ADDIS ABABA UNIVERSITY

COLLEGE OF HEALTH SCIENCES

SCHOOL OF NURSING AND MIDWIFERY

KNOWLEDGE, ATTITUDE, AND PRACTICE OF MEDICATION ABORTION AND ASSOCIATED FACTORS AMONG REPRODUCTIVE AGE WOMEN IN SELECTED SEXUAL AND REPRODUCTIVE HEALTH CLINICS OF ADDIS ABABA, ETHIOPIA, 2018.

BY:

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A RESEARCH THESIS SUBMITTED TO ADDIS ABABA UNIVERSITY, COLLEGE OF HEALTH SCIENCES, SCHOOL NURSING AND MIDWIFERY, IN THE PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF MATERNITY AND REPRODUCTIVE HEALTH NURSING

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LIST OF ABBREVIATIONS AND ACRONYMS

EDHS	Ethiopian Demographic Health survey
FMHACA	Food, Medicine and Health administrative and control authority
HTC	HIV testing and counselling
G/A	Gestational age
LNMP	Last normal menstrual period
MA	Medication abortion
MCH	Maternal and child Health
MOH	Ministry of Health
MVA	Manual vacuum aspiration
PMTCT	Prevention of mother to child transmission
RH	Reproductive Health
SA	Surgical abortion
SMC	Sharp metallic curettage
SNNRP	Southern Nation, Nationalities and People's region
SPSS	Statistical package for social sciences
STI	Sexually transmitted infections
SRH	Sexual and reproductive Health
WHO	World Health organization

ABSTRACT

Background: Abortion rates following unintended pregnancies is increasing in developing countries like Africa and unsafe abortion is commonly neglected reproductive health care problem. In Ethiopia, the number of women receiving treatment for complications from unsafe abortion nearly doubled from 2008-2014 which is 52,600 to 103,600. Medication abortion is one of the safest abortion interventions. Adequate level of knowledge and attitude among women of reproductive age group on MA contributes to prevention and control of unsafe abortion and the resulting mortality and morbidity.

Objective: Knowledge, attitude and practice of medication abortion and associated factors among reproductive age women in selected SRH clinics of Addis Ababa, Ethiopia, 2018.

Method: A cross-sectional quantitative study design was conducted to collect data from study participants in SRH clinics of Addis Ababa from February–March 30, 2018. Study participants were selected through systematic random sampling based on their proportional distribution of sample size to each clinic. Structured questionnaire was used to collect data. The data was coded and entered into Epi data version 4.2 and the analysis was carried out by using SPSS version 23. Bivariate and multivariate analysis with 95 % CI was employed. Variables found to have a P-value<0.2 in the binary logistic regression were entered into multivariate analysis and strength of association was declared at P value<0.05.

Results: From the total of 423 mothers interviewed 412 responded the questionnaire with a response rate of (97.4%).The overall knowledge, attitude and practice of MA was 72.1 %, 44.2% and 33% respectively. Majority (36.5%) of the study participants would advise someone with unwanted pregnancy to undergo an abortion and 55.6% would consider abortion if they had unplanned pregnancy. From 205 respondents who had ever terminated their pregnancy, 136 (66.7%) used MA. Participants level of education, father education; income and history of unwanted pregnancy were some of the factors associated with MA.

Conclusion and recommendations: this study provided that women were relatively knowledgeable but their attitude and practice on MA is low. Low attitude and practice of MA calls health care providers giving due attention on MA, women empowerment, awareness creation on MA in the community, strengthened action to provide quality of maternal care for all childbearing mothers towards MA and unsafe abortion in particular.

Keywords: knowledge, attitude, practice, medication abortion, reproductive age women

1. INTRODUCTION

1.1. Background

Abortion can be defined as termination of pregnancy (spontaneous, therapeutic or induced) before the fetus has become viable outside the uterus or before the fetus is capable to have a life outside of the womb(1).

Spontaneous abortion refers to a natural biological process by which some pregnancies end with no known cause and usually referred as miscarriage and an induced abortion takes place when a pregnancy is terminated by the deliberate removal of the fetus from the uterus by the use of external methods as a result of an unwanted pregnancy(2). Elective abortion is the voluntary termination of pregnancy performed either surgically or medically. A therapeutic abortion takes place when a pregnancy is terminated by the removal of the fetus from the uterus by the use of external methods, however, unlike an induced abortion, therapeutic abortion is performed to either to save the life of a pregnant woman or when a woman's physical or mental health is in jeopardy or severe fetal congenital disorder or to selectively decrease the number of fetuses to reduce health risks linked with multiple pregnancies(3).

Changing maternal mortality will be achievable if unsafe abortion will be replaced by medical abortion since thousands of lives could be saved each year by implementing medication abortion(4). Medical abortion is the commonly performed safe abortion technology which uses medications in place of traditional surgical interventions for terminating an early unintended pregnancy. It is convenient, non-invasive and effective method with mortality rates for mifepristone-misoprostol combination regimens that are comparable to spontaneous abortion and success rates of 95–98%(5).

Legal abortion like medication abortion can be performed if the life of the woman will be jeopardized by the pregnancy and unsafe abortion will usually occurs where abortion is illegal. Unsafe abortion is defined by WHO as a procedure for terminating an unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking the minimal medical standards, or both(6).

Throughout the years, the abortion law in Ethiopia has been amended and modified. The 2004 Ethiopian revised criminal code allows abortion under certain circumstances. When; the pregnancy is resulted from rape or incest, the woman's or fetus lives are threatened, the fetus has severe abnormalities, the woman has physical or mental disabilities and when a minor is

physically or psychologically unprepared to raise a child. According to the new law there is no need of proof for age or whether the pregnancy is resulted from rape or incest(7).

Unwanted pregnancies and unsafe abortion are commonly neglected reproductive health care problems in developing countries and pose major health risks to women in the reproductive age group(8). In many cases women with unintended pregnancy may try to end their pregnancies by themselves with the assistance of untrained personnel. It is reported that regardless of the availability of different modern methods of contraceptives, the problem of unwanted pregnancies is very big worldwide (9). Death and morbidity as a result of unsafe abortion is perhaps one of the least discussed health problems in the Ethiopia. Thus, Problems like lack of women's awareness and perception over sexual and reproductive matters, incorrect or inconsistent use of contraceptive methods, forced sexual intercourse, economic conditions, legal obstacles and potential contraceptive method failure are not easily resolved and may lead to unintended pregnancies and lead to a profound impact on women's recourse to abortion and especially unsafe abortion(9).

Despite of the magnitude the problem of unintended pregnancy and unsafe abortion, it is one of the most easily preventable causes of maternal morbidity and mortality. Where abortion services are legal, safe, and accessible and if community/society awareness are good on safe abortion methods, complications of abortion will be rare. Restrictive abortion laws, lack of awareness, negative cultural and religious attitudes and poor health infrastructure for the treatment of abortion related complications are the main burdens of women's health that could be prevented (10).

1.2. Statement of the problem

According to the study done by WHO and Guttmacher institute in 2010- 2014, an estimated 56 million abortions occurred every year worldwide, of this 25 million (45%) are unsafe abortions. The majority of unsafe abortions(97%), occurred in developing countries in Africa, Asia and Latin America(11). This number represents an increase from 50 million annually during 1990–1994, mainly because of population growth(12). Women in developing regions have a higher likelihood of having an abortion than their counterparts in developed regions(11, 12).

Despite this progress and the availability of different modern methods of contraceptives, the problem of unwanted pregnancies is very big worldwide(9). Most women undergoing abortion do so because they became pregnant when they did not intend to, and 84% of unintended pregnancies in developing countries occur among women who have an unmet need for modern contraception(11). Although induced abortion is medically safe when done in accordance with recommended guidelines, many women undergo unsafe procedures that put their well-being at risk. Estimates for 2012 indicate that 6.9 million women aged 15-44 in developing regions were treated for complications from unsafe abortions(11, 13).

Ethiopia has a high maternal mortality ratio, 412 deaths per 100,000 live births for the period 2009-2016(14) and reproductive health experts in the country believe that the proportion due to abortion complications is also excessive which is an estimated 1.9 million (38%) Ethiopian women have unintended of 4.9 million (62%) total pregnancies and 620,300 induced abortions (13%) were performed in 2014(15, 16). Between 2008 and 2014, the proportion of abortions occurring in facilities raise from 27% to 53%, nonetheless, an estimated 294,100 abortions occurred outside of health facilities in 2014(15). The number of women receiving treatment for complications from induced abortion nearly doubled which is 52,600 to 103,600(16, 17).

To address the large number of maternal deaths caused by unsafely-performed abortions, the Ethiopian Parliament liberalized the indications for legal abortion in 2004. Indications for legal abortion include: cases of rape or incest, if the woman has physical or mental disabilities, to preserve the woman's life or her physical health, or if the woman is a minor who is physically or mentally unprepared for childbirth(18).

Medication abortion using drugs has recently come into focus as a plausible alternative to manual vacuum aspiration to induce abortion(19). A prospective study which was conducted

in two hospitals and two clinics from March 2009 to November 2009 on client preferences and acceptability for medical abortion and manual vacuum aspiration as early pregnancy termination method in northwest Ethiopia showed that subjects undergoing medical abortions reported significantly greater satisfaction and more likely to choose the same method again than were subjects undergoing manual vacuum aspiration (91.2% vs. 82.4%; P < .001)(20).

However, in Ethiopia, barriers and challenges to accessing medication abortion exist at multiple levels which may deprive women from using safe medication abortion and exposing them to unwanted births or to unsafe abortion and its devastating consequences of death and disability(21). Access to medication abortion is commonly restricted, not only by the law, but also by other barriers like Social, religious, cultural impediments, lack awareness, maternal perception towards abortion also contribute to delays in seeking abortion to a time beyond the limit set by the law and thus when faced with an unintended pregnancy, women seek abortion and self-induce it or find providers, irrespective of the law and Unsafe abortions present a critical public health and human rights challenge of the present time(21, 22).

Deaths and disability due to unsafe abortion continue to occur against the backdrop of major advances in the medical profession, especially in terms of the availability of safe and effective technologies and skills for induced abortion. The combination of mifepristone and misoprostol has been shown by various studies to be safe, effective and well-established method for termination of pregnancy. However, many women used less recognized and less effective abortive drugs(19).

Even though many studies were conducted on abortion in Ethiopia, there seems to be a gap in evidence synthesis for women's knowledge, attitude and practice of medication abortion and as far as my knowledge is concerned, no facility based studies were conducted on knowledge, attitude, and practice of medication abortion among reproductive age women in Ethiopia. So to be widely used, medication abortion should be perceived and accepted by the women. Therefore, the aim of this study will be to assess the knowledge, attitude and practice of medication abortion and associated factors among reproductive age women in selected sexual and reproductive clinics of Addis Ababa, Ethiopia.

1.3. Significance of the Study

In most studies, over 80% of women who chose medical abortion found it acceptable and would choose the same method again if they needed another abortion in the future(23).

Currently, many development partners have started to respond for the multifaceted problem faced by women with reproductive age. Since the abortion issue in Ethiopia is still controversial and sensitive, women acquiring knowledge, attitude, and practice and knowing determinant factors of safe abortion like medication abortion service will make the overall challenges ease within the society and will reduce maternal morbidity and mortality. Consequently this study will help women's to enhance/exercise their reproductive health rights regardless of the existing social and cultural stigma/limitations. It will help different development partner's, primarily those who involve in maternal health to utilize findings and recommendations of this research for the betterment and advancement of the regional and national medication abortion related intervention of Ethiopia. Future researchers will also use this finding for further study.

Furthermore, policy makers in sexual and reproductive health clinics, religious and community stakeholders will also use the evidence of this finding to improve strategies, and program policies to tackle the root causes.

2. LITERATURE REVIEW

2.1. Overview of global law and abortion practices

Abortion is the premature termination of pregnancy before the fetus is able to survive independently. In medical terms if spontaneous abortion is made use of it refers to failure of a fertilized egg to be implanted into the womb as well as miscarriage(1). induced abortion a deliberate termination of pregnancy in fear of unhealthy development of the fetus, endangerment of the life and health of the pregnant or due to other reasons(2) Abortion is also classified as safe and unsafe depending on the professional capability of the individuals who perform it as well as the medical standard of the environment where it is performed(1, 7). According to the WHO, unsafe abortion is performed by people who do not have adequate skill, or in an environment that does not fulfil the minimal medical requirement, or both(6).

Unsafe abortion and related morbidity and mortality are both higher in countries with narrow grounds for legal abortion. An estimated 620,300 induced abortions were performed in Ethiopia in 2014. The annual abortion rate was 28 per 1,000 women aged 15–49, an increase from 22 per 1,000 in 2008, and was highest in urban regions (Addis Ababa, Dire Dawa and Harari). In the middle of 2008 and 2014, the proportion of abortions occurring in facilities rose from 27% to 53%, and the number of such abortions increased substantially; nonetheless, an estimated 294,100 abortions occurred outside of health facilities in 2014. The number of women receiving treatment for complications from induced abortion nearly doubled between 2008 and 2014, from 52,600 to 103,600. 38%of pregnancies were unintended in 2014, a slight decline from 42% in 2008(16, 24).

A woman dies every eighth minute somewhere in a developing country due to complications arising from unsafe abortion(13). When faced with an unintended pregnancy, women seek abortion and self-induce it or find providers, irrespective of the law(13). Deaths and disability due to unsafe abortion continue to occur against the backdrop of major advances in the medical profession, especially in terms of the availability of safe and effective technologies and skills for induced abortion(9, 25).

A host of barriers and challenges result in unintended pregnancies and restrict access to safe abortion. Lack of awareness of what the law actually permits among the public, women, legal and health staff alike persists. Access to abortion is commonly restricted, not only by the law, but also by other barriers. Social, economic, religious, cultural impediments, national laws

and policies also contribute to delays in seeking abortion to a time beyond the limit set by the law and thus leaving no option for women other than having an unwanted birth or a clandestine risky abortion(13, 26).

In the Ethiopian context, factors associated with culture, diverse religious opinions, and views on women's rights to control over their own lives and bodies and the right of the fetus to life highly affects the positions on abortion issue(22).

The abortion law varies across the world while countries can be categorized into four based on their abortion laws: abortion is permitted only to save the woman's life or is prohibited altogether; permitted to preserve the health of the pregnant which includes mental health according to the definition of WHO which covers various social issues; permitted on the basis of socio-economic grounds which includes the age, economic status or marital status. Yet, the majority of the countries agree on explicitly permitting abortion when pregnancy results from rape, incest and high probability of fetal impairment(27).

According to the new liberalized law, abortion in Ethiopia is permitted when; the pregnancy is resulted from rape or incest, the woman's or fetus lives are threatened, the fetus has severe abnormalities, the woman has physical or mental disabilities and when a minor is physically or psychologically unprepared to raise a child. According to the new law there is no need of proof for age or whether the pregnancy is resulted from rape or incest(7, 22)

2.2. Socio- cultural context of abortion

Most studies conducted on abortion have failed to explain the socio-cultural and economic situations of the women who undertake the procedure. Majority of women in developing countries prefer to undertake unsafe abortion by untrained providers or by using different dangerous self-inducement techniques which put them in a high risk of death like Swallowing large doses of drugs, anti-malarial or oral contraceptives (pills), Inserting a sharp object into the uterus, Drinking or flushing the vagina with caustic liquids like bleach, Physical abuse (jumping or falling), vigorous dancing, or sustained and vigorous sexual intercourse over long periods, prolonged and hard massage to manipulate the uterus, or repeated blows to the stomach(1, 28).

Barriers to improving women's health and access to safe abortion services are often embedded in social, economic, cultural and legal conditions that infringe upon women's human rights(22, 29). A human rights needs assessment might reveal that social factors,

including lack of literacy and of educational or employment opportunities deny women alternatives to early unwanted or repeated pregnancy and deny women's economic and other means of access to contraception. A gender-sensitive approach to social science and legal research can help to identify the ways underlying socio-legal conditions positively or negatively affect advances in women's independence and access to safe abortion services(2, 7, 21).

According to the Ethiopian MOH, technical and procedural guidelines for safe abortion in 2006, there are two methods where pregnancies can be terminated. The first one is MA: termination of pregnancy through the use of medicines. An alternative method to SA and MVA, it does not require the insertion of any instruments into the uterus, thus reducing the risk of infection and other complications such as the tearing of the uterus. This procedure is applied to a pregnancy up to 9 completed weeks since the LNMP. First Mifepristone 200 mg will be provided followed 36-48 hours later by misoprostol 800ug vaginally. The second one is surgical Methods; which includes vacuum aspiration which is an alternative safe method of terminating an otherwise uncomplicated pregnancy up to 12 completed weeks of gestation from the first day of the LNMP and Sharp Metallic Curettage (28, 30, 31).

2.3. Women at risk of abortion

Every woman in reproductive age carries the risk of an unwanted pregnancy. There is no typical profile of women which puts them to an unwanted pregnancy regarding age, parity, socio-economic background, educational status, type of current union, even not the state of knowledge on contraception. There are, however, women who are particularly at risk of an unsafe abortion: Young and/or unmarried women; Women in crises, conflict and refugee situations; Women exposed to sexual violence and Poor women(9, 32).

