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POSTGRADUATE PROGRAM

EXPLORING HEALTHCARE PROVIDERS' AND REPRODUCTIVE-AGE WOMEN'S PERSPECTIVES ON THE PRACTICE OF A RIGHTS-BASED APPROACH TO ABORTION CARE AND ITS BARRIERS: A QUALITATIVE DESCRIPTIVE STUDY IN SELECTED PUBLIC HEALTH CENTERS, ADDIS ABABA, ETHIOPIA, 2026.

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A THESIS SUBMITTED TO THE DEPARTMENT OF PEDIATRIC AND CHILD HEALTH NURSING AND MIDWIFERY, SCHOOL OF NURSING AND MIDWIFERY, COLLEGE OF HEALTH SCIENCES, ADDIS ABABA UNIVERSITY, IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR A MASTER'S DEGREE IN MATERNITY HEALTH NURSING.

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This thesis by Temesgen Shiferaw is accepted in its present form by the board of examiners as satisfying the partial fulfillment of the requirements for a master's degree in maternity health nursing.

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DECLARATION

I, the undersigned, declare that this thesis, "Exploring Healthcare Providers and Reproductive-Age Women's perspectives on the practice of a Rights-Based Approach to abortion care and its barriers: a descriptive qualitative study in selected public health centers", is my own original work. It has been carried out under the supervision of my principal advisor, Haweni Adugna (PhD fellow), and co-advisor, Tefera Mulugeta (PhD fellow). I solemnly affirm that all scholarly materials, data, and ideas included in this document have been duly acknowledged through appropriate citations and references. I further declare that this work has not been previously submitted, in whole or in part, to Addis Ababa University or any other institution for the award of any degree, diploma, or certificate.

I also confirm that this research was conducted in full compliance with the ethical guidelines for qualitative research involving human subjects. All necessary ethical approvals were obtained from the Department of Pediatrics, Child Health Nursing & Midwifery Research Ethical Review Committee, Addis Ababa University, and the rights, privacy, and confidentiality of the participants were strictly protected throughout the study.

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LIST OF ABBREVIATIONS AND ACRONYMS

AAU	Addis Ababa University
CAC	Comprehensive abortion care
HCPs:	Health care providers
MCH	Maternal Child Health
MENA	Middle East and North Africa
MOH	Ministry of Health
NGO	Non-governmental organization
PAC	Post abortion care
RBAS	Rights-based approach
SAC	Safe abortion care
SSC	Sub-Saharan country
TPA's	Third-party authorization
UNFPA	United Nations Population Fund for Population Activities
WHO	World Health Organization

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ABSTRACT

Background: Rights-based access to abortion care is crucial for reproductive health. Despite policy improvements in Ethiopia, gaps remain in ensuring care that fully respects women's rights. This study aims to address the disconnect between the established rights-based framework and the lived realities of women seeking abortion care.

Objectives: To explore healthcare providers' and reproductive-age women's perspectives regarding the practice of rights-based approach to abortion care and its barriers within selected public health centers in Addis Ababa, Ethiopia.

Method: A qualitative descriptive study employing inductive and deductive thematic analysis was conducted from March 6 to April 24, 2026. Participants were purposively sampled, with the sample size of 24 participants (11 healthcare providers and 13 reproductive-age women) determined by data saturation. Face-to-face, in-depth interviews were conducted using a semi-structured, open-ended interview guide. Data analysis was facilitated by ATLAS.ti 9, qualitative data analysis software for coding and classification**.**

Findings: The study identified three interrelated themes: perspectives on the practice of rights-based care; provider experiences and challenges in delivering such care; and the multilevel barriers hindering its implementation. While some providers demonstrated respectful, rights-based care practices, significant gaps persisted in privacy, accountability, and nonjudgmental care. Stigma and structural constraints, such as inadequate infrastructure, further exacerbated these issues. Furthermore, while healthcare providers across all disciplines encounter routine professional stressors, those in abortion care face unique stressors.

Conclusion: This study reveals a persistent rights-reality gap where a convergence of structural and socio-cultural barriers obstructs the transition from policy to clinical practice. The practice of a rights-based approach (RBA) is currently fragmented and fragile, relying more on the individual resilience of providers than on a robust institutional system. Capacity building" must move beyond clinical skills to address the institutionalization of rights.

Keywords: Rights-based approach, health care providers, reproductive-age women's perspectives.

1. INTRODUCTION

1.1. Background

According to the 2022 WHO abortion care guideline, a rights-based approach to abortion care is care provided in adherence to human rights principles. In practice, the person seeking care is at the center of the process, ensuring their human rights are respected, protected, and fulfilled. The core principles of this approach include: Timely health care, Non-Discrimination and Equality, Privacy and Confidentiality, Agency and Autonomy, Informed consent, and Access to safe service (1).

Crucially, a rights-based approach is characterized not only by the human rights that a program aims to uphold, but also by the application of certain principles in how those rights are put into practice during the planning, implementation, monitoring, and evaluation of clinical care (2). This framework (rights-based approach) grounds reproductive health services and programs in ethics and social justice, valuing human dignity, agency, equity, and equality, and institutional accountability (3). Under this approach to abortion care, all those seeking abortion care should benefit from supportive, empathetic relationships with their communities and healthcare providers (4) .

Despite these clear global standards, Global evidence from a systematic review of women's experiences of abortion care revealed a significant gap in the practical implementation of a rights-based approach to abortion care, manifested by healthcare providers' lack of understanding of abortion rights and procedures, a scarcity of support and empathy, stigmatization, and lack of confidentiality (5). This gap is particularly obvious in sub-Saharan African countries, including Ethiopia. The review revealed that a lack of quality care and the absence of support from healthcare providers (6).

Several interrelated factors influence this rights-based approach to abortion. At the institutional and individual level, healthcare provider bias, demanding workplace workloads, limited autonomy for women, and low awareness of reproductive rights (7). Furthermore, societal stigmatization and low community awareness of reproductive rights continuously erode women's autonomy.

The effects of this breakdown of rights-based approach principles like Privacy and Confidentiality, Autonomy and Agency, and Informed consent to abortion care, result in severe emotional and physical trauma to women. Literature review from sub-Saharan African countries revealed that women faced a range of challenges, self-blame, guilt, depression, sadness, devastation, bodily stress, and physical pain (6).

To combat these problems, legal and educational frameworks have been established at the global and regional levels. Medical schools have integrated rights-based approaches to abortion into their curricula (7,8). For instance, midwives' perspectives highlight that holistic, woman-centered interventions position nursing professionals as essential contributors to sustainable public health outcomes and policy development (9). Furthermore, international human rights law explicitly protects the principles of informed consent, mandating that all adults possess the capacity to consent irrespective of marital status, while concurrently safeguarding the evolving capacities of adolescents (10,11).

However, existing policies and interventions are only useful if concrete steps are taken to uphold them in daily practice (12). In Ethiopia, despite a progressive legal framework explicitly designed to ensure access to legal abortion, significant barriers persist. These barriers are primarily driven by healthcare providers' personal judgments, negative biases, and restrictive interpretations of the law (8). Consequently, services are often only partially provided, effectively compromising women's reproductive autonomy (13).

The disconnect between policy and clinical reality suggests an urgent need to conduct research that explores the perspectives of reproductive-age women and healthcare providers through a rights-based lens.

1.2. Statement of the Problem

According to the UNFPA (2023) data report, nearly half of all pregnancies globally are unintended, and approximately 60% of these end in abortion, of which 45% being unsafe globally, accounting for an estimated 5 to 13 percent of maternal deaths (14). Among all unsafe abortions globally, 97 occur in developing countries. Sub-Saharan Africans, including Ethiopia, have the highest maternal mortality ratio, estimated at 533 maternal deaths per 100,000 live births (15). According to the WHO 2025 factsheet, unsafe abortion remains a leading cause of

maternal deaths. It is estimated that 4.7%-13.2% of maternal deaths every year can be attributed to unsafe abortion. Timely, affordable, and respectful abortion care is a critical public health and human rights issue that is a major contributing factor to the decrease in maternal death related to unsafe abortion in the developing world (16).

While a rights-based approach advocates for safe, legal abortion to uphold women's health and human rights, the persistence of unsafe abortion, particularly in regions like Africa and countries including Ethiopia, indicates that the legal framework alone is insufficient (17).

Despite the expansion of abortion services in Ethiopia following legal and policy reforms, the quality of care remains uneven, particularly in relation to the application of a rights-based approach. on how healthcare providers and women of reproductive age understand, perceive, and practice a rights-based approach to abortion care (18). Most existing studies in Ethiopia and other sub-Saharan countries have focused on accessibility, utilization, and outcomes of abortion services, with limited exploration of how rights-based principles are understood, perceived, and practiced by both health care providers and reproductive-age women's (19).

The absence of an inclusive understanding of healthcare providers' and reproductive-age women's perspectives on a rights-based approach to abortion services prevents the effective identification of barriers to safe abortion care, making it challenging to ensure women's needs are met in a respectful and supportive environment. This gap further hinders efforts to review and revise policies, strategies, guidelines, and training materials to align them with rights-based principles (20,21).

Pervasive stigma from communities and providers forces women—especially young, unmarried individuals facing heightened abuse—to prioritize confidentiality over safety. This leads them away from formal care towards expensive private options, unreliable peer advice, or dangerous informal methods, despite their ineffectiveness and risks (22,23). Moreover, provider restrictions and the fear of mistreatment in public facilities significantly delay access to quality care, consistently contributing to unsafe abortion practices (24).

A quantitative study in Ethiopia revealed that healthcare providers' perception of safe abortion care services was less than 50(which is low) (25). Additionally, the prevalence of women's

positive perception of the Ethiopian abortion law among women of reproductive age is 21.18%, which is (unexpectedly low) (26).

Specifically, in Addis Ababa, where abortion services are relatively more accessible, little is known about whether women's reproductive rights are fully respected in practice, or how providers interpret and implement rights-based care in their daily interactions (27). This study, therefore, seeks to examine healthcare providers' and reproductive-age women's perspectives on the practice of a rights-based approach to abortion care and identify the key barriers influencing its implementation in selected public health centers in Addis Ababa.

1.3. Significance of the Study

A rights-based approach to abortion care is central to achieving equitable, respectful, and high-quality reproductive services.

Exploring the perspectives of both healthcare providers and reproductive-age women on this approach is critical to ensuring that the principles of autonomy, dignity, privacy, informed choice, and non-discrimination are truly upheld in health facilities.

This study's results will contribute to

- Generate empirical evidence on the lived realities of the policy-practice gap, providing actionable insights for health managers and policymakers to improve the quality of rights-based care, training, and accountability.
- Contributing to the knowledge gap: add to the limited qualitative evidence on a rights-based approach to abortion care in Ethiopia, particularly in urban contexts like Addis Ababa.
- It can serve as a reference for future studies and contribute to broader research on reproductive justice in low- and middle-income countries.

2. LITERATURE REVIEW

2.1. Introduction

The literature review was conducted through a systematic search. Key databases such as PubMed/MEDLINE, Google Scholar, and CINAHL were searched using a comprehensive set of keywords, phrase searches, and Boolean operators (AND, OR, NOT). Only peer-reviewed qualitative studies or mixed-methods studies with a significant qualitative component, published in English within the past five years, were included. The subsequent sections of this literature review are purposefully organized and directly inform the specific objectives of the proposed qualitative study.

2.2. Overview of a Rights-based Approach to Abortion Care

Globally, evidence shows a significant gap between the legal right to abortion and the actual "rights-based approach experience" once a woman enters a health facility. Even in countries where abortion is legal, the quality of care often fails to meet human rights standards during the procedure, and the immediate post-procedure phase shows that stigma within facilities is the most common barrier to a rights-based experience, leading to psychological trauma even when the clinical outcome is successful (28).

In sub-Saharan Africa, evidence from a systematic review of abortion care experiences and outcomes in countries revealed that, despite wide variation, outcomes vary widely due to the diverse social, cultural, legal, and healthcare contexts within the region. Women face multifactorial challenges and encounter various types of difficulties throughout their engagement with health facilities, from admission to discharge (29).

