. እስማማለሁ</p> <p>2. ምንም ማለት አልችልም</p> <p>3. አልስማማም</p>	
331	<p>እናቶች ፅንሰ ማቋረጥን በማኝኛውም ሁኔታ ቢመርጡት ተቀባይነት አለው?</p>	<p>1. እስማማለሁ</p> <p>2. ምንም ማለት አልችልም</p> <p>3. አልስማማም</p>	
332	<p>በመካከለኛ ደረጃ የሚገኙ የጤና ባለሙያዎች በመድኃኒት የሚደረጉ የፅንሰ ማቋረጥ መስራት ይችላሉ?</p>	<p>1. እስማማለሁ</p> <p>2. ምንም ማለት አልችልም</p> <p>3. አልስማማም</p>	
333	<p>በመካከለኛ ደረጃ የሚገኙ የጤና ባለሙያዎች በመሣሪያ የሚደረጉ የፅንሰ ማቋረጥ ሥራ መሥራት ይችላሉ።</p>	<p>1. እስማማለሁ</p> <p>2. ምንም ማለት አልችልም</p> <p>3. አልስማማም</p>	
334	<p>የእናቶችን ጤና የሚመለከት</p>	<p>1. እስማማለሁ</p>	

	ፕሮግራም የፅንሰ ማቋረጥ ስልጠናና ልምምድ ማካተት አለባቸው።	2. ምንም ማለት አልችልም 3. አልስማማም	
335	ይህ ጤና ድርጅት በቂና የፅንሰ ማቋረጥ አገልግሎት የሚሰጡ መሣሪያዎች አሉት ብለው ያስባሉ?	1. አዎ 2. ምንም ማለት አልችልም 88. አላውቅም	
336	ይህ ጤና ድርጅት ጥንቃቄ ያለው የፅንሰ ማቋረጥ አገልግሎት የሚሰጡ የሠለጠኑ የጤና ባለሙያ አለው ብለው ያስባሉ?	1. አዎ 2. ምንም ማለት አልችልም 88. አላውቅም	
337	ይህ ጤና ድርጅት ጥንቃቄ ላለው የፅንሰ ማቋረጥ የሚሆን መድሃኒቶችና ሌሎች አስፈላጊ ነገሮች በበቂ ሁኔታ ያሉት ይመስልዎታል?	1. አዎ 2. ምንም ማለት አልችልም 88. አላውቅም	
338	ይህ ጤና ድርጅት ጥንቃቄ ላለው የፅንሰ ማቋረጥ ስራ አገልግሎት ለመስጠት ዝግጁ ነው ብለው ያስባሉ?	1. አዎ 2. ምንም ማለት አልችልም 88. አላውቅም	

ክፍል አራት: የጤና ባለሙያዎች ጥንቃቄ ስለአለው ፅንሰ ማቋረጥ ሥራ ጋር የተያየዘ የልምድ ጥያቄዎች

	ሠርቻሊሁ	አልስራሁም	ኮድ
401 ፕሮሲጀር			
401.1 የማህፀን በር በማስፋት መጥረጥ			
401.2 ማህፀን ውስጥ ያለውን ነገር ማውጣትና መጥረጥ			
401.3 በእጅ ቫኪዩም መምጠጥ			
402 ለበሽተኛው የሚሰጥ እንክብካቤ			
402.1 ስነልቦናን መፈተሽ?			
402.2 ስነልቦናን ማዘጋጀት			
402.3 በፅንሰ ማቋረጡ ጊዜ የሚሰጥ እንክብካቤ			
402.4 ከፅንሰ ማቋረጡ በኋላ ወዲያውኑ የሚሰጡ እንክብካቤ			
403 ለበሽተኛው የሚሰጥ ምክርና ትምህርት			
403.1 የፅንሰ ማቋረጥ ዘዴዎች			
403.2 ፅንሰ ማቋረጥን ማበረታታት			
403.3 የፅንሰ ማቋረጥ አገልግሎት መስጠት			
403.4 ስለወሊድ መቆጣጠሪያ ምክር መስጠት			

ጤና ድርጅትን ለማየት የሚጠቅም መመሪያ

- የጤና ድርጅቱ ስም -----
- መረጃውን ለመሙላት የወሰዱበት ምንጭ -----
- ይህን ፎርም የሞላው መረጃ ስብሰቢ-----
- ይህ ፎርም የተሞላበት ቀን -----

የጤና ድርጅቱ አይነት

- ሆስፒታል
- ጤና ጣቢያ
- ክሊኒክ

የጤና ድርጅቱ ይዘታ

- የመንግስት
- የግለሰብ

1. ይህ ጤና ድርጅት ጥንቃቄ ያለው የጽንሰ ማቋረጥ ወይም ከጽንሰ ማቋረጥ በኋላ የሚሰጥ አገልግሎት ይሰጣል?

2. ጥንቃቄ ያለው የጽንሰ ማቋረጥ ወይም ከጽንሰ ማቋረጥ በኋላ አገልግሎት የት ይሰጣል?

3. ምን ያክል የጤና ባለሞያዎች በእጅ ቫኩዩም መምጠጥ ስልጠና ወስደዋል?

-የማገጸን እስፔሻሊስት ቁጥር

-አዋላጅ ነርስ ቁጥር

-ጤና መኮነን ቁጥር

- ነርስ ቁጥር

- ሌላ አባል

4. የጤና ድርጅቱ የቤተሰብ ምጣኔ አገልግሎት ይሰጣል?