2.4. Acceptability of medication abortion by reproductive age women

Medication has several advantages over surgical abortion in that the overall cost is usually lower, medical staff with surgical skills are not required, and in terminations below 9 weeks gestation no hospital admission is required. MA virtually eliminates the risks of surgery and anaesthesia, and allows more flexible timing, with out-patient treatment, and the convenience of completion in the home environment; also women feel more in control and many feel that an induced miscarriage is a more natural process(23, 33-37).

The combination of mifepristone and misoprostol is now a well-established method for MA in many countries worldwide. It has been shown by various studies to be a safe and effective

method for the termination of pregnancy. However, to be widely used, it must also be acceptable to women, especially since there is an alternative (MVA) that is also a safe and effective method for the termination of pregnancy. The reasons why women choose MA vary in different countries. In most countries, the most common reasons for choosing MA are avoidance of surgery or general anaesthesia, perception that it is safer and perception that it is more natural than a surgical procedure(5, 30, 38). In most studies, over 80% of women who chose MA found it acceptable and would choose the same method again if they needed another abortion in the future. They would also recommend this procedure to other women who need an abortion. (23, 31).

2.5. The drug of choice for medication abortion

MVA has been used for many years for termination of early pregnancy but now agents are available which can terminate pregnancy if taken orally/ vaginally or parent-rally obviating the need for the surgical procedures thus reducing the complications of the procedure(29).

Medication abortion using drugs has recently come into focus as a plausible alternative to MVA to induce abortion(19). But studies show that the maternal awareness and perception for mifepristone and misoprostol medication is too less & used less recognized and less effective abortive drugs. For instance, a descriptive, cross sectional study done on MA seekers in South-eastern Nigeria shows that 48% had used drugs for pregnancy terminations. Drugs used for termination included quinine combined with other drugs in 8%; gynaecosid alone in 6%, gynaecosid combined with other drugs in 6% menstrogen combined with other drugs in 6% and an unclassified drug in 14%. 3%, 2%, and 0% of subjects had knowledge of misoprostol, mifepristone and methotrexate, respectively. 1% of respondents had used misoprostol(19).

Desirable characteristics of a method of MA for the early first trimester are: effective up to 63 days of gestation, easy to administer, safe, and have acceptable side-effects, affordable, widely available and blood loss should be similar to, or less than, that associated with vacuum aspiration(4, 29).

2.6. Legal status/issues of abortion in Ethiopia

A quantitative, community based cross-sectional survey conducted on women of reproductive age in three selected lower districts in Bahir Dar, North-West Ethiopia, showed that Of 845 eligible women selected, 774 (92%) consented to participate and completed the interview. A total of 512 (66%) women were aware of the legal status of the Ethiopian abortion law and

their primary sources of information were electronic media such as television and radio (43%) followed by healthcare providers (38.7%). Among women with awareness of the law, 293 (57.2%) were poor in knowledge, 188 (36.7%) fairly knowledgeable, and 31 (6.1%) good in knowledge about the cases where abortion is allowed by law. Of the total 774 women included, 438 (56.5%) hold liberal and 336 (43.5%) conservative attitude toward legalization of abortion. Age had statistically significant association with knowledge. Women with their age between 35 and 44 years were six times more likely to have good knowledge of the current abortion law as compared with those older than 45 years (adjusted OR, 5.75; 95% confidence interval) & occupational status, showed significant association with attitude toward the abortion. Being self/private employee was two times more likely to increase positive attitude toward abortion than being a student (AOR, 0.41; 95% CI, 0.21e0.80)(39).

A cross sectional community based study done in Yirga cheffe town SNNPR from march 29-April 10, 2010 showed that of 422 total sample sizes, out of the response rate was 97.3%. The respondent was in the age range of 15-49years.The mean age of respondents was 26 years in a range of 25-29 years. Of the respondents 78.21% have knowledge about abortion and its complication. This study shows 48.9% have knowledge about the legalization of abortion. From these 61.17% had a positive attitude on the legalization of abortion and the rest 33.51% had negative attitudes on the legalization of abortion and around 5.32% had a neutral idea(40).

2.7. Studies on knowledge, attitude and practice of medication abortion

A cross sectional study, carried out from August 2010 to July 2012 in India to assess the knowledge, attitude and practice of medical abortion in women (15-45) showed that majority of women 112(53.33%) had taken abortifacient at <12 weeks of gestation. However, 56 (26.67%) women did not know about their gestation age. Majority of women, 187(89.05%) had taken medicine at home. Only 10.95% women had taken medicine at hospital under supervision. Out of 210 women, 191 women took the Mifepristone/Misoprostol regime of MA and only 19 women had undergone abortion using other medicines. Out of the 191 Women only 23 women (12.01%) heard about this regime from doctors and 87 women (45.55%) had gained information from media, mainly the internet and television. Out of the 19 women who had heard that abortion can be obtained by using other medicines, 16 women (84.21%) had heard about it from Relatives, 1 (5.26%) from Media, 2 (10.53%) from others (friends)(41).

Another prospective hospital based cross sectional study carried out on 200 married women to assess attitude and Experiences of Young Women towards MA in India showed that, the average age of women included in the study was 23.4 years ±4.2. The knowledge and usage of MA drugs among the participants was 92.5 % and 17.5% respectively. Majority of the participants seek MA to limit family size, birth spacing, unwanted pregnancy, failure of contraception and socioeconomic limitations. Television, chemists, friends and relatives were the most important source of information about medical abortion(36).

A study done on the assessment of the level of knowledge regarding safe abortion among reproductive age group women, a short cross sectional study in lekhnath, kaski, Nepal showed that 40% knew about induced abortion, only 28% gave the correct meaning about safe abortion, the rest 72% gave incorrect meaning about the safe abortion. The respondents who heard about safe abortion, only 51% knows about the legal period of safe abortion for women and remaining 49% of them did not have any idea for legal time of legal abortion. In addition, 40% of respondents had good knowledge about safe abortion and 20% of the respondents had poor/low level of knowledge regarding safe abortion(42).

The study conducted in Brazil on the knowledge of Brazilian medical students regarding medical abortion (MA) and the use of misoprostol for MA, and to investigate factors influencing their knowledge. Methods: Of about 1260 participants invited to participate, 88% reported having heard how to use it, only 8% showed satisfactory knowledge of its use and effects. From the respondent majority, 91% were heard about misoprostol as a means to induce abortion(43).

Data are drawn from a survey of 371 abortion clients on knowledge and attitudes about abortion legislation and abortion methods from 16 purposively selected abortion clinics in Latvia showed that most women knew that abortion is legal either under any (53%) or certain (37%) circumstances. Almost one third (31%) of women interviewed were aware of medical abortion. After hearing a description of MA, respondents felt the method as described would be advantageous because it could avoid a surgical intervention (33%) or found it simple, easy, convenient, or natural (12%). Majority of women knew that abortion is legal in Latvia under any circumstance (53%) or certain circumstances (37%). Among them who were aware that abortion was legal, over half (57%) believed that a woman can have an abortion until the twelfth week of her pregnancy. One third (31%) of the sampled abortion clients had heard of medical abortion.(44).

Descriptive, cross sectional survey carried out on 100 consecutive MA seekers in south-eastern Nigeria showed, 64% had a secondary educational level, 33% had a tertiary education level and 3% had a primary educational level. Fifty-eight percent of subjects were ages 18-20 years; 25% had one or more previous deliveries and 49% had a previous termination of pregnancy. Forty-eight percent had used drugs for pregnancy terminations. Drugs used for termination included quinine combined with other drugs in 8%; gynaecosid alone in 6%, gynaecosid combined with other drugs in 6% menstrogen combined with other drugs in 6% and an unclassified drug in 14%. Thirty-three percent of subjects purchased their abortion drugs in a pharmacy. Three percent, 2%, and 0% of subjects had knowledge of misoprostol, mifepristone and methotrexate, respectively. One percent of respondents had used misoprostol(19).

A community based cross sectional quantitative study carried out to assess the attitude towards induced abortion among adults residing in Mizan Aman town, Bench Maji zone showed that Out of 498 study participants 486 responds to the questions which gives response rate of 97.6%. Among the study participants, 200 (41.15%) had positive attitude towards induced abortion and the rest 286 (58.85%) had negative attitude. From the sampled population 270 (55.6%) of the participants support induced abortion if the fetus has serious defect in utero, 394 (81.1%) of the participants support induced abortion if the pregnancy seriously threatens the mother life, 249 (51.2%) of the participants support induced abortion if the family has low income and cannot afford more children and 261 (53.7%) of the participants support induced abortion if the pregnancy is due to rape(2).

Institution based cross-sectional study conducted in eight health facilities in Guraghe zone showed that 68 (17%) of the respondents had previous history of abortion, which was experienced once in 86.8%, twice in 11.7%, and three times in 1.5% of the respondents. The majority, 302 (75.5%), of the post-abortion patients revealed that the current pregnancy which ended in abortion was unwanted while the remaining 98(24.5%) of the patients said it is wanted. Materials used to induce the pregnancy were herbs, 18 (36.7%); plastics, 15 (30.6%); and different medications in 11 (22.4%) of the patients. Twenty (40.8%) reported that interference was done by themselves followed by health workers, 25 (51%). Main reasons given for resorting to induced abortion by those who admitted interference were to complete education, 20 (40.8%), and for economic reasons, 18 (36.7%)(8).

A cross sectional study conducted on 341 evangelical women of ages 15 and older residing in Addis Ababa in a period of four months to assess their knowledge, attitude and practice about induced abortion and family planning. (93.5%) respondents replied that they know about abortion. 10.8% mentioned church, 9.3% mentioned family, 15.6% mentioned friends, 13.% mentioned radio, 15.1% mentioned television, while 12.3% mentioned health facility as their source of knowledge. About 61.9% (211) responded that they know about the law while 38.1% (130) replied that they do not have knowledge about the law concerning abortion. 22.5% replied if the pregnancy happens from incest, 15.1% replied if the pregnant is under 18 years old, 27.3% replied if the pregnancy endangers the health of the pregnant, 21.4% replied if there is fetal malformation, 7.4% replied that abortion can be done whenever the pregnant requests while 6.3% replied that they do not know about the conditions where the law permits abortion to be done. Concerning attitudes about Abortion; 85.3% replied that abortion is sin, 11.7% of respondents claimed that they have difficulty of concluding whether abortion is sin or not; while 2.6% replied that abortion is not sin. Regarding the practice of abortion; 23.8% (81) replied that they had at least one abortion while 76.2% (260) replied that they never had abortion. 20.8% replied that they knew specific abortifacient medicines like Mifepristone and Misoprostol, 13.20% know about antibiotics, 13.4% replied that they do not know any method (7).

Across sectional descriptive study design conducted on 384 women in Debre Markos referral Hospital showed that a total of 384 make the response rate of 91%. The majority of 292(76%) participants had knowledge about legal abortion service and 92 (23%) had poor knowledge and who think about abortion, 97(25%) were said that it is good and 73(19%) were said that it is harm full practice and 9 (2%) were they don't knew. Among the sampled population those who practice when unwanted pregnancy were happen 178 (46%) were said that we would continue the pregnancy, 131(34%) were said that we would abort the pregnancy and 75 (19%) were they do not knew. From the participants who said that we would abort the pregnancy the place where they abort were70(18%)were from government,22(5.729%)were from private clinic 21(5.4%) were using local rural drugs or traditional medicine and18(4%)were from non-government organization(45).

A cross-sectional quantitative study supplemented by key informants' interview conducted on social science in Addis Ababa university students between 1st of June of 5th of July 2013 showed that the mean age of the study participants were 20.6 ± 1.5. Three- fourth of the respondents (159, 74.6%) knew what MA meant where 11 (6.9%) and 97(61%) of them had

high and low knowledge on MA respectively. Most (142, 66.7%) of the study participants would advise someone with unintended pregnancy to undergo an abortion and 86 (40.4%) would consider abortion if they had unplanned pregnancy. From 21 respondents who had abortion experience, 13 (61.9%) used MA (32).

2.8 Factors Associated with medication abortion

2.8.1. Socio-demographic & economic factor

Prospective hospital based cross sectional study carried out on 200 married women to assess the attitude and Experiences of Young Women towards MA attending in India showed that, Age, education, socio-economic status, and religion had the significant role in knowledge and attitude towards MA. The average age of women included in the study was 23.4 years ±4.2. From the participants, 39% studied up to middle school, 55% up to high school, 5% had university degree and 1% was uneducated. Though the overall awareness about MA was significantly high (92.5%) in the participants. The knowledge about MA was relatively high among younger participants (aged <25 years), better educated group, urban residents, in higher socioeconomic strata, in Hindus compared to Christian and Muslim population. The usage of MA drugs was significantly higher among women aged >25 years ($p \leq 0.01$), educated group ($p \leq 0.01$), urban residents ($p \leq 0.01$) and in Hindu's ($p \leq 0.01$) in comparison to Christian and Muslim participants(36).

A cross sectional study conducted on 341 evangelical women of ages 15 and older residing in Addis Ababa in a period of four months (February-May 2015) to assess their knowledge, attitude and practice about induced abortion and family planning showed that age, religion, marital status, occupation, educational status and income have showed significant association with abortion. Age of the respondents (P-value=.000), occupation (P-value=.000) and income (P-value=.009) have shown association with their knowledge about abortion. Age ((P-value=.014), occupation (P-value=.013), educational status (P-value=.032) have significant association with their attitude and all of the independent variables; age (P-Value=.000), age when the respondents converted to evangelical Christianity (P-Value=.000), marital status (P-Value=.003), occupation (P-Value=.001), educational status(P-value=0.000) and income (P-Value=.031) have significant association with the respondents practice of abortion(7).

A facility based cross-sectional study done on determinants of abortion practice in Addis Ababa, was described that 183 (67.5%) of them women with abortion cases have secondary and above educational level followed by women with primary education (20.7%) and with no

education (11.8%) and socio demographic characteristics of respondents with their knowledge about safe abortion, educational status showed a strong association p value < 0.001. Friend / relatives about abortion p value is less than 0.000), education, religion, marital status (p value is less than 0.05) had also show strong association with attitude of respondents. Marital status (p<0.000), unwanted pregnancy (p=0.000), occupation (p< 0.000), knowing a friend/a relative who has practiced abortion (p=0.000), Place of birth (p=0.000), income (p=0.002 had a strong relation with their abortion practice. Respondents who were born in Addis (n=195) 55% of them explained that they did have abortion practice than 70% of (235) women who said their place of birth is outside Addis. Women who do not have adequate knowledge on contraceptive methods make them susceptible for the root cause of abortion; unintended pregnancy(28).

Another study conducted in Addis Ababa on unwanted pregnancy and induced abortion among female youths: showed that age and occupation was statistically significant with the P value of 0.016 and 0.004 respectively with induced abortion. The majority17 (65.4%) of the respondents living with their boyfriend and 3(11.5) living with their friends were significant knowledge on induced abortion. In-case of unwanted pregnancy with single women are more likely in having unwanted pregnancies (78%) as well as they are also more likely to end up having an abortion (58 %) as compared to the married counterparts. Most of the respondents mentioned that the reason for not wanting the pregnancy was they were still in school. (47%), followed by don't have enough money to take care of the baby (40%).As for to why youths ended up into having induced abortion majority of them mentioned that they didn't have enough money to take care of the baby 14(53.8%) followed by they were still in school 10 (35.8 %). 78 % of singles were more likely to have unwanted pregnancy compared to their married counterparts with the P value of 0.001 the same group is affected more on having induced abortion with the proportion of 58 % and P value of 0.001(9).

2.8.2 Parental socio-demographic factor

A cross-sectional quantitative study supplemented by key informants' interview conducted on social science in Addis Ababa university students between 1st of June of 5th of July 2013 showed that participants with father who are illiterate had low knowledge regarding MA compared to students having fathers who are educated (AOR=0.112 [0.013-0.969]) and it showed statistically significant association. Though mother educational status (illiterate) shows statistical significance at crude odds ratio, upon adjustment for, age group, Religion,

Department, marital status, residence, Mother Education, Father Education, Parent medical profession the effect of mother's educational status (illiterate) was not found to be statistically significant (OR=0.258 [0.088-.762])(32).

2.8.3. Obstetric and RH related factors

Prospective hospital based cross sectional study carried out on 200 married women to assess the attitude and Experiences of Young Women towards MA attending in India showed that relatively higher number of MA was observed in low parity women. Out of 35 women who had used abortion kits, 15 were primipara, out of which 6 had used kits once, 8 had used twice and 1 had used thrice. 13 participants were para 2, out of which 7 had used kits once, 4 used twice and 2 had used three times. Participants who were para 3 and more, 2 had used once and 5 used kits twice. Significantly higher usage was observed among participants with lesser parity ($p \leq 0.05$)(36)

A facility based study in Addis Ababa showed that Parity had an association with their abortion practice with X2 9.38 and p= 0.025. Women whose pregnancy ranges between1-2 (n=306) 61% of them have abortion practice than women whose number of pregnancy is three and above (n= 187) >80 % of them have had abortion record. Unwanted pregnancy History; Being faced with unwanted pregnancy shows a strong association with their previous abortion practice with chi square value of 150 and significant at p=0.000). Women who report that they have faced unwanted pregnancy (n=192) 94.7% of them report that they did have abortion history. Women who said they did not face unwanted pregnancy (n=238) only (89) 37.3% of them had terminated one or more of their pregnancy through abortion(28).