Qualitative studies further clarify these challenges. For instance, a study conducted in Uganda on access to and quality of post-abortion care, as reported by both care providers and young women (15-24), revealed that stigma extended to both healthcare providers and women seeking care, especially to women who had induced an abortion (30). Similarly, in Kenya, a study on the experiences of abortion service recipients, women reported being mistreated by medical professionals in facilities where they sought an abortion, particularly young, single women, despite standards and guidelines recommending a rights-based approach to abortion care (31). Furthermore, even when the conditions for safe abortion in the guidelines were satisfied

in Uganda, most women who experienced complications sought care from health facilities judged to provide safe and quality care (32).

In Ethiopia, despite progressive legalization of abortion, the implementation of rights-based care faces significant challenges. Studies indicate that many healthcare providers hold personal, religious, or moral objections. This often manifests as mistreatment once the woman is inside the clinic (33). While improvements in abortion care have been noted, ongoing opportunities and support are required to enhance both the quality and rights-based nature of this care (34). A mixed-method study on safe abortion care in Ethiopia in a public hospital revealed that there were delays in providing abortion services, and varying levels of healthcare providers' compliance with the national abortion care guidelines (35). Moreover, abortion care users in Ethiopia have been identified with challenges like increased waiting time, concerns about confidentiality, fear of stigma and discrimination, healthcare providers may be overwhelmed, and experience decreased service quality. Healthcare providers also mentioned challenges, such as a lack of awareness of socio-cultural issues in the community (36).

2.3. Health Care Providers' Perspectives on Rights-based Approach Practice

Healthcare providers universally encounter a complex range of experiences in delivering abortion care, often marked by significant personal, professional, and societal challenges. A scoping review of providers' experiences with abortion care conducted in 28 countries across six continents indicates that providers worldwide face obstacles in their communities, workplaces, and society that perpetuate the stigmatization and marginalization of abortion and raise ethical concerns about this work (37). Despite these challenges, a separate scoping review on healthcare providers' reasons for participating in abortion care. Abortion providers participated in abortion for a range of reasons. The main reasons were supporting women's choices and rights; providing professional health care; and providing services that aligned with the provider's personal, religious, or moral values (38).

A systematic review of healthcare providers in sub-Saharan Africa and Southeast Asia reveals that personal, moral, social, and gender-based biases significantly impact their professional attitudes toward induced abortion. These deep-seated reservations often compromise the quality

of the relationship and interaction between providers and women seeking abortion services (39). Fundamentally, Providers' conceptualizations of abortion are influenced by numerous factors, including moral and religious views. Some view access to safe abortion services as a crucial part of a woman's right to reproductive autonomy and choice, while others view abortion as a sin (40).

Within the Ethiopian context, A mixed-methods study on midwives' professionalism, stigma, and willingness to offer patient-centered, safe abortion care (SAC) identified critical systemic and educational needs. The findings suggest the need to implement new guidelines to clarify conscientious objection and refusal procedures for SAC, alongside a need for programs that better equip midwives to provide rights-based, patient-centered care, thereby reducing instances of refusal to provide SAC (41). Further research in Ethiopia points to specific systemic barriers, such as a lack of willing providers for second-trimester abortion care and vague regulatory frameworks, leading to high-pressure working conditions. Healthcare providers in these demanding environments are frequently compelled to navigate ethical tensions between the potential viability of the fetus and the desperate circumstances of women requesting services past the legal timeframe (42).

2.4. Reproductive-age Women's Perspectives on Rights-based Approach Practice

The existing literature consistently highlights that women of reproductive age frequently experience a profound disconnect between the legal right to abortion and the actual delivery of rights-based care. Findings from the scoping review of young women who experienced abortion decisions show that young women suffer, experience frustration, and lack autonomy in making decisions based on their preferences (43). This is a global phenomenon, as evidenced by a qualitative study in South Africa where, despite knowing abortion is legal and accessible, many women choose informal providers over public clinics to avoid stigma, judgment, and mistreatment by healthcare providers. By prioritizing privacy and dignity, even while being aware of the potential safety and effectiveness risks (23,44).

Similarly, in Rwanda, abortion care-seeking outside of formal healthcare settings is due to stigma associated with terminating unintended pregnancies before marriage (45). The fear of

these negative societal attitudes and judgmental healthcare provider reactions also leads women in Zambia to delay seeking essential care, despite the legality of abortion (46).

Erosion of Autonomy and Agency in Decision-Making: Beyond external judgment, women frequently describe experiences where their autonomy and agency in decision-making are compromised. Research indicates that healthcare providers treated patients differently based on their attributes (spontaneous versus induced abortion, single versus married, young versus older). For instance, women who experienced miscarriages reported supportive care, whereas women suspected of having induced abortion face differential treatment (31). Within the Ethiopian context, revealed that, despite changes in abortion law, women with unwanted pregnancies and those seeking abortions are still heavily stigmatized and sanctioned in many communities (47). A qualitative study was conducted in both private and public health in Ethiopia, more confirm that women seeking legal abortion services often encounter disrespect and judgment from providers, who act as gatekeepers to care (8).

2.5. Barriers to the Practice of a Rights-based Approach to Abortion Care.

Barriers to the implementation of a rights-based approach emanate from different levels, including infrastructure limitations, Human resource constraints, and socio-cultural challenges. Globally, broad structural, policy, and health systems barriers, financial staffing and time constraints, as well as a lack of understanding of how to include human rights in abortion care, are barriers to the implementation of a rights-based approach (48).

In particular, privacy and confidentiality are essential components of the right to health. As noted, the thin walls, shared recovery rooms, and lack of private consultation space are barriers that discourage women from seeking care and violate their right to dignity and privacy (1). While the Technical and Procedural Guidelines for Safe Abortion Care in Ethiopia (Revised Edition 2023). abortion services must ensure auditory and visual privacy, as overcrowded and lacking separate counseling rooms remain a major barrier to a rights-based implementation (49). Beyond physical infrastructure, several factors obstruct the provision of rights-based reproductive health services: Medical schools often struggle with integrated rights-based

approaches to abortion into their curricula, with inadequate space, staffing, and logistical support, which can hinder comprehensive training in rights-based care (50).

A quantitative study in South Africa identified staffing shortages, unclear conscientious objection guidelines, facility-based stigma, and inadequate managerial support, alongside discrimination against women seeking services, directly compromising a rights-based framework (51). Additionally, women's reproductive rights are often undermined by their low socio-economic status, restricted decision-making autonomy, and prevailing social and gender biases. Furthermore, provider bias, high workload, and less autonomy and lower awareness of reproductive rights among women are barriers to a rights-based approach to abortion care (52).

A significant barrier to a rights-based approach to care, identified in Ethiopian women's experiences with safe abortion services, is the persisting lack of women's involvement in their own decision-making processes, despite guidelines advocating for a rights-based approach (53). Specifically, women describe how healthcare providers often make decisions on their behalf, frequently involving family members in the process, thus diminishing the woman's central role in her own healthcare choices (54).

2.6. Conclusion of the Literature Review

Most of the research reviewed in this document often focuses on either providers or reproductive-age women; concentrating on one side creates a blind spot regarding the power dynamics and communication barriers between the two. Additionally, many studies assess the quality of care using clinical indicators but do not include the rights-based approach domain, and most research is conducted in hospitals.

This study uses a dual-perspective approach by interviewing both reproductive-age women (the right holders) and providers (the duty-bearers). It also evaluates a rights-based approach framework beyond clinical quality, focusing on primary health centers.

2.7. Conceptual Framework

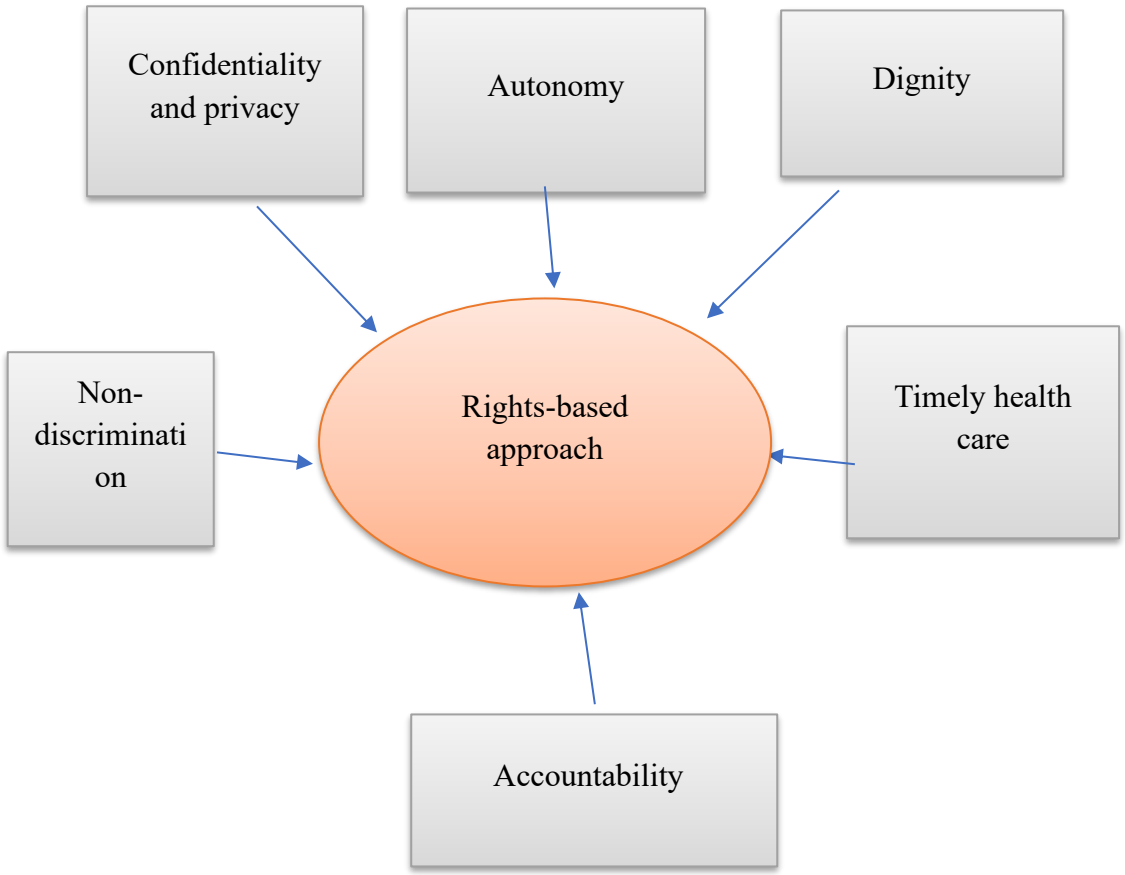


Figure 1: Conceptual framework developed from the WHO 2022 guideline(1).

3. OBJECTIVES

3.1. General Objective

To explore healthcare providers' and reproductive-age women's perspectives on the practice of a rights-based approach to abortion care in selected public health centers in Addis Ababa, Ethiopia, 2026.

3.2. Specific Objectives

- ✓ To explore healthcare providers' perspectives on the practice of a rights-based approach to abortion care in selected public health centers, Addis Ababa, Ethiopia, 2026.
- ✓ To explore reproductive-age women's perspectives on the practice of a rights-based approach to abortion care in selected public health centers, Addis Ababa, Ethiopia, 2026.
- ✓ To identify perceived barriers to the practice of a rights-based approach to abortion care in selected public health centers, Addis Ababa, Ethiopia, 2026.

4. METHODS

4.1. Study Setting and Period

The study was conducted in five purposively selected public health centers in Addis Ababa, the capital city of Ethiopia (55). Access to abortion care is more readily available than in a regional town (27). This facilitates a study that goes beyond access to quality or rights. In this city, abortion care is mainly provided through health centers, which serve as the first point of entry for health care and referral. They provide outpatient and basic primary care services typical of Ethiopian health centers (OPD, maternal and child health, immunization, abortion, and pharmacy. On average, the case ranges from ten to thirty women per month, including those receiving induced and post-abortion care, and one to two care providers offering the services. The city has over 98 operational public health centers (56).

