

ADDIS ABABA UNIVERSITY



FACULTY OF MEDICINE

SCHOOL OF PUBLIC HEALTH

ASSESSMENT OF QUALITY OF SAFE ABORTION CARE IN PRIVATE FOR NON-  
PROFIT INSTITUTIONS, ADDIS ABABA, ETHIOPIA.

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A THESIS SUBMITTED TO THE SCHOOL OF GRADUATE STUDIES ADDIS  
ABABA UNIVERSITY IN PARTIAL FULLFILLMENT OF THE  
REQUIREMENT FOR MASTER OF PUBLIC HEALTH

JULY, 2010  
ADDIS ABABA, ETHIOPIA

## **I. ACKNOWLEDGEMENT**

First of all, I would like to present my deepest gratitude for my advisor Dr. Asefa Seme (MD, MPH) for his unlimited productive and incessant support preliminary from the beginning of this paper.

Secondly, I want to extend my thanks to Addis Ababa health bureau, and all the institutions incorporated in the study for their good collaboration.

I am also grateful to the supervisor and data collectors for their hard work and patience in collecting the data despite the existing work burden.

Finally, none of this study would have been possible to conduct without support from the different individuals and health care providers and I want to express my heartfelt appreciation & thanks to all individuals who participated in carrying out of this study and all clients and health care providers involved in the study.

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## V. ACRONYMS

AIDS	Acquired Immuno Deficiency Syndrome
AOR	Adjusted Odd Ratio
CAC	Comprehensive Abortion Care
CI	Confidence Interval
COR	Crude Odd Ratio
EDHS	Ethiopian Demographic Health and Survey
EVA	Electrical Vacuum Aspiration
HIV	Human Immunodeficiency Virus
IUD	Intra uterine Device
IEC	Information, education, and communication
IPAS	International Projects Assistance Service
IRB	Institutional Review Board
MOH	Ministry of Health
MVA	Manual Vacuum Aspiration
SD	Standard Deviation
SNNPR	Southern Nations, Nationalist and People Region
SPH	School of Public Health
SPSS	Statistical Package for Social Sciences
STI	Sexual Transmitted Infections
TPNPI	Total Private Non-Profit Institutions
VCT	Voluntary Counseling and Testing

## **VI. Abstract**

**Background:** Nearly 52 million abortions are carried out worldwide, of these 20 million are unsafe and 68,000 die each year. Of all unsafe abortions practiced, 97% is problems of developing countries. In Ethiopia, unsafe abortion is the most common cause of maternal mortality, accounting for up to 32% of maternal deaths in the country.

**Objective:** To assess quality of safe abortion services in private for non-profit institutions in Addis Ababa.

**Methods:** A facility based cross-sectional study was conducted among safe abortion users from August, 2009 to June, 2010. The study used multiple research approach of quality of abortion care: A structured interviewer administered questionnaire, observation, provider interview and supplies and equipment assessment were employed. The institutions which were included in the study sample were selected using the rule of thumb and a total of seven institutions incorporated in the sample. A total of four hundred twenty two clients for exit interview, forty-two observations, and forty-three health service providers interview were done. Data entry, cleaning, and analysis was done using Epi-info version 3.5.1 and SPSS version 11.

**Result:** From total of 422 safe abortion clients interviewed 192 (45.5%) were never married, the mean age of respondents were  $23.5 \pm SD 3.9$  and 60 (14.2%) of the respondents have had history of previous abortion. The average clients waiting time was 3.2hours. Ninety-two percent of clients claimed that they were treated with politeness & respect. Forty-five percent of clients given information about danger sign that need re-visiting the health institutions & information regarding other reproductive issues like tetanus immunization, Rh counseling, and VCT were very low. Two hundred ninety five (88.9%) of post abortion clients were left with family planning methods. Those women who said the counseling time adequate four times more likely to be satisfied with the overall service [Adjusted OR=3.6, (95% CI (1.6, 8.2)].

*Women who received anti-pain treatment on the average three times more likely satisfied with the service [Adjusted OR=2.6, 95% CI (1.1, 6.2)]. The likelihood of satisfaction in those clients who were given appointment for follow-up was six times [Adjusted OR=5.9, 95% CI (2.2, 15.9)]. Majority of health service providers had got refresher training.*

***Conclusion:*** *Ninety-three percent of the clients were expressed their overall satisfaction with the service they received. The majority of post-abortion clients were left with contraceptive, but linkage to other reproductive health like Rh screening, VCT and TT immunization were not adequately adept across all the institutions. Follow-up appointment, anti-pain, and adequate counseling statistically significant with the overall satisfaction of clients. Majority of health service providers had got refresher training & positive attitude towards safe abortion clients, Infection prevention uniformly practiced.*

***Recommendations:*** *Offering Anti-pain management, appropriate counseling & follow up appointment provide for all clients' to deliver quality service by reducing the waiting time as much as possible, reducing miss opportunity on family planning counseling & linkage to other reproductive health, capacity building for care service providers & supportive supervision are crucial to improve the quality of safe abortion service.*

# **1. INTRODUCTION**

## **1.1. Background**

Globally, nearly 52 million abortions are carried out, of these 20 million are unsafe and 68,000 die each year [1]. Of all unsafe abortions practiced, 97% is in developing countries [2]. Even if data suggest that the overall abortion rate has declined, the proportion of unsafe abortion is on the rise in developing countries (55%) like Latin America, Africa, and South East Asia [3]. Among the women who survive, 5 million will suffer long-term health complications and high burden of unsafe abortion and abortion-related death are rising among unmarried adolescent women of age group between 15-19 years and 70% of all women who receive treatment for complications of abortion are under age 20 [2, 4, 5].

The private sector is a major provider of abortion services all around the world because privacy concerns and legal restrictions drive clients to them, and new technologies, such as Manual Vacuum Aspiration (MVA) have been introduced around the world [6]. Although abortion is restricted in several developing countries and that providers often express negative attitudes about the service and its clients, a substantial proportion of providers still perform abortions, both safe or unsafe [2,3,4].

In Ethiopia, of the estimated 3.27 million pregnancies every year, nearly 500,000 end up in either spontaneous or induced abortion and unsafe abortion is the most common cause of maternal mortality, accounting for up to 32% of maternal deaths in the country [7, 8]. Safe abortion has recently been made liberalized and new technical guidelines have been developed by the Ethiopian Ministry of Health to provide standards in the provision of abortion-care services (to reduce abortion-related maternal mortality since June 2006 under the Criminal Code of the Federal Republic of Ethiopia article 551, in particular circumstances, such as where the pregnancy is owing to 1) rape or incest, 2) the continuation of the pregnancy endangers

the life of the mother or the child, 3) the fetus has an incurable and serious deformity, 4) physical or mental deficiency she suffer from or her minority, 5) in case of grave and imminent danger, which can be averted by an immediate intervention by public and private health institutions [7]. Nevertheless, this is a huge step forward for women who need safe services in short supply, they are still go to street abortionist, herbalist or a pharmacist for drugs [9]. The aim of the current study is to offer information on the way safe abortion service is provided to those in need of the service. Because, studies are very limited on the assessment of quality of safe abortion care in our country, it will serve as baseline information for other operational studies and especially performance of those private for non-profit organization.

## **1.2. Significance of the study**

In Ethiopia maternal mortality ratio is 673/100,000 lives birth (maternal mortality rate 1.68/1000 women age 15 to 49 years), high morbidity and disability along with the very low contraceptive coverage rate (14.8%) and high fertility rate (5.4%) [8]. Unsafe abortion is one the major cause of maternal mortality ratio and a very serious public health problem in Ethiopia. Therefore, apart from revised abortion law, there is a need to work on the capacity building of health facilities and health workers. This study is expected to be an important step to see and assess status of safe abortion care services in private for non-profit institutions in Addis Ababa. The findings of this study are believed to be useful:

- ✓ Data in relation to abortion found just the tip of ice berg so the studies provide baseline information about the current status of safe abortion service in circumstance where it is legally permitted.
- ✓ It will also provide future direction for the programme managers as well as policy makers in expanding safe abortion services.

## **2. LITERATURE REVIEW**

### **2.1. Characteristics and reason of clients seeking safe abortion.**

A woman obtains an abortion may be associated with a number of her characteristics: her age, marital status, number of live-born children (number of living children) [10]. In the study done Viet Nam, situational analysis of abortion care show that the mean number of pregnancies and age was 3.1 (range 1-11) & 29years, respectively [11]. A number of studies of clandestine abortion in developing countries have reported that abortion and abortion morbidity are most common among young, unmarried women. For instance, among women hospitalized with abortion-related complications in Uganda, about two-thirds were aged 15-19, two-thirds were students and four out of five had never been married [ 12]. A study done in Ethiopia to assess quality of post abortion care show that women of age groups 18-30 & never married account for 68% & 17.5%, respectively [13]. A study done in Addis Ababa to assess quality of post- abortion care showed that mean  $\pm$  SD age was  $26 \pm 6.4$ , 20-24 years, single, & women without child account for 30.2%, 24.4%, & 39.7%, respectively [14]. Another study done in SNNPR to assess status of safe abortion care and level of satisfaction of clients showed that median  $\pm$  SD age was  $21.4 \pm 6.4$ , 20-24 years, single, and married constituted 32.3%, 56.8% & 34.9%, respectively [15]. Women mention contraceptive failure or the conflict between work and childbearing as a reason for abortion [16]. A study on Nigerian adolescents showed that fear of adverse effect of modern contraception continuity on future fertility adolescent prefer to seek induced abortion rather than using contraception [17]. Adolescents are vulnerable to rape and sexual abuse in many contexts, including school and work place and many young girls face unwanted pregnancies as a result of rape [18]. Contraceptive

method failure was responsible for 18% of all the pregnancies that result in unsafe abortion, and was the second commonest reason for occurrence of unwanted and unplanned pregnancies [8]. Rape also contributed for 3% of the abortion cases [19]. A study done in Addis Ababa to assess quality of post abortion care showed that cause of pregnancy was contraceptive failure 19.2% , forget to take contraceptives 25.6%, & partner pressure 11.5%, respectively [14]. Likewise, a study done in SNNPR to assess status of safe abortion care & level of client satisfaction showed that cause of pregnancy low risk perception, non-use of contraceptive, rape, method failure, & incest account for 32.3%, 30.2% , 13% & 6.3%, respectively [15].

## **2.2. Client's satisfaction on abortion service**

In a research, which was conducted on assessment of abortion services in public health facilities in Mozambique had shown that clients were dissatisfied with long waiting times from arrival to treatment, not getting pain medication and follow-up care information [20]. Similarly, a study on quality of post abortion care in public health facilities of Ethiopia showed great majority of the clients (79.6%) responded that they were satisfied with services they have obtained and 88.3% of the respondent believed that the service delivered in confidential way, but 22 (21.3%) dissatisfied in the manner that 31.8% they were not being given pain treatment and 22.7% complained of absence of relevant education and facilities such as toilet [13].