2.9. Conceptual frame work

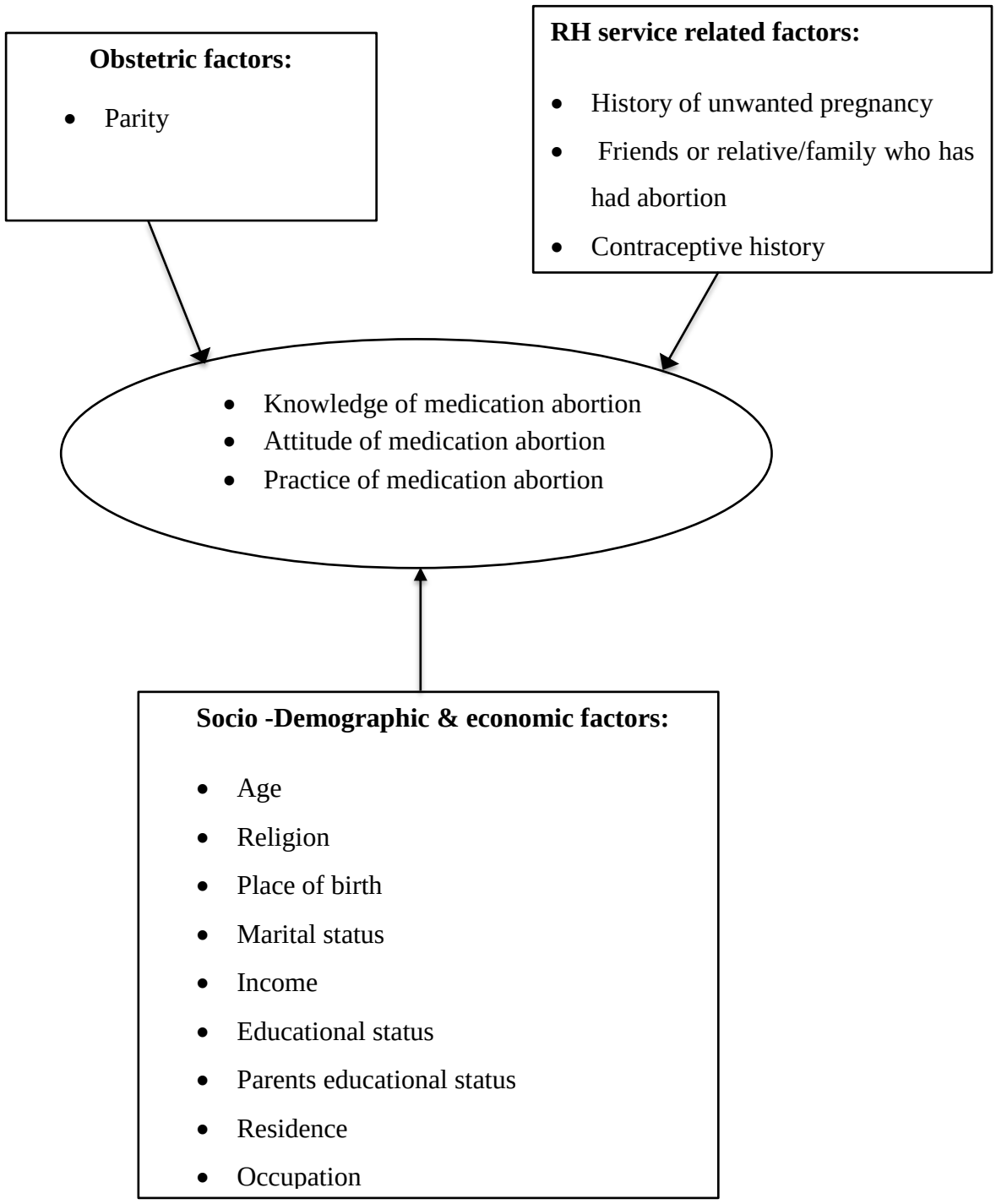

Figure 1: The conceptual frame work on assessment of knowledge, attitude and practice of medication abortion adapted from Mehiret Habte, July 2010 and Hermela Solomon, June 1, 2015 (7, 28).

3. OBJECTIVES OF THE STUDY

3.1. General objective

- To assess the knowledge, attitude and practice of medication abortion and associated factors among reproductive age women in selected SRH clinics of Addis Ababa, Ethiopia, 2018.

3.2. Specific objectives of the study

- ❖ To determine the level of knowledge of medication abortion among reproductive age women in selected SRH clinics of Addis Ababa.
- ❖ To determine the attitude towards medication abortion among reproductive age women in selected SRH clinics of Addis Ababa.
- ❖ To describe the practice of medication abortion among reproductive age women in selected SRH clinics of Addis Ababa.
- ❖ To determine associated factors affecting women's knowledge, attitudes and practices related to medication abortion.

4. METHODS

4.1. Study area and setting

The study was conducted in Addis Ababa, the capital of Ethiopia. Addis Ababa is set up in to ten sub-cities. According to the 2007 population and housing census, the city has a total population of 2,739,551 (3.7%) and annual growth rate of 2.1% between 1994 -2007. Out of these, female population accounted for 1,434,164 (52%). Women of reproductive age group among the total population are 947,855(46). According to the report from Addis Ababa FMHACA and Ethiopian MOH, in the city, there are thirteen governmental hospitals, thirteen private hospitals, two NGO hospitals, twenty three governmental health centres, nine governmental clinics, one private health centre, three hundred seventy six private clinics, and seven SRH-clinics(47).

The outpatient service of SRH clinic shall provide services like (adolescent reproductive health service, delivery service (optional), ante natal Care service, post natal Care service, (optional), removal of retained concepts products following miscarriage or abortion, family planning service, New-born resuscitation, Immunization, abortion care (as per law), PMTCT services, STIs and HTC and referral service(48).

4.2. Study design and period

Facility based cross-sectional quantitative study design was employed from February 30-March 30, 2018.

4.3. Population

4.3.1. Source population

All reproductive age women attending in sexual and reproductive health clinics of Addis Ababa, Ethiopia, in 2018.

4.3.2. Study population

All reproductive age women attending in selected SRH clinics of Addis Ababa, Ethiopia in 2018.

4.4. Eligibility criteria

4.4.1. Inclusion criteria

All reproductive age women coming for service in selected SRH clinics during data collection period were included.

4.4.2. Exclusion criteria

Reproductive age women coming for the service but involuntary, severely ill and whose age less than 18 years were excluded from the sample.

4.5. Sample size determination

The sample size required for study was calculated based on a single population proportion formula as follows.

$$n=\frac{(Z\alpha/2)^2P(1-P)}{d^2}$$

Where: n=sample size

Z = standard normal distribution corresponding to significance level at $\alpha = 0.05$

p = P is anticipated proportion of women's knowledge, attitude and practice of medication abortion and it is assumed to be 50% taken to increase the sample size**.**

d = margin of error assumed to be 5%

$$n=\frac{(1.96)^2(0.5)(1-0.5)}{(0.05)^2}$$

$$= 384$$

By considering 10% non-response rate, the total sample size was 384+39= 423

To allocate the sample size for the selected SRH clinics, their previous 12 months achievement was used which is (Arada maternal &Health clinic=22305=, Torhayloch clinic =20985, Addis ketema clinic=9474) and Megnaga clinic=18795). Then the allocation for each clinic was done as follows:

$N_y = \frac{n}{N} * NY$ where

N_y= the sample size allocated for "Y" clinic

N_Y =Population size that "Y" clinic achieve in the previous 12 months

n = Total sample size =423

N= Total population size = $Y_1+Y_2+Y_3+Y_4$ =71,559 and

For Arada maternal &Health clinic:

$$N_{Arada} = \frac{423}{71559} * 22305 = 132$$

For Torhayloch clinic:

$$N_{Torhayloch} = \frac{423}{71559} * 20985 = 124$$

For Addis ketema clinic:

$$N_{Addis\ ketema} = \frac{423}{71559} * 9474 = 56$$

For Megnaga clinic:

$$N_{Megnaga} = \frac{423}{71559} * 18795 = 111$$

NB: Y_1, Y_2, Y_3, and Y_4 represents Arada, Torhayloch, Addis ketema and Megnaga SRH clinics and the "pooled k" value was calculated by taking the average achievements of the selected SRH clinics and the average achievement was divided in to 12months to get the estimated population during the data collection period. Finally, when it is divided by the sample size, "pooled k" value was obtained. That is:

$K = \frac{NY1+NY2+NY3+NY4}{4} = \frac{22305+20985+9474+18795}{4} = 17890$ this further divided in to data collection period which is $\frac{17890}{12} = 1491$ then finally divided by the sample size: $\frac{1491}{423} = 4$

So the subjects were selected every k^{th} which is 4.

4.6. Sampling procedure

Clinics were selected by using simple random sampling and systematic random sampling technique was employed to select subjects. First the total sample size was distributed to each selected SRH clinics proportionally to make it representative. Then exit interview was employed (participants were selected using systematic random sampling technique or every k^{th} exit (k^{th} value=4))

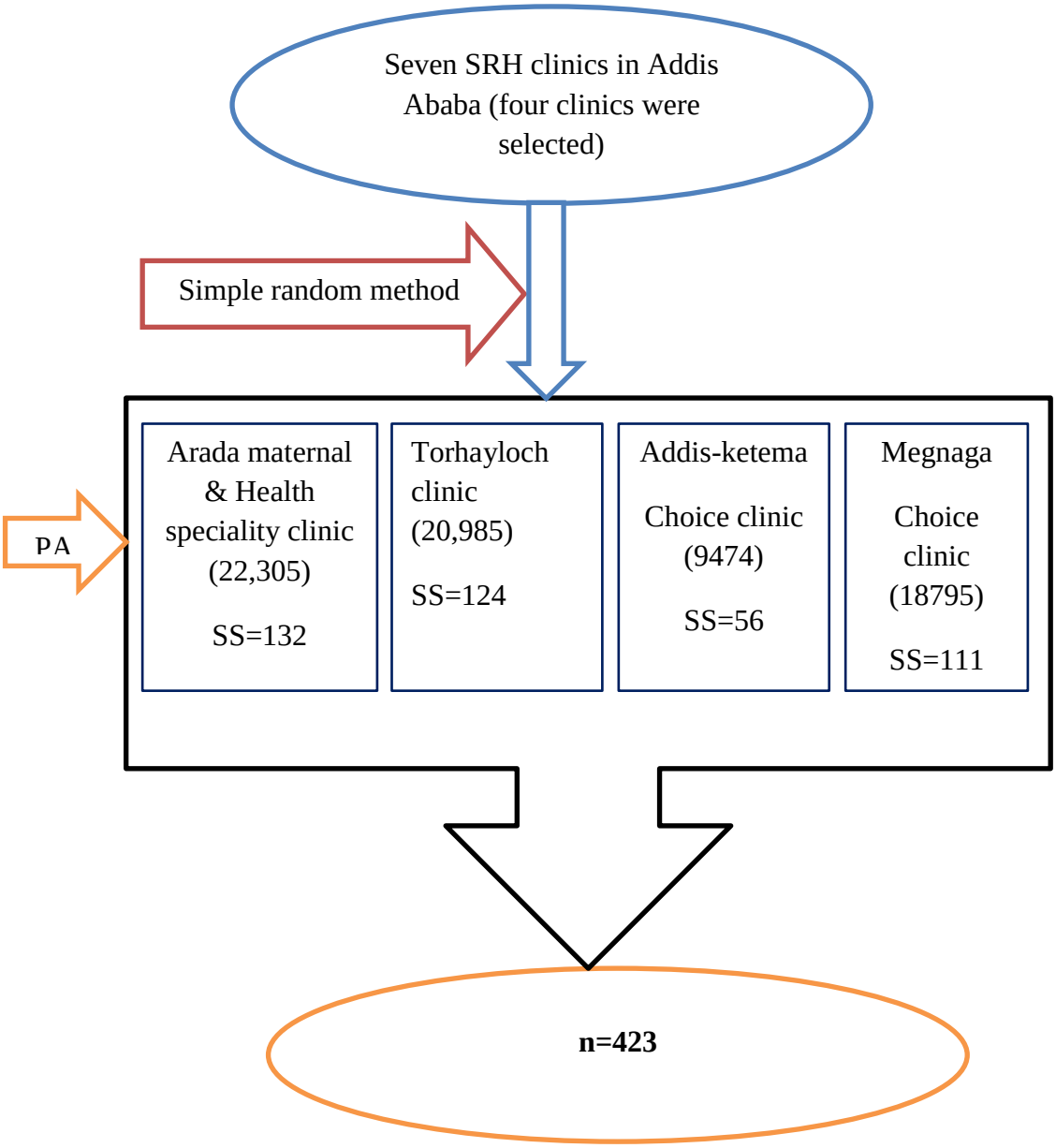

Figure 2: Sampling procedure for selection of the study participant in the study

Where (SS=sample size, PA=proportional allocation)

4.7. Study variable

4.7.1. Dependent variable

- Knowledge on medication abortion
- Attitude towards medication abortion
- Practices of medication abortion

4.7.2. Independent variable

- Socio-demographic & economic variables including:

- Age
- Educational status
- Residence
- Religion
- Place of birth
- Marital status
- Occupation
- Income
- Parental educational status

o Obstetric variables(parity) and

o RH service variables(contraceptive history, Friends or relative/family who has had abortion, history of unwanted pregnancy)

4.8. Operational definition

- **Medication abortion**: is a method of pharmacologic termination of the early first trimester of pregnancy (meaning by using mifepristone, misoprostol or both). Depending on the agent(s), the regimen, and the provider, medication abortion may be initiated as soon as a woman finds out she is pregnant, through 7–9 weeks (49–63 days) of gestation (via menstrual dating).
- **Knowledge:** what a woman knows about medication abortion (Meaning, place where it is done, drugs used for medication abortion and gestational age medication abortion is used).
  - **Low knowledge:** If the participant score's less than or equal to 2 on the knowledge part questions
  - **Satisfactory knowledge:** A score of 3 on the knowledge part of the assessment
  - **High knowledge:** A score of greater than or equal to 4 on the knowledge part of the assessment(43)
- **Attitude:** the predisposition to respond in a favourable or unfavourable manner towards abortion, medication abortion and related issues such as advising colleague to have abortion or for oneself in case of unplanned pregnancy, which type of abortion is preferable.
  - **Positive attitude:** participants who scored the mean and above value from the provided attitude related questions about the medication abortion.
  - **Negative attitude:** participants who scored below the mean value of the provided attitude questions about the medication abortion

- **Practice**: is the overt health behaviour, habit or customs of a woman related to medication abortion or those who have experienced or practiced medication abortion at least once in past.

4.9. Methods of data collection and tools

For data collection a pretested, structured interview questionnaire consisting of items with pre-coded response categories was used. The questionnaire was adapted & modified by reviewing a literature(32).

The tool consists of four sections: the first section was used to assess socio-demographic characteristics of women's and their parents, the second section was used to assess knowledge characteristics of participants, the third section was used to assess the attitude of women towards medication abortion and the last was used to assess their experience of medication abortion.

The questionnaire was designed in English and translated in to local Amharic language by and then translated back to English by translators to check for consistency.

4.10. Data collection procedure and quality control

Data was collected by face to face interview using structured questionnaires. Five BSc nurses and three BSc midwifes were selected to collect the data and two BSc midwives were selected for supervision. Before data collection, one day data collection training was given to data collectors and supervisors on the objectives, benefits of the study, individual's right, informed consent and techniques of the interview.

Before starting the actual data collection to assure the data quality, high emphasis was given to designing data collection instrument, first the questionnaire was pre-tested on 10% of sample size or 43 mothers on Gotera SRH clinics. After pre-testing the questionnaire, further adjustments to the data collection tool was made to improve clarity, understand-ability, and simplicity of the messages. All of the questionnaires were checked for completeness and accuracy before, during and after the period of data collection. Throughout the course of the data collection, interviewers were supervised, regular meetings were held between the data collectors and the principal investigator together in which problematic issues arising from interviews during the data collection were discussed. The collected data was again reviewed and checked for completeness before data entry. Data entry format template was prepared and programmed by principal investigator.

4.11. Data analysis and interpretation

First the collected data was checked manually for completion and any incomplete or misfiled questions. Then the data was cleaned and stored for consistency and entered in to Epi Data version 4.2, and then it was exported to statistical package for social sciences (SPSS) version 23.0 software for analysis.