A sample was drawn from the 11 sub-cities of Addis Ababa. Using Purposive Sampling to capture diverse urban dynamics, Janmeda Health Center was selected from the central/commercial sub-city (Arada). Kolife Health Center was selected from the densely populated/low-income sub-city (Addis Ketema). Keranio Health Center was selected from the expanding/peripheral sub-city (Kolfe Keranio). From the sub-city (Gullele), which has the most significant medical institutions, Michew and Addisu Gebayas Health Centers were selected based on case flow, from the total of four sub-cities (57).

Study period

The study was conducted from March 06 to April 24/2026, at the Addis Ababa City public health centers in Ethiopia.

4.2. Study Design

A qualitative descriptive study was carried out to explore healthcare providers' and reproductive-age women's perspectives on the practice of a rights-based approach to abortion care and its barriers.

4.3. Source Population

- ✓ All healthcare providers offering abortion-related services in Addis Ababa public health centers, and

- ✓ All Reproductive-age women receiving abortion care in Addis Ababa public health centers.

4.4. Study Population

Healthcare providers involved in offering abortion-related services to women seeking or receiving abortion care. And reproductive-aged women receiving abortion care in selected public health centers in Addis Ababa.

4.5. Eligibility Criteria

4.5.1. Inclusion Criteria

Healthcare providers

- ✓ Healthcare providers who provide abortion related services (Midwives, Nurses, health officers, and physicians) in selected public health centers
- ✓ Healthcare providers who have at least 6 months of experience in providing abortion care.
- ✓ Those who are currently working in the abortion unit, or rotating to another unit, and can provide rich information (who have attended workshops on reproductive rights, medical ethics, received training on rights-based care, or WHO guidelines).

Reproductive-age women

- ✓ Reproductive-age women's abortion care experience (Induced abortion, post-abortion, and first-trimester abortion.
- ✓ Reproductive-age women who can provide rich information (women from different educational backgrounds, marital statuses).

4.5.2. Exclusion Criteria

- ✓ Women currently experiencing medical emergencies (e.g., heavy hemorrhaging, septic shock).
- ✓ Healthcare providers have taken training but are not involved in actual clinical practice.

4.6. Sample Size

The sample size was 24 participants (11 healthcare providers and 13 reproductive-age women). Initially, 18 participants (8 healthcare providers and 10 reproductive-age women) were

interviewed in depth once saturation was observed; an additional 6 participants (3 healthcare providers and 3 reproductive-age women) were then added. We then analyzed these six interviews against our initial codes. No new themes emerged, confirming that thematic saturation had been reached across both participant groups.

4.7. Sampling and Participant Recruitment

Purposive sampling, specifically utilizing the maximum variation strategy, was used with information-rich cases that could provide the nature of a rights-based approach to abortion care from diverse perspectives of the healthcare providers and reproductive-age women.

For reproductive-age women, variation in age (18-24, 25-34,35-49 years), marital status (single, married, divorced/widowed), educational status (primary, secondary, tertiary), occupation (employed, unemployed, student), and reason for abortion (socio-economic, health risk, unintended pregnancy, sexual violence).

Similarly, healthcare providers were selected based on their experience in abortion care (less than 2 years, 2-5 years, and 5-10 years), their professional roles (frontline providers and coordinators), and their personal beliefs (supportive, neutral, or conflicted).

The principal investigator identified study participants among healthcare providers with assistance from MCH Department heads in each facility. Reproductive-age women were identified with assistance from an abortion care provider who discreetly introduced the researcher to eligible women.

4.8. Operational Definition

- ✓ Reproductive-age women; age groups from 15-49years. While some researchers occasionally look at the "extended reproductive age" (10–49 or 15–54), the 15–49 range remains the universal standard and comparative analysis (58).
- ✓ Autonomy is defined as the patient's foundational right to be the primary decision-maker in their care, and the patient is provided with evidence-based information regarding the procedure, potential risks, and side effects.
- ✓ Non-discrimination (Equity in service delivery), the provision of care that is untainted by the provider's personal biases or the patient's socio-demographic profile.

- ✓ Confidentiality and privacy, the physical shielding of the patient from other staff and patients during consultation and procedure.
- ✓ Dignity (the absence of "disrespect and abuse), the absence of obstetric Violence, which includes verbal shaming, scolding, and physical neglect.
- ✓ Timely health care measures the gap between the woman's first contact with the facility and the successful completion of the procedure.
- ✓ Accountability (Existence of feedback loops), where women can report poor service without fear of future retaliation. (1).

4.9. Data Collection Procedure and Guidance

Semi-structured open-ended interview guides were utilized for the in-depth interviews. These guides were developed in alignment with the study objectives and the WHO recommendation for a rights-based framework. The objective was to examine abortion care from the perspectives of both health care providers and reproductive-age women. The guides consisted of two sections: socio-demographic factors and the semi-structured interview guide.

At the health facilities, the MCH department head initially approached potential participants to facilitate access to abortion care providers. After this initial contact, all communication and consent processes were handled exclusively by the principal investigator to maintain confidentiality. Similarly, reproductive-age women were identified by the abortion care provider, and the principal investigator then independently outlined the study's objectives, emphasizing the right to refuse participation without consequence.

Interviews were conducted in Amharic at times and locations convenient for the participants. The principal investigator conducted all interviews using audio recorders and field notes, continuing until information saturation was achieved. During the sessions, a non-threatening and relaxed environment was maintained to build rapport. Field notes were used to capture body language, mood, and informal conversations occurring outside the formal interview.

To establish face validity and ensure the reliability of the research instruments, the interview guides were pretested at three public health centers—Ras Emiru, Tekile Haymanot, and Hidasie—which were specifically selected because they were not part of the actual study sites.

The pretest involved six participants (three healthcare providers and three women of reproductive age), mirroring the study's target population.

Based on the pilot findings, the guides underwent iterative refinement: questions were rephrased to be more expansive and supportive to mitigate social desirability bias and encourage candid disclosure. Furthermore, the interview architecture was restructured to follow a 'funneling' approach, initiating with neutral, non-threatening questions to facilitate rapport-building before addressing sensitive aspects of abortion care. The final versions of the instruments were consolidated and frozen one week before the commencement of formal data collection.

4.10. Data Analysis Method

The principal investigator transcribed all audio recordings verbatim in Amharic. These were then translated into English for analysis. To preserve data integrity, a back-translation of key sections was conducted to ensure that cultural idioms and medical terminology related to abortion care remained accurate and contextually relevant. To protect participant privacy, all transcripts were fully de-identified during transcription.

The analysis followed a hybrid approach, moving from inductive coding to deductive mapping. Initially, an inductive process was used to generate open codes grounded in the participants' raw narratives, ensuring that the unique socio-cultural nuances of the Ethiopian context were captured without the constraints of a pre-defined structure.

Subsequently, these emergent codes were mapped onto the WHO Rights-Based Framework. This deductive phase allowed for the categorization of grounded findings into globally recognized domains of reproductive health rights (such as Confidentiality and privacy, Dignity, and Accountability), ensuring the findings are both locally relevant and internationally comparable.

The analysis followed the six-step reflexive thematic analysis framework established by Braun and Clarke (59,60). Following verbatim transcription and translation—with careful attention to conceptual equivalence between Amharic and English—the data were imported into Atlas ti 9. This facilitated a hybrid coding approach: Step 1 involved immersion; Step 2 involved systematic initial coding. In Step 3, codes were organized into potential themes. Step 4 involved reviewing and refining these themes using a constant comparative technique to triangulate the

perspectives of women and providers. During Step 5, these themes were deductively mapped onto the WHO Rights-Based Framework to ensure global relevance. While remaining open to new, unexpected themes emerging directly from participants lived experiences. Finally, Step 6 involved the write-up, prioritizing the 'vividness' of participants' voices through illustrative verbatim quotes to support the theoretical claims.

4.11. Trustworthiness

The principles of credibility, transferability, dependability, and conformability were well thought out. To assure the precision and consistency of the data (61).

4. 11.1. Credibility (truth value)

To ensure the credibility and truth value of the findings, data collection and analysis were conducted iteratively. The principal investigator engaged in repeated listening of the initial audio recordings to identify early codes, data gaps, and refine them for subsequent interviews. Data source triangulation was achieved by integrating in-depth interviews with reproductive-age women and healthcare providers with direct observations and detailed field notes. Furthermore, to enhance descriptive validity, member checking was utilized; select verbatim transcripts were shared with participants to verify that the documentation accurately reflected their perspectives and lived experiences, while strictly maintaining participant confidentiality.

4.11.2. Transferability (applicability)

To ensure the transferability (or applicability) of our research, the principal investigator deliberately selected participants through purposive sampling for Maximum Variation, for reproductive-age women, educational status, marital status, occupation, and reason for abortion, similarly for health care providers, experience in abortion care, professional roles, personal beliefs in addition to this study sites also selected from different Sub-Cities Arada, Addis Ketema, Kolfe Keranio, and Gullele, alongside collected and presented rich contextual data, healthcare providers and reproductive- age women experience, health facility environment/ facility layout, supported by direct quotes.

4.11.3. Dependability (consistency)

To ensure the reliability of our research process, the principal investigator created a detailed audit trail that records significant decisions and steps undertaken during data collection, analysis, and interpretation. All audio recordings were transcribed exactly as spoken. All collected data, analytical tools employed (Atlas ti 9), raw data, and the evolution of codes throughout the entire analysis stage were archived. Furthermore, the study's findings and discussion were consistently supported by relevant and directly related literature.

4.11.4. Conformability (neutrality)

To ensure the confirmability (or neutrality) of our findings, align our analysis with the research's aims and objectives. Maintaining self-awareness of our own potential biases and personal opinions. The process involved careful revision of interview transcripts and a systematic linking of codes back to the raw data, creating a transparent audit trail. Furthermore, the principal investigator employed member checking by repeatedly comparing emerging results and interpretations with participants' views to ensure accuracy and alignment with their experiences. This entire process was further verified and confirmed by our supervisor and other researchers skilled in qualitative methodologies, contributing to the overall neutrality and trustworthiness of the research.

4.12. Ethical Consideration

Institutional Approval and Access: Ethical clearance was granted by the Department of Pediatrics, Child Health Nursing & Midwifery Research Ethical Review Committee at Addis Ababa University (Protocol: PCHN/MID/066/18). Following this, a formal letter of support was obtained from the Addis Ababa Health Bureau, and administrative authorization from the Addis Ababa Sub-City Health Bureau. Site-specific entry was facilitated through support letters delivered to the management of each participating public health center.

Informed Consent and Voluntariness: Participants were provided with comprehensive information regarding the study’s objective—to explore multi-stakeholder perspectives on rights-based abortion care. Verbal informed consent was obtained in a language the participant was fluent in (Amharic). To protect the voluntariness of the process, it was explicitly communicated to women that participation (or refusal) would have no impact on the quality of

clinical services received. Similarly, healthcare providers were assured that their responses would be handled with strict anonymity and would not affect their employment status or performance evaluations.

Risk Mitigation and Participant Well-being: Given the sensitive nature of reproductive health and abortion, the study adopted a trauma-informed interviewing approach. The interview guide was structured to build rapport through neutral opening questions before progressing to sensitive themes. The Principal Investigator was prepared to provide Psychological First Aid (PFA) if distress was observed. Protocols were in place for immediate "warm handoff" referrals to on-site mental health professionals if a participant required clinical support. Participants maintained the right to pause, skip questions, or withdraw from the study at any point without penalty.

Anonymity and Data Stewardship: To ensure confidentiality, interviews were conducted in private, sound-secure settings at health centers. All raw data were de-identified at the point of transcription using unique alphanumeric codes (e.g., HCP-01, RAW-02). Access to identifiable data was strictly limited to the core research team. Following the dissemination of findings and the completion of the institutional data retention period, digital records will be permanently wiped using secure deletion software, and physical transcripts will be destroyed via industrial shredding to prevent any breach of privacy.