In a study done in Addis Ababa to assess the quality of post-abortion service, majority of the patients 370 (92.3%) responded that they were satisfied with the services they have obtained but 31 (7.7%) were not satisfied with the service. The reasons included 24.2%

not receiving pain treatment, 29.9% very long waiting time between arrival and treatment and those clients who said long waiting time statistically significant [14]. Providing treatment within two hours of arrival at health-care-facility was the recommended and acceptable waiting time for efficient service delivery and for greater satisfaction of post abortion patients [21, 22]. According to the study done in SNNPR in public health facilities, to assess the status of safe abortion and level of satisfaction, 138 (71.9%) were satisfied by the service given before the abortion procedure, but 54 (28.1%) were not satisfied, according to the parameter set to measure satisfaction, 17.7% and 5.2% of users were not satisfied by absence of appointment for follow up and lack of confidentiality respectively [15].

### **2.3. Quality of Abortion Care Service**

Quality of care relates to the treatment and personal attention that clients receive at a health-care facility. Greens L. et al. 1998 developed elements of quality-of-care framework for abortion care [23]. The basic premise underlying the conceptual framework is that if women who plan to terminate their pregnancies have access to and obtain abortions under safe conditions, they will be more satisfied with the service & less likely to suffer from abortion complications or to die from such complications [7, 24]. Some of the elements are discussed below.

#### **2.3.1. Provider-client Interactions**

Interaction means respect and support, non-judgmental attitude, respect to women's ability and right to make informed decisions/choices about their health and fertility, absences of provider bias or coercion in provision of care, an opportunity to express their

views, concerns and questions [25]. In the survey done in Viet Nam to assess the quality of safe abortion care, 92% of the women said that they were treated respectfully by health staff, but clients expressed their hesitation and recession about privacy and dignity [11]. A study done in Ethiopia and Addis Ababa to assess the quality of post-abortion care showed that information given about the important precaution and warning signs was uniformly very low in all the study facilities [13,14]. Similarly, in these two study patients were treated politely and respectfully 30.1% and 94.3% respectively [13, 14]. Sixty- two percent of patients were asked questions and respond answer to the questions [14].

### **2.3.2. Information Provision and Counseling**

Less restrictive abortion laws alone are not enough to practices safe abortion for those in need. Appropriate education and access to health care are necessary. For example, in India, unsafe clandestine abortions persist in spite of Indian's declaration of the medical Termination of Pregnancy Act in the early 1970s [26]. In a study done in Viet Nam to assess the quality of abortion care, the majority of the women received information about the range of contraceptive methods, but only half of them had understood the information completely and one-third (33.3%) want to know more about abortion-related issue [11]. Study done in Ethiopia showed that 22% of the post-abortion participant receives information about the warning sign and only 23.3% of the cases were provided with follow-up information by the providers [13]. More than three-quarter (>75%) of the case provider offer information on their current problems while 94% of cases were not told about danger signs. Follow-up appointment & educational materials was offered only

for 12.1% & 2 (0.5%) of the women. Issues related to other reproductive health like STI, HIV/AIDS and multiple partners were raised only for 3% of the cases [14].

### **3.3. Post-abortion contraceptive Choice**

In developing nations, two-thirds of unintended pregnancies occur among women who were not using any methods of contraception [27]. Studies from several countries also show that many women receiving services for the treatment of abortion complications accept contraceptive methods when offered prior to discharge. This is an important strategy for reducing unwanted pregnancy, repeat unsafe abortion and risk for abortion-related mortality [21, 22]. Increase contraceptive access use alone can drastically reduce safe and unsafe abortion by reducing unplanned pregnancies. For instance, in the Russian Federation, abortion rate drastically decline just with the introduction of modern contraceptive technologies [28]. Contraceptive counseling & methods provided to postabortion-care patients in Zimbabwe at the time of their hospital treatment led to greater than 50 percent decline in the number of unintended pregnancies & to decrease in repeat abortion as compared to who didn't receive such service [29]. A study done in Mozambique show that 27% of postabortion women have received a contraceptive method [20]. In the study done in Viet Nam, 84% of women were intended to use contraception, but 42% were actually using a method and even there was a discrepancy between the method they intended to use and actually using [11]. In the study done in Ethiopia and Addis Ababa showed that 53.4%, 22.3%, 44.7% of patients were provided information about family planning, asked for contraception, and received the methods, respectively, and 19.5% of the patients were provided information about family planning ,and only 2.7% received contraception [13,14]. In the study done in SNNPR in

public health facilities to assess the status of safe abortion and level of satisfaction showed that 62% of post abortion clients took any of contraceptive methods [15]. According to the baseline assessment safe abortion care provision in Tigray region, greater proportion of abortion cases receive contraception at health centers (52%) than at hospital (28%), but it falls short of the recommended level of 60% [30].

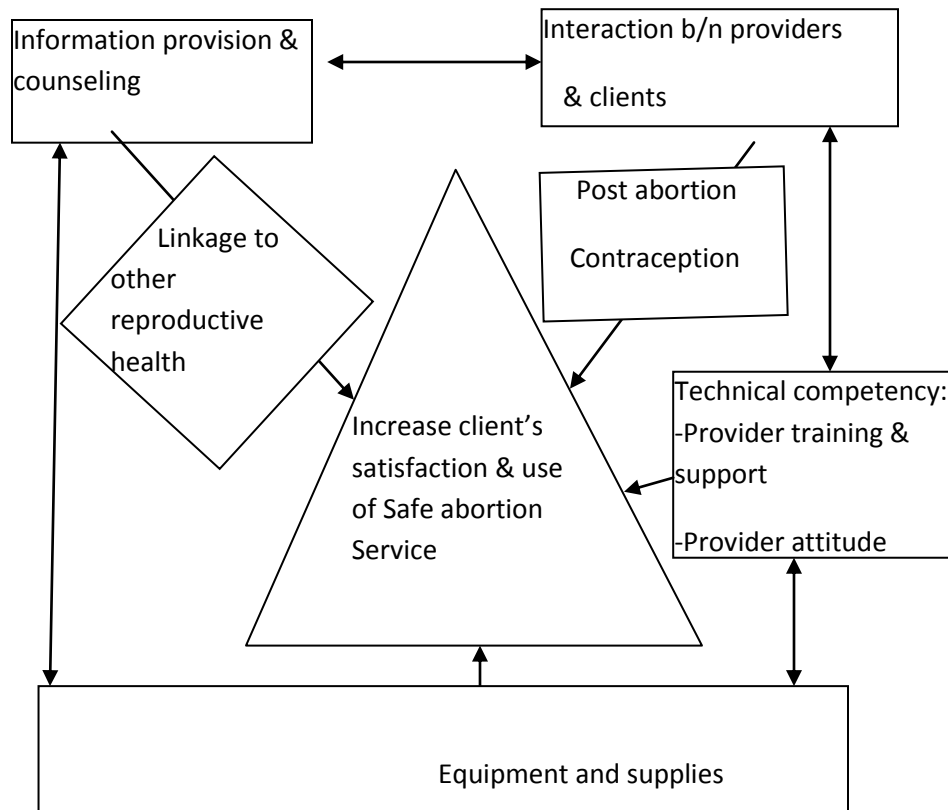
#### **2.3.4. Technical Competence**

Technical Competence is the proficiency with which all member of the health care team perform the tasks involved in abortion care, with adequate trained staff and appropriate supervision, following standard protocol and referral when in need [25]. Safe abortion, especially in developing nations carries risk that depends on the skill (qualification and tolerance) of the provider. Unskilled provider could improperly perform dilatation and curettage in unhygienic setting, causing uterine perforation and infection [2, 25]. The study done in India showed that most of the abortion care providers were trained and women ranked the facilities as high or intermediate in quality, but about 30% of the women experienced moderate to serious post-abortion complication [31]. According to the study done in Viet Nam show that only 5% of the women received any assistance from the staff in getting to the recovery room and none of the staff were present in the recovery room, and none of the women had their condition checked before they were discharged during any of the observations [11]. In a study done in Ethiopia to assess quality of post-abortion care showed that only two of the providers wore goggles during procedure and 26 (74.3%) of providers were assisted clients to the recovery room [13]. Concerning provider's attitude towards unsafe abortion patients, 70.1% of providers said that women suffering from unsafe abortion should not denied the service, 85.1% of

providers said that they deserve equal attention, and 8.6% not deserve equal attention, 53.4% of providers were comfortable to confront with unsafe abortion, but 35.6% were not interested to deal with them, and 55.2% of the respondent were believed that married, unmarried, and adolescent deserve equal attention, but 35.6% do not believe [13]. Another study done in Addis Ababa revealed that 18 (42.9%), 10 (23.8%) and 15 (35.7%) of service providers had training on STIs counseling, HIV/AIDS Counseling and MVA/EVA, respectively during their basic training [14].

### 2.3.5. Equipment, supplies, & medications

Essential equipment, supplies, and medications should be present at every level in sufficient quantities. There should be established management system [7, 32, 33].



**Figure 1.** Quality of care framework for Safe Abortion Care.

### **3. OBJECTIVES**

#### **3.1. General objective**

To assess quality of safe abortion services in private for non- profit institutions in Addis Ababa.

#### **3.2. Specific objectives**

1. To describe the background characteristics of clients seeking safe abortion services
2. To assess the clients level of satisfaction on safe abortion services
3. To assess provider's technical competence in providing safe abortion services
4. To assess the availability of equipment, supplies and medication for optimal abortion care

## **4. METHODS AND MATERIALS**

### **4.1. STUDY DESIGN**

The study was a cross-sectional descriptive facility based study (to assess quality of safe abortion care in private for non -profit institutions in Addis Ababa). A quantitative research method with a structured interviewer administered questionnaire, observation, provider interview and supplies and equipment assessment were employed.

### **4.2. STUDY AREA**

The study was conducted in Addis Ababa. Addis Ababa is the capital city and one of the eleven regions of the Federal State of Ethiopia. It is set up in to ten sub-cities. According to the 2007 E.C population and housing census, the city has a total population of 2,738,248 (3.7%) and annual growth rate of 2.1% between 1994-2007 [34]. Out of these population, female population account for 1,433,730 (52%). Women of reproductive age group among the total population are 948,784 and by age category: 15-19(233,011), 20-24 (220793), 25-29 (191,941), 30-34 (106,815), 35-39 (90,996), 40-44 (54,151) and 45-49 (51,077). In the city there are 11 governmental hospitals, 19 private hospitals, 24 governmental health centers, 8 governmental clinics, 382 private for profit clinics (Higher clinics, Medium clinics, and Lower clinics). There are 35 private for non-profit institutions out of these 6 health centers, three higher clinics, 16 medium clinics, 5 lower clinics, one model clinic, & others eye, VCT laboratory, special clinics. According to the Ethiopian liberalized abortion law: heath centers, higher clinics and medium clinics are expected to perform safe abortion by using vacuum aspiration up to 12 weeks and medical abortion up to nine completed weeks of pregnancy [7]. The contraceptive prevalence rate of the city is 45.2 % [8]

### **4.3. STUDY PERIOD**

The study was conducted from Aug, 2009 to June, 2010 G.C.