Descriptive statistics like frequency, proportion, mean, and standard deviation were computed to describe study variables in relation to the population. Logistic regression (bivariate and multivariate) was used to determine the effect of independent variables on the outcome variables. The strength of association was declared at P value<0.05. Variables found to have a P-value<0.2 in the binary logistic regression was entered/exported into multivariate analysis to identify their independent effects and the final results were presented as odds ratio (OR). Finally, results were compiled and presented using texts, tables, graphs.

4.12. Ethical consideration

Ethical clearance and approval were obtained from Addis Ababa University, College of Health Sciences, and school of nursing and midwifery ethical review committee. Then, letter from the Research Ethics Committee was submitted to Addis Ababa Health Bureau and research committee of SRH clinics then letters from research committee of SRH clinics was submitted to the selected SRH clinics. After explaining the objectives of the study in detail, informed verbal consent was taken from all study participants. All the participants were reassured of the anonymity, and as personal identifiers were not used. Then, after obtaining informed consent from every participant, the data collectors were continued the job by giving due respect to the norms, values, beliefs, culture, and ensured the confidentiality of the data.

4.13. Dissemination of the result

The results of this finding will be disseminated or communicated to Addis Ababa University, College of Health Science, School of Nursing and Midwifery. It will also disseminated to Addis Ababa Health bureau and other concerned bodies through reports and publication on an appropriate journal. Efforts made to present the results on scientific conferences and publications will be considered.

5. RESULTS

5.1. Socio-Demographic Characteristics of Study Population

From the total of 423 mothers who were invited for interview, 412 filled the questionnaires completely resulting in a response rate of (97.4%). Mean age of the respondents was 25.0 (SD±5.11) years with a minimum and maximum age of 18 and 43 respectively. Majority of the respondents 133 (32.3%) fall in between 24-27 years age group. Out of the total respondents, 294 (71.4%) of them were born in Addis Ababa and majority 238 (57.8%) of the study participants were orthodox religion followers. From the total participants; 145 (35.2%) had attended up to secondary education followed by college/university 139 (33.7%). Regarding the marital status of the respondents 132 (32%) were married, while the majority which account 178 (43.2%) were single without relationship. Almost all 386 (93.7%) were live in Addis Ababa where 88 (21.4%) were private employers and out of the total respondents 138 (33.5%) of them had a monthly income of <500 Ethiopian birr (Table 1).

Table 1: Socio-demographic characteristics of reproductive age women in SRH clinics of Addis Ababa, February 30-March 30, 2018(n=412).

Variables	frequency	percentage
Age distribution		
18-20	88	21.4
21-23	82	19.9
24-27	133	32.3
≥28	109	26.5
Place of birth		
Addis Ababa	294	71.4
Out of Addis Ababa	118	28.6
Religion		
Orthodox	238	57.8
Muslim	82	19.9
Catholic	45	10.9
Protestant	47	11.4
level of education		
Illiterate	25	6.1
Primary education	103	25
Secondary education	145	35.2
College/university	139	33.7
Marital status		
Married	132	32
Single without relationship	58	14.1
Single with relationship	178	43.2
Divorced	38	9.2
Widowed	6	1.5
With whom you live		
With my relatives	68	16.5
With my boyfriend	67	16.3
With my husband	95	23.3
With my friends	66	16
Alone	65	15.8
With my family	51	12.4
Residence		
Urban	386	93.7
Rural	26	6.3
Occupation		
Day labourer	44	10.7
House maid	48	11.7
House wife	55	13.3
Government employee	45	10.9
Private employee	88	21.4
Merchant	28	6.8
Jobless	72	17.5
Self-business	26	6.3
Student	6	1.5
Parity		
Zero	254	61.7
One	90	21.8
Two	46	11.2
Three and above	22	5.3
Monthly income(n=412)		
<500	138	33.5
500-1000	111	26.9
>1000	163	39.6

5.2. Socio-demographic background of their parents

Majority 199 (48.3%) of the study participants had illiterate mother, 114 (27.7%) with primary education, 54 (13.1%) had secondary education and 45 (10.9%) had some forms of college education. On the other hand 180 (43.7%) of their fathers' were reported to be illiterate, whereas, 87 (21.1%), had some forms of college education. Regarding the medical related profession in their family, 130 (31.6%) of the study participants were reported to have medical related profession in their family (Table 2).

Table 2: Socio-demographic characteristics of their parents of reproductive age women in SRH clinics of Addis Ababa, February 30-March 30, 2018(n=412)

Variables	frequency	percentage
Mothers level of education		
Illiterate	199	48.3
Primary education	114	27.7
Secondary education	54	13.1
Above secondary school	45	10.9
Fathers level of education		
Illiterate	180	43.7
Primary education	84	20.4
Secondary education	61	14.8
Above secondary school	87	21.1
Medical related profession in their family		
Yes	130	31.6
No	282	68.4

5.3. The respondent's general knowledge on abortion

When they were asked about the possible outcomes of pregnancy, more than two thirds of the participants responded as giving birth 281 (68.2%) and 232 (56.2%) said abortion. Majority 325 (78.9%) of study participants were heard about abortion. From the ways of performing abortion respondents replied was; by medication /drugs 260 (80%), by Surgical procedures 50 (15.4%), and by traditional practitioners 29 (8.9%). More than half 240 (58.3%) of the participants knew what safe abortion means (Table 3).

Table 3: Respondents knowledge on abortion among reproductive age woman in selected SRH clinics of Addis Ababa, February 30-March 30, 2018(n=412).

Variables	frequency	percentage
The possible outcome of pregnancy		
Give birth	281	68.2
Abortion	232	56.2
Heard about abortion		
Yes	325	78.9
No	87	21.1
Ways of performing abortion that participants know		
Abortion by surgical procedures	50	15.4
Abortion by medication/drugs	260	80
Abortion by traditional practitioners	29	8.9
I don't know	33	10.2
Do you know about safe abortion		
Yes	240	58.3
No	172	41.3
Safe abortion means:		
By qualified persons	185	77.5
By using correct techniques	90	37.5
In sanitary condition	95	39.6
By untrained persons	11	4.6
Do you know about unsafe abortion		
Yes	236	57.3
No	176	42.7
Unsafe abortion means: when it is performed….		
By persons lacking the necessary skills	163	69.1
In an environment lacking minimal medical standards	88	37.3
By the woman herself	61	25.8
By health worker under unhygienic condition	69	29.2

NB: For multiple responses the sum of the percentage may add up more than 100.

More than one third of respondents 180 (55.4%) mentioned friends as the information source for abortion followed by health facility 87 (26.8%), and media (television, radio and newspapers) 59 (18.2%) respectively (Fig 4).

5.4. Respondents general Knowledge and attitude towards abortion law

When we observe respondents general knowledge and attitude towards abortion law, more than one third of the respondents 168 (40.8%) reported that abortion is legally allowed in

Ethiopia while 135 (32.8%) believed that abortion is not legally allowed in the country. Among those study participants who believe abortion is legally allowed in Ethiopia (n=168), most of the participants mentioned conditions as when the pregnancy results from rape or incest 131 (78%) followed by when the woman or fetus lives are threatened 107 (63.6%)(figure 3). More than half of the respondents, 247 (60%) support government allowing abortion in Ethiopia. Among those who support that government should allow abortion (n=247), the mentioned conditions under which abortion should be allowed were: to prevent the death of women due to unsafe abortion 167 (67.7%), followed by to prevent unsafe abortion and it is a human right which is 103 (41.7%), 64 (25.9%) respectively. Accordingly from those who do not support (n=165), the reasons given were: not allowed in their religion 122 (73.9%), it encourages many women to have unplanned pregnancy 93 (56.4%), it is crime 45 (27.3%), and it will risk the health of women 45 (27.3%)(Table 4).

Table 4: Knowledge and attitude of reproductive age women towards Ethiopian abortion law in SRH clinics of Addis Ababa, February 30-March 30, 2018.

Variables	frequency	percentage
Abortion legally allowed in Ethiopia(n=412)		
Yes	168	40.8
No	243	59.2
In support if government of Ethiopia allows abortion (n=412)		
Yes	247	60
No	165	40
If you support, at what condition(n=247)		
To prevent unsafe abortion	103	41.7
To prevent the death of women due to unsafe	167	67.7
It is human right	64	25.9
If not, your reason (n=165)		
Not allowed in my religion	122	73.9
It is crime	45	27.3
It encourages many women to have unplanned pregnancy	93	56.4
It will risk the health of women	45	27.3

NB: For multiple responses the sum of the percentages may add up to more than 100.

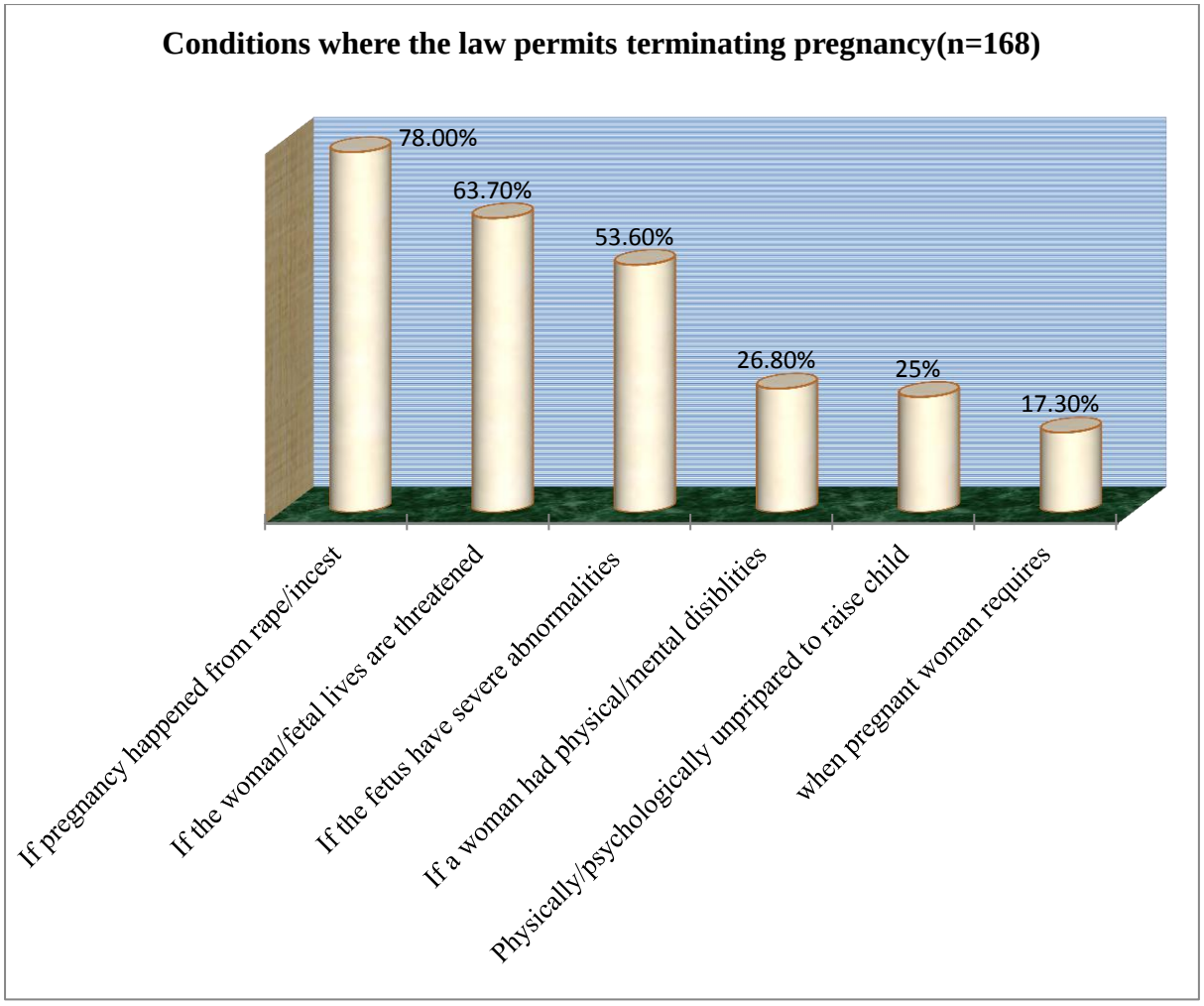

Figure 3: Participant's response on conditions where the Law permits abortion in SRH clinics of Addis Ababa, February 30-March 30, 2018**.**

5.5. Knowledge regarding Medication Abortion

Three fourth 312 (75.7%) reported that as they knew what MA means. Among those respondents who claimed to know MA, 221 (70.8%), 51 (16.3%), 33 (10.6%) and 7 (2.2%)) said a MA means; abortion using abortion pill/drug, abortion using any drugs/medication, abortion by inserting objects through female genital and abortion by drinking chemicals respectively. Of 312 respondents who knew what MA means, 263 (84.3%) also reported as they knew where someone could have a medical abortion service. The majority of the respondents 199 (63.8%) did not know which drugs are used in case of MA however, some of the respondents mentioned Misoprostol 86 (27.6%), Mifepristone 67 (21.5%), Amoxicillin 6 (1.9%), Ampicillin 7(2.2%), Methotrexate 8 (2.6%), Gemprost 5 (1.6%) and Safe-T 5 (1.6%). Most of the respondents 116 (37.2%) who claimed to know MA did not know the preferred gestational age to perform MA. But 111 (35.6%) of respondents mentioned gestational age

less than or equal to 9 weeks and gestational age less than or equal 63 days 74 (23.7%), and few of them 5 (1.6%) responded MA to be performed at any gestational age (Table 5).

Table 5: Knowledge of reproductive age women towards medication abortion in SRH clinics of Addis Ababa, February 30-March 30, 2018.

Variables	frequency	percentage
Know what medication abortion means(n=412)		
Yes	312	75.7
No	100	24.3
If yes, it means(n=312)		
Abortion using abortion pill/drug	221	70.8
Abortion using any drugs/medication	51	16.3
Abortion by inserting objects through female genital	33	10.6
Abortion by drinking chemicals	7	2.2
Know where someone can have medical-abortion done(n=312)		
Yes	263	84.3
No	49	15.7
Drug/drugs is/are used to abort pregnancy (n=312)		
Misoprostol	86	27.6
Mifepristone	67	21.5
Amoxicillin	6	1.9
Ampicillin	7	2.2
Methotrexate	8	2.6
Gemprost	5	1.6
Safe-T	5	1.6
I do not know	199	63.8
Gestational age medication abortion is preferable(n=312)		
Gestational age less than or equal to 63 days	74	23.7
Gestational age less than or equal 9 weeks	111	35.6
Gestational age greater than or equal 9 weeks	31	9.9
At any gestational age	5	1.6
I do not know	116	37.2

NB: For multiple responses, the sum of the percentages may add up to more than 100.

As it has been shown in (Fig 4), out of 312 respondents who knew about MA, 148 (47.4%) said that they got the information from friends followed by health facility/hospital, 133 (42.6%). When asked where the MA will be performed, the majority of the respondents 181 (68.8%), from those who claimed to know where to perform (n=263), answered health centre

followed by hospital 103 (39.2%) (Fig 5). Though the majority of the respondent knows what MA means, when knowledge score was done from the knowledge questions, it was found that most of the study participants have high knowledge towards MA 159 (38.6%) followed by satisfactory knowledge 138 (33.5%)(Fig 6).

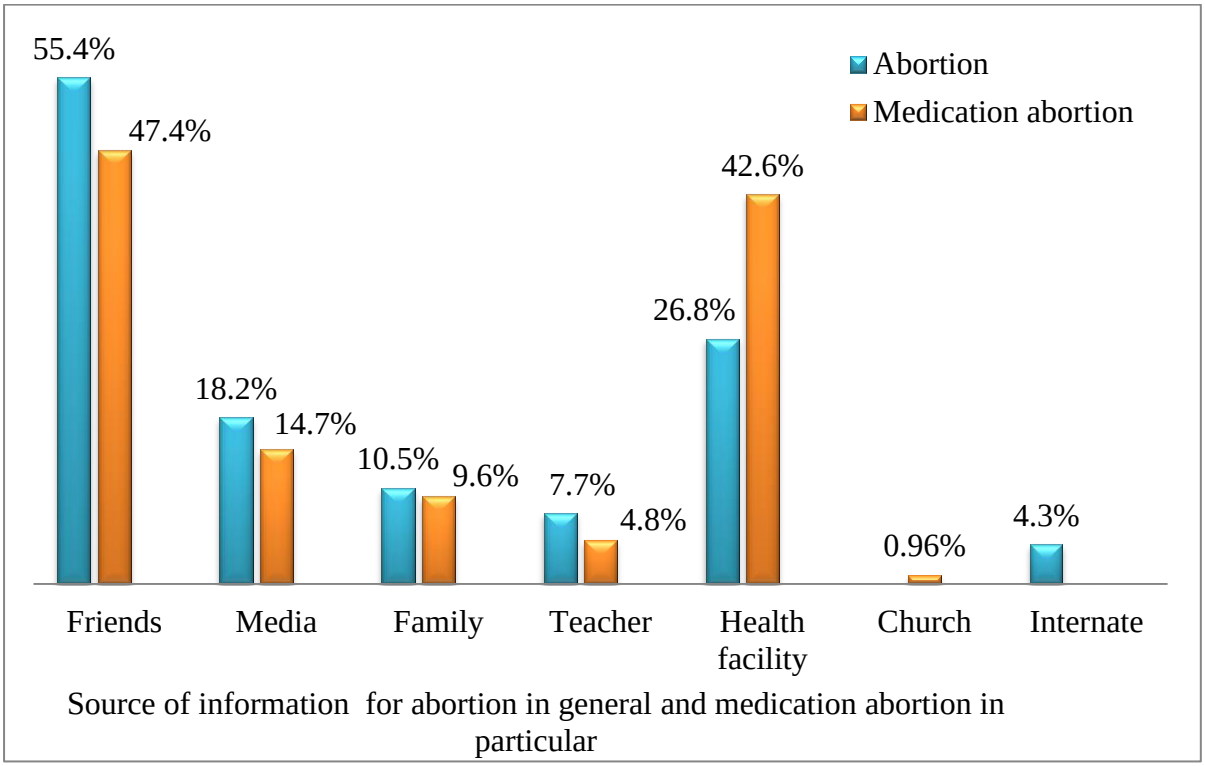

Figure 4: Major sources of information for abortion in general and medication abortion for reproductive age woman in selected SRH clinics of Addis Ababa, February 30-March 30, 2018.