4.13. Dissemination of the Findings

Academic Dissemination: The full study report will be submitted as part of the academic requirements to the Addis Ababa University College of Health Sciences, School of Nursing and Midwifery, Department of Pediatrics and Child Health Nursing and Midwifery. Additionally, efforts will be made to publish the research in reputable peer-reviewed journals focused on public health and women's health. The findings might also be presented at national or international scientific conferences.

Policy and Practice Engagement: Key findings, particularly regarding provider beliefs and variations in care quality, will be shared with policymakers and decision-makers. This includes the Addis Ababa Health Bureau and the leadership of the study site health centers. Engagement will involve targeted policy briefs, stakeholder workshops, and formal presentations, turning findings into actionable recommendations.

5. FINDINGS

This section presents the findings of the study, which explores health care providers and reproductive-age group women's perspectives on the practice of a rights-based approach to abortion care. The results are structured into two parts. The first portion provides the individual socio-demographic profiles of all participants, and the second portion presents the emerged themes and subthemes

5.1. Socio-demographic profiles of the study participants

This study included a total of 24 study participants (11 healthcare providers and 13 reproductive-age women), selected to provide insights into a rights-based approach to abortion care.

5.1.1. Healthcare Provider participates in profiles that offer abortion care.

Table 1: Socio-demographic characteristics of participants who offer abortion care within selected public health centers at Addis Ababa, Ethiopia,2026 (n=11).

Variables	Categories	Frequency
Age	25-34 years	9
	35-49 years	2
Sex	Male	8
	Female	3
Profession	Midwifery	10
	Health officer	1
Experience in abortion care	6month-1 year	4
	2-5 years	6
	5-10 years	1
Role	Abortion Care provides	7
	Abortion Care providers and focal	4

5.1.2. Reproductive-Age Women Participants Profile who received abortion care

Table 2: Socio-demographic characteristics of participants who received abortion care during the data collection period within selected public health centers at Addis Ababa, Ethiopia,2026 (n=13).

Variables	Categories	Frequency
Age	18-24 years	5
	25-34 years	7
	35-49 years	1
Educational level	Primary	2
	Secondary	3
	College and above	8
Occupation	Housewife	2
	Government employ	3
	Private	3
	Student	5
Marital status	Single	7
	Married	4
	Divorced	2
Children	Yes	3
	No	10
Previous abortion history	Yes	2
	No	11
Were the reproductive-age women's pregnancy status	Wanted	3
	Unwanted	10
contraceptive utilization, if yes, which type of contraceptive	Yes (7 post-pill,1 injection, and 2 implants)	10
	No	3

5.2. EMERGED THEMES

This study aims to explore healthcare providers' and reproductive-age women's perspectives on the practice of a rights-based approach to abortion care at Addis Ababa selected public health centers, Ethiopia, 2026. Three major themes emerged from the comprehensive thematic analysis of the in-depth interview. Data collected using an open-ended interview guide: Perspective on rights-based approach practice, Provider Experiences and Challenges in Delivering Rights-Based Care, and Multilevel Barriers to Practicing Rights-Based Abortion Care. The initial coding process generated 88 codes and 17 sub-themes. Following careful refinement, these were consolidated into 40 codes and 15 sub-themes, the findings supported by 347 quotations.

Table 3: Themes and sub-themes

Themes	Sub-themes
Perspective on rights-based approach practice	Autonomy and Agency
	Confidentiality & Privacy
	Dignity and Non-discrimination
	Timely health care
	Accountability
Provider Experiences and Challenges in Delivering Rights-Based Care	Psychological effect
	Occupational Marginalization
	Providers Vulnerability and safety risk
	Regulatory Gaps and the Impact of Private Pharmacy Distribution
Multilevel Barriers to Practicing Rights-Based Abortion Care	Legal Framework barrier
	Structural erosion to privacy
	Human Resource Constraints and Risk
	The Supply-Choice Gap
	Provider Level barrier
	Community & Societal barrier

5.2.1. Perspective on rights-based approach practice

In this study, nearly all interviewed health care providers and reproductive-age women noted that a rights-based approach (RBA) to abortion care was inconsistent in its practical implementation, which was heavily mediated by institutional infrastructure and the varying levels of barriers. Under this main theme, autonomy and agency, confidentiality & privacy, dignity and non-discrimination, timely health care, and accountability were grouped as sub-themes.

5.2.1.1. Autonomy and Agency

The majority of health care providers and reproductive-age women reported that agency and autonomy of reproductive-age women regarding decision making and informed consent are generally respected at the point of care. Providers emphasized their role as counselors rather than decision-makers.

"*She decides for herself. Since it is her own decision, we don't give directions saying, 'Do this' or 'Don't do that'; we only do counseling" (provider, interview 4).*

Women supported this sense of independent agency, often noting the private nature of their decision-making process:

"*……I came here and told the nurse. Then, when I told the nurse, I mean, I told her crying. She said, "It's your decision, are you sure?" I told her that I had called him and he didn't want it, and that it was my own decision. She said, "Okay." I feel that my rights and freedom were respected*" *(reproductive-age women, interview 13).*

5.2.1.2. Confidentiality & Privacy

While healthcare providers strive to protect reproductive-age women's privacy, a lack of private spaces for sensitive abortion care often undermines these efforts. This environmental limitation can lead to "social exposure. Additionally, while abortion care providers view relocating patients to maternity wards as a clinical necessity to manage other emergency cases, the following account from a reproductive-age woman demonstrates how this overlap exposes women to unintended social encounters, and potentially dangerous post-procedural supervision and follow-up:

"*I don't leave the door open as much as possible. I close the door, and they tell me every single thing. Even if you don't lock it, you keep it closed. Beyond that, you'll build trust.' I make her build trust in me. I tell her, 'Don't worry, be free, tell us what is happening, nothing will leave this room" (provider, interview 3).*

"*For example, I came here, and after the "scraping" was done for me, a woman came in bleeding heavily. Many people were with her; they entered in a commotion. It was right around the time I had just finished. They told me, "Get up, you will go to another room," and they put me in the room where women who have just given birth stay. While I was in there, I happened to run into someone I know. A friend, my friend's sister's friend, had given birth. When the sister came to visit her friend, she found me. She asked me, "Wait, what are you doing here? Did you give birth? Why are you lying here?" I felt [humiliated]. To avoid being further shamed and fearing that other people might see me, I just got up and left without consulting the doctors or saying anything. I just went home on my own after the procedure because I wasn't being watched*" *(reproductive-age women, interview 10).*

These reproductive-age women's experience of compromised privacy is explicitly verified by the structural limitations recognized by the facility staff:

"*Currently, the unit where I work has only one room. The procedure is there, and the counseling is there. So, that creates a challenge. It is just one room; if it becomes very difficult, there are instances where I might bring them to the post-Natal [ward] to lay them down and resuscitate them" (provider, interview 10).*

5.2.1.3. Dignity and Non-discrimination

A notable discrepancy exists between provider perceptions and reproductive-age women's experiences regarding dignity. While most providers asserted that they offer equitable care to both married and unmarried women—often citing professional empathy and extra efforts to counsel younger patients—many participants reported experiencing "reproductive shaming" and judgmental communication during triage and card room.

"*I handle them in a properly respectful way. You might 'invest' more in this young person; for example, the case I told you about earlier, the one I said is in 10th grade—it has been almost four weeks. She is so pitiful; she is a very 'small' [naive/young] child. She has no one to advise*

her. She doesn't know about contraceptives; I am serious, she doesn't know what a contraceptive is. One day, she had intercourse that day. I even asked her, 'Why didn't you take the Post Pill?' Then she said to me, 'What is a Post Pill?' Okay, you have no know-how? 'Yes.' What I want to tell you is, I invest a lot in them. They need a lot of investment in counseling. You counsel them; you really help them emotionally" (provider, interview 3).

In contrast, a student participant recounted a judgmental encounter with a provider:

"*He asked me, "Are you married? What is your job?", and I said, "No, I'm not married, I'm a student." he said, "If you're a student, why don't you sit still? Why do you get into this kind of thing?" (reproductive-age women, interview 5).*

Another reproductive-age woman described how confrontation from staff made her feel her rights were being violated:

"*For example, when I went [to the facility], there was some hesitation and resistance. They would say things like, 'Don't you care about your own safety?', 'Aren't you an adult?', 'Why don't you just raise the child?' 'Don't you have a job?" (reproductive-age women, interview 3).*

5.2.1.4. Timely health care

The findings highlight that while timely health care is the crucial component of rights-based approach (RBA) abortion care, as delay leads to procedural complication, restricted termination options, and psychological distress, most participants experienced significant waiting periods, often exceeding one week. These systemic delays were acknowledged by both providers and patients

"……Six days, there's a reason I waited many days. When I came at the time, I was told she was on a five-day leave" (reproductive-age women, interview 8).

"*For example, I was away on training for two full weeks. No one was working; it was closed. Those who came while I was away were turned back. Those who came bleeding were referred*" *(provider, interview 6).*

5.2.1.5. Accountability

A fundamental pillar of a rights-based approach is the establishment of transparent, confidential, and easily accessible grievance mechanisms, which are required due to the high sensitivity and social stigma of abortion services. However, according to this study, none of the health centers have a separate grievance mechanism for abortion services. Furthermore, reproductive-age women reported not filing grievances due to concerns regarding privacy and the risk of social exposure.

"*As an institution, we have grievance methods, but we don't have one specifically for abortion*" *(provider, interview 6)*

"*There is no complaint mechanism. We don't have an office for that" (provider, interview 8).*

For the reproductive-age women, the fear of being identified often outweighed the desire to report suboptimal care:

"…… Also, at that moment, you don't have the energy to go and lodge a complaint. Furthermore, because abortion is considered a shameful thing (taboo) in the community, it's a time when I am anxious about whether people are watching me or not" (reproductive-age women, interview 3).

5.2.2. Provider Experiences and Challenges in Delivering Rights-Based Care

While healthcare providers across all disciplines encounter routine professional stressors, those specializing in abortion care face unique stressors. Under this main theme, psychological effect, occupational marginalization, provider vulnerability and safety risk, and regulatory gaps and the Impact of private pharmacy distribution were grouped as sub-themes

5.2.2.1. Psychological effect

The data analysis of this study finding show that all abortion care providers face severe occupational stigma. Despite viewing their work as an essential medical service and a professional duty, they are labeled as a human killer, not only a human killer, but also the room is considered a human killing room by other health professional even not want to enter the room.

"*For example, they ask me, 'Don't children cry out to you at night?' meaning, 'You worked aborting fetuses all day, don't the children cry out to you at night?" They talk about how I "killed them all day*" *(provider, interview 8).*

This stigma extends to the physical workspace:

"*They even give the room another name. They used to call it 'the room where people die' or 'the killing room.' The professionals themselves said this*" *(provider, interview 7).*

"*No one wants to come here because of discrimination. Even when the medical directors come, they stand outside. They don't want to enter the room*" *(provider, interview 5).*

5.2.2.2. Occupational Marginalization

Providers reported a sense of being marginalized by the healthcare system itself. There is a stark disparity in the distribution of incentives, promotions, and government support when abortion care is compared to other maternal and child health services, such as Family Planning or Expanded Programs on Immunization (EPI).

"*If you look at Family Planning or EPI [Vaccination], they have 'cards' [incentives] and many things. Here, there is nothing. It feels like a burden placed on just one person. "To be honest, the government should really think about this working unit" (provider, interview 7).*

5.2.2.3. Providers' Vulnerability and Safety Risk

According to the data analysis of this study, the findings highlight external vulnerability for providers, which includes death threats from the husbands of reproductive-age women

"*He got my phone number from here, pretending to be a relative asking who the person doing this work was. Then he called and said, 'I will kill you; I'll find you outside, you won't escape me" (provider, interview 6).*

5.2.2.4. Regulatory Gaps and the Impact of Private Pharmacy Distribution

Providers identified the unregulated sale of abortifacients by private pharmacies as a major challenge. This creates a two-wing crisis: first, women often present at health centers with severe

clinical complications following unmonitored self-medication; second, providers are frequently blamed by husbands or partners for procedures they did not initiate.