### **4.4. STUDY POPULATION**

#### **4.4.1. Source population**

The source populations were all women in the reproductive age group (15-49 years), who came for comprehensive abortion care (CAC) in the comprehensive abortion care unit and fulfill the eligibility criteria.

#### **4.4.2. Study subjects**

The study subjects were women in the reproductive age group (15-49 years), who came for safe abortion services, and who fulfill the set criteria.

### **4.5. SAMPLE SIZE AND SAMPLING TECHNIQUE**

#### **4.5.1. EXIT INTERVIEW**

A total of 422 safe abortion clients were interviewed for the services they came according to the WHO recommendation study sampling method for abortion at clinical setting which is by non probability (quota) sampling method till the required sample size was reached. There was interview before the procedure to collect socio-demographic information and after the procedure before the discharge of the clients to collect information about the services they received.

### **Sample size calculation for exit interview**

p= with the assumption that 50% of safe abortion clients would be satisfied with the service because of the absence of similar study in private for non-profit institutions which could give us adequate sample size.

$Z_{\alpha/2}$  = confidence level at 95% = standard value of 1.96

d= Margin of error=5%,      q= 1-p

$$\text{Required sample size, } n = \frac{(Z_{\alpha/2})^2 P(1-P)}{d^2}$$

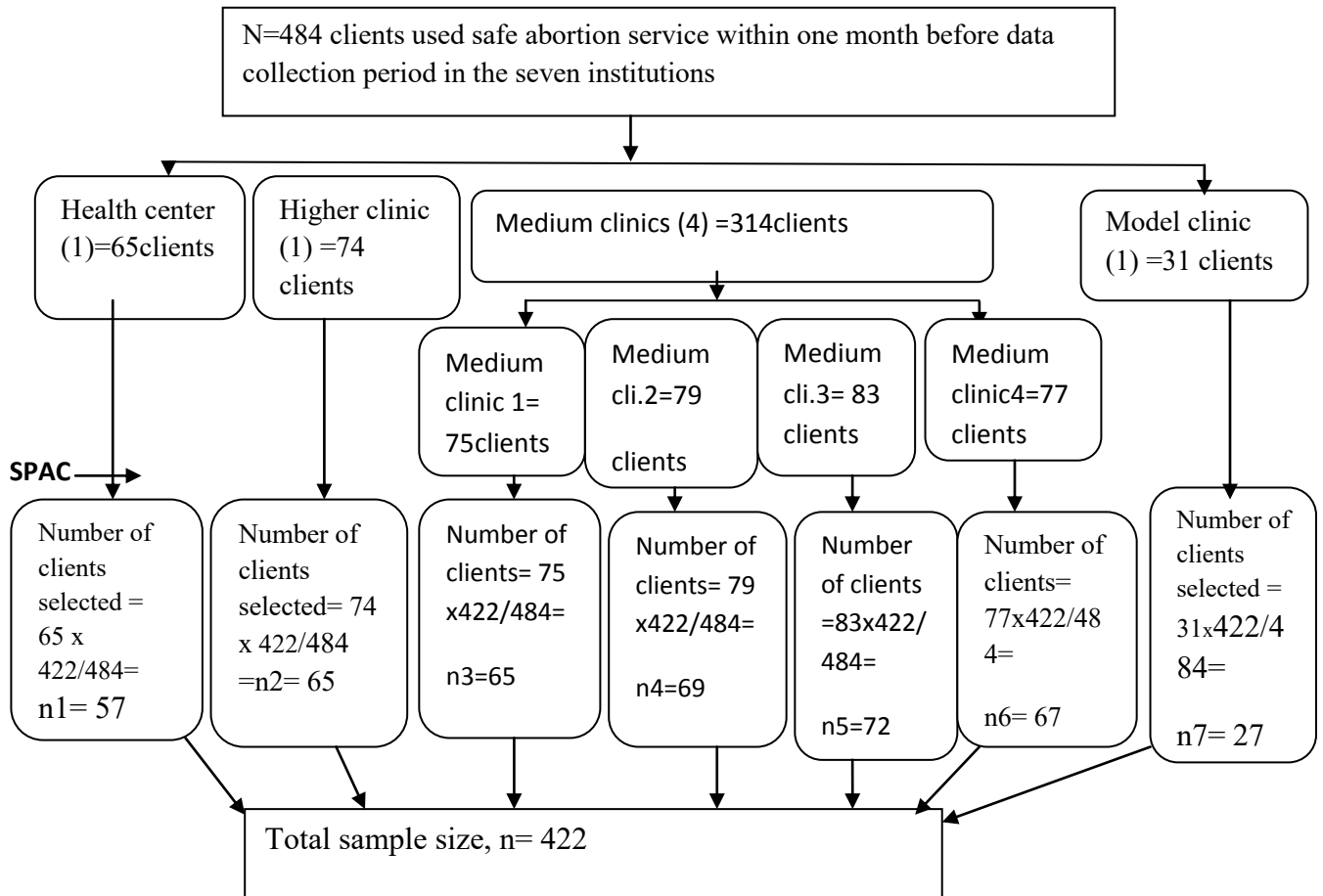
To allow for possible non-response the sample size was adjusted by 10% =384+10%

$$n=422$$

### **Sampling procedure**

The institution that were selected as source population by the rule of thumb in sampling for quality of care study recommendation that is if the number of institution is very large ( $\geq 500$ ) take 10% of the sample; if from 100 to 500 institution, take 20-30% of sample; if they are less than 100 health institutions, take 30-50% of the sample [35]. Based on the rule, we took 30% of the institutions that means 7 institutions were included in the sample out of twenty six institutions. Due to the disparity in the availability of staff, essential equipment, and adequate infrastructure to provide the service, institutions were purposively selected in order to maximize and get the required sample size. Accordingly, institutions included in our sample were one health center, one higher clinic, four medium clinics, and one model clinic.

A one month data was revised to identify the number of clients received safe abortion service in the selected study institutions before the data collection period & then allocated proportionately to each of the institutions. Accordingly, there were 65 clients used safe abortion service in one health center, 74 in one higher clinic, 314 clients in four medium clinics, & 31 clients in one model clinic (Figure 2).



**Figure 2:** Schematic sampling procedure of study clients

SPAC= Sampling proportionate allocation of clients

#### **4.5.2. OBSERVATION**

A qualitative method for checking the quality of service delivery at health institution. Since the procedure is time consuming and difficult to confront especially with sensitive issues, with the recommendation of World Health Organization we took 10% (42clients) of the sample for observation which was proportionately divided among all private for non-profit institutions, that were included in the study.

#### **4.5.3. PROVIDER INTERVIEW**

Those who were directly engaged in the services provision of safe abortion including history-taking, physical examination, and counseling at the time of data collection were included in the study. Gynecologists, General practitioners, Nurses, Midwifery, and Bsc nurses were included.

#### **4.6. ELIGIBILITY CRITERIA**

**Inclusion criteria:** - All women who came for safe abortion service: without bleeding, not seriously sick, without mental problem, and those who were volunteer to participate in the study were included in the study.

**Exclusion criteria:** - Those women who came with bleeding, with mental problem, with serious illness, and unwilling women were not included in the study.

#### **4.7. METHODS OF DATA COLLECTION**

##### **4.7.1. EXIT INTERVIEW**

Questionnaire was adopted and developed which was suitable for the exit interview which is initially developed by IPAS for assessment of abortion services. First, it was

translated into Amharic and then back to English to ensure consistency. The questionnaire has three parts: 1) Socio-demographic: age, marital status, educational status, religion, ethnicity, and occupational status. 2) Reproductive history, 3) Quality related variables: interaction between providers and clients, information provision, family planning methods provision, access service and satisfaction.

#### **4.7.2. OBSERVATION**

To conduct observation checklist was prepared and done in phases.

Phase I: Before the procedure interaction between providers and clients and information provision observation was conducted. Observation during the counseling session about contraceptive benefits and risks, the procedure to be performed, complication of abortion and support.

Phase II: Within the procedure interaction between service providers and clients and information provision was conducted.

Phase III: During termination and recovery. After the procedure post-abortion family planning counseling, methods provision, and assisted to recovery room, observation was conducted.

The observation was conducted by nurse experienced in abortion care from government hospital after the principal investigator gave training for two days. Pre-test was done to check the uniformity of the two investigators. That means to collect & cross match relevant information from clients and providers, consistency between exit interviewer and observer were checked.

#### **4.7.3. PROVIDERS INTERVIEW**

To trace information and technical competence concerning safe abortion care questionnaire was developed. The questionnaire has three different components. 1) Socio-demographic characteristics, 2) Training back ground, 3) Opinion/attitude of providers towards safe abortion clients. Client-provider interaction and infection prevention throughout the contact time of clients were done by using check list.

#### **4.7.4. EQUIPMENT AND SUPPLIES**

Health facilities providing safe abortion services should be equipped with basic equipment, instruments, and consumables that have to be replenished regularly. To assess the availability of essential equipment and supplies, checklist was developed and has four different parts. 1) facility assessment, 2) basic supplies, 3) instrument and equipment for first-trimester uterine evacuation (basic uterine evacuation instrument and equipment, vacuum aspiration with electric pump, manual vacuum aspiration and twelve-weeks plus instrument and equipment), & 4) laboratory for basic test was observed.

#### **4.8. OPERATIONAL DEFINITIONS**

**Safe abortion:** - Is termination of pregnancy less than 28 weeks of gestation by qualified and skilled persons using correct techniques in sanitary condition.

**Provider:** - In this study refers to health professionals involved in history taking, physical examination, treatment and counseling of safe abortion clients.

## **4.9. STUDY VARIABLES**

### **4.9.1. Dependent variables**

Overall client's satisfaction on safe abortion service;

### **4.9.2. Independent variables**

Socio-demographic variable: - Age, occupational status, marital status, religion, ethnicity, and education.

Reproductive factors: gravidity, parity, previous abortion, future pregnancy & contraceptive use.

Quality related variables:-

Client-provider interaction, information provision and counseling, access to service, technical competence, availability of equipment.

## **4.10. DATA PROCESSING AND DATA ANALYSIS**

Data entry and analysis was done by principal investigators using Epi info version 3.5.1 and SPSS version 11.0, respectively. During data analysis, frequencies, percentages, means, and SD of the different variables were first computed. The association between dependant and independent variables were measured by means of Chi-square ( $X^2$ ) and odds ratio with 95 % confidence interval. Variables with P-value less than 5% were considered significant and further analyzed at multivariate level by means of logistic regression to control potential confounding factors.