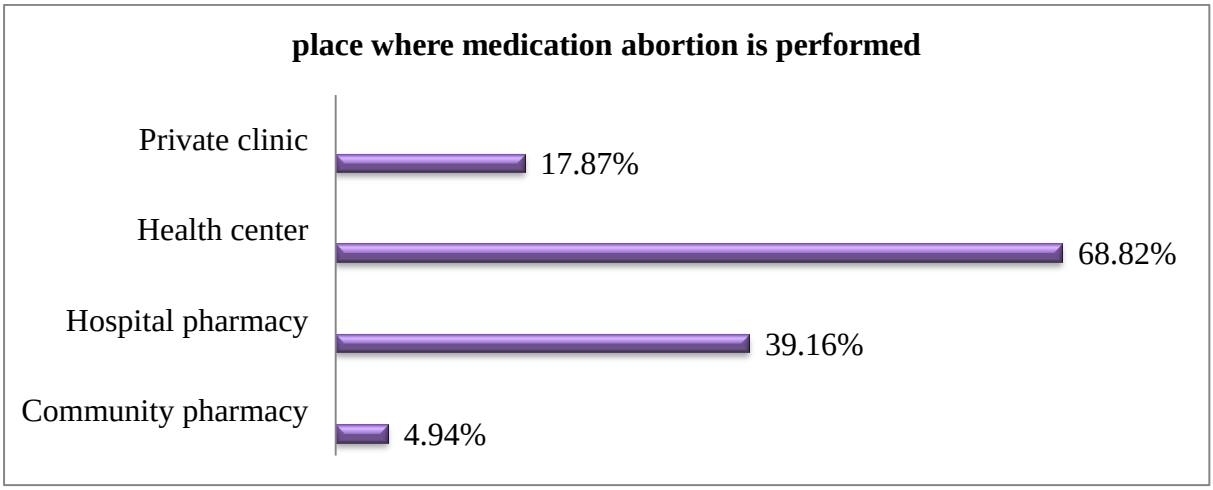

Figure 5: Place where medication abortion is performed, Addis Ababa, February30-March 30, 2018.

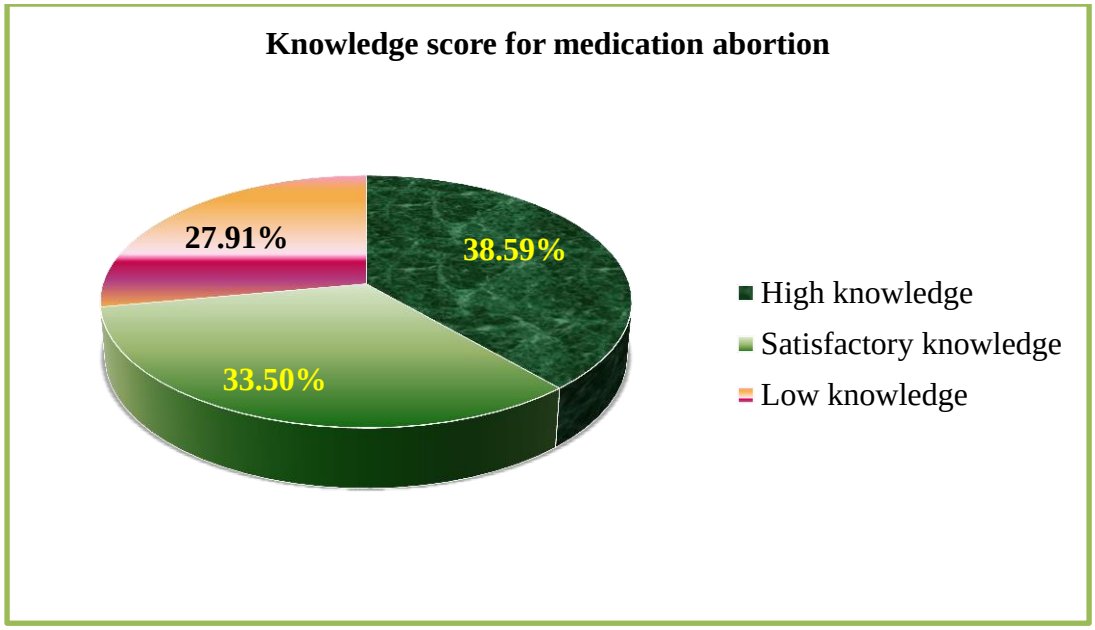

Figure 6: Knowledge score for medication abortion among reproductive woman in selected SRH clinics of Addis Ababa, February 30-March 30, 2018.

5.6. Attitude towards medication abortion

From the total respondents, 150 (36.4) reported that as they would advise or encourage someone with unwanted pregnancies to undergo abortion. The most preferred method that they advise for someone was abortion by medication 131 (87.3%) followed by surgical procedures 18 (12%) and by traditional practitioner 10 (6.7%). More than half of the respondents, 230 (55.8%) believed that if they had an unplanned pregnancy, they would consider abortion to terminate it and the reasons that they believe were: inability to raise their child 139 (60.7%) followed by it will affect my education 69 (44.5%). Abortion by medication /drugs from health facility was the preferred way of abortion 195 (84.8%). Of the respondents who didn't consider abortion (n=182) if they had an unplanned pregnancy, majority 146 (80.2%) reported that as their religion cannot allow abortion followed by I don't want to kill my own baby 94 (51.6%) (Table 6).

Table 6: Attitude of reproductive age woman towards medication abortion in selected SRH clinics of Addis Ababa, February 30-March 30, 2018.

Variables	frequency	percentage
Advise or encourage a colleague with an unwanted pregnancy to undergo abortion(n=412)		
Yes	150	36.4
No	262	63.6
Type of abortion would you advise or encourage a colleague…(n=150)		
Abortion by Surgical procedures	18	12
Abortion by medication /drugs	131	87.3
Abortion by traditional practitioners	10	6.7
If you have unplanned pregnancy will you consider abortion to terminate(n=412)		
Yes	230	55.8
No	182	44.2
Why would you consider abortion if you have unplanned pregnancy(n=230)		
I cannot raise the child	139	60.7
It will affect my education	102	44.5
To protect social stigma	59	25.8
Type of abortion would you consider if you have unplanned pregnancy(n=230)		
Abortion by Surgical procedures in the health facility	39	17
Abortion by medication /drugs from health facility	195	84.8
Abortion by medication /drugs from friends	15	6.5
Abortion by traditional practitioner	3	1.3
If not , reason for not considering abortion for unplanned pregnancy		
My religion cannot allow abortion	146	80.2
It is crime in our country	53	29.1
I don’t want to kill my own baby	94	51.6
Gave birth	22	12.1
Undergone abortion	21	11.5

NB: For multiple responses, the sum of the percentages may add up to more than 100.

5.7. Sexual and medication abortion practice

Nearly half 201 (48.8%) of the respondents know a friend/neighbour who had terminated pregnancies and almost all 409 (99.3%) of the respondents had sexual intercourse experience, from those who had sexual intercourse before, 193 (46.8%) of them had history of unwanted pregnancy. Out of the total study participants, 206 (50%) had a history of termination of

pregnancy and majority of the respondents report as: I know, but I did not use contraceptives 97 (47.1%) followed by I know and used contraceptives but I faced pregnancy 53 (25.1%) as a reason for termination. From those (n=206) respondents, majority 136 (66.2) used medication/drugs for termination followed by abortion by surgical procedure 35 (17.2%). Being easy to take 81 (39.71%) is the most given reason for MA preference (table 7).

Table 7: Practice of reproductive age woman towards medication abortion in SRH clinics of Addis Ababa, February 30-March 30, 2018.

Variables	frequency	percentage
Know a family member/friend /neighbour who had terminated pregnancy(n=412)		
Yes	201	48.8
No	211	51.2
Ever had sexual intercourse before(n=412)		
Yes	409	99.3
No	3	0.7
History of unwanted pregnancy(n=409)		
Yes	193	46.8
No	219	53.2
Ever terminated your pregnancy (n=409)		
Yes	206	50
No	206	50
If you had terminated pregnancy, reason(n=206)		
I did not know contraceptives	56	27.2
I know but I did not use contraceptives	97	47.1
I know and used contraceptives but I faced	53	25.1
Type of abortion undergone		
Abortion by Surgical procedures	35	17.2
Abortion by medication	136	66.7
Abortion by traditional practitioners	33	16.2
Reason for MA preference:		
Easy to take	81	39.7
Low continuing pregnancy	56	27.5
More natural	47	23
Avoid surgery/anaesthesia	49	24
More effective	50	24.5
Increase privacy and confidentiality	52	25.5
Much quicker in short period of time	50	24.5
Safe	69	33.8
No side effect	47	23

NB: For multiple responses the sum of the percentages may add up to more than 100.

5.8. Determinants of knowledge, attitude and practice towards medication abortion

5.8.1. Socio-economic variables, parent related factors, and RH service related factors associated with medication abortion knowledge

Binary Logistic regression was performed to assess the association of each independent variable with medication abortion knowledge. The factors that showed a p-value of less than 0.2 were added to the multivariate regression model. The result revealed that on the bivariate analysis: Age group, place of birth, their way of living, their father's educational level, medical related profession in their family and history of unwanted pregnancy were significantly associated with medication abortion knowledge. In multivariate logistic regression, fathers' levels of education and their way of living were significantly associated with medication abortion knowledge at P-value of <0.05 (table 8). Respondents who have a father learnt up to secondary education were 2.03 times more knowledgeable on the MA than with a father who is illiterate (AOR=2.03, 95% CI [1.01, 4.10]. Similarly, those respondents whose father learnt some forms of college or university education were 2.80 times more likely knowledgeable on MA than respondents with a father who is illiterate(AOR=2.80, 95% CI[1.42, 5.52]. In addition to this, those respondents living with their relatives (2.34 times), with their boyfriends (6.08 times), and with their friends (5.35 times) were more likely knowledge on MA compared with those living with their family (AOR=2.34, 95% CI [1.05, 5.25]), (AOR=6.08, 95% CI [2.41, 15.33]), and (AOR=5.35, 95% CI[2.18, 13.16]) respectively (table 8).

Table 8: Bivariate and multivariate logistic regression analysis of medication abortion knowledge and its explanatory variables (n= 412)

Variables	Yes	No	OR (95% CI)	AOR (95%CI)
Age group				
18-20	54	34	0.52[0.28-0.96]**	0.57(0.29-1.12)
21-23	62	20	1.02[0.53-2.00]	1.03[0.50-2.13]
24-27	99	34	0.96[0.54-1.72]	1.06[0.56-1.98]
≥ 28	82	27	1	1
Place of birth				
Addis Ababa	220	74	1.58[1.00-2.51]*	1.43[0.86-2.36]
Out of Addis Ababa	77	41	1	1
With whom you live?				
With my relatives	48	20	2.13(1.00-4.55)*	2.34(1.05-5.25)**
With my boyfriend	58	9	5.73[2.35—13.97]***	6.08[2.41-15.33]***
With my husband	65	30	1.93[0.96-3.88]*	1.83[0.87-3.84]
With my friends	56	10	4.98[2.09-11.87]***	5.35[2.18-13.16]***
Alone	43	22	1.74[0.82-3.69]*	1.80[0.81-4.00]
With my family	27	24	1	1
Your father's educational level				
Illiterate	118	62	1	1
primary education	59	25	1.24[0.71-2.17]	1.19[0.65-2.16]
up to secondary education	47	14	1.76[0.90-3.45] *	2.03[1.01-4.10]*
above secondary school	73	14	2.74[1.43-5.24]***	2.80[1.42-5.52]***
medical related family profession				
Yes	88	42	0.73[0.46-1.15]*	0.77[0.47-1.25]
No	209	73	1	1
History of unwanted pregnancy?				
Yes	147	46	1.47[0.95-2.28] *	1.37[0.86-2.20]
No	150	69	1	1

NB: *= p-value < 0.2, ** = p-value < 0.05, *** = p-value < 0.01

5.8.2. Socio-economic variables, parent related factors, obstetric factor and RH service related factors associated with respondent's attitude towards medication abortion

Bivariate and multivariate logistic regression analysis was employed to calculate odds ratios and corresponding 95% confidence intervals for the predictors of MA attitude. Variables which were significant in the bivariate analysis of p-value <0.2 were place of birth, religion, marital status, income, their fathers' level of education, and medical related profession in the family. As a result, medical related profession in the family was remained in the multivariate

logistic regression due to its statistical significance. Hence, the result of multivariate analysis showed that study participants who had a medical related profession in their family had positive attitude towards MA compared with those who had no medical related profession in their family(AOR=1.56, 95% CI [1.01, 2.42]] (Table 9**).**

Table 9: Bivariate and multivariate logistic regression analysis towards medication abortion attitude and its explanatory variables (n= 412)

Variables	Yes	No	OR (95% CI)	AOR (95%CI)
Place of birth				
Addis Ababa	120	174	0.62[0.41-0.96] **	0.67[0.42-1.05]
Out of Addis Ababa	62	56	1	1
Religion				
Orthodox	97	141	1.01[0.54-1.92]	1.48[0.87-2.52]
Muslim	43	39	1.63[0.79-3.36]*	1.63[0.83-3.18]
Catholic	23	22	1.54[0.68-3.52]	0.96[0.50-1.87]
Protestant	19	28	1	1
Marital status				
Married	66	66	0.50[0.09-2.82]	0.72[0.12-4.28]
Single without relationship	26	32	0.41[0.70-2.40]	0.26[0.09-3.24]
Single with relationship	65	113	0.29[0.51-1.61]*	0.38[0.07-2.25]
Divorced	21	17	0.62[0.10-3.79]	0.65[0.10-4.23]
Widowed	4	2	1	1
Income				
<500	67	71	1	1
500-1000	52	59	0.93[0.57-1.54]	0.96[0.56-1.63]
>1000	63	100	0.67[0.42-1.06]*	0.72[0.45-1.17]
Your father's educational level				
Illiterate	72	108	1	1
primary education	41	43	1.43[0.85-2.41]*	1.50[0.87-2,58]
up to secondary education	32	29	1.66[0.92-2.97]*	1.71[0.94-3.13]
above secondary school	37	50	1.11[0.66-1.87]*	1.17[0.68-2.01]
medical related family profession				
Yes	62	68	1.62[1.06-2.46]**	1.56[1.01-2.42]**
No	114	168	1	1

NB: *= p-value < 0.2, ** = p-value < 0.05, *** = p-value < 0.01

5.8.3. Socio-economic variables, parent related factors, and RH service related factors associated with respondent's practice towards medication abortion

As shown in table 10, variables which show significant association in the bivariate analysis of p<0.2 (respondents' level of education, income, knowing a family member/friend/neighbour

who had terminated a pregnancy, respondents who had history of unwanted pregnancy and respondents who know contraceptives) were entered into multivariate analysis. The participants' level of education, income and respondents who had history of unwanted pregnancy were significantly associated with the respondents MA practice (table 10). When we compare MA practice among educated and illiterate respondents, respondents who had learnt secondary education (3.54 times) and college/university (3.49 times) were more likely to practice MA than illiterates(AOR=3.54, 95% CI[1.02, 12.26]), (AOR=3.49, 95% CI[1.02, 11.92]) respectively. Similarly respondents who had history of unwanted pregnancy were 11.7 times more likely practice to MA than those respondents who had no history of unwanted pregnancy (AOR=11.7, 95% CI(1.11, 12.46]) In addition, respondents who get a monthly salary of greater than 1000 ETB were 2.19 times more likely to practice MA than those who get monthly salary less than 500 ETB(AOR=2.19, 95% CI[1.02, 4.75])(table 10).