"*For example, a woman came, not to me for the abortion, she had it done elsewhere—she had taken Miso [Misoprostol]. She took Miso, and her follow-up was with us. It was a first-trimester abortion, ten weeks. Then the husband came, wearing his uniform and bringing a contraceptive, and asked, 'Which health center did you have it removed at?' He questioned me" (provider, interview 2).*

"I've encountered it—not [the procedure] at my place, but she took medication somewhere else and came bleeding. We managed it. Then her husband came and sued: 'How is it done for her without consulting me? But she came bleeding, and she was anemic when she arrived. Then [he said], 'How [can you do this] without consulting me? I am her husband.' He didn't even give us time to explain our side" (provider, interview 1).

5.2.3. **Multilevel Barriers to Practicing Rights-Based Abortion Care**

Based on this study, nearly all study participants, health care providers, and reproductive-age women mentioned that the socio-cultural climate from the external environment and the internal environment of the institution or health centers hinder the implementation of a rights-based approach to abortion care. Under this main theme, the legal framework barrier, structural erosion of privacy, human resource constraints, and risk, the supply-choice gap, provider-level barrier, and community & societal barrier were grouped as sub-themes.

5.2.3.1. **Legal Framework barriers**

A fundamental barrier identified by providers is the uncertain nature of their legal protection. Although abortion is legal under specific criteria, providers view the law as a "weak shield." This creates a climate of fear in which the threat of legal repercussions overrides the commitment to rights-based care.

"The law doesn't truly set you free. The law does not protect you. Do you know why? Even when we were trained, what we were told was something like, 'At most, you might be jailed for four or five days, and then you'll be released" (Provider, Interview 7).

5.2.3.2. Structural Erosion of Privacy

Both providers and service users highlighted that the placement of abortion services in high-traffic zones, combined with explicit signage, transforms the healthcare facility into an environment of heightened visibility.

"*Right now, most of the time, the place where the abortion is performed is in the middle [of the facility], or in a place where people are constantly coming and going—like that" (Reproductive-age woman, Interview 1).*

"……I received the service, there is a men's inpatient ward nearby, it is close, so I don't think my secret was well-kept or that I was safe. I didn't feel like my privacy was protected because many people who know me could come there, and that is a bit... I didn't feel safe. Also, there is a sign [writing], and it's not something else—they used the exact word; they call it 'Abortion' [Pregnancy Termination]. And I think everyone living in Addis Ababa can read, and it is readable" (reproductive-age women, interview 3).

Providers corroborated this, noting that the proximity to other maternal services creates a conflict of clinical space:

"Our Family Planning and Antenatal Clinic, which is side-by-side with the abortion service... either these two should be moved out, or the abortion service itself should be shifted to another location" (Provider, Interview 8).

5.2.3.3. Human Resource Constraints and Clinical Risk

The study revealed that RBA practice is undermined by understaffing. The "single-provider" model common in health centers creates a dangerous bottleneck, where the absence of one staff member for training or leave results in the total suspension of rights-based access.

"They told me he had gone for an eleven-day training. The professional who was there said, 'I can't work two positions alone. Besides, your ultrasound shows you are only four weeks along; there is no problem, you can wait "(Reproductive-age woman, Interview 5).

This lack of staff from an administrative delay to a life-threatening clinical risk during complications.

"One day, I had a case where the patient started bleeding on me... the kidney dish filled up. There were membranes; the fetus had already formed. Then the woman really started bleeding. I started IV fluids on both sides, arranged for an ambulance, and then I had to go out and scream for help" (Provider, Interview 7).

5.2.3.4. The Supply-Choice Gap

The fundamental tenet of the rights-based approach (RBA) is the alignment of clinical services with the patient's informed preferences. However, the findings reveal a profound supply -choice pap, where persistent medication shortages effectively strip women of their right to choose their preferred method of care.

The data indicate that the preference for medical abortion (pills) is often rooted in a desire to avoid the perceived trauma or "medicalization" of a surgical procedure. As one provider observed:

"*When patients come, I give them a choice, but most prefer the medication (pills) because they are afraid of the [MVA] procedure" (Provider, Interview 5).*

This preference cannot be met due to stock-outs, reported by some facilities to last nearly half a year

"It has been almost 5 months since we got the medication" (provider, interview 6).

This medication constrains, as one reproductive-age woman explained:

"…….. But then, since I had no other option, my sister works at Jimma University, and I tricked her by saying I needed 2,000 birr for shoes and took it from her. Then I went to many private pharmacies to buy the medicine myself, and after a lot of searching, I found it. I bought it for two thousand four hundred, adding the four hundred, and I took the medicine" *(reproductive-age women, interview 9).*

5.2.3.5. **Provider Level barriers**

A Rights-Based Approach (RBA) necessitates a healthcare environment characterized by dignity, non-discrimination, and the preservation of patient agency. However, the findings reveal

that institutional staff, particularly supportive staff (card room and triage), frequently act as "Moral Gatekeepers," utilizing judgmental communication and reproductive shaming to alienate service users.

"*……For example, at that time, I was embarrassed/anxious. I was thinking, 'Should I just leave it and go? Should I try somewhere else?' It created some questions in my mind. In the end, I changed my mind and got the service there; I received the service right there" (reproductive-age women, interview 3).*

Other reproductive-age women also said

"This is the card room, what they call the identification room. They were talking, "Abortion has become easy, like a joke, like birth control, it's become this easy." That's what they were saying. When I first came, they asked me why I came here. When I told them it was for abortion, for terminating a pregnancy, then they started talking like that among themselves, but I was also hearing them" (*reproductive-age women interview 13).*

5.2.3.6. **Community & Societal barriers**

The study participants mentioned that the community awareness also had challenges with the practice of the rights-based approach.

"*When I say family, now, family might not want you to do such a thing; they might try to prevent you from having an abortion, from a religious perspective*" *(reproductive-age women, interview 12).*

The health care providers also acknowledged these external factors

"*For example, one woman came and said, 'I am going to an Arab country.' She said, 'My husband is willing,' she was telling me 'Wollahi' [I swear to God], you know? She said, 'I've already started the [travel] process.' Okay, if she started the process, the husband might not want it [the pregnancy] either, since she's going abroad—that's what I thought, so I explained it and did the procedure for her. You know what? She went and told him. He came here holding his head like someone whose person had died; he was screaming. He turned this place upside down, holding his head and crying 'Woyeyee' [lamenting]" (provider, interview 6).*

Diagrammatic representation of the study's findings

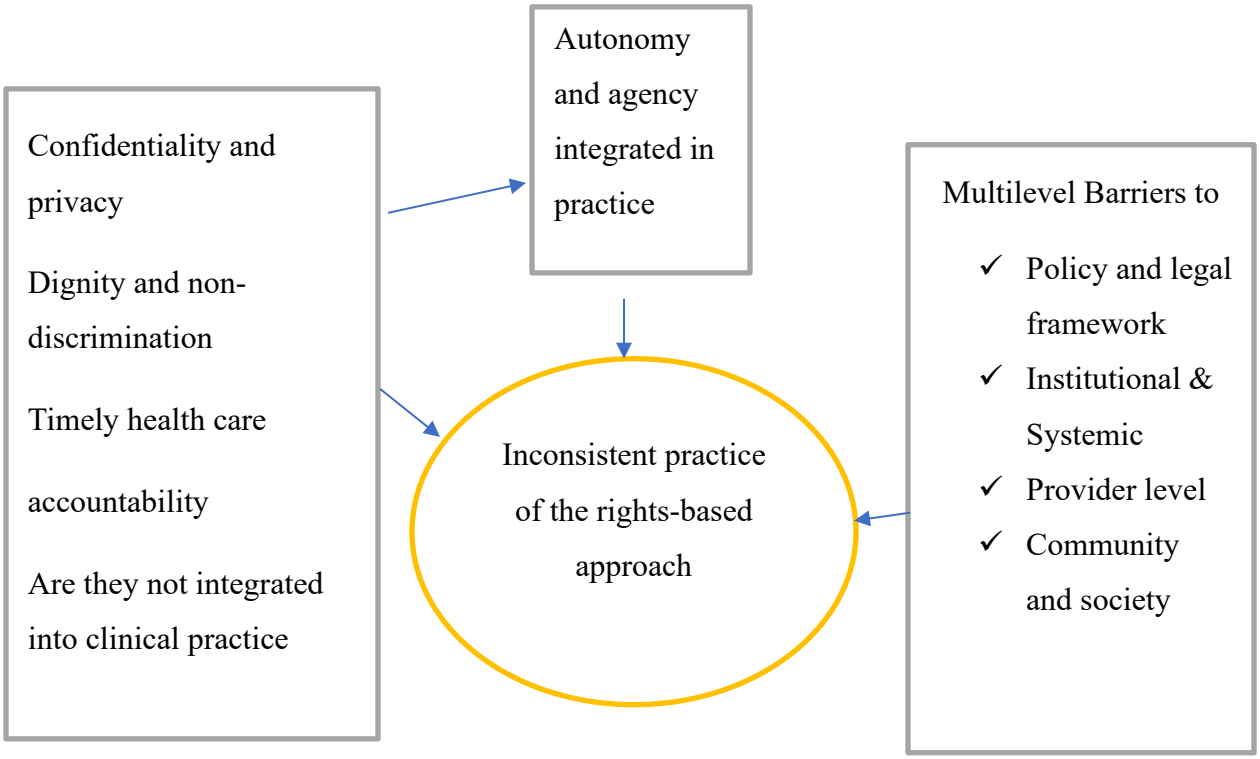


Figure 2: Conceptual Framework of Findings.

6. DISCUSSION

This study explored the practice of a Rights-Based Approach (RBA) to abortion care within the public health centers in Addis Ababa, capturing the critical intersection between healthcare providers' experiences and women's lived realities. The findings reveal that despite some ongoing improvements, there is a profound discordance between Ethiopia's progressive reproductive health policies and the practicalities of service delivery at the point of care. The findings are categorized as Perspective on rights-based approach practice, provider experiences and challenges in delivering rights-based care, and multilevel barriers to practicing rights-based abortion care. Although distinct, each theme highlights the complex realities and systemic barriers that influence the provision and experience of rights-based abortion care, providing a comprehensive overview of the current situation and areas needing improvement.

A critical finding of this study is the fragmented nature of autonomy at the point of care. While the procedural elements of agency—such as decision-making and informed consent—have been integrated into the clinical routine, they are frequently undermined by a lack of spatial and relational privacy. The physical environment, characterized by shared recovery rooms and exposed waiting areas, creates a 'spatiality of shame' that contradicts the core tenets of the Rights-Based Approach. Furthermore, ongoing 'reproductive shaming' and judgmental communication turn what should be a rights-based service into a form of social surveillance, rather than a medical service. This explains a significant behavioral trend identified in this study: women often bypass public health centers in favor of private, secondary options. This suggests that for the Rights-Based Approach to be effective in Addis Ababa, it must move beyond procedural compliance and address the environmental and moral barriers that currently devalue the patient experience.

This fragmented application stands in contrast to the WHO 2022 guideline Rights-Based Approach (RBA) to abortion care, which revealed that privacy and confidentiality, timely health care, dignity, non-discrimination, and accountability are the key principles of the rights-based approach to abortion care (1). The possible justification for this discrepancy might be a result of the local law, the economic status of low and middle-income countries affecting healthcare infrastructure, and the persistent and powerful influence of socio-cultural beliefs. These

elements collectively shape the environment in which care is provided, making comprehensive RBA practice challenging (62).

Despite the above-mentioned systemic challenges, our findings indicate a notable improvement in the respect for agency and autonomy regarding decision-making for women seeking abortion care. This represents a significant shift from previous research in Ethiopia, which found that healthcare providers often make decisions on behalf of the women seeking abortion, and they involve parents and partners in decision-making processes (54). The observed progression in respecting individual autonomy likely reflects the positive impact of Ethiopia's progressive abortion policy and the enhancement of provider training, indicating a significant step forward in upholding a woman's right to self-determination within the formal care pathway (63,64).