#### **4.11. DATA QUALITY ASSURANCE**

Data quality assurance was primarily the responsibility of the principal investigator. Exit interview questionnaire was designed in English carefully, then translated into Amharic and back translated in to English so as to be able to obtain the necessary information that can answer the objective of the study. Data collectors were 12+, non-health professional female interviewer recruited to reduce interviewer bias. An intensive training was provided for both data collectors and supervisors two days before the pre-test and for two days after the pre-test and five percent of the questionnaire was pre-tested which was not include in the final sample. Completeness of forms or questionnaire was checked on the first line by supervisors and then by the principal investigator on arrival. Data was entered by principal investigator and according to the pre-coded response; entered data was checked for completeness and accuracy on daily basis.

#### **4.12. ETHICAL CONSIDERATIONS**

Ethical clearance was obtained from the Institutional Review Board (IRB) of the Medical Faculty of Addis Ababa University, School of Public Health (SPH). Then support letter with written consent was obtained from Research Review Board of Addis Ababa Health Bureau to communicate the respective private for non-profit institutions. The head managers of private for non-profit institutions then wrote letter to each of the selected institute. Respondents were informed about the purpose/objective, benefits, and harm of the study. Informed consent for exit interview and verbal consents for observation was obtained from each woman of age group 18-49 years old. Owing to the perceptive nature of the service and the challenge to expose to the guardian, verbal assent was obtained from those female children of age less than 18 years. Concerning supplies and equipment assessment, using official letter from Addis Ababa health bureau permission was requested from service provider institutions. To ensure privacy and confidentiality (anonymity) the interview took place in a convenient place chosen by the respondents and explanation was given to the study participants that their name was unnecessary.

#### **4.13. DISSEMINATION OF THE FINDINGS**

The finding of the study is disseminated to organizations/ institutions or individuals who have direct or indirect responsibility to the project. This includes Addis Ababa University, Addis Ababa health Bureau, private for non-profit institutions and others. We are using different opportunity to present the finding and also to publish in reputable journal.

## **5. Result**

### **5.1. Socio-demographic characteristics**

A total of four hundred twenty two safe abortion services users were interviewed with response rate of 100%. The mean age  $\pm$  SD of the women was 23.5 $\pm$ 3.9 with the median age of 23 years. The minimum and the maximum ages were 16 and 40 years, respectively. The vast majority of women 211(50%) were in the age group of 20-24 years, 121(28.7%) were in the age group 25-29 years. One hundred ninety two (45.5%) were never married, 149(35.3%) were currently married, 59(14%) were cohabiting, and the rest were divorced, separated or widowed. As to religion of the respondents, more than half of them (66.1%) were Orthodox Christianity, 96(22.7%) of them were Muslim and 43(10.2 %) of them were Protestants. From the total respondents, 105 (24.9%) had private business, 82 (19.4%) were students, 66 (15.6) were housewives, 47 (11.1%) were employed in private sector, 38 (9%) were unemployed, and 36 (8.5%) were house maid. The ethnic origin of clients showed that 186 (44.1%) were Amharas, 94 (22.3%) were Oromos, 78 (18.5%) were Gurages, 41 (9.7%) were Tigres, and others accounted for 23(5.4%). Regarding educational status of the participants, 34 (8.1%) were illiterate, and 182 (43.1%) were in the secondary educational level (Table1).

**Table 1:** Socio-demographic characteristics of safe abortion clients in private for non-profit institutions, Addis Ababa, Ethiopia, 2009/2010 (n=422).

<b>Variables</b>	<b>Frequency(n=422)</b>	<b>Percent</b>
<b>Age</b>		
15-19	60	14.2
20-24	211	50
25-29	121	28.7
30+	30	7.1
<b>Marital Status</b>		
Never married	192	45.5
Currently married	149	35.3
Cohabiting	59	14
Divorced, Separated, or widowed	22	5.2
<b>Religion Affiliation</b>		
Orthodox	279	66.1
Muslim	96	22.7
Protestant	43	10.2
Catholic	2	0.5
No response	2	0.5
<b>Occupation</b>		
Have private business	105	24.9
Students	82	19.4
Housewife	66	15.6
Employed in private sectors	47	11.1
Unemployed	38	9
House maid	36	8.5
Government employee	28	6.6
Others	20	4.8
<b>Ethnics Origin</b>		
Amhara	186	44.1
Oromo	94	22.3
Gurage	78	18.5
Tigre	41	9.7
Others	23	5.4
<b>Educational Status</b>		
Illiterate	34	8.1
Read and write	19	4.5
1-8 grade	101	23.5
9-12 grade	182	43.1
12+	86	20.4

## **5.2.Reproductive History of Safe Abortion Service users**

Two hundred thirty two (55%) of the service users were found to be gravida I, 114(27%) were gravida II, 41(9.7%) were gravida III, 26(6.2%) were gravida IV and 9(2.1%) were gravida V and above. The mean number of pregnancies was 1.8 (range 1-7).

The mean age  $\pm$  SD at first pregnancy was  $21 \pm 3.02$ . The minimum and maximum ages at first pregnancy were 13 and 30, respectively with median age of 21. Of the total women who came to get the safe abortion care service, 266 (63%) didn't have children, 94(22.3%) had one child, 38(9.0%) had 2 children, 24(5.7%) of them had 3 or more children. Sixty (14.2%) of the respondents have had history of previous abortion with mean number of 0.2 (rang 1-3), which was experienced once in 12.3%, twice in 1.7 % and three times in 0.2%. Regarding the current pregnancy, 68 (16.1%) of the respondents reported that current pregnancy is wanted. The cause of the current pregnancy among those respondents who didn't want the current pregnancy and interfere with it, were 137(38.7%) non use of contraceptive, 88 (24.9%) low risk perceptions, 83 (23.5%) inappropriate use of contraceptive (Table 2).

**Table 2:** Reproductive history of safe abortion clients, private for non- profit institutions, Addis Ababa, Ethiopia, 2009/2010.

Variables	Frequency(n= 422)	Percent
<b>Number of Pregnancy</b>		
1	232	55
2-4	181	42.9
≥5	9	2.1
<b>Previous live birth</b>		
None	266	63
1-2	132	31.3
≥ 3	24	5.7
<b>Had previous abortion</b>		
yes	60	14.2
No	362	85.8
<b>Current pregnancy</b>		
Wanted	68	16.1
Unwanted	354	83.9
<b>Cause of the current pregnancy (n=354)</b>		
Rape	15	4.2
Incest	1	0.3
Non use of contraceptive	137	38.7
Contraceptive failure	30	8.5
Low risk perception	88	24.9
Inappropriate use of contraceptive	83	23.5

Regarding previous knowledge of contraceptive that help to prevent unplanned pregnancy, 397 (94.1%) of them know at least one contraceptive method. Two hundred fifty nine (61.4%) of the women had used a contraceptive method at some time. Of this group, 139(53.7%) had used oral contraceptive, 102 (39.4%) used injectable, 28 (10.8) used condom, and 20 (7.7%) of them used traditional. Three hundred nine (73.2%) of them didn't use contraceptive before the current pregnancy ended up abortion. The main reason were, didn't expected to have intercourse 82 (26.5%), initially it was wanted 60

(19.4%), feared the side effect of contraceptive 48 (15.5%), unavailability of the method 46 (15%), have no idea about contraceptives 27 (8.7%), religious prohibition 10 (3.2%), mistimed 13 (4.2%), cost 8 (2.6%), partner lobbying 8 (2.6%), and 7 (2.3%) of them accounted for other reason.

### **5.3. Provider-Clients Interactions**

Among the study participants who were asked about their attitude towards the service providers revealed that, 388 (91.9%) claimed that they were handled and treated with politeness and respect. Concerning the counseling time they spent with the service provider, 307 (72.7%) of them said it was adequate. The average consulting time at these private for non-profit institutions was  $6.3 \pm 0.7$  min/day/person. Out of 129 clients who were asked questions about abortion, family planning, and other health related issue, 123 (95.4%) said that the providers listened and got satisfactory answer to their questions. Three hundred ninety six (93.8%) of the respondents stated that their privacy was maintained (Table 3).

Likewise data from 42 client's observations, the interaction between health service providers and clients revealed that the entire clients were greeted friendly and respectfully by the health providers. Thirteen (31.0%) clients had got the opportunity to ask questions before and after the examination were completed and responded to all of them.

**Table 3:** Interaction between service providers and safe abortion clients, private for non-profit Institutions, Addis Ababa, Ethiopia, 2009/2010.

Variables	Frequency (n=422)	Percent
<b>Treated with politeness</b>		
Yes	388	91.9
No	34	8.1
<b>Counseling time</b>		
Adequate	307	72.7
Short	64	15.2
Long	7	1.7
I don't know	44	10.4
<b>Privacy maintained</b>		
Yes	396	93.8
No	11	2.6
I don't know	15	3.6
<b>Clients asked questions</b>		
Yes	129	30.6
No	293	69.4
<b>Got satisfactory response</b>		
Yes	123	95.4
No	6	4.6

#### **5.4. Information provision and Counseling**

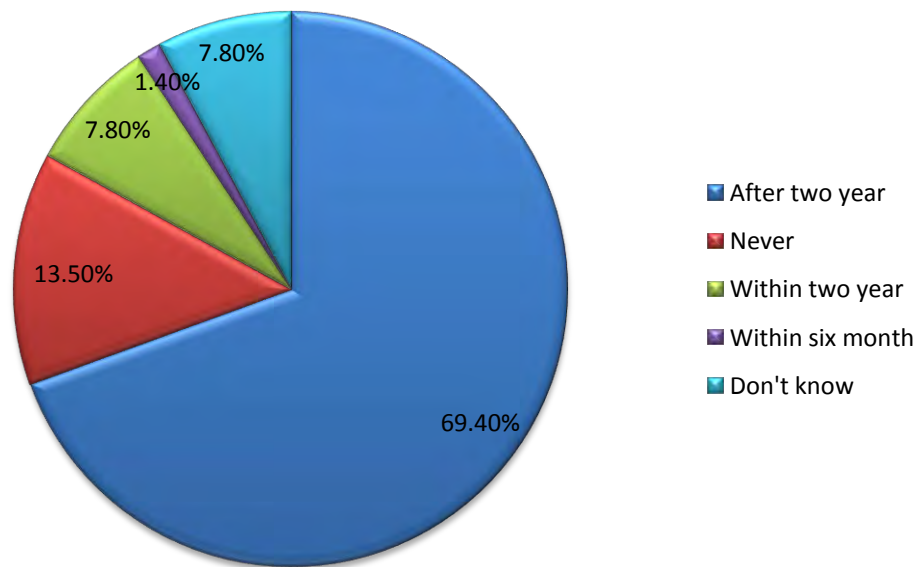
From the total 422, three hundred one (71.3%) mentioned that source of information was friends, 129 (30.6%) heard about the service from previous or current service users, 74 (17.5%) heard from health professional, and 3 (0.7%) heard from school.