Table 10: Bivariate and multivariate logistic regression analysis towards medication abortion practice and its explanatory variables (n= 412)

Variables	Yes	No	OR (95% CI)	AOR (95%CI)
Your level of education				
Illiterate	6	19	1	1
Primary education	30	73	1.30[0.47-3.58]	2.51[0.70-8.94]
Secondary education	43	102	1.34[0.50-3.57]	3.54[1.02-12.26]**
College/university	57	82	2.20[0.83-5.85]*	3.49[1.02-11.92]**
Income				
<500	35	103	1	1
500-1000	32	79	0.46[0.28-0.76]***	1.12[0.51-2.47]
>1000	69	94	0.55[0.33-0.92]**	2.197[1.02-4.75]*
Do-you-know-a-family member/friend/neighbour who-had-terminated pregnancy?				
Yes	115	86	12.1[7.12-20.56)***	0.21[0.02-2.39]
No	21	190	1	1
History of unwanted pregnancy?				
Yes	114	79	12.92[7.64-21.86] ***	11.77[1.11-12.46]**
No	79	22	1	1
Do you know contraceptive?				
Yes	24	24	1	1
No	104	46	1.70[0.90-3.19]*	0.65[0.32-1.30]

NB: *= p-value < 0.2, ** = p-value < 0.05, *** = p-value < 0.01

6. DISCUSSION

The study has investigated the knowledge, attitude and practices of MA and associated factors among reproductive age women in selected SRH clinics of Addis Ababa, Ethiopia. Around 325(78.9%) of the respondents have heard about abortion. Friends (55.4%) were the main source of information followed by from health facility (18.2%) and media (26.8%). This finding was lower than the study conducted in evangelical women in Addis Ababa where 93.5% have heard about abortion where media accounts (28.1%)(7),and social science students in Addis Ababa University which showed that the entire population (100%) have heard about abortion and media (82.6%) was the main source of information about abortion followed by friends (70.0%)(32). This difference might be due to study group differences or the negligence/decreased emphasises of media (Radio, television, newspaper, and the like) and health care providers on information dissemination regarding reproductive issues.

According to this study, more than half of the respondents have heard about safe abortion (58.3%) and unsafe abortion (57.3%) and this study was higher than the descriptive study carried out on 50 reproductive age women in Lekhnath, kaski, Nepal, on the assessment of the level of knowledge regarding safe abortion which showed that only 40% of the respondents knew safe abortion(42). This might be due to study time difference or due to small sample size carried out in Nepal.

About 168 (48.8%) of the study participants said abortion is liberal and allowed in Ethiopia under some conditions, however, 135 (32.8%) said abortion is not legally allowed in Ethiopia, and 109 (26.5%) said they don't know whether it is allowed or not. Among those respondents who said abortion is legally allowed in Ethiopia (n=168), most of the respondents mentioned that abortion is allowed only for the conditions like; when the pregnancy is resulted from rape or incest (131 (78.0%)), when the woman or fetus lives are threatened (107 (63.7%)), when the fetus has severe abnormalities (90 (53.6)) and some of the study participants (29 (17.3%) responded on request for everyone. This finding was in line with the study done in Yirga cheffe town SNNPR on knowledge and attitude of women of childbearing age towards legalization of abortion in Ethiopia, which showed that 48.9% were aware of legalization of abortion law(40). This might be due to the same sample size used in both studies or the contribution of the health care providers on the dissemination of information towards legalization. In contrast to this, the finding was slightly lower than the study done in Nepal(42), the study conducted in Addis Ababa among evangelical woman

which showed that abortion is allowed only for the conditions like; when the pregnancy is resulted from rape or incest (11.5%)), when the woman lives are threatened (37.20%)), every women's request(8.33%)(7) and the study done in three lower districts in Bihar Dar, north west Ethiopia, which showed that 512 (66%) were aware of the legal status of the Ethiopian abortion law(39). This difference might be due the large sample size used in the study conducted in Bihar Dar, small sample size used in study conducted in Addis Ababa and it may be due to the health policy, program and strategy differences and technological differences with Nepal.

Regarding to MA, more than three-fourth of respondents 312 (75.7%) have aware of what MA means, but 88(21.4%) of them do not know about it. Among the 312 respondents who claimed to know about MA, majority 221 (70.8%) has reported as MA means: abortion using abortion pill/drugs. When the knowledge score was done 38.6%, 33.5% of the respondents who knows MA had high and satisfactory knowledge respectively, and the reaming 27.9% of them had low knowledge towards MA. This study was higher than the study done in Brazil on medication abortion knowledge showed that the percentage of the respondents who had heard about medication drugs as a means to induce abortion was 72% though only less than 3% had satisfactory general knowledge(43). The difference in the result might be due to socio cultural and socio economical or health police, implementation program difference.

Accordingly the finding of this study revealed that, more than two thirds of the respondents 199 (63.8%) do not know which drugs are used in case of MA but some of the respondents who had reported to know MA reported as Misoprostol 86 (27.6%), mifepristone 67 (21.5%), Amoxicillin 6 (1.9%), Ampicillin 7 (2.2%), Methotrexate 8 (2.6%), Gemprost 5 (1.6%) and Safe-T 5 (1.6%). This finding was higher than the study done on MA seekers in south eastern Nigeria, which showed that only 3%, 2% and 0% knew misoprostol, mifepristone and methotrexate(42). These differences might be due to small sample size used in previous study or it might be due poor access of reproductive services, restrictive abortion laws or difference in health police, implementation program and study time differences. Similarly the findings of this study were higher than the study done in reproductive age group Evangelical women residing in Addis Ababa where 20.8% knew specific abortifacient medicines like Mifepristone and Misoprostol, 13.20% knew about antibiotics and while 13.4% replied that they do not know any method and study done in social students in Addis Ababa which showed that Misoprostol 3 (1.9%), Mifepristone 2 (1.2%), Methotrexate 2 (1.2%), and Safe-T 3 (1.9%)(32). These discrepancies might be due to the difference in study setting and subject

or it may be sampling technique or sample size used or might be due to the fact that students can access better information than woman.

In this study most of the respondents who claimed to know MA, reported as when medication abortion was preferable. From those respondents 111 (35.6%) said, when the pregnancy is less or equal to 9 weeks, 74 (23.7%) said when the pregnancy was less or equal to 63 days and few 5 (1.6%) said at any gestational age. However, majority 116 (37.2%) did not know when medication abortion will be performed. This finding was slightly lower than the study done in India to assess the knowledge, attitude and practice of MA which showed that majority 53.3% taken abortifacient at less than 12 weeks gestation and 26.6% of them did not know were MA will be given(41). These might be due to the educational level, technological differences or may be due to better health policy and program implementation in India.

On the other category, more than two thirds of the respondents 247 (60%) were reported to support the idea that government should allow abortion in Ethiopia. From the respondents (n=247), majority 167 (67.6%) reported to support the idea to prevent death of women due to unsafe abortion, 41.7% said to prevent unsafe abortion as a result of unwanted pregnancy and some (25.9%) reported as it was a human right. And from the respondents who do not support the government to allow abortion, majority 122 (73.9%) claimed that their religion did not allow them to abort, 56.3% of them reported that as it will encourage many women to have unplanned pregnancy and 27.3% of them said as it is a crime in the country. The study was consistent with the study done in India on the assessment of attitude and experience of married women which showed that the majority of the study participants would seek MA to prevent unwanted pregnancy which will mostly lead to unsafe abortion. This might be due to the common understanding of the countries on the prevention of unwanted pregnancy which may mostly end up unsafely.

In this finding, 44.2% of the participants had positive attitude towards MA and majority 150 (36.4%) of them reported to advise or encourage a colleague with unwanted pregnancies to undergo an abortion. Of those, 87.3% of them may advise their colleague to choose abortion with medication/drugs. On the other hand more than half, 55.9% of the respondents consider abortion as a means of solution when they face unwanted/unplanned pregnancy and most 60.7% claimed that as they can't raise the child, 44.5% of them reported that as it may affect their education and around 25.8% of them consider abortion due to fear of social stigma. The study was consistent with the study done in Guraghe zone, which showed that 40.8% of them

had induced abortion as it may affect their education followed by 36.7% had due to unable to raise their children because of economic reasons(8). This might be due to the attitude of the respondents for pregnancy and socio economic similarities across the regions in country.

Regarding to medication abortion practice, only 33% practiced medication abortion from the total study participants. 46.8% of the respondents had history of unwanted pregnancy and 49.8% of them had history of termination of pregnancy. From those who had terminated their pregnancy, majority 66.7% used abortion pill/drugs for termination followed by abortion by surgical procedures 17.2% and by traditional Practitioners 16.2%. Many of them claimed the reason for termination were they know, but negligent to use contraceptives(47.1%), followed by lack of knowledge (27.2%) and some of them were claimed that as they become pregnant as they were on contraceptives(25.7%). This figure was higher than the study conducted in India which showed only 17.5% used MA (36) and the study was slightly higher than the study done in Nigeria, which showed 49% had previous termination and 48% had used drugs for termination of pregnancy(19). This inconsistency might be due to difference in health police, implementation program and small sample size used in the previous study.

In this study father's educational level were significantly associated with medication abortion knowledge which shows that respondents who have a father learnt secondary education were 2.03 times more knowledgeable on MA than with fathers who are illiterate. Similarly, those respondents whose father learnt college/university were 2.80 times more knowledgeable on MA than respondents whose father is illiterate. This finding was consistent with the study done in India(36), Addis Ababa(32), which showed that respondents with fathers who are illiterate had low knowledge regarding MA compared to respondents having fathers who are educated (AOR=0.112 [0.013-0.969]). In addition to this, from this study 'participant's way of living' were significantly associated with MA abortion. Those respondents living with their relatives [AOR=2.34, CI [1.05-5.25]], boyfriends [AOR= [6.08, CI [2.41-15.33]] and with their friends [AOR=5.35, CI [2.18-13.16]] had knowledge on MA compared with those living with their family respectively. This finding was comparable to the study conducted in Dar Es Salaam, Tanzania, on unwanted pregnancy and induced abortion among females, which showed that majority17 (65.4%) of the respondents living with their boyfriend and 3 (11.5) living with their friends had significant knowledge on abortion.

In addition to this, when we compare MA practice among educated and illiterate respondents, respondents who had secondary education (3.54 times) and college/university (3.49 times)

were more likely to practice MA than illiterates. This finding was similar to the study done in India (36) and in Addis Ababa (7) which showed that, usage of MA drugs was significantly higher than in educated group. Similarly, respondents who had history of unwanted pregnancy were 11.7 times more likely to practice MA than those respondents who had no history of unwanted pregnancy. This finding was consistent with the study done on determinants of abortion practice in Addis Ababa, which showed that respondents with history of unwanted pregnancy ($p<0.000$) had a strong association with their unwanted pregnancy (28). In addition to the above factors, respondents who get a monthly salary of greater than 1000 ETB were 2.19 times more likely to practice MA than those who get less than 500ETB. This finding is comparable with the study conducted in evangelical woman residing in Addis Ababa(7) which showed that respondents' income level were strongly associated with abortion practices. This might be due the same socio-economic background of the country.

6.1 **Strength and limitation of the study**

6.1.1. Strengths of the study

- Since it is primary data, those governmental and non-governmental organizations involved in maternal empowerment can utilize the findings of the study as information for intervention of programs and for further study.

6.1.2. Study limitations

Abortion is still a sensitive issue; some of the responses by the respondents might have been influenced by religious, cultural and personal beliefs. So that respondent may answer questions in a manner that would be viewed favourable by others (may under /inaccurately report their view towards medication abortion). Recall bias and white coat bias might not be minimized. Since the data is collected at a single point in time, temporal relationship could not be established.

7. CONCLUSION AND RECOMMENDATIONS

7.1. Conclusion

Generally, from this study majority (78.9%) of the study participants heard about abortion, only 75.7% had awareness on MA and the major sources of information were friends and from a health facility. Nearly one-third of the respondents (27.9%) were found to have low knowledge score on MA. Medication abortion is acceptable by the study participants where one third of the respondents have positive attitude (44.2%) towards abortion by advising or encouraging colleague (36.2%) with an unwanted pregnancy to undergo an abortion where most of them would advise or encourage abortion by medication /drugs (Medication Abortion). Of all the respondents, 230 (55.8%) would consider abortion to terminate if they have unplanned pregnancy and 33% of them had practiced MA from the total participants. Respondents' level of education, father's educational level, their way of living, history of unwanted pregnancies, medical related profession in family and monthly income were identified as major determinants (predictors) of MA knowledge, attitude and practice in this particular study.

7.2. Recommendations

In Ethiopian women have not reached at a stage where they can fully exercise their reproductive health right including preventing unwanted pregnancy which end up unsafely. They are the primary victims from any kinds of consequences that are resulting from unsafe abortion or giving birth in unwelcoming environment. By observing the existing problems thoroughly in the study, the following recommendations are forwarded accordingly:

Sexual and reproductive health (SRH) clinics: Should take broad actions to empower women in every aspect of their lives especially in control of their reproductive lives. They should help a woman to make:

- Their own fertility decisions and have access to and know where to find medication abortion services in their communities.
- Permitting services to be visible, accessible and affordable for all women
- Helping health professionals feel protected in providing compassionate abortion services
- Allowing women to choose abortion methods and providers
- Better enabling women to take legal action when their rights are violated

Media: Should better disseminate the conditions under which abortion is currently permitted, the availability of MA, and where the woman's can access information regarding about MA.

Health care providers: The Health workers, particularly health extensions should teach the community about the consequence of unsafe abortion and stigma.

Organizations: Both governmental and non-governmental organizations who were primarily involved in maternal health should address the issue of negative attitude to change the communities towards safe abortion services especially on medication abortion.

Policymakers and MOH: Should put restrictions on the over the counter sale of drugs that are used for medical abortion and provision should be made to make these drugs available only on authorised prescription from qualified personals.

Researchers: Similar studies should be undertaken in different parts of the country to see the trends, magnitude and the determinant factors of medication abortion.

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9. ANNEX

Annex I: English Version Information Sheet

Questionnaire Identification Number _____

My name is _____. I am working as data collector in the research conducted by Addisu Yeshambel, who is conducting this research for the partial fulfilment of his Master degree in Maternity and Reproductive Health Nursing Specialty track in Addis Ababa University. He is trying to assess the knowledge, attitude and practice of medication abortion and associated factors among reproductive age women. As the study is directly related to women of reproductive group (18-49 years) you are one of the women who are selected to participate in this study. Therefore you are kindly requested to participate in this interview.

Name of advisor; Semarya Berhe (Asst. professor, PhD fellow) and Abdisa Boka (BSc, MSc)
Name of the organization: Addis Ababa University, College of Health Sciences, School Of Nursing and Midwifery.
Name of the Sponsor: Addis Ababa University

Introduction: Information sheet and consent form is prepared for mothers who attending service in selected SRH clinics and who will be volunteer to participate in research project.

Purpose: I am hopeful that this research will benefit all reproductive age mothers for health care improvement and quality of care. The information that you provide are very essential, not only for the successful accomplishment of the study but also for producing relevant information which will help in improving the provision of the service. I will provide research results to concerned body for intervention.

Procedure: To assess the knowledge, attitude and practice of medication abortion and associated factors among reproductive age women in selected SRH clinics in Addis Ababa city, you are invited to take part in this project. If you are willing to participate in this project, you need to understand and say "yes" on the agreement form. Then after, you will be interviewed by the data collector. All your responses and the results obtained will be kept confidential by using coding system, whereby no one will have access to your response.

Risk/ Discomfort: By participating in this research project, you may feel that it has some discomfort especially on spending your time. We hope you will participate in the study for

the sake of the Benefit of the research result. I am Sure there is no risk in participating in this research project.

Benefits: there may not be direct benefit to you but your Participation is likely to help us in assessment of knowledge, attitude and practice of medication abortion among reproductive age women, this will help us to identify the gap and take the appropriate intervention by the authorized stakeholder. You will not be provided any incentive or payment to take part in this project.

Confidentiality: The information collected from this research project will be kept confidential and information about you that will be collected by this study will be stored in a file, without your name, but a code number assigned to it. In addition, it will not be revealed to anyone except the principal investigator and will be kept locked with key. Right to refuse or withdraw: I am going to ask some very personal questions, your participation in this interview is completely on voluntary bases and you have the right to refuse the participation. You have the right to withdraw from the interview at any time or refuse to answer any questions you feel uncomfortable about.

If you have any question, you can ask at any time. If you have additional questions about the study please contact:

Addisu Yeshambel principal investigator
Tel: +251-926-72-51-28
Email: addisyes3@gmail.com

Annex II: English Version Consent Form

I understand all conditions stated above. I have understood that Participation in this study is entirely voluntarily. I will tell that the answers to the questions will not be given to anyone else. If respondent does not agree to be interviewed, let them thanks and go to the next respondent.

If respondent say "YES" continue

Checked by:

Supervisor Name _____ signature_____

Date_____/_____/____E.C.