However, our study also aligns with earlier research conducted in Ethiopia (36), and a similar study conducted in low and middle-income African countries (31,32,44), which shows that abortion care users reported issues such as increased waiting time, concerns about confidentiality, fear of stigma, and discrimination. This persistent environmental negligence, privacy, and dignity often force women to seek care from informal providers rather than public clinics, a trend observed across similar contexts. This consistent pattern highlights how shared health system infrastructure, provider training gaps, and entrenched socio-cultural beliefs about abortion continue to shape and often limit women's access to truly rights-based care (65).

These findings align with a global systematic review of women's experiences of abortion care, which identified a significant gap in practical implementation, a lack of understanding of abortion rights and procedures, a scarcity of support and empathy, stigmatization, and a lack of confidentiality (5). Such inferences may emanate from a fundamental misalignment between the high-level policy and legal frameworks and their effective, rights-based translation into clinical practice (66).

The findings illuminate a critical but often overlooked dimension of the RBA framework: the socio-occupational vulnerability of the healthcare provider. Unlike other medical disciplines, abortion care in Addis Ababa is characterized by a 'parallel stigma,' where providers experience a form of occupational marginalization that mirrors the social shaming of the women they serve. This study demonstrates that psychological distress and systemic isolation are not merely side

effects of the job but are structural barriers to rights-based care. When providers are forced to navigate a hostile professional landscape, their capacity to act as 'rights-guarantors' is compromised. Consequently, any intervention aimed at improving the Rights-Based Approach must move beyond patient-centric models to address the institutional protection and psychological fortification of the providers themselves.

Globally, providers similarly encounter these common challenges with their communities (37). This might be a result of socio-cultural beliefs perceiving abortion as morally and socially unacceptable, creating a hostile environment that extends its shadow over those who facilitate the service, irrespective of its legal status (28).

Furthermore, a similar study, in Uganda, on access to and quality of post-abortion care, as reported by both care providers and young women (15-24), revealed that stigma extended to both providers and women seeking care, especially to women who had induced an abortion (30). This persistent alignment across low-resource settings, like Ethiopia and Uganda, highlights a shared foundation of socio-cultural beliefs about abortion that shape the experiences of both recipients and providers of care (29).

The findings of this study demonstrate that the transition from a policy-based right to a practice-based reality is obstructed by a continuum of resistance. This continuum spans from the macro-level (community perceptions of 'sin') to the micro-level (clinical resource constraints and provider fear). Crucially, the study reveals that institutional infrastructure acts as a physical manifestation of social stigma; the lack of private spaces for abortion care is not merely an architectural oversight but a reflection of the low priority afforded to stigmatized services. Consequently, the 'Rights-Based Approach' in this context is fragmented. To bridge this gap, interventions must address the 'legal anxiety' of providers and the 'atmospheric stigma' of the health centers, recognizing that clinical care cannot be separated from the moral and material landscape in which it is situated.

This is in line with a systematic review of abortion care experiences and outcomes in sub-Saharan Africa, which revealed that, despite wide variation, in diverse social, cultural, legal, and healthcare contexts within the region. Women face multifactorial challenges and encounter various types of difficulties in health facilities, from admission to discharge (29). The possible

justification for the alignment of the findings might be a result of persistent socio-cultural beliefs on abortion in low and middle-income countries (67).

In contrast, the Technical and Procedural Guidelines for Safe Abortion Care in Ethiopia (Revised Edition 2023), which recommends that abortion services must ensure auditory and visual privacy (16). This discrepancy might be a result of resource limitations and the implementation gap between the recommendations of the guideline and actual practice (68).

This aligns with the review, conducted in Nepal on barriers and facilitators of safe abortion care, which identifies overcrowding and a lack of separate counseling rooms as a major barrier to a rights-based implementation (48). Additional consistency observed in similar studies, which revealed that health care providers face moral, cultural, or institutional constraints that limit their ability to fully apply a rights-based approach (69). Moreover, our findings also agree with a study on women's experiences during abortion care, which shows stigma and discrimination, religious beliefs, male dominance, and pressure from the family or community are barriers to safe abortion care (70).

Furthermore, these findings align with a similar study conducted in South Africa, which revealed that staffing shortages, unclear conscientious objection guidelines, facility-based stigma, and inadequate managerial support, alongside discrimination against women seeking services, were barriers to a rights-based approach to abortion care (51). This consistency across low-resource settings, such as Ethiopia and South Africa, might be a result of a shared foundation of socio-cultural beliefs about abortion that shape the experiences of socio-cultural beliefs and resource limitation effects on the infrastructure of health facilities (29).

STRENGTHS AND LIMITATIONS

This section outlines the methodological strengths that underpin the validity and trustworthiness of this study. Simultaneously, it offers an open acknowledgment of the study's inherent limitations. Such an open disclosure not only enhances the credibility and transferability of our findings but also guides future research by identifying areas ripe for further investigation or alternative methodological approaches**.**

Strength

- ✓ Since abortion care recipients and abortion care providers are the primary stakeholders and lived-experience experts, the result of this study shows the real experience of abortion care providers and reproductive-age women, a rights-based approach to abortion care
- ✓ The greatest strength is that it triangulates the perspective of health care providers and reproductive-age women, and the principal investigator's observation during the data collection period
- ✓ This study used the WHO 2022, a rights-based approach framework, to identify the "Implementation Gap"—the space between what the law/policy says (women have a right to abortion) and what actually happens in a public health center.

Limitation

- ✓ As this study focused on selected public health centers within the urban context of Addis Ababa, the findings may not fully represent the experiences in rural settings or private healthcare sectors.

7. CONCLUSION AND RECOMMENDATION

7.1. Conclusion

This study reveals a persistent rights-reality gap where a convergence of structural and socio-cultural barriers obstructs the transition from policy to clinical practice. The practice of a rights-based approach (RBA) is currently fragmented and fragile, relying more on the individual resilience of providers than on a robust institutional system. Capacity building" must move beyond clinical skills to address the institutionalization of rights. This requires a three-fold strategy: first, the professional de-stigmatization of abortion care to protect providers from "occupational marginalization"; second, the materialization of rights through guaranteed infrastructure and supply chains that ensure privacy and safety; and third, the establishment of transparency-centered accountability.

7.2. Recommendation

Based on the findings from reproductive-age women and healthcare providers, the following recommendations are put forth to enhance the rights-based approach to abortion care.

To the Ministry of Health (MOH)

- ✓ Transition to "One-Stop-Shop" models for SRH (Sexual and Reproductive Health) where counseling, procedure, and recovery happen in a single, private area, away from the delivery ward.
- ✓ Develop and implement a provider-protection program that strengthens safety, legal safeguards, and support mechanisms for all health workers delivering abortion services.
- ✓ Develop a Public-Private Partnership (PPP) accreditation system for pharmacies.

To the Addis Ababa Health Bureau

- ✓ Implement a mandatory and recurring Values Clarification and Attitude Transformation (VCAT) training program for all staff involved in abortion care, including clinical and supportive personnel.
- ✓ Strengthening Reproductive Health Commodity Security (RHCS) and Last-Mile Distribution of Medication Abortion (MA) Supplies.

To health centers

- ✓ Maintain that abortion care is integrated into 'Private Consultative Spaces' that are used for various sensitive SRH services.
- ✓ Eliminate overt signage or labeling identifying 'abortion care' at the entrance of designated service rooms.
- ✓ Assign at least two trained abortion care providers within the abortion unit.
- ✓ Establish a clear, confidential, and easily accessible patient feedback mechanism, such as a secure suggestion box or anonymous digital survey options) within or immediately adjacent to the abortion care unit.

To the researcher

- ✓ Conduct Participatory Action Research (PAR) to Co-Design Autonomy-Enhancing Interventions, health facility barriers for a rights-based approach implementation to abortion care.

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ANNEX

Annex I: English version of information sheet

Study title–health care providers and reproductive-age women's perspectives on the practice a rights-based approach to abortion care and its barriers in selected health centers, Addis Ababa, Ethiopia, 2026.

Greetings!

My name is Temesgen Shiferaw, and I am a master's student at Addis Ababa University. I am conducting a research study for my degree, and I am inviting you to consider participating.

Purpose of the Study: We are conducting this study focusing on how a rights-based approach is understood, practiced, and perceived. We want to learn what makes it easier or harder for women to receive respectful and safe abortion care. Our ultimate goal is to use this important information to potentially improve policies, training, and practices related to abortion services, ensuring better care for women in Ethiopia.

If you agree to participate, I will conduct a one-on-one, confidential interview with you. The interview is expected to last approximately 45 to 60 minutes.

Rights: Your participation in this study is voluntary. You have the right to declare not to participate in this study, and you have the right to withdraw from participating at any time.

Confidentiality: The information that you provide us will be confidential. The interview guide will be coded to exclude your name from the interview guide and consent form.

Potential Risks and Discomforts: - less likely to be affected by participation in the study, which may waste some time.

Potential Benefits of Participation-while there is no direct benefit you will directly gain from participating in this study, but the information that they provide will help to eliminate or reduce the deaths of women.

Contact address: If you have any questions about this study, you are welcome to contact Mr. Temesgen Shiferaw at +251922934492 or teme19212712@gmail.com.

Annex II: Amharic version of information sheet

የጥናቱ ርዕስ፡ በ2026 ዓ.ም. በአዲስ አበባ፣ ኢትዮጵያ በተመረጡ የጤና ተቋማት ውስጥ ባሉ የጤና ባለሙያዎች እና በመውለድ ዕድሜ ላይ ባሉ ሴቶች የፅንስ ማስወረድ አገልግሎት ላይ ባለው የመብቶች-መሰረት አቀራረብ አተገባበር ላይ ያላቸው አመለካከት እና የሚያጋጥሙት እንቅፋቶች።

ሰላም!

ስሜ ተመስገን ሽፈራው እባላለሁ። በአዲስ አበባ ዩኒቨርሲቲ የማስተርስ ተማሪ ነኝ። ለትምህርቴ ማጠናቀቂያ የሚያስፈልገኝን የምርምር ጥናት እያካሄድኩኝ ሲሆን፣ በእዚህ ጥናት ላይ እንዲሳተፉ በትህትና እጋብዝችኋለሁ።

የጥናቱ ዓላማ፡ ይህንን ጥናት የምናካሂደው በመብቶች-ላይ የተመሰረተ አካሄድ እንዴት እንደሚታወቅ፣ በተግባር ላይ እንደሚውል እና እንደሚታሰብ ላይ በማተኮር ነው። ሴቶች ተገቢ እና አስተማማኝ የፅንስ ማስወረድ አገልግሎት እንዲያገኙ ምን ያቀላል ወይም ያከብዳል የሚለውን ለማወቅ እንፈልጋለን። የመጨረሻ ግባችን ይህንን ጠቃሚ መረጃ በመጠቀም ከፅንስ ማስወረድ አገልግሎቶች ጋር የተያያዙ ፖሊሲዎችን፣ ስልጠናዎችን እና አሰራሮችን ማሻሻል፣ ለኢትዮጵያ ሴቶች የተሻለ እንክብካቤ ማረጋገጥ ነው።

በጥናቱ ለመሳተፍ ከተስማሙ፣ እኔ በግል ከእርስዎ ጋር ሚስጥራዊ ቃለ-መጠይቅ አደርጋለሁ። ቃለ-መጠይቁ ከ45 እስከ 60 ደቂቃ ሊወስድ ይችላል ተብሎ ይጠበቃል።

መብቶችዎ፡ በዚህ ጥናት ውስጥ ተሳትፎዎ በፈቃደኝነት ላይ የተመሰረተ ነው። በዚህ ጥናት ላይ ላለመሳተፍ መብት አልዎት፣ እንዲሁም በማንኛውም ጊዜ ከተሳትፎዎ የመውጣት መብት አልዎት።

ሚስጥራዊነት፡ እርስዎ የሚሰጡን መረጃ ሚስጥራዊ ይሆናል። ማንነትዎን ለመደበቅ ከቃለ-መጠይቅ መመሪያው (interview guide) እና ከስምምነት ቅጹ (consent form) ላይ ስምዎ አይካተትም፤ በምትኩ ኮድ ጥቅም ላይ ይውላል።

ሊከሰቱ የሚችሉ አደጋዎች እና ምቾት ማጣት፡- በጥናቱ በመሳተፍ የመጎዳት ዕድሉ አነስተኛ ነው። ሆኖም የተወሰነ ጊዜዎን ሊወስድ ይችላል።

ሊገኙ የሚችሉ ጥቅሞች፡- በዚህ ጥናት በመሳተፍ በቀጥታ የሚያገኙት ጥቅም ባይኖርም፣ እርስዎ የሚሰጡት መረጃ የሴቶችን ሞት ለማስወገድ ወይም ለመቀነስ ይረዳል።

የመገናኛ አድራሻ፡ ስለ ጥናቱ ምንም አይነት ጥያቄ ካለዎት፣ አቶ ተመስገን ሽፈራውን በ +251922934492 **ወይም በ** teme19212712@gmail.com **ማግኘት ይችላሉ።**

Annex III: English version of consent form

I have read the information sheet concerning this study (or have understood the verbal explanation), and what will be required of me and what will happen to me if I take part in it. I also know that I may withdraw from this study at any time without providing a reason, and that my family's routine service utilization will not be affected by my refusal.