One hundred ninety one (45.3%) of the respondents were told about danger signs that may necessitate re-visiting the health institutions for check up (Table 4). Information received on danger signs and symptoms include 156 (81.7%) vaginal bleeding, 155 (81.2%) abdominal pain, 133 (69.6%) fever, 137 (71.7%) abnormal discharge, and 56 (29.3%) amenorrhea. Four hundred twelve (97.6%) of the participants received pelvic examination. Out of these 174 (42.2%) were informed what would happen during pelvic examination, 296 (71.8%) were informed the result of the examination, and 182 (44.2%) were informed how to interfere with the pregnancy. All of the study participants did not receive any information about Rh factor examination. One hundred two (24.2%) of the respondents received educational materials. The educational materials received were about HIV/AIDS in 76 (74.5%), STIS 49 (48%), abortion 31 (30.4%) and family planning 72 (70.6%) of the cases. Fifteen (35.7%) of the observed providers asked questions and discussed about STI/HIV and only ten (23.8%) of clients were offered Voluntary counseling and testing (VCT).

**Table 4:** Information provision to safe abortion clients, private for Non-Profit institutions, Addis Ababa, Ethiopia, 2009/2010

Variables	Frequency (n=422)	Percent
Revisit the facility for danger sign		
Yes	191	45.3
No	231	54.7
Informed about pelvic examination		
Yes	412	97.6
No	10	2.4
Informed about abortion procedure (n= 412)		
Yes	174	41.2
No	238	56.4
Informed the result of examination		
Yes	296	71.8
No	116	28.2
Discussed about Rh factor		
Yes	0	0
No	422	100
Educational materials given		
Yes	102	24.2
No	320	75.8

As to intention for future pregnancy, 293 (69.4%) of the respondents wanted to be pregnant after two years, 57 (13.5%) of the participants never want to be pregnant at all indicating that the need to access contraception, and 33 (7.8%) intended to be pregnant within two years (Figure 3).

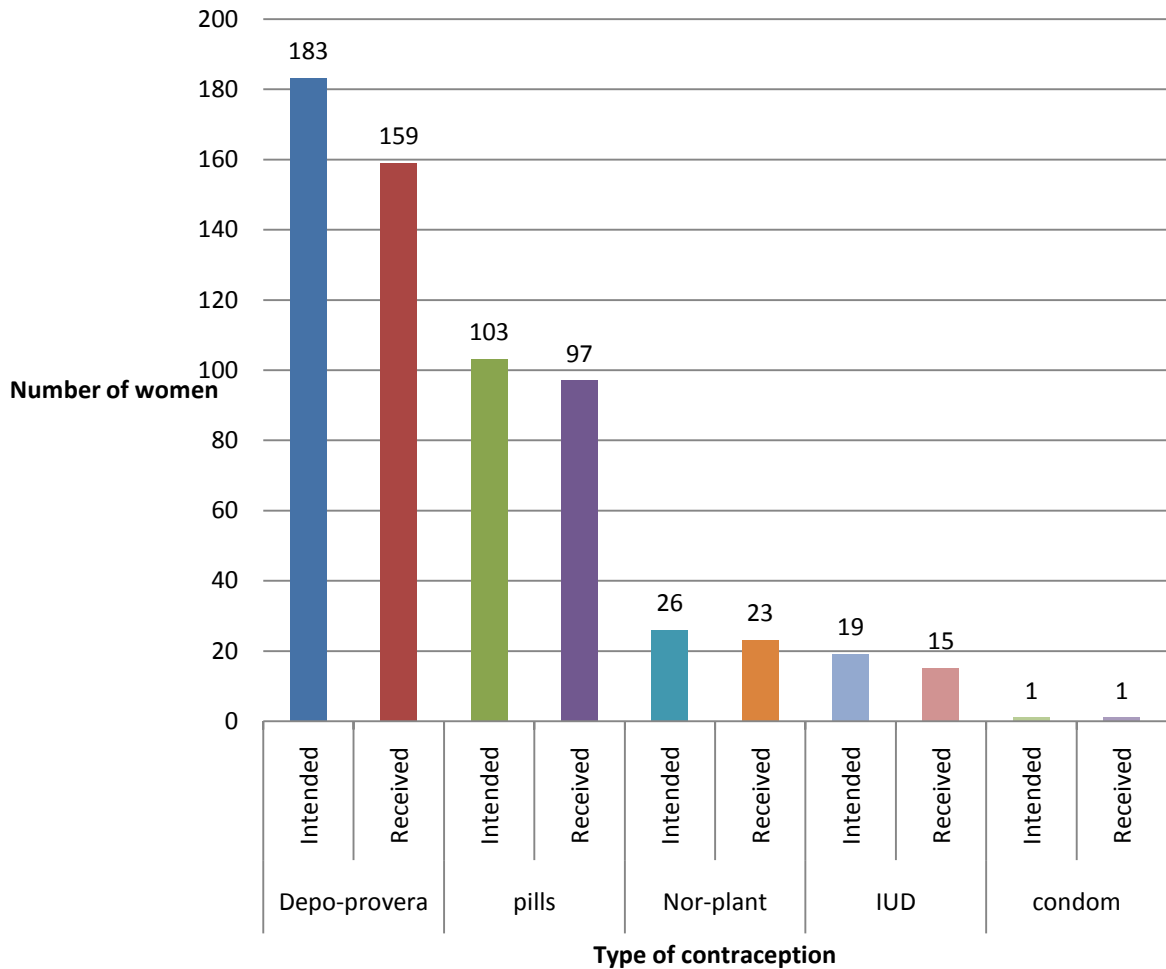


**Figure 3:** Intention for future pregnancy in selected private for non-profit institutions, Addis Ababa, Ethiopia, 2009/2010.

## 5.5. Post-abortion contraception

Three hundred thirty two (78.7%) of the respondents were volunteer to take post abortion family planning methods, but 90 (21.3%) of the respondents were not interested to take the methods. Among the respondents who were volunteer to take family planning methods, 183 (55.1%) were intended to take injectables, 103 (31%) oral contraceptive, 26 (7.8%) nor-plants, 19 (5.8%) intera uterine device (IUD), and 1 (0.3%) intended to take condom. Two hundred ninety five (88.9%) of clients received family planning methods of their choice, but 37 (11.1%) didn't get their choice of method. Of those women who received their choice of methods, 97 (32.9%) received pills, and 159 (53.9%) received Depo-Provera (Figure 4). Women's most common reasons who didn't get their choice of method were no one raise the issue 12 (32.4%), to go to other health facility 4 (10.8%), health problems 1 (2.7%), have an appointment 13 (35.2%), want to be abstinence 6 (16.2%), and 1 (2.7%) to use rhythm method. Three hundred forty six (82%) of clients said they discussed about the benefit of the methods, but only 192 (45.5%) of the participants discussed the side effect of the methods with the provider. Similarly, during observation the entire clients were offered post abortion family planning counseling, and all of the clients expressed their desire to use contraception, of whom, 16 (38.1%) interested to take Depo-Provera, 9 (21.4%) interested to take oral contraceptives, 8 (19.1%) of them were interested to take nor-plants, and 9 (21.4) of them were interested to take Intera uterine Device (IUD). Providers discussed with the clients both the benefit and risk of contraceptive methods, provide opportunity to ask questions concerning contraceptive for the forty two clients, and fostered the intended choice of contraception for all observed clients.

Accordingly, 9(21.4%), 16 (38.1%), 8 (19.1%), and 9 (21.4%) of clients were given pills, Depo-Provera, nor-plants, and IUD, respectively.



**Figure 4:** Number of women with their intention and type of contraception they received in selected private for non-profit institution, Addis Ababa, Ethiopia, 2009/2010.

## **5.6. Access to services and client Satisfaction**

From the total 422 respondents, 98 (23.3%) of the clients waited for up to one hour to get the service, 114 (27%) of the participants waited from one hour to two hours, and 210 (49.6%) of them waited for more than two hours to get the service. The mean waiting time was 3.2 hours. One hundred eight nine (44.8%) of the respondents said the waiting time was reasonable, 89 (21.1%) of them said too short, 144 (34.1%) of them said too long. Four hundred six (96.2%) of the respondents stated the working time comfortable, 404 (95.7%) of them said suitable waiting area, and 402 (95.3%) of them said there was adequate latrine. Concerning cost of the service, 306 (72.5%) of the participants claimed the cost of the service they got was reasonable, 76 (18%) of them said it was expensive, 35 (8.3%) of them said it was cheap. As to medication for pain, 316 (74.9%) of the respondents said medication was given for pain. For the questions asked about confidentiality, 365 (86.5%) of the participants said their anonymity was kept, 10 (2.4%) of them said confidentiality was not kept (Table 5). Three hundred eighty (90%) of the respondents were given follow up appointment to come back for check up next time. Out of these, 89 (23.4%) of clients was given appointment within 7-10 days, and 291 (76.6%) were told to come back after 10 days. During observation, 36 (85.7%) of the observed clients were given follow-up appointment within 7-10days.

**Table 5:** Distributions of responses of clients“ to variables related to satisfaction of safe abortion care in private for non- profit institutions, Addis Ababa, Ethiopia, 2009/2010.

Variables	Frequency (n=422)	Percent
<b>Waiting time</b>		
Reasonable	189	44.8
Longer than expected	144	34.1
Shorter than expected	89	21.1
<b>Adequate latrine</b>		
Yes	379	89.8
No	43	10.2
<b>Cost of the service</b>		
Expensive	76	18
Reasonable	306	72.5
Cheap	35	8.3
I don't know	5	1.2
<b>Pain medication given</b>		
Yes	316	74.9
No	106	25.1
<b>Follow-up appointment</b>		
Yes	380	90
No	42	10
<b>Confidentiality kept</b>		
Yes	365	86.5
No	10	2.4
I don't know	47	11.1
<b>Comfortable working time</b>		
Yes	406	96.2
No	16	3.8

From a total of 422 participants interviewed, about 391(92.7%) of them expressed their overall satisfaction with the service they were given, but 31 (7.3%) were not satisfied. Despite four hundred-thirteen (92.7%) clients avowed their overall satisfaction, when clients asked if they had comments on general service provision and that need in improvement of the institutions using open- ended question; 75 (17.8%) commented on the absence of anti-pain medication, 35 (8.3%) said that the waiting time between arrival and procedure was too long and providers were not using the time appropriately, 34 (8.1%) said that counseling about contraceptive and other related issue were not enough, 28 (6.6%) commented on some providers reflect lack of respectfulness, support, and aggressive behavior, 15 (3.6%) commented on lack of adequate bed in the recovery room and they were leave with their pain and adequate assessment, and 7 (1.7%) of clients commented on the lack of availability of some facilities like latrine and water and 2 (0.5%) commented providers need to improve repeat procedure after first one.

Binary and multivariate logistic regression analysis of overall satisfaction of clients by socio-demographic variables of the respondents, and quality related variables were done. The result showed that there was no statistical difference among women of service users with regard to their socio-demographic characteristics: age, educational status, occupation and marital status in the level of service satisfaction. However, the following variables were found to be significantly associated with the overall satisfaction: Those women who said the counseling time adequate four times more likely to be satisfied with the overall service than the referent group who said the time was short [Adjusted OR=3.6, (95% CI (1.6, 8.2))] (Table 6). Women who received anti-pain treatment on the average three times more likely satisfied with the service compared to those who didn't receive the treatment in multivariate analysis after adjusting for other confounders [Adjusted OR=2.6, 95% CI (1.1, 6.2)]. The likelihood of satisfaction in those clients who were given appointment for follow-up was six times compared to those clients who were not given appointment for follow-up [Adjusted OR=5.9, 95% CI (2.2, 15.9)].