Time Interview Started: Hour: _____ Minute: _____

Questionnaire No_____

Time Interview Ended: Hour: _____ Minute: _____

Name of interviewer _____

Date _____/_____/____ ____E.C. signature_____

Annex III: English Version Questionnaires

Part- I: **Socio-demographic background of respondents and their parents**			
S.No	Questions	Response	Skip
001	How old are you?	Age (years)_____	
002	Place of birth	1. Addis Ababa 2. Out of Addis Ababa	
003	What is your religion?	1. Orthodox 2. Muslim 3. Catholic 4. Protestant 5. Other, Specify_____	
004	What is your level of education?	1. Illiterate 2. Primary education 3. Secondary education 4. College/university	
005	Your current marital status?	1. Married 2. Single without relationship 3. Single with relationship 4. Divorced 5. Widowed 6. Other, Specify_____	
006	With whom are you living?	1. With my relatives 2. With my boyfriend 3. With my husband 4. With my friends 5. Alone 6. With my family 7. Others, specify_____	
007	Your residence	1. Rural 2. urban	

008	Your occupation?	1. Day laborer 2. Housemaid 3. Housewife 4. Government employee 5. Private employee 6. Merchant 7. Jobless 8. self- business 9. others, specify_____	
009	parity	1. zero 2. one 2. two 3. three and above(≥3)	
010	Your monthly income level	_____Ethiopian birr	
011	Your mother's level of education?	1. Illiterate 2. Primary education 3. Secondary education 4. Above secondary school	
012	Your father's level of education?	1. Illiterate 2. Primary education 3. Secondary education 4. Above secondary school	
013	Is there anyone who has medical related profession in your family?	1. Yes 2. No	
Part II**: Knowledge of Medication Abortion**			

014	What is the possible outcome of pregnancy? (more than one answer is possible)	1. Giving birth 2. Abortion	
015	Have you ever heard about abortion?	1. Yes 2. No 3. Not sure	If no skip to 018
016	If yes, what was source of information? (more than one answer is possible)	1. Friends 2. Media 3. Family 4. Teacher 5. Health facility 6. Internet 7. Church 8. Conference 9. Other , specify)_____	
017	Which ways of performing abortion do you know? (more than one answer is possible)	1. Abortion by Surgical procedures 2. Abortion by medication /drugs 3. Abortion by traditional practitioners 4. I do not know 5. Others specify)_____	
018	Do you know what safe abortion means?	1. Yes 2. No 3. Not sure	If no go to 020

019	If yes, what does it mean? (more than one answer is possible)	1. When induced abortion is performed by qualified persons 2. When induced abortion is performed using correct techniques 3. When induced abortion is performed in sanitary condition 4. When induced abortion is performed by untrained persons 5. Other, specify_____	
020	Do you know what unsafe abortion means?	1. Yes 2. No 3. Not sure	If no go to 022
021	If yes, what does it mean? (more than one answer is possible)	1. Termination of unwanted pregnancy by persons lacking the necessary skills 2. Termination of unwanted pregnancy in an environment lacking minimal medical standards 3. Termination of unwanted pregnancy by the woman herself 4. Termination of unwanted pregnancy by health worker under unhygienic Condition 5. Other, specify_____	
022	Do you know what a medication abortion means?	1. Yes 2. No 3. Not sure	If no go to 029

023	If yes, what does it mean?	1. Abortion using abortion pill/drug 2. Abortion using any drugs/medication 3. Abortion by inserting objects through female genital 4. Abortion by drinking chemicals 5. Other, specify_____	
024	Where did you get information about medication abortion from? (more than one answer is possible)	1. Friends 2. Media 3. Health facility/hospital 4. Family 5. Teacher 6. Church 7. Conference 8. Other sources, specify)_____	
025	Do you know where someone can have medication abortion done?	1. Yes 2. No 3. Not sure	If no go to 027
026	If yes to the above question, from where? (more than one answer is possible)	1. Community Pharmacy 2. Hospital pharmacy 3. Health centre 4. Private clinic 5. Other, specify_____	

027	Which drug/drugs is/are used to abort pregnancy? (more than one answer is possible)	1. Misoprostol 2. Mifiprostol 3. Amoxicillin 4. Ampicillin 5. Methotrixate 6. Gemprost 7. Safe-T 8. I do not know 9. Other, specify_____	
028	At what gestational age medication abortion preferable? (more than one answer is possible)	1. Gestational age ≤ 63 days 2. Gestational age ≤ 9 weeks 3. Gestational age ≥ 9 weeks 4. At any gestational age 5. I do not know 6. Other, specify _____	
029	Is abortion legally allowed in Ethiopia?	1. Yes 2. No 3. Not sure	If no go to 031
030	If yes to the above question at what condition? (more than one answer is possible)	1. When the pregnancy is resulted from rape or incest, 2. When the woman's or fetus lives are threatened, 3. When the fetus has severe abnormalities, 4. When the woman has physical or mental disabilities 5. When a woman is physically or psychologically unprepared to raise a child 6. On request for everyone 7. Other, specify, _____	
Part III: Attitude towards Medication/Medical Abortion			

031	Do you support that government should allow abortion in this country?	1. Yes 2. No	If no go to 033
032	If yes, what is your reason? (more than one answer is possible)	1. to prevent unsafe abortion 2. to prevent the death of women due to unsafe abortion 3. it is human right 4. Other specify, _____	
033	If no, what is your reason? (more than one answer is possible)	1. not allowed in my religion 2. it is crime 3. it encourages many women to have unplanned pregnancy 4. it will risk the health of women 5. Other, specify_____	
034	Would you advise or encourage a colleague with an unwanted pregnancy to undergo an abortion?	1. Yes 2. No 3. Not sure	If no go to 036
035	If yes, which type?	1. Abortion by Surgical procedures 2. Abortion by medication /drugs 3. Abortion by traditional practitioners 4. Others, specify _____	

036	If you have unplanned pregnancy, will you consider using abortion as a means of terminating it?	1. Yes 2. No 3. Not sure	If no go to 039
037	If yes why? (more than one answer is possible)	1. I cannot raise the child 2. It will affect my education 3. To protect social stigma 4. Others, specify_____	
038	If you consider abortion, which type would you use?	1. Abortion by Surgical procedures in the health facility 2. Abortion by medication /drugs from health facility 3. Abortion by medication /drugs from friends 4. Abortion by traditional practitioners 5. Others, specify_____	
039	If no why? (more than one answer is possible)	1. My religion cannot allow abortion 2. It is crime in our country 3. I don't want to kill my own baby 4. Gave birth 5. Undergone abortion 6. Others, specify_____	
Part IV: Practice of Medication Abortion			
040	Do you know a family member/friend /neighbour who had terminated pregnancy	1. Yes 2. No	

041	Have you ever had sexual intercourse before?	1. Yes 2. No	
042	Did you have history of unwanted pregnancy?	1. Yes 2. No	
43	Have you ever terminated your pregnancy before?	1. Yes 2. No	If No stop
044	If you terminated your pregnancy, what was the reason termination?	1. I did not know contraceptives 2. I know but I did not use contraceptives 3. I know and used contraceptives but I faced unwanted pregnancy 4. other, specify_____	
045	If you have undergone termination; which type of procedure did you use?	1. Abortion by Surgical procedures 2. Abortion by medication /drugs 3. Abortion by traditional practitioners 4. Others, specify _____	

046	What is the reason for your choice of abortion method? (more than one answer is possible)	1. It is easy to take 2. has low continuing pregnancy 3. it is more natural 4. avoids surgery and anaesthesia 5. more effective 6. increased privacy and confidentiality 7. Much quicker in a short period of time 8. It is safe 9. It doesn't have side effect 10. Others(specify)_____	

Thank you for your time!!!

Annex IV: Amharic Version Information Sheet

አባሪ 4፡ የመረጃ ቅፅ

መለያ ኮድ ቁጥር_____

ስሜ _____ እባላለሁኝ፡፡ በአዲስ አበባ ዩኒቨርሲቲ በማስትረስ ዲግሪ የእናቶችና የስነ ተዋልዶ ጤና ተማሪ የሆነው አዲሱ የሻምበል በሚያደረገው ጥናትና ምርምር ላይ መረጃ ሰብሳቢ ሆኜ እየሰራሁ ነው ፡፡ ማርገዝ በሚቻልበት እድሜ ክልል ውስጥ ያሉ ሴቶች/እናቶች በመድሓኒት በሚደረግ ውርጃ/ ጽንስ ማቋረጥ ላይ ያላቸወን እውቀጥ፣አመለካከት እና ልምድ እንዲሁም እንዳይጠቀሙ የሚድርጓዋቸውን ችግሮች በተመለከተ ጥናት እያደረገ ይገኛል፡፡ ጥናቱ በቀጥታ ማርገዝ በሚቻልበት እድሜ ክልል ውስጥ ያሉ ሴቶች/እናቶችን ስለሚመለከት እርሶዎም የጥናቱ አካል ሁነው ተመርጠዋል፡፡ ስለሆነም የእርስዎን ታማኝ እና ቀና የሆነ ትብብር ለጥያቄዎቹ መለስ እንፈልጋለን፡፡

የአማካሪዎች ስም፡ ሰማርያ ብርሌ (**Asst. professor, PhD fellow**) እና አብዴሣ ቦካ (**BSc, MSc**) የተቋሙ ስም፡ አዲስ አበባ ዩኒቨርሲቲ፣ ጤና ሳይንስ ኮሌጅ፣ የነርሲግ እና ሚድዋይፈሪ ት/ክፍል የድጋፍ ሰጪ ተቋም ስም፡ አዲስ አበባ ዩኒቨርሲቲ

መግቢያ፡ ወደ ኤስ-አሬች ክሊኒኮች ለአገልግሎት ለሚመጡ እና ፍቃደኛ ለሆኑ እናቶች የመረጃ እና የፈቃደኝነት ማረጋገጫ ቅጽ ተዘጋጅቷል፡፡ ማርገዝ በሚቻልበት እድሜ ክልል ውስጥ ያሉ ሴቶች/እናቶች በመድሓኒት በሚደረግ ውርጃ/ ጽንስ ማቋረጥ ላይ ያላቸወን እውቀጥ፣አመለካከት እና ልምድ እዲሁም እንዳይጠቀሙ የሚድርጓዋቸውን ችግሮች በተመለከተ ጥናቱ በአዲስ አበባ ይደረጋል፡፡

ዓላማ፡ ይህ ጥናት ማርገዝ በሚቻልበት እድሜ ክልል ውስጥ ያሉ ሴቶችን/እናቶችን ጤና እና የአገልግሎት አሰጣጥ መሻሻልን ያመጣል ተብሎ ይታሰባል፡፡ እርሶዎ የሚሰጡጥ መረጃም ለጥናቱ መሳካት ብቻ ሳይሆን አገልግሎቱን ለማሻሻል፣ ለእናቶች ትክክለኛውን መረጃ ለመስጠጥም ከፍተኛ አስተዋጾ ይኖረዋል፡፡ በመጨረሻም የጥናቱ ውጤት ለሚመለከታቸው አካላት ይሰጣል፡፡

አካሔድ፡ ማርገዝ በሚቻልበት እድሜ ክልል ውስጥ ያሉ ሴቶች/እናቶች በመድሓኒት በሚደረግ ውርጃ/ ጽንስ ማቋረጥ ላይ ያላቸወን እውቀጥ፣አመለካከት እና ልምድ እንዲሁም እንዳይጠቀሙ የሚድርጓዋቸውን ችግሮች በተመከተ በአዲስ አበባ በኤስ-አሬች ክሊኒኮች በሚደረግው ጥናት ላይ እንዲሳተፉ ተጋብዘዋል፡፡ በትናቱ ላይ ለመሳተፍ ከተስማሙ ‘‘አዎን’’ በማለት መስማማቷን ያመልክቱ፡፡ ከዚህም በኋላ በመረጃ ሰብሳቢው መጠይቅ ይደረግሎታል፡፡ የሚሰጡት መረጃ በጠቅላላ በሚስጥር ኮድ ተደርጎ ለማንም ሳይሰጥ ታሽጎ ይቀመጣል፡፡

ጉዳት/ሲጋት፡ በጥናቱ ላይ በመሳተፍ ግዚዎትን እንደምንሻሞዎት ሊሰሞት ይችላል፣ ሆኖም ግን የጥናቱ ውጤት ለሚያመጣው ለውጥ ብለው እንደሚሳተፉ እናምናለን፡፡ እንዲሁም በጥናቱ በመሳተፎ ምንም አይነት ጉዳት አያደርስቦትም፡፡

ጥቅም፡ ቀጥተኛ የሆነ ጥቅም በዚሁ ጥናት ላይ በመሳተፎ ላያገኙ ይችላሉ፡፡ ነገር ግን እርሶዎ የሚሰጡጥ መረጃ ማርገዝ በሚቻልበት እድሜ ክልል ውስጥ ያሉ ሴቶች/እናቶች በመድሓኒት በሚደረግ ውርጃ/ ጽንስ ማቋረጥ ላይ ያላቸወን

እውቀጥ፣አመለካከት እና ልምድ ለማወቅ ይረዳል፡፡ ይህም መረጃ እናቶች በዚሁ ዙሪያ ያላቸውን ክፍተት አውቆ ትክክለኛውን መፍትሄ ለማስቀመጥ ይረዳል፡፡ በጥናቱ ላይ በመሳተፎ የተለየ ጥቅም ወይም ክፍያ አያገኙም፡፡

ምስጢራዊነት፡ በዚሁ ጥናት ላይ የሚገኘው መረጃ በሙሉ ምስጢራዊነቱ ተጠብቆ ይቀመጣል፡፡ የእርስዎም መረጃ በፍይል ከእርስዎ ስም ውጪ በኮድ ተደርጎ ይቀመጣል፡፡ በተጨማሪም ከጠናቱ ውጪ ለማንም ሰው አይሰጥም፡፡

በጥናቱ ያለመሳተፍ መብት፡ በጥናቱ ያለመሳተፍ ሙለ መብት አለዎት፡፡ በጥናቱ ውስጥ ላሉ ጥያቄዎችም መልስ ያለመስጠት መብት አለዎት፡፡ በማንኛውም ግዜ ከጥናቱ ያለመሳተፍ መብት አለዎት፡፡ ተጨማሪ ጥያቄ ካለዎት በሚከተለው አድራሻ ያገኙናል፡፡

አዲሱ የሻምበል ስልክ፡ +251-926-72-51-28 ኢሜል፡ addisyes3@gmail.com

Annex V: Amharic Version Consent Form

አባሪ 5፡ የስምምነት የፈቃደኝነት ማረጋገጫ ቅጽ

ከላይ የተጠቀሱትን በሙሉ ተረድቻለሁ፡፡ በዚህ ጥናት ላይ የምሳተፈው በሙሉ ፈቃደኝነት ነው፡፡ እንደተነገረኝ ከሆነ የምሰጠው መልስ ለሌላ ለማንም ሰው አይሰጥም፤ እንዲሁም ስለኔ ማንነት ለማንም አይገለፅም፡፡ ስለሆነም በጥናቱ ላይ ለመሳተፍ ፍቃደኛ ነኝ፡፡ ተሳታፊዋ ፍቃደኛ ካልሆኑ አመስግነው ወደሚቀጥለው ተሳታፊ ይለፍ፡፡ ተሳታፊው ፍቃደኛ ከሆኑ ግን ይቀጥሉ፡፡

ተረጋገጠ በ፡

የተቆጣጣሪ ስም _____ ፊርማ _____

ቀን _____

ቃለ መጠይቁ የተጀመረበት ሰዓት _____ደቂቃ _____

መለያ ኮድ ቁጥር _____

ቃለ መጠይቁ ያለቀበት ሰዓት _____ ደቂቃ _____

ቃለ መጠይቁን ያደረገው ባለሙያ ስም _____

ቀን _____ ፊርማ _____

Annex VI. Amharic Version Questioner

አባሪ 6- የመጠየቆቹ የአማረኛ ትርጓሜ

ክፍል 1፡ የተሳታፊዎች እና የቤተሰቦቻቸው ማህበራዊና ዲሞግራፊያዊ ሁኔታዎች			
ተ.ቁ	**ጥያቄዎች**	**መልስ**	**እለፊ**
001	እድሜዎት ስንት ነው?	_____ዓመት	
002	የትውልድ ቦታዎ የት ነው?	1. አዲስ አበባ 2. ከአዲስ አበባ ውጭ	
003	ሓይማኖትዎ ምንድን ነው?	1. ኦርቶዶክስ 2. ሙስሊም 3. ካቶሊክ 4. ፕሮቴስታንት 5. ሌላ ከሆነ ይግለጹ_____	
004	የትምህርት ደረጃዎትን ቢገልጹልኝ?	1. አልተማርኩም 2. የመጀመሪያ ደረጃ ተምህርት ተምሪያለሁ 3. እስከ ሁለተኛ ደረጃ ትምህርት ተምሪያለሁ 4. ኮሌጅ/ዩኒቨርሲትዬ ጨርሻለሁ	
005	በአሁኑ ሰዓት የጋብቻ ሁኔታዎ ምን ይመስላል?	1. አግብቻለሁ 2. ጓደኛ የለኝም 3. ጓደኛ አለኝ ግን አላገባሁም 4. ከባሌ ተፋትቻለሁ 5. ባሌ ሙቶብኛል 6 ሌላ ካለ ይግለጹ _____	
006	በአሁኑ ሰዓት ከማጋር ነው የሚኖሩት?	1. ከዘመድ ጋር 2. ከፍቅረኛዬ ጋር 3. ከባለቤቴ ጋር 4. ከጓደኞቼ ጋር 5. ብቻዬን 6. ከቤተሰቦቼ ጋር 7. ሌላ ካለ ይግለጹ_____	
007	የት ነው ሚኖሩት?	1. ከተማ 2. ገጠር	