Participant's signature _____ Date _____

Interviewer's signature certifying that the informed consent will be given verbally.

Interviewer's name _____

Interviewer's signature _____

Date _____

May I continue the interview?

1. Yes, _____ continue the interview

2. No _____ Stop the interview and thank the respondent

Annex IV: Amharic version consent form

ጥናቱን አስመልክቶ የተሰጠውን ማብራሪያ አንብቤአለሁ (በቃል) ተብራርቶልኛል፡፡ስለሆነም በጥናቱ ላይ ስመሳተፍ ከኔ የሚጠበቁትን ነገሮች እና በመሳተፌ የሚደርሱብኝን ነገሮች ተረድቻለሁ፡፡ በማንኛውም ሰአት ምንም አይነት ምክንያት ሳልሰጥ ጥናቱን ማቋረጥ እንደምችል ተረድቻለሁ፡፡ጥናቱን በማቋረጤ ምክንያት እኔም ሆነ ቤተሰቦቼ በምናገኛቸው ገልግሎቶች ላይ ተፅኖ አይኖረውም፡፡

የተሳታፊው ፊርማ_____ ቀን_____

የስምምነት ቅፅ ስለመሞላቱ የሚያረጋግጥ የመረጃ ሰብሳቢው ፊረማ

የመረጃ ሰብሳቢው ፊርማ_____

የመረጃ ሰብሳቢው ስም_____

ቀን_____

ቃለ ምልልሱን መቀጠል እችላለሁ?

1. አዎ
2. አትችልም(አመሰግናለሁ)

Annex V: English version interview guide

Part I Socio-demographic factors

Instructions: For each open-ended question, provide your response, and your responses will be audio-recorded for a better understanding of what you say. We are trying to understand what makes it easier or harder for people to get a rights-based approach to abortion care. Your experiences are very important, and there are no right or wrong answers.

Reproductive-age women

S.No	Questions	Options
1	How old are you? ----------	
2	What is your level of education?	A. No formal education B. Read and write C. Primary D. Secondary and preparatory E. college and above
3	What is your occupation?	A. Merchant B. Government employees C. Private employee D. Housewife E. Others
4	What is your marital status?	A. Unmarried B. Married C. Widow D. Divorced/ Separated E. Other--------
5	Was the pregnancy untended?	A. Yes B. No
6	Do you have Prior abortion experience?	A. Yes B. No
7	Do you have prior contraceptive use?	A. Yes B. No

Part II: Semi-structured in-depth interview guide

Experience with a rights-based approach in abortion care

Reproductive-age women's perspectives on abortion care

1. What does a rights-based approach to abortion care mean to you?
2. To your knowledge, is abortion legally permitted in Ethiopia? Probing: Are you aware of the current legal status of abortion in Ethiopia?
3. Please explain the decision and the initial decision-making process. Probing: Did you feel this was entirely your own choice, or was it a joint decision with someone else (like a partner, family member, or friend)? Were your rights and freedom respected in this process?
4. How important do you believe the principles of self-determination and informed consent are in abortion care?
5. Did the provider discuss any potential risks or complications that might happen during or after the abortion? Probing: Did you receive adequate information and counseling?
6. When you were at the health center, how was the professional's service? Probing: Do you feel your age and marital status played a role in how the health workers spoke to you? Probing did they speak down to you or judge you for being 'too young' or 'too old'? Were there any judgmental comments made about your personal life, your choices, or the reason you were at the clinic? Or did you feel respected and supported by health care providers?
7. Does the physical environment of the clinic feel confidential to you during the service? Probing the location of the service room, entrance
8. What was the communication like between you and the professionals during your time at the facility? Probing: Did any staff member speak to you in a way that made you feel humiliated? About your personal life, your choices, or why you were at the clinic? From a professional or someone else?
9. From the moment you entered the facility, how long did it take before you were first seen by a staff member (even just for registration)? Probing: How much time did you spend in the waiting area before you actually spoke with a healthcare provider about your procedure? In your opinion, was the waiting time reasonable for the type of

service you were seeking? Do you spend more time receiving care after arrival at the health center?

10. Do you think the management of this clinic would actually listen and change something if you made a complaint about your abortion care? Probing if you face refusal from providers.

11. What are barriers and facilitators for a rights-based approach to abortion care, probing the facility, provider, and the community

12. What changes would improve abortion services from your perspective? Probing from the provider, institutions, and community

I have finished my questions. Let me give you a chance if you have anything you want to add that you did not mention before closing our discussion. I greatly appreciate your willingness to help with this research. Thanks so much for taking the time to talk with me.

Health care providers

Instructions: For each open-ended question, provide your response, and your responses will be audio-recorded for a better understanding of what you say. We are trying to understand what makes it easier or harder for people to get a rights-based approach to abortion care. Your experiences are very important, and there are no right or wrong answers.

S. No	Question	Options
1.	How old are you?	
2.	What is your Sex?	A. Female B. Male
3.	What is your Profession?	A. Midwife B. Nurse C. Others_____
4.	What are the years or months of experience in abortion care?	
5.	What is your role in abortion care provision	A. Direct providers B. Coordinator

Health care providers' perspectives on a rights-based approach to abortion care

1. What does a rights-based approach in abortion care mean to you? Probing: How important are the principles of autonomy and informed consent in abortion care?
2. Who makes final decisions? Probing: Do you involve partners/parents? Or providers?
3. What happens if you disagree with a client's decision? Probing, did you respect or take any other action?
4. How do you explain procedures? Probing: Do you discuss alternatives? Do clients feel free to refuse?
5. How is privacy maintained? How important is patient confidentiality, and how can it be protected? Probing: What strategies do you use to reduce stigma and ensure a supportive environment for women? Have there been breaches?
6. Do providers refuse? Probing: What happens when they refuse?
7. How are unmarried/young women treated?
8. Are complaint mechanisms available? Probing functioning properly
9. How do your personal beliefs influence your approach to abortion care? Probing your religious and personal values, how do you balance your personal beliefs with personal responsibility to provide care? What challenges do you face in providing comprehensive abortion care?
10. Do you feel comfortable providing abortion services within the existing legal framework?
11. How do legal restrictions and regulations affect your ability to provide care? Have you observed any impact of restrictive laws on women's health outcomes?
12. What are the barriers and facilitators of a rights-based approach to abortion care? Probing from providers, institutions, and the community, what support do you need to provide a rights-based approach to care effectively? From the provider, institution, and community

I have finished my questions. Let me give you a chance if you have anything you want to add that you did not mention before closing our discussion. I greatly appreciate your willingness to help with this research.

Annex VI: Amharic version interview guide

ክፍል ፤ -ስነ-ሕዝብ ምክንያቶች

መመሪያ በቃለ መጠይቁ ወቅት በተጠየቁት ጥያቄዎች መሰረት መልሶችን ይስጡ. ለእያንዳንዱ ክፍት ጥያቄ፣ መልሶችዎን በነፃነት ይስጡ፣ እና ምላሾችዎ የእርስዎን አመለካከት በተሻለ ለመረዳት በድምጽ ይቀዳሉ። ሰዎች በመብታቸው ላይ ተመስርተው ፅንስ ማስወረድ እንዲችሉ ቀላል ወይም አስቸጋሪ የሚያደርገው ምን እንደሆነ ለመረዳት እየሞከርን ነው። የእርስዎ ልምዶች በጣም አስፈላጊ ናቸው, እና ምንም ትክክለኛ ወይም የተሳሳቱ መልሶች የሉም.

የመራቢያ-እድሜ ላይ ያሉ ሴቶች

ተቁ	ጥያቄ	አማራጭ መልሰ
1	እድሜዎት ስንት ነው?	
2	የትምህርት ደረጃዎት ምን ይመስላል?	ሀ. መደበኛ ትምህርት ያልተማረች ለ. ማንበብ እና መጻፍ የምችል ሐ. አንደኛ ደረጃ መ. ሁለተኛ እና መሰናዶ ሠ. ኮሌጅ እና ከዛ በላይ
3	ስራዎት ምንድነዉ?	ሀ. ነጋዴ ለ. የመንግስት ሰራተኛ ሐ. የግል ሰራተኛ መ. የቤት እመቤት ሠ. ሌላ
4	የጋብቻ ሁኔታ ምን ይመስላል?	ሀ. ያገባች ለ. ያላገባች

		ሐ. የፈታኙ መ. የሞተባት
5	እርግዝናው ያልተፈለገ ነበር?	ሀ. አዎ ለ. አይ
6	ከዚህ በፊት ጽንስ አቋርጠው ያውቃሉ??	ሀ. አዎ ለ. አይ
7	ከዚህ በፊት የወሊድ መከላከያ ተጠቅመው ያውቃሉ?	ሀ. አዎ ለ. አይ

ክፍል II ከፊል የተዋቀረ ጥልቅ የቃለ መጠይቅ መመሪያ

ፅንስ ማስወረድ እንክብካቤን በመብት ላይ የተመሰረተ አቀራረብ ልምድ

የመራቢያ ዕድሜ ያሉ ሴቶች ፅንስ ማስወረድ እንክብካቤን በተመለከተ ያላቸው አመለካከት

1. **በመብት ላይ የተመሰረተ ፅንስ የማቋረጥ እንክብካቤ አቀራረብ ለእርስዎ ምን ማለት ነው?**

2. **በኢትዮጵያ ፅንስ ማቋረጥ በህጋዊ መንገድ ይፈቀዳል? አሁን ያለውን ህጋዊ ሁኔታ ያውቃሉ? እርስዎ ከሚፈቀድባው ሁኔታዎች ወጪ መሆኖ አገልግሎቱን ላመግኘት ተቸግረዋል? ስለ ህጋዊ ሁኔታ መናገር የሚፈልጉት አስታያየት አለ?**

3. **ስለ ውሳኔ እና መጀመሪያ ላይ ስለ ነበረው የውሳኔ ሂደት እስኪ ያስረዱኝ. ይህ ሙሉ በሙሉ የራስዎ ምርጫ እንደሆነ ተሰምቶዎታል ወይንስ ከሌላ ሰው ጋር (እንደ አጋር፣ የቤተሰብ አባል ወይም ጓደኛ) አብሮ የተደረገ ውሳኔ ነው? በዚህ ሂደት ውስጥ መብቶችዎ እና ነፃነትዎ የተከበሩ ነበሩ?**

4. **ፅንስ በማቋረጥ እንክብካቤ ውስጥ በራስ መወሰን እና በመረጃ ላይ የተመሰረተ ስምምነት መርሆዎች ምን ያህል አስፈላጊ ናቸው ብለው ያምናሉ?**

5. **ፅንስ የማቋረጥ እንክብካቤ አቅራቢ ፅንስ ማቋረጥ በሚደረግበት ጊዜ ወይም በኋላ ሊከሰቱ ስለሚችሉ አደጋዎች ወይም ችግሮች ተናግረዋል? በቂ መረጃ እና መመሪያ አግኝተዋል?**

6. **ጤና ጣቢያ በነበሩበት ጊዜ የባለሙያች አገልገሎት እንዴት ነበር? እድሜዎ፣ ለተወሰኑ አገልግሎቶች የመክፈል ችሎታዎ እና የጋብቻ ሁኔታዎ ፅንስ የማቋረጥ እንክብካቤ አቅራቢ ከእርስዎ ጋር እንዴት እንደሚነጋገሩ ተጽዕኖ አሳድሮበዎታል? (ለምሳሌ፣ 'በጣም ወጣት' ወይም 'በጣም አርጅቷል' ብለው አናገሮዎታል ወይም ዒሳኔ ሰትዋል?) ፣ በዚህ ሂደት በጤና እንክብካቤ አቅራቢዎች መከበር እና ድጋፍ ተሰምቶዎታል?**

7. በአገልግሎቱ ወቅት የክሊኒኩ አካባቢ ሚስጥሮዎን እንደሚያረጋግጥ ወይም እንደሚጠብቅ ይሰማዎታል?