**Table 6:** The relationship between socio-demographic variables and quality related variables by Service satisfaction, private for non- profit institutions, Addis Ababa, Ethiopia, 2009/2010.

Variables	Satisfaction with the service		COR*95%CI***	AOR*95%CI***
	Yes	No		
<b>Age</b>				
15-29	366	26	2.8(.9, 7.6)	2.4(.8, 7.6)
30+	25	5	1	1
<b>Marital status</b>				
Single	256	17	1.6(.8, 3.3)	1.6(.7, 3.7)
Married	135	14	1	1
<b>Occupation</b>				
Employed	208	19	.7(.3, 1.5)	.7(.3, 1.6)
Unemployed	183	12	1	1
<b>Treat politely</b>				
Yes	360	28	1.2(.4, 4.3)	.7(.2, 2.9)
No	31	3	1	1
<b>Consultation time</b>				
Adequate	300	14	<b>4 (1.9, 8.4)</b>	<b>3.6(1.6, 8.2)</b>
Short	91	17	1	1
<b>Waiting time</b>				
Reasonable	262	16	1.9(.9, 3.9)	1.8(.8, 4.2)
Too long	129	15	1	1
<b>Cost of the service</b>				
Reasonable	317	24	1.1(.5, 2.9)	.93(.3, 2.6)
Expensive	70	6	1	1
<b>Pain treatment</b>				
Given	296	20	1.7(.8, 3.7)	<b>2.6(1.1, 6.2)</b>
Not given	95	11	1	1
<b>Follow up appointment</b>				
Yes	358	22	<b>4.4(1.9, 10.4)</b>	<b>5.9(2.2, 15.9)</b>
No	33	9	1	1

\*Crud odd ratio

\*\*Adjusted odd ratio

\*\*\*95 % confidence interval

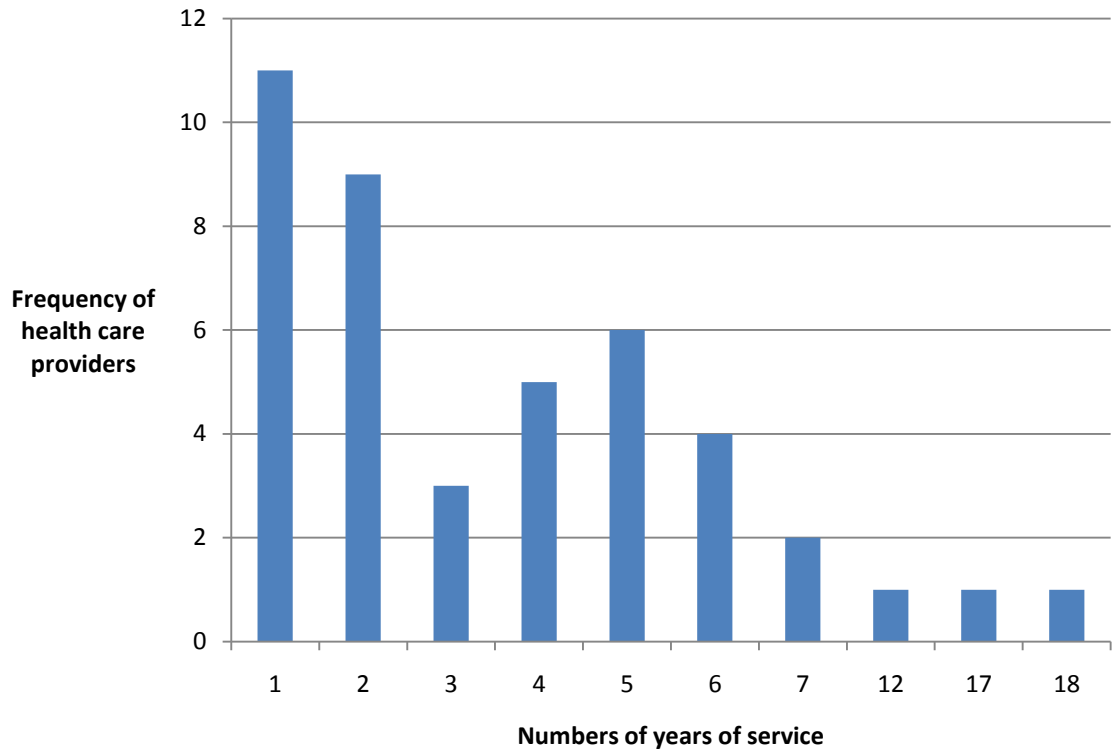
## 5.7. Measuring Technical Competency of Providers

**Provider's interview:** A total of 49 health service providers directly involved in abortion service provision were interviewed using self administer questionnaires. Six questionnaires were not completed. From the interviewed health professionals, 5 (11.6%) were gynecologists, 6(14%) were general practitioners and 21 (48.8%) were general nurses (Table 7). Eighteen (41.9%) were males and twenty-five (58.1%) were female providers. Over 30% of the providers were between 25 and 29 years. Twenty-three (53.5%) were married and seventeen (39.5%) were never married. As to religion, more than three-fourth (76.7%) of providers were followers of orthodox Christianity followed by Muslim (14%).

**Table 7:** Background Characteristics of Safe abortion Care Providers in selected Private for Non-profit Institutions, Addis Ababa, Ethiopia, 2009/2010.

Variables	Frequency	Percent
Age 20-24	6	13.9
25-29	14	32.6
30+	23	53.5
<b>Sex</b>		
Male	18	41.9
Female	25	58.1
<b>Marital status</b>		
Never married	17	39.5
Married	23	53.5
Separated	3	7
<b>Religion affiliation</b>		
Orthodox	33	76.7
Muslim	6	14
Protestant	4	9.3
<b>Qualification</b>		
Gynecologist	5	11.6
General practitioner	6	14
General nurse	21	48.8
Midwife	5	11.6
Bsc nurse	6	14

Eleven (25.6%) of providers worked in the current facility for one year and 9 (20.9%) worked for two years (Figure 5). The average number of years the providers worked in the current institutions was 4 (range 1-18).



**Figure 5:** Health care providers and number of years of service who were worked in the selected private for non-profit institutions, Addis Ababa, Ethiopia, 2009/2010.

The majority of providers reported that their basic training included antenatal care, abortion, family planning, sexual transmitted infection diagnosis and treatment, and maternity and delivery services. Thirty-eight (88.4%) of providers have attended refresher training in one or more of reproductive health matters of which training in general clinical skills in family planning, sexual transmitted infections risk assessment and counseling, manual vacuum aspiration, safe and post abortion care were included, 5

(11.6%) of them didn't attend refresher training. Forty-one (95.3%) of providers were actually fostered one or more type of family planning methods to the clients in the last three months.

Thirty-nine (90.7%) of providers responded that women who sought for safe abortion care should not be denied of service. Likewise, thirty-eight (88.4%) of providers agreed that women seeking safe abortion care deserve equal attention like other women seeking medical services. Thirty-eight (88.4%) of providers were comfortable to deal with safe abortion clients. Forty-one (95.3%) of health providers believed that all women including married, unmarried and adolescents deserve equal attention (Table 8).

**Table 8:** Provider's attitude towards safe abortion service provision in selected private for non- profit institutions, Addis Ababa, Ethiopia, 2009/2010.

Variables	Frequency (n=43)	Percent
Safe abortion clients should be deprived of services		
Yes	4	9.3%
No	39	90.7%
Safe abortion clients do not deserve equal attention		
Yes	5	11.6%
No	38	88.4%
Contented to confront with cases of safe abortion clients		
Yes	38	88.4%
No	5	11.6%
Married, Unmarried and adolescent girls should be treated equally		
Yes	41	95.3%
No	2	4.7%

## **Observation of providers**

**Client-provider interaction:** Out of forty-two, only twenty (47.6%) of the providers introduce their name to the clients. All the observed clients were asked about their last normal menstrual period. Providers listen to the counseling session attentively, support during counseling, and ordered urine pregnancy test for all clients. Thirty-one (73.8%) of them provided emotional support during procedure. Thirteen (31.0%) of them had got the opportunity to ask questions before and after the examination was completed and respond to all of them. Twenty-nine (69%) of the observed clients had got the opportunity to ask questions about the abortion procedure. Twenty-seven (64.3%) of the clients were asked their previous methods use, and 34 (81%) of the clients discussed the risk of pregnancy if they were not use contraception. Thirty-six (85.7%) of clients were offered the available methods of contraception. Also, for the method proposed, providers talked about how to use the method for 35 (83.5%), advantage of the methods for 36 (85.7%), disadvantage for 2 (4.8%), and medical side effect for 36 (85.7%) using flip chart for 1(2.4%), brocher/pamphlets 18 (42.9%), and contraceptive sample 36(85.7%) of them.

**Procedure:** There were an auxiliary in all the observed clients. Nine (21.4%) of the providers explain the steps of the procedure. Twenty-two (52.4%) of providers measured size and position of the uterus using uterine sound and 17 (40.5%) of providers given anti-pain to the clients.

Forty-one (97.6%) of the providers checked aspirators for negative pressure before the procedure. Thirty-eight (90.5%) of the providers mentioned the danger sign to the clients

that necessitate to re-visit the facility. Thirty-five (83.3%) of the providers told to the clients when to revisit the institution. Twelve (28.6%) of clients were asked if they were in pain. All the forty-two of providers have checked for sign of completion and tissue. Before and after the completion of the procedure, only 12(28.6%) of clients were provided an opportunity to ask questions. Twenty-seven (64.3%) of providers provided an assist to the clients to the recovery room after the completion of the procedure.

**Infection prevention:** Forty-two of providers followed no-touch technique during the procedure, wear eye goggles and boots. All of the providers cleaned the vagina and cervix before the procedure with swaps.

**Instrument reuse:** Instruments that were used in the procedure soaked in the decontamination solution and draw in to the cannulae after the completion of the procedure in all observed case. In the forty two the observed case, medical waste disposed by the provider properly.

**Post-procedure:** Forty (95.2%) of clients were rested in the recovery room after the completion the procedure, but 2 (4.8%) of them were not rested. Regarding status of the clients, 3 (7.1%), 3 (7.1%), and 22 (52.4%) of clients were assessed for vital sign, pallor, and abdominal and vaginal examination before the clients discharge, respectively. Concerning infection prevention, 29(69%) of clients were offered information about post-abortion infection and prevention. All eligible clients for tetanus toxoid was not received the vaccination.

## **5.8. Facility and Equipment**

### **Facility**

A total of seven private for non-profit institutions practitioners were observed. It was observed that adequate space for waiting was available in 100% institutions. Drinking and running water for the waiting clients was available in 100% institutions. A provision for a screen to ensure privacy during examination was available in 100% institutions. In all the institutions there was adequate toilet for the user clients. The availability and display of IEC materials to impart health education was grossly poor (85.5%) .