5. ከሚከተሉት የወሊድ መቆጣጠሪያ መንገዶች በጤና ድርጅቱ ይገኛሉ?

ሀ.በአፍ የሚወሰድ እንክብል

ለ. በአፍ የሚወሰድ እንክብል(ፐሮጀስትሮን ብቻ ያለው)

ሐ.ሉፕ

መ.መርፌ

ሰ.ክንድ ዉስጥ የሚቀበር

ረ.ኮንዶም

ሸ.የማሸጸን ኮብ

በ.ሌላ ይገለጽ

6. የወሊድ መቆጣጠሪያ የት ነው የሚሰጠው?

- ሀ. ቤተሰብ ምጣኔ አገልግሎት ክፍል
 - ለ. ጽንሰ ማቋረጫ ክፍል
 - ሐ. ሌላ ይገለጽ
7. ደረጃውን የጠበቀ መመዝገቢያ ደብተር አለ?

ለሚከተሉት ነገሮች አዎ ወይም አይደለም ላይ ምልክት ያድርጉ::

የሚከተሉት የጤና አገልግሎቶች ባለፉት 3 ወራት ውስጥ ቢያንስ አንድ ጊዜ ተካሂደዋል?

1. ከ12 ሳምንት በታች ማህፀን ውስጥ የቀረ ነገር ካለ የተሰራ ቁጥር
2. ከ12 ሳምንት በላይ ማህፀን ውስጥ የቀረ ነገር ካለ የተሰራ ቁጥር
3. ከ12 ሳምንት በታች ጥንቃቄ ያለው የጽንሰ ማቋረጥ የተሰራ ቁጥር
4. ከ12 ሳምንት በታች ለሆነ የማህፀን መጠን የፅንሰ ማቋረጥ ሥራ ተሠርቷል
 - 1 አዎ
 - 2 አልተሠራም

ካልተሰራ ለምን? _____
5. ከ12 ሳምንት በታች ለሆነ የማህፀን መጠን ማህፀን ውስጥ የቀረ ነገር ካለ ማስወጣት
 - 1 አዎ
 - 2 አልተሠራም

ካልተሰራ ለምን? _____
6. ከ12 ሳምንት በላይ ለሆነ የማህፀን መጠን የፅንሰ ማቋረጥ መሰረት
 - 1 አዎ
 - 2 አልተሠራም

ካልተሰራ ለምን? _____
7. ከ12 ሳምንት በላይ ለሆነ የማህፀን መጠን ማህፀን ውስጥ የቀረ ነገር ማስወጣት
 - 1 አዎ
 - 2 አይሠራም

ካልተሰራ ለምን? _____
8. ጥንቃቄ ያለው የፅንሰ ማቋረጥ ወይም ከፅንሰ ማቋረጥ በኋላ የወለድ መቆጣጠሪያ መስጠት
 - 1. አዎ
 - 2. አይሠጥም

ካልተሰራ ለምን? _____
9. አስፈላጊ ሆኖ ሲገኝ ደም መስጠት
 - 1. አዎ
 - 2. አይሠጥም

ካልተሰራ ለምን? _____
10. በማዋላጃና ማህፀን ክፍል ላሉ በሽተኞች አስፈላጊ የፀረ ረቂቅ ህዋስ (Antibiotic) መሰጠት
 - 1. አዎ
 - 2. አይሠጥም

ካልተሰራ ለምን? _____
11. በማዋላጃና ማህፀን ክፍል ለሚገኙ በሽተኞች በደም ስር የሚሰጡ ፈሳሽ (IV-flude) ይሠጣቸዋል::
 - 1 አዎ
 - 2 አይሰጥም

ቆሻሻ መጣያ						
ኮንታሚኔትድ ትራቭ						
ጀርም ማጥፊያ መዘፍዘፊያ						
አክሲድን						
በእጅ አየር መስጫ						
ጀሳሽ ከአፍና ከፍንጫ መምጠጫ						
በእጅ ቫኪዩም መምጠጥ(MVA)						
የተለያየ መጠን ያለው ታዛዥ ካኑላ						
ማህጻን መጥረጊያ						
ማህጻን ማስፊያ						
ማስተማሪያ						
የሚጣሉ መሳሪያዎች						
ጓጓተ						
ማስክ						
ሲርንጅ እና መርፌ						
ከጥጥ የሚዘጋጅ ማዕጃ እስዋብ						
ጎዘ						
ጥጥ						
አልኮል						
ዲስእንፊኬታንት						
አንቲ ሴብቲክ ሶሊውሽን						
ክሎሪን ለጀርም ማስወገጃ						
ሣሙና						
ለበሽተኛ የሚሰጥ ማስተማሪያ						
የወሊድ መቆጣጠሪያ						
መ. መድሃኒት						
አጠቃላይ ማደንዘዣ						
የተለየ ቦታ ማደንዘዣ						
ማስታገሻ						
አንቲባዮቲክ						
ፒቶሲን						
በደም ስር የሚሠጡ ግሉኮስና መስጫ መሣሪያዎች						

DECLARATION

I, the undersigned, declare that this thesis is my original work, has never been presented for a degree in this or any other University, and that all sources of materials used for this thesis have been duly acknowledged.

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Place: Addis Ababa

Date of submission: July 23, 2008

This thesis has been submitted for examination with my approval as a University advisor.

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