8. በተቋሙ ውስጥ በነበሩበት ጊዜ የርሶዎ እና የባለሙያዎች የሃሳብ ልውውጥ እንዴት ነበር? ውርደት እንዲሰማዎት በሚያደርግ መንገድ ማንም ሰራተኛ አነጋግሮዎታል?ስለግል ሕይወትዎ፣ ስለ ምርጫዎችዎ ወይም ለምን ክሊኒኩ እንደነበሩ? ከባለሙያ ወይም ከሌላ?

9. ወደ ተቋሙ ከገቡበት ጊዜ ጀምሮ ለመጀመሪያ ጊዜ በሰራተኛ (ለምዝገባ ብቻም ቢሆን) ከመታየትዎ በፊት ምን ያህል ጊዜ ፈጅቷል?ስለ ሂደትዎ ከጤና እንክብካቤ አቅራቢ ጋር ከመነጋገርዎ በፊት በመጠባበቂያ ቦታ ምን ያህል ጊዜ ጠብቀዋል? በእርስዎ አስተያየት የጥበቃ ጊዜ ለሚፈልጉት የአገልግሎት አይነት ምክንያታዊ ነበር? ወደ ጤና ጣቢያ ከደረሱ በኋላ እንክብካቤን ለማግኘት ብዙ ጊዜ ያሳልፋሉ?

10. ስለ ፅንስ ማቋረጥ እንክብካቤዎ ቅሬታ ካቀረቡ የዚህ ክሊኒክ አስተዳደር በትክክል ያዳምጣል እና ለውጦችን ያደርጋል ብለው ያስባሉ?

11. በመብት ላይ የተመሰረተ ፅንስ የማቋረጥ እንክብካቤ አቀራረብ እንቅፋቶች እና አመቻቾች ምንድን ናቸው? ከባለሙያ፣ ከጤና ተቋም እና ከማህበረሰቡ

12. ከእርስዎ እይታ አንጻር ፅንስ ማቋረጥ አገልግሎቶችን የሚያሻሽሉ ለውጦች የትኞቹ ናቸው? ከባለሙያ፣ ከጤና ተቋም እና ከማህበረሰቡ

ጥያቄዎቼን ጨርሻለሁ። ውይይታችንን ከመዝጋታችን በፊት ያልጠቀስከውን ማንኛውንም ነገር እንድትጨምር እድል ልስጥህ። በዚህ ምርምር ላይ ለመርዳት ያለዎትን ፍላጎት በእውነት አደንቃለሁ። ከእኔ ጋር ለመነጋገር ጊዜ ስለወሰዱ በጣም አመሰግናለሁ ።

ለጤና ባለሙያ የቀረበ -ስነ-ሕዝብ ምክንያቶች

መመሪያ- **በቃለ መጠይቁ ወቅት በተጠየቁት ጥያቄዎች መሰረት መልሶችን ይስጡ. ለእያንዳንዱ ክፍት ጥያቄ፣ መልሶችዎን በነፃነት ይስጡ፣ እና ምላሾችዎ የእርስዎን አመለካከት በተሻለ ለመረዳት በድምጽ ይቀዳሉ። ሰዎች በመብታቸው ላይ ተመስርተው ፅንስ ማስወረድ እንዲችሉ ቀላል ወይም አስቸጋሪ የሚያደርገው ምን እንደሆነ ለመረዳት እየሞከርን ነው። የእርስዎ ልምዶች በጣም አስፈላጊ ናቸው, እና ምንም ትክክለኛ ወይም የተሳሳቱ መልሶች የሉም.**

ተቁ	ጥያቄ	አማራጭ መልሰ
1	እድሜዎት ስንት ነው?	
2	ጸታ	ሀ. ወንድ ለ. ሴት
3	የሙያ መጠረያ	ሀ. ሚድዋፈረ ለ. ነርስ ሐ. ሌላ
4	የስራ ልምድ በዓመት ወይም በወር	
5	ፅንስ ማስወረድ እንክብካቤን በመስጠት ረገድ የእርስዎ ሚና ምንድን ነው?	ሀ. ፅንስ በማቋረጥ ለ. ዓስተባባሪ

የጤና ባለሙያዎች ፅንስ በማቋረጥ እንክብካቤ በተመለከተ ያላቸው አመለካከት

1. በመብት ላይ የተመሰረተ ፅንስ የማቋረጥ እንክብካቤ አቀራረብ ለእርስዎ ምን ማለት ነው?

2. ፅንስ በማቋረጥ እንክብካቤ ውስጥ የታካሚዋ በራስ መወሰን እና በመረጃ ላይ የተመሰረተ ስምምነት መርሆዎች ምን ያህል አስፈላጊ ናቸው? የታካሚዋን በራስ መወሰን እና በመረጃ ላይ የተመሰረተ ስምምነትን እንዴት ያረጋግጣሉ ወይም ምንያደርጋሉ?

3. ፅንስን በማቋረጥ ሂደት የመጨረሻውን ውሳኔ የሚወስነው ማነው?አጋሮች፣ ወላጆች ወይስ ባልሞያዎችያሳትፋሉ?

4. በታካሚዋ ውሳኔ ካልተስማሙ ምን ይከሰታል? አክበረዉ ይቀበላሉ ወይስ ሌላ አማራጭ ይፈልጋሉ?

5. ባለሙያዎች ፅንስ የማቋረጥ ሂደቶችን እንዴት ያብራራሉ? ስለ አማራጮች ይወያያሉ?ታካሚዎች እምቢ ለማለት ነፃነት ይሰማቸዋል?

6. ባለሙያዎች የታካሚዎችን ሚስጥር እንዴት ይጠበቃል? ምን ያህል አስፈላጊ ነው ብለዉ ያምናሉ? ጥሰቶች ነበሩ? ጽንስ የሚያቋርጡ ሴቶችን መገለልን ለመቀነስ እና ሚስጥራዊ አካባቢ ለመፍጠር ምን ስልቶችን ይጠቀማሉ?

7. ፅንስ ማቋረጥ እንክብካቤ አቅራቢ ባለሙያዎች እምቢ ይላሉ? እምቢ ሲሉ ምን ይሆናል?/ ምን ይደረጋሉ?

8. ያላገቡ ወይም ወጣት ሴቶች በተለየ መንገድ ይስተናገዳሉ? የቅሬታ ማቅረቢያ ዘዴዎች ይገኛሉ?

9. የባለሙያዎች የግል እምነቶዎ ፅንስ የማቋረጥ እንክብካቤ በሚሰጡበት ምን ተጽዕኖ ያሳድራል? የግል እምነትዎን ከግል ኃላፊነትዎ ጋር እንዴት ማመጣጠን ይቻላሉ? ከሥራ ባልደረቦች ወይም ከተቋሙ የህሊና ተቃዋሚዎችን እንዴት ይይዛሉ?አጠቃላይ ፅንስን የማቋረጥ እንክብካቤ በማቅረብ ረገድ ምን ተግዳሮቶች ያጋጥሙዎታል? ከባለሙያ፣ ከጤና ተቋም እና ከማህበረሰቡ

10. አሁን ባለው ህግ መሰረት ፅንስ የማቋረጥ እንክብካቤ/ አገልግሎት ለመስጠት ምቾት ይሰማዎታል?

11. ህጋዊ ገደቦች እና ደንቦች የባለሙያዎችን ፅንስን የማቋረጥ እንክብካቤ የመስጠት ችሎታዎ ላይ ምን ተጽዕኖ ያሳድራሉ? ገዳቢ ህጎች በሴቶች ጤና ውጤቶች ላይ የሚያስከትለውን ውጤት አስተውለዉ ያዉቃሉ? ምን ምን ተጽኖ ያድራሉ?

12. በመብት ላይ የተመሰረተ ፅንስን የማቋረጥ እንክብካቤ አቀራረብ እንቅፋቶች እና አበረታቾች ምንድን ናቸው? ከባለሙያ፣ ከጤና ተቋም እና ከማህበረሰቡ በብቃት ለማቅረብ ምን ድጋፍ ያስፈልግዎታል? ከባለሙያ፣ ከጤና ተቋም እና ከማህበረሰቡ

ጥያቄዎቼን ጨርሻለሁ። ውይይታችንን ከመዝጋታችን በፊት ያልጠቀስከውን ማንኛውንም ነገር እንድትጨምር እድል ልስጥህ። በዚህ ምርምር ላይ ለመርዳት ያለዎትን ፍላጎት በእውነት አደንቃለሁ። ከእኔ ጋር ለመነጋገር ጊዜ ስለወሰዱ በጣም አመሰግናለሁ ።

Annex VII: Themes, sub-themes, and codes with their description

Themes	Sub-themes	Codes	Code description
Perspective on the rights-based approach practice	Agency and Autonomy	Informed consent	Sign the consent after the information is provided
		Empower women in decision-making	Providers explain the risks and benefits of abortion, and leave the decision to her
	Confidentiality & Privacy	Practices around protecting patient privacy	Providers' action to protect patient privacy
		Shared waiting collider	the same waiting area as the women's ANC
		Shared recovery room	Admit women to the postnatal unit after the procedure
	Dignity and Non-discrimination	Reproductive Shaming	Using the patient's status as a tool to make them feel guilty or "wrong" for their choice
		Provision of care in a similar way	Give care to married and unmarried women in a similar manner
	Timely health care	Delays in care	Waiting up to a week
		Postponed care	repeated appointment
	Accountability	The Silence of the Patient	Not filled compliant
		Absence of a separate anonymous	A single Feedback Loop for all cases

Provider Experiences and Challenges in Delivering Rights-Based Care	Psychological effect	Provider moral damage	Consider an abortion care provider as a human killer
		dilemma between saving life and religious	Experience of Conflict between religious and saving life
	Occupational marginalization	lack of promotion	Absence of incentives for providers
	Providers Vulnerability and Safety Risk	External threats	Exposed to external social risk
		Internal pressure	Pressure from administrative
	Regulatory Gaps and the Impact of Private Pharmacy Distribution	unmonitored Private Pharmacy Distribution	Absence of a private abortion drug distribution control and its impact on women's health
Multilevel Barriers to Practicing Rights-Based Abortion Care	Legal Framework barriers	Providers' fears of reputation	Providers' fears of inducing abortion for married women
		Ambiguity between the training material and the local law	Discrepancy between the training material and local law
	Structural erosion to privacy	Proximity to other units	Abortion care is delivered side by side with other units
		Shared recovery room	Admit women to the postnatal unit after the procedure
	Human Resource Constraints and Risk	Shortage of providers	A single provider gives care in the abortion unit

		Challenges during case management	Faces the difficulty of shock management
	The Supply-Choice Gap	Medication Constraints	Stockout medication
	Provider Level Barriers	Judgmental Communication	personal criticism
		Reproductive Shaming	Using the patient's status as a tool to make them feel guilty or "wrong" for their choice
	Community & Societal Barriers	view abortion as a sin	Termination of pregnancy is seen as human killing
		External social pressure	Family influence on reproductive-age women