### **Essential equipments and supplies**

The availability of basic supplies was reasonably good in the institutions (Table 9). However, among instruments for first-trimester uterine evacuation: Pratt or Denniston dilators size of 13-27 French in five (71.4%) of institutions, medium self-retaining speculum in one (14.3%), 500ml container for antiseptics in one (14.3%) was missing. The availability of vacuum pump with extra glass bottles in two (28.6%), connecting tube in three (42.9%), curved rigid cannulae of size 7-10, 12, and 14mm to provide the service was not found in the institutions. As to the availability of laboratory kits, Rh factor test reagent entirely was not found in the institutions.

**Table 9:** The availability of basic equipments and supplies in private for Non-profit institutions, Addis Ababa, Ethiopia, 2009/2010.

Basic equipments and supplies at private for non-profit institutions	number (n=7)	percent
<b>Basic supplies</b>		
Intravenous fluid	7	100
Syring, needles, gloves, cotton, antibiotics	7	100
Pain medications, sterilizer	7	100
<b>Basic uterine evacuation instrument and equipment &lt; 12wks</b>		
Sponge forceps, uterine sound,	7	100
Pratt or Denniston dilators of size 13-27 french	2	28.6
Medium self-retaining speculum	6	85.7
500ml container for antiseptics	6	85.7
Container for cleansing solution	7	100
Clean glass dish for tissue inspection	7	100
Single tooth tenaculum forceps	7	100
<b>Vacuum aspiration with electric pump</b>		
Vacuum pump with extra glass bottles	5	71.4
Connecting tubing	4	57.1
Cannulae flexible size 4-10, and 12mm	7	100
<b>Manual vacuum aspiration</b>		
Vacuum aspirators, adaptors, and flexible cannulae	7	100
<b>Laboratory kits</b>		
Pregnancy test kit	7	100
Blood group reagent	7	100
RH test reagent	-	-
Hematocrit reader/Hemoglobin reagent	7	100

## 6. Discussion

Apart from the revised abortion law, there is a need to work on the capacity building of health facilities and health workers to increase safe abortion service utilization. This study is expected to be an important step to assess & provide an insight about the quality of safe abortion care services and clients satisfaction at private for non-profit institutions in Addis Ababa.

The vast majority of the service users in this study were females of age group 20-29years which is almost consistent with studies done in, Ethiopia, Addis Ababa to assess quality post abortion care and SNNPR to assess the status of safe abortion & level of satisfaction, & to the distributions of our source population [13, 14, 15, 34]. This finding indicates that the majority of service users in this study were young and the current liberalized abortion law help those younger and even others age groups to use safe abortion service which in turn suggest that it reduce unsafe induced abortion and abortion related complication and the need to further access health education and reproductive health services. The majority of service users were single (45.5%) and married women accounts for 35.3% which is almost similar to study done in SNNPR [15]. This result of the study clearly indicates that safe abortion service primarily is not only the service of young, single, childless women but also it is the service of married women. The occupation status of most of the service users were private business (24.9%) and students" accounts for 19.4%. The majority of the study participants 87.4% attended formal education which is higher than studies done in Ethiopia, Addis Ababa and SNNPR 45.6%, 70.1%, and 72.4%, respectively [13, 14, 15].

The study finding indicates that wide variety of factors is responsible for cause of pregnancy in the current safe abortion seekers. The major factors include non-use of contraceptive, low risk perception, inappropriate use of contraceptive, contraceptive failure, and rape which accounts for 38.7%, 24.9%, 23.5%, 8.5%, and 4.5%, respectively. This finding showed that the causes of unwanted pregnancy in the study participants were almost similar to others studies [14, 15]. Two hundred fifty nine (61.4%) of clients were ever used any contraceptive.

Regarding the current provider-clients interaction exit interview revealed that 92% of clients were handled and treated politely and respectfully. The study finding was similar to the study finding that was done in Viet Nam which was 92% [11]. Out of one hundred twenty nine clients those who have questions about different reproductive health issues 95.4% of them had got satisfactory answer to their questions. The finding is higher than study done in Addis Ababa to assess quality of post abortion care which is 62% [14]. This might owing to educational status of the client. As to privacy of the clients 93.8% of them were assured their privacy and dignity during an exit interview. This finding is different from study done in Viet Nam, a situational analysis of quality of abortion care comment where clients were hesitant about having to be bared in front of others [11]. This could be due to cultural difference and the current study institutions provide other service in addition to safe abortion care and fostering consideration for the service users.

The majority of clients (71.3%) claimed that their sources of information about the availability of service in those institutions were friends. This finding is higher than study

done at SNNPR to assess status of safe abortion care and level of satisfaction which is 30.2% [15]. This could be explained by the availability of service institutions. Forty-five percent of the study participants were received information about danger signs that need re-visiting of the institutions while that of study done in Amhara and Oromia region and Addis Ababa quality of post abortion care at public health facility only 22% and 6% of clients receive the information, respectively [13, 14]. Information provision about other reproductive health issues was an important strategy to provide dual protection of both unwanted pregnancy and STI/HIV, but the finding of this study show that 15 (35.7%) of observed clients discussed with providers & only ten (23.8%) of clients were offered VCT. The finding is slightly higher than the study done in Addis Ababa public health facilities [14].

In this study, 69.4% of clients wanted to be pregnant after two years. Based on this fact, immediate post-abortion contraceptive counseling and method provision is the ideal period of high contraceptive demand and most effective way to reduce future unintended and repeat unplanned abortions and also it has long-term benefit [7, 21, 28, 30]. The most significant finding in this study is that large proportion of women (88.9%) received post abortion contraceptive. This finding was higher than the study done in Viet Nam & Mozambique where, out of 84% who intended to use contraception only half (42%) of them were actually using a method at the follow-up visit and 27% of women had received a contraceptive method, respectively [11, 20]. Likewise, the finding is higher than study done in Ethiopia, Addis Ababa, SNNPR on quality of post abortion care and status of safe abortion care and level of satisfaction where 44.7%, 2.7%, and 62% of clients received contraceptive, respectively [13, 14, 15]. Also the finding shows that higher than

the recommended level of post abortion contraception uptake which is 60% [30]. This could be explained by wide range of different types of contraceptive options were accessed to clients by the current study institutions. Even though there was an adequate educational material displayed on the table in most of the study institutions during observation, only 24.2% of clients were provided the educational materials. The figure was better than study done in Addis Ababa [14]. Since these educational materials are as equally essential as other component of abortion care as source of information for clients and their families refresher training need be to in place to improve beyond the current achievement.

Time elapsed until treatment is provide for abortion care emergencies & the length of clients stay in the health-care facility an important indicators of quality & delivery of efficient service for grater clients satisfaction of abortion care [21, 22]. The average amount of time that the clients spent in the facility in this study was 3.2hour, but this is longer than the time required health facility to treat post abortion patient which is within 2 hours of arrival at health facility [21]. This is owing to the nature of the procedure is safe which takes long time relatively. Forty-five percent of the service users said that the waiting time was reasonable and 34% of clients said it was long. Seventy-three percent of the service users said that the cost of the service was reasonable and satisfied with the service. Pain management was given for 74.9% of clients. This finding was higher than study done in Amhara and Oromia region 68.2% and almost the same as finding of study done in Addis Ababa quality of post abortion care 74.8% were given anti-pain treatment [13, 14]. Medication for pain during abortion procedure is recommended for all clients

who want to receive the service & it is also one of the important components of service improvement & users satisfaction [7, 13, 14].

Follow-up appointment was given for 90% of clients, out of which 21.1% and 69% of clients were given appointment within 7-10 days and after 10 days of after the completion of procedure, respectively. The finding was higher than the finding of study done in Addis Ababa and SNNPR quality of post abortion care and status of safe abortion care and level of satisfaction was 12.1% and 82.3%, respectively [14, 15]. This could be the fact that all post-abortion clients needed follow up visit. Nevertheless, its indispensability to monitor the possible complication the recommended days (7-10days) of follow-up appointment was not practiced well in these study institutions [7]. Nearly 87% of clients were satisfied with the confidentiality kept during abortion services. The finding is consistent with study done to assess the quality of post abortion care in Ethiopia [13].

The majority (92.7) of clients have expressed their overall satisfaction with services they have been offered. This finding was almost same as the study conducted in Addis Ababa which is 92.3% in public health facility [14]. Even if the overall satisfaction of this study was high enough, clients provided general comment about the need to improve service provision.

By taking overall clients satisfaction on safe abortion service as an outcome variable, logistic regression was performed and as a result those clients who were given medication for pain, follow-up appointment and adequate counseling more satisfied with the service they were provided. This is the fact that all safe abortion service users need to

provide such service. Significant proportions of health providers were attended refresher training in one or more reproductive health matters including abortion. Clinical training without attention to provider attitudes may undermine the quality of services and their ultimate utility and values clarification exercises alone may not eliminate all provider stigma [7, 13, 14]. Despite their small number 4(9.3%) of providers agreed that safe abortion clients denied the service, 5(11.6%) of providers believed that safe abortion clients are not provided equal consideration and five (11.6%) of providers were not happy to deal with safe abortion clients. Forty-eight percent of the providers introduced their name to the clients before the procedure and nine (21.4%) of providers explained the steps during the procedure. Only 3(7.1%), 3 (7.1%), and 52.4% of clients checked their vital sign, pallor, and did abdominal and vaginal examinations, respectively. This finding is slightly better than the study done to assess quality of post abortion care in Ethiopia [13]. The fact that every post abortion clients needs to check their status before discharge to prevent complication [7, 13, 14]. Tetanus toxoid vaccination was not raised in all institutions uniformly. This shows that periodic refresher training & follow-up supervision need to be in place. Practicing of universal precaution with regard to infection prevention and instrument reuse were uniformly undergone in all institutions. In all the institutions there were adequate equipments and supplies except Rh factor testing reagent which was not found in all of the institutions.

## **7. Strength and Limitations of the study**

### **Strength**

- It could be considered as providing useful baseline information
- Quality of data was maintained by training and pretest
- The study tried to use multiple research method of approach of quality of care

### **Limitations**

- ✓ Observer bias there.

## **8. Conclusions and Recommendations**

### **Conclusions**

- Most of the study participants seem younger age groups.
- Providers and clients interaction by and large satisfactory. The majority of service users were went to their home with their choice of contraceptive, but there were some women who were volunteer to take the methods and return back to their home without contraceptive. Medication for pain, follow-up appointment, and adequate time counseling statistically significant associated with the overall service satisfaction of clients. Also linkage of clients to other reproductive health services like voluntary counseling, Rh counseling and screening, and tetanus toxoid immunization was not practice almost all the institutions but few.
- The majority of health care providers attained refresher training, but Lack of support, aggressive behavior of some health providers contributes drop-down effect on the overall satisfaction of the service users on the general comment of clients. Also there

are some providers who didn't agree to deal with safe abortion clients, and equal service consideration.