008	ስራዎ ምንድን ነው?	1. የቀን ሰራተኛ 2. የቤት ሰራተኛ 3. የቤት እመቤት 4. የመንግስት ሰራተኛ 5. የግል ተቀጣሪ 6. ነጋዴ 7. ስራ-አጥ 8. የግል ቢዝነስ 9. ሌላ ካለ ይግለፁ_____	
009	ስንት ጊዜ ወልደሽ ታቂለሽ?	1. አላቅም 2. አንዴ 3. ሁለት ጊዜ 4. ሶስት እና ከዚያ በላይ	
010	የወር ገቢ መጠንዎ ምን ያህል ነው?	_____ብር	
011	የእናትዎ የትምህርት ደረጃ?	1. አልተማሩውም 2. የመጀመሪያ ደረጃ ተምህርት ተምራለች 3. እስከ ሁለተኛ ደረጃ ትምህርት ተምራለች 4. ከሁለተኛ ደረጃ ትምህርት በላይ ተምራለች	
012	የአባትዎ የትምህርት ደረጃ?	1. አልተማሩውም 2. የመጀመሪያ ደረጃ ተምህርት ተምርዋል 3. እስከ ሁለተኛ ደረጃ ትምህርት ተምርዋል 4. ከሁለተኛ ደረጃ ትምህርት በላይ ተምርዋል	
013	ከቤተሰቦዎ ውስጥ ከሕክምና ጋር የተያያዘ ትምህርት የተማረ አለ?	1. አዎ 2. የለም	
ክፍል 2፡ በመድሓኒት በሚደረግ ጽንስ ማቋረጥ ላይ ያሎዎት እውቀት			
014	የእርግዝና ውጤት ሊሆን የሚችለው ምንድን ነው? (ከአንድ በላይ መልስ መስጠት ይቻላል)	1. መውለድ 2. ጽንስ ማቋረጥ	

015	ስለ ጽንስ ማቋረጥ ሰምተው ያውቃሉ?	1. አዎን 2. አይ የለም 3. እርግጠኛ አይደለሁም	አይ የለም ከሆነ ወደ 18ኛ ጥያቄ ይለፉ
016	መልስዎ አዎ ከሆነ መረጃዎን ከየት አገኙ? (ከአንድ በላይ መልስ መስጠት ይቻላል)	1. ከጓደኞቼ 2. ከመገናኛ ብዙሃን 3. ከቤተሰብ 4. ከአስተማሪዬ 5. ከጤና ጠቋም 6. ከኢንተርኔት 7. ከቤተ ክርስቲያን 8. ከኮንፍረንስ 9. ሌሎች ምንጮች ይግለጹ_____	
017	የትኛውን የጽንስ ማቋረጫ መንገድ ነው እርሶ የሚያውቁት? (ከአንድ በላይ መልስ መስጠት ይቻላል)	1. በቀዶ ጥገና አሰራር ጽንስ ማቋረጥ 2. በህክምና/መድሃኒቶች 3. በባህላዊ የጽንስ ማቋረጥ የሚሰሩ ሰዎች 4. አላውቀውም 5. ሌሎች ይጥቀሱ _____	
018	ደህንነቱ የተጠበቀ ጽንስ ማቋረጥ ማለት ምን ማለት እንደሆነ ያውቃሉ?	1. አዎን 2. አይ የለም 3. እርግጠኛ አይደለሁም	አይ የለም ከሆነ ወደ 20ኛ ጥያቄ ይለፉ
019	መልስዎ አዎ ከሆነ ምን ማለት ነው? (ከአንድ በላይ መልስ መስጠት ይቻላል)	1. የማይፈለግ እርግዝና ጽንስ ማቋረጥ በሰለጠኑ ባለሞያዎች ሲሰራ 2. የማይፈለግ እርግዝና ጽንስ ማቋረጥ በትክክለኛው ዘዴ ሲከናወን 3. የማይፈለግ እርግዝና ጽንስ ማቋረጥ ጽዳቱን በጠበቀ ሁኔታ ሲከናወን 4. የማይፈለግ እርግዝና ጽንስ ማቋረጥ ባልሰለጠኑ ሰዎች ሲሰራ 5. ሌላ ይግለጹ _____	
020	ደህንነቱ ያልተጠበቀ ጽንስ ማቋረጥ ማለት ምን ማለት እንደሆነ ያውቃሉ?	1. አዎን 2. አይ የለም 3. እርግጠኛ አይደለሁም	አይ የለም ከሆነ ወደ 22ኛ ጥያቄ ይለፉ

021	መልስዎ አዎ ከሆነ ምን ማለት ነው? (ከአንድ በላይ መልስ መስጠት ይቻላል)	1. አስፈላጊ የሆነ እውቀት በሌላቸው ሰዎች ያልተፈለገ እርግዝና ሲቋረጥ 2. ዝቅተኛውን የህክምና መስፈርት በማያሟላ ከባቢ ያልተፈለገ እርግዝና ሲቋረጥ 3. ያልተፈለገ እርግዝናው በሴትየዋ በራሷ ሲቋረጥ 4. ያልተፈለገ እርግዝና ጽዳትን ባልጠበቀ ሁኔታ በጤና ባለሞያ ሲቋረጥ 5. ሌላ ይግለፁ _____	
022	በመድሃኒት ጽንስ ማቋረጥ/ውርጃ ማለት ምን ማለት እንደሆነ ያውቃሉ?	1. አዎ 2. አይ የለም 3. እርግጠኛ አይደለሁም	አይ የለም ከሆነ ወደ 29ኛ ጥያቄ ይለፉ
023	መልስዎ አዎ ከሆነ ምን ማለት ነው?	1. የጽንስ ማቋረጫ እንክብልን (መድሓኒትን) በመጠቀም ጽንስ ሲቋረጥ 2. በማንኛውም አይነት መድሃኒት ጽንስ ሲቋረጥ 3. የተለያዩ ነገሮችን በብልት ውስጥ በማስገባት 4. ኬሚካሎችን በመጠጣት 5. ሌላ ይግለፁ _____	
024	በመድሃኒት ስለሚደረግ ውርጃ/ጽንስ ማቋረጥ መረጃዎን ከየት ነው ያገኙት?(ከአንድ በላይ መልስ መስጠት ይቻላል)	1. ከጓደኞቼ 2. ከመገናኛ ብዙሀን 3. በጤና ተቋም/ሆስፒታል 4. ከቤተሰብ 5. ከአስተማሪዬ 6. ከቤተ ክርስቲያን 7. ከኮንፍረንስ 8. ሌሎች ምንጮች ይግለጹ_____	
025	የሆነ ሰው በመድሃኒት ጽንስ የት ሄዶ ሊያቋርጥ እንደሚችልስ ያውቃሉ?	1. አዎ 2. አይ የለም 3. እርግጠኛ አይደለሁም	አይ የለም ከሆነ ወደ 27ኛ ጥያቄ ይለፉ
026	ከላይ ለተጠየቀው ጥያቄ አዎ ከሆነ ከየት ? (ከአንድ በላይ መልስ መስጠት ይቻላል)	1. በማህበረሰብ መድሃኒት ቤት 2. በሆስፒታል መድሃኒት ቤት 3. በጤና ማእከል 4. በግል ክሊኒክ 5. በሌላ ይግለጹ _____	

027	ጽንስ ለማቋረጥ ጥቅም ላይ የሚውለው መድሃኒት /መድሃኒቶች/ የትኛው/ኞቹ መድሃኒት /መድሃኒቶች/ ናቸው? (ከአንድ በላይ መልስ መስጠት ይቻላል)	1. ሜሶፕሪስቶል 2. ሚፊፕሪስቶል 3. አሞክሳስሊን 4. አምፒሲሊን 5. ሜትሮትሪክሴት 6. ጌምፕሮስት 7. ሴፍ-ቲ 8. አላውቀውም 9. ሌላ ካለ ይጥቀሱ _____	
028	በየትኛው የእርግዝና ወቅት ነው የመድሃኒት ውርጃ/ ጽንስ ማቋረጥ ቢደረግ ተመራጭ የሚሆነው? (ከአንድ በላይ መልስ መስጠት ይቻላል)	1. የእርግዝናው ወቅት ከ63 ≤ ቀናት 2. የእርግዝናው ወቅት ≤ ከ9 ሳምንታት 3. የእርግዝናው ወቅት ≥ ከ9 ሳምንታት 4. በማንኛውም የእርግዝና ወቅት 5. አላውቅም 6. ሌላ ይግለጹ _____	
029	ውርጃ/ጽንስ ማቋረጥ በኢትዮጵያ ውስጥ በህግ ይፈቀዳል ?	1. አዎ 2. አልተፈቀደም 3. እርግጠኛ አይደለሁም	አልተፈቀደም ከሆነ ወደ 31ኛ ጥያቄ ይለፉ
030	ከላይ ለተጠየቀው ጥያቄ መልሶ አዎ ከሆነ የትኛው ሁኔታ? (ከአንድ በላይ መልስ መስጠት ይቻላል)	1. እርግዝናው በመደፈር ወይም ከሥጋ ዘመድ የተከሰተ ከሆነ 2. እርግዝናው የእናትዬዋን ወይም የጽንሱን ጤና አደጋ ላይ የሚጥል ከሆነ 3. ጽንሱ በጤናማ ዕድገት ላይ ካልሆነ 4. እርጉዟ ሴት አካል ጉዳተኛ ወይም የስነ-አዕምሮ ችግር ካለባት 5. ጽንሱን ለማሳደግ እርጉዟ ሴት አካላዊም ሆነ ስነ-ልቦናዊ ዘግጅት ከለላት 6. ማነኛውም እርጉዝ ሴት ጽንሱ እንዲቋረጥላት ስትጠይቅ 7. ሌላ ካለ ይግለጹ _____	
ክፍል 3፡ በመድሓኒት ጽንስ ማቋረጥን አስመልክቶ ያሎዎት አመለካከት			

031	በዚች አገር ውስጥ መንግስት ጽንስ ማቋረጥን መፍቀድ አለበት የሚለውን አስተያየት ይደግፋሉ?	1. አዎ 2. የለበትም	የለበትም ከሆነ ወደ 33ኛ ጥያቄ ይለፉ
032	መልስዎ አዎ ከሆነ ምክንያትዎ ምንድን ነው? (ከአንድ በላይ መልስ መስጠት ይቻላል)	1. አደገኛ የሆነ የጽንስ ማቋረጥን ለማስወገድ 2. አደገኛ በሆነ ጽንስ ማቋረጥ ምክንያት በሴቷ ላይ የሚመጣ የሞት አደጋን ለማስወገድ 3. ሰብአዊ መብት ነው 4. ሌላ ይግለጹ _____	
033	መልስዎ የለበትም ከሆነ ምክንያትዎ ምንድን ነው? (ከአንድ በላይ መልስ መስጠት ይቻላል)	1. በሀይማኖቴ ስለማይፈቀድ 2. ወንጀል ስለሆነ 3. ብዙ ሴቶችን ላልተፈለገ እርግዝና ስለሚያበረታታ 4. በሴቶች ጤንነት ላይ አደጋ የሚያስከትል ስለሆነ 5. ሌላ ይግለጹ _____	
034	ያልተፈለገ እርግዝና ያጋጠማት ጓደኛዎን ወይም ደግሞ የስራ ባልደረባዎን ጽንሱን እንድታቋርጥ ይመክሯታል ወይም ያበረታቷታል?	1. አዎን 2. አይ የለም 3. እርግጠኛ አይደለሁም	አይ የለም ከሆነ ወደ 36ኛ ጥያቄ ይለፉ
035	መልስዎ አዎ ከሆነ የትኛው አይነት?	1. በቀዶ ጥገና አሰራር ጽንስ ማቋረጥን 2. በህክምና /መድሃኒት ጽንስ ማቋረጥን 3. በባህላዊ ጽንስ አቋራጮች ጽንስ ማቋረጥን 4. ሌላ ይግለጹ _____	
036	ያልታሰበ እርግዝና ቢያጋጥምዎ ጽንስ ማቋረጥን ከዚህ አይነት እርግዝና ነፃ ለመሆን ይጠቀሙበታል?	1. አዎ 2. አልጠቀምም 3. እርግጠኛ አይደለሁም	አልጠቀምም ከሆነ ወደ 39ኛ ጥያቄ ይለፉ
037	መልስዎ አዎ ከሆነ ለምን? (ከአንድ በላይ መልስ መስጠት ይቻላል)	1. ልጅ ማሳደግ አልችልም 2. ትምህርቴ ላይ ተጽእኖ ያሳድርብኛል 3. በማህበረሰቡ እንዳልገለል 4. ሌላ ይግለጹ _____	

038	ጽንስ ማቋረጥን እንደ መፍትሄ የሚጠቀሙበት ከሆነ የትኛውን አይነት ጽንስ ማቋረጥን ነው የሚጠቀሙበት?	1. በጤና ተቋም ውስጥ በሚሰጥ የቀዶ ጥገና ዘዴ ጽንስ ማቋረጥ 2. ከጤና ተቋም በሚሰጥ መድሃኒት ጽንስ ማቋረጥ 3. ከጓደኞች በሚገኝ መድሃኒት/እንክብል ጽንስ ማቋረጥ 4. በባህላዊ ሀኪም ጽንስ ማቋረጥ 6. ሌላ ይግለጹ _____	
039	አይደለም ከሆነ ለምን? (ከአንድ በላይ መልስ መስጠት ይቻላል)	1. ሐይማኖቴ ጽንስ ማቋረጥን ስለማይፈቅድ 2. በእኛ አገር ጽንስ ቋረጥ ወንጀል ስለሆነ 3. የራሴን ልጅ መግደል ስለማልፈልግ 4. መውለድ ስለምፈልግ 5. ከዚህ በፊት ውርጃ አድርጌ ስለማውቅ 6. ሌላ ይግለጹ _____	

ክፍል 4፡ በመድሓኒት በሚደረግ የጽንስ ማቋረጫ ዘዴ ላይ ያሎዎት ልምድ

040	ከዚህ በፊት ጽንስ ያስወረዱ/ች ቤተሰብ/ጓደኛ/ጐረቤት ያቃሉ?	1. አዎ 2. አላቅም	
041	ከዚህ ቀደም የግብረስጋ ግንኙነት ፈፅመው ያውቃሉ?	ነ. አዎ 2. አይ የለም	
42	ከዚህ በፊት ያልተፈለገ እርግዝና አጋጥሞት ያውቃል?	ነ. አዎ 2. አይ የለም	
043	ከዚህ በፊት ጽንስ አቋርጠው/ውርጃስ ፈጽመው ያቃሉ;	1. አዎ 2. የለም	የለም ከሆነ ያቁሙ
44	መልሶዎ አዎ ከሆነ፤ ጽንስ ለማቋረጦዎ ምክንያቱ ምንድን ነው ብለው ያስባሉ?	ነ. የእርግዝና መከላከያ ስለማላቅ 2. የእርግዝና መከላከያ እያውቅሁ በለመጠቀምዬ 3. የእርግዝና መከላከያ እየጠቀምኩ ነው እርግዝናው የተከሰተው 4. ሌላ ካለ ይግለጹ_____	

045	ጽንስ አቋርጠው ያውቃሉ ከሆነ ምን አይነት አግባብ ተጠቀሙ?	1. በቀዶ ጥገና ዘዴዎች ጽንሱን በማቋረጥ 2. በመድሃኒት/እንክብል ጽንሱን በማቋረጥ 3. በባህላዊ ሀኪሞች ጽንሱን በማቋረጥ 4. ሌላ ይግለጹ _____	
046	ጽንስ ያቋረጡትን ዘዴ ለመጠቀም የመረጡበት ምክንያት ምንድን ነው? (ከአንድ በላይ መልስ መስጠት ይቻላል)	1. ለመውሰድ ቀላል ነው 2. ዝቅተኛ የሆነ ቀጣይ የእርግዝና ወቅት ስላለው 3. የበለጠ ተፈጥሮአዊ በመሆኑ 4. ቀዶ ጥገናና ማደንዘዣ ስለሚያስወግድ 5. የበለጠ ውጤታማ ስለሆነ 6. የበለጠ ሚስጢራዊ ስለሆነ 7. በአጭር ጊዜ ውስጥ በበለጠ ፍጥነት ስለሚከናወን 8. ደህንነቱ የተጠበቀ ስለሆነ 9. ምንም አይነት የጎንዮሽ ጉዳት የለበትም 10. ሌሎች (ይግለጹ)_____	

ጊዜዎን ሰውተው ምላሾን ስለሰጡን እናመሰግናለን !!