- Almost all institutions have basic and appropriate medical equipment and supplies required for providing optimal safe abortion services.

### **Recommendations**

- ✚ Those institutions need to focus miss opportunity on family planning counseling and to send with the methods. Anti-pain management, appropriate counseling and provision of follow-up appointment to all clients need to be strengthening.
- ✚ The institution need to focus to link clients to other reproductive services especially Rh screening and counseling, tetanus toxoid immunizations for all eligible women and Voluntary counseling and Testing (VCT).
- ✚ Periodic refreshing training and follow-up of the service provides need to in place.
- ✚ Addis Ababa health bureau need to strengthening follow-up supervision whether those institutions enact their activities consistently according to the technical and procedural guideline for safe abortion services.

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**ANNEX I. Exit interview information sheet and Consent form for 18-49 years old women received safe abortion care (English Version)**

Addis Ababa University, Medical Faculty, School of public health

**Section I. Information sheet**

1. Name of the study area (kifle-ketema) \_\_\_\_\_

2. Questionnaire identification no. \_\_\_\_\_

**INTRODUCTION:** Good morning/afternoon? My name is \_\_\_\_\_. I am a graduate student at Addis Ababa University, faculty of medicine, schools of public health. I would have a short discussion with you for about 30-35 minutes only and I am asking you to help us. Before we go to our discussion, I will request you to listen carefully to what I am going to read to you about the purpose and general condition of the study and you will tell me whether you agree or disagree to participate in this study at the end.

The purpose of this study is to assess quality of safe abortion service care in private for non-profit institution in Addis Ababa. The study will be conducted through interviews. The information that you will give us could help to expand quality safe abortion service in the region as well as in the country. The interview involves private life questions. I would like to assure you that privacy will be maintained strictly throughout. A code number will identify every participant and no name will be used. Your responses to any of the questions will not be given to anyone else and no reports of the study will ever identify you. If a report of results is published, only information about the total group will appear.

The interview is voluntary and your participation / non-participation, or refusal to respond or stop responding to the questions will have no effect now or in the future on services that you or any member of your family may receive from the service providers.

Are you willing to participate in this study?

1.  Yes. 2.  No

Thank you!!

**NB:** 1. If the study subjects agree to participate in the study, go to consent form

2. No need of enforcing the clients to be included in the study

3. Please register the age of study subjects who refuse to participate in the study

## Section II. Consent form for 18-49 years old women (English Version)

I the undersigned have been informed about the purpose of this particular research project. I have been informed that I am going to respond to this question by answering what I know concerning the issue. I have been informed that the information I give will be used only for the purpose of this study and my identity as well as the information I give will be treated confidentially. I have also been informed that I can refuse to participate in the study or not to respond to questions if I am not interested. Furthermore I have been informed that I can stop responding to the questions at any time in the process. Based on the above information I agree to participate in this research voluntarily.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

- NB:** 1. If the study subject is voluntary to participate in the study, start the interview.  
2. Interviewer signature certifying that informed consent has been given verbal

by the respondent.

Name : \_\_\_\_\_

Signature: \_\_\_\_\_

Date : \_\_\_\_\_

Tel. : \_\_\_\_\_

3. If there are things that require clarification please don't hesitate to ask the interviewer or the principal investigator for clarification. Address of the principal investigator:

Teshome Mulugeta

Addis Ababa University, Faculty of Medicine, School of public health

P.o.box: 9086, Cell Phone: 0911- 80 -80 -47, Addis Ababa

## **Annex II. Voluntary information sheet and assent form for female children**

### **With age group of 15-17 years old (English Version)**

#### **Section I. Voluntary information sheet for female children with age group of 15-17 years old.**

01. Name of the study area (Kifle-ketema) \_\_\_\_\_

02. Questionnaire identification no \_\_\_\_\_

**INTRODUCTION:** Good morning/afternoon? My name is \_\_\_\_\_. I am a graduate student in practice of public health at Addis Ababa University, faculty of medicine schools of public health. I would have a short discussion with you for about 30-35 minutes and I am asking you to help us. Before we go to our discussion, I will request you to listen carefully to what I am going to read to you about the purpose and general condition of the study and you will tell me whether you agree or disagree to participate in this study at the end.

The purpose of this study is to assess quality of safe abortion service care in Addis Ababa. The study will be conducted through interviews. The interview involves private life questions. There will not be any risk that will occur throughout your participation. Similarly there will not be any benefit that you will get; but the information that you will give us could help to expand safe abortion service care in the region as well as in the country. I would like to assure you that privacy will be maintained strictly throughout. A code number will identify every participant and no name will be used. Your responses to any of the questions will not be given to anyone else and no reports of the study will ever identify you. If a report of results is published, only information about the total group will appear.

The interview is voluntary and your participation / non-participation, or refusal to respond or stop responding to the questions will have no effect now or in the future on services that you or any member of your family may receive from the service providers.

Are you voluntary to participate in this study?

1.  Yes.

2.  No

Thank you!!

**NB:** 1. If the study subject is voluntary to participate in the study, go to assent form.

2. No need of enforcing the clients to be included in the study.
3. Please register the age of study subjects who refuse to participate in the study.

**Section II. Assent form for female children with age group of 15-17 years old**

**(English Version)**

I the undersigned have been informed about the purpose of this particular research project.

I have been informed that I am going to respond to this question by answering what I know concerning the issue. I have been informed that the risk and benefit that will occur during my participation. I have been informed that the information I give will be used only for the purpose of this study; my identity and the information I give will be treated confidentially. I have also been informed that I can refuse to participate in the study or not to respond to questions if I am not interested. Furthermore I have been informed that I can stop responding to the questions at any time in the process. Based on the above information I agree to participate in this research voluntarily.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**NB:** 1. If the study subject is voluntary to participate in the study, start the interview.

2. Interviewer signature certifying that informed consent has been given verbally  
by the respondent.

Name : \_\_\_\_\_

Signature: \_\_\_\_\_

Date : \_\_\_\_\_

3. If there are things that require clarification please don't hesitate to ask the interviewer or the principal investigator for clarification.

**Address of the principal investigator:**

Teshome Mulugeta

Addis Ababa University

Faculty of Medicine

School of public health

P.o.box: 9086

Cell Phone: 0911- 80 -80- 47

Addis Ababa

**Section I. Socio- Demographic characteristics**

Sr. no	Question/variables	Response	Skip
101	Age in years	.....	
102	What is your current marital status	1. Never Married 2. Currently Married 3. Divorced 4. Widowed 5. Separated 6. Cohabiting.	
103	What is your current religion?	1. Orthodox 2. Muslim 3. Catholic 4. Protestant 88. Others (specify) ____	
104	What is your occupation?	1. Student 2. House wife 3. Government employee 4. Merchant 5. Employed in private sector. 6. Have Private business 7. Commercial sex worker 8. House maid 88. Others (specify)____	
105	What is your current ethnic group?	1. Oromo 2. Amhara 3. Gurage 4. Tigre 88. Other_____	
106	What is your education level?	Illiterate Read and write Primary Secondary 12+	

**Section II. Concerning reproductive history**

201	How many times have you been pregnant?	1. _____ 99. No response	
202	What was your age at first pregnancy?	_____	
203	The total number of live births	1. _____ 2. None	
204	Have you had miscarriage before?	1. Yes 2. No	If <2> the to Q206
205	If <yes> to <Q204> for how many times?	_____	
206	Was this current pregnancy wanted?	1. Yes 2. No	If "No", Q208
207	If „yes“ to „Q206“, Why did you decide to terminate this pregnancy?	1. Financial reason 2. Health reason 3. partner pressure 4. Too many/too close pregnancies 5. Being students and to complete my education 6. out of wedlock 88. Other _____	
208	If "No" to question "Q206", what is the reason for being unwanted?	1. Caused by rape 2. Caused by incest 3. Non use of contraceptive 4. Caused by contraceptive failure 5. Low risk perception 6. Inappropriate use of contraceptive 88. Others (specify) _____	
209	Do you desire a future pregnancy?	1. No- never 2. Yes- immediately (within 3 months) 3. Yes- within two years 4. Yes- more than two years	

		88. Other (other) _____ 99. don't know	
210	If you are involved in sexual intercourse again, how soon do you think you become pregnant again?	1. Two weeks 2. One month 3. Three months 4. Six months 88. Other _____ 99. Don't know	
211	What methods do you know to prevent unwanted or unplanned pregnancy? (don't read methods but probe for answers) <b>(Multiple response possible)</b>	1. Condom (Male or Female) 2. Oral Contraceptives 3. Injectable (Depo-Provera, Net pelle 4. Implant (Norplant) 5. IUD 6. Female Sterilization 7. Male Sterilization 88. Other (specify) _____	
212	Have you ever used contraceptive?	1. Yes 2. No	If "No" Q214
213	If yes, to question „Q18“ which method did you use? <b>(more than one response is possible)</b>	1. Traditional (specify) _____ 2. Injectable (Depo-Provera) 3. Pills 4. Condom 88. Others (specify) _____	
214	If you were not using a contraceptive method when you got pregnant this time, why not? <b>(Choose all that apply)</b>	1. Current pregnancy was planned 2. Not planning to have sex 3. Contraceptives not available 4. Cost of contraceptives(s) 5. Partner opposed 6. Concerns about contraceptive (s effects, health risks, etc.) 7. Religious of moral reasons 88. Other(specify) _____	

**Section III: Clients exit interview on quality of safe abortion care satisfaction of the service**

Sr.No	Questions	Response	Skip
	Provider-clients interactions		
Q301	Were you treated politely and respectfully by the provider during your stay in this health center/clinic?	1. Yes 2. No 99. Don't know	
Q302	How long did you wait during counseling?	.....minutes	
Q302	How was the length of counseling time?	1. Good 2.Short 3. Long 99. Don't know	
Q304	Was there good privacy during counseling?	1. Yes 2. No 99. Don't know	
Q05	Did you ask any question about abortion, family planning or other health issues to the provider?	1. Yes 2. No	If 2-Q307
Q306	If „Yes“ to „Q310“, did you get satisfactory answer?	1. Yes 2. No	
	Information provision & counseling		
Q307	How did you hear about this facility (Multiple response possible)	1. Radio 2. Television 3. Friends 4. Service users 5. Health professional 88. other(specify)	
Q308	Did the provider tell you danger signs/ that may necessitate revisiting the health facility?	1. Yes 2. No 99. Don't know	If 2, 99-Q310
Q309	If „yes“ to „Q321“, what are these signs/symptoms? (Multiple answers possible)	1. Massive or prolonged bleed 2. Abdominal pain 3. Fever 4. Abnormal discharge 5. Delay (6 weeks or more) in resuming menstrual periods 88. Other (specify)	
Q310	During this visit, were you given or did you take any brochure or educational material to bring home?	1. Yes 2. No 99. Don't know	If 2, 99-Q312
Q311	If „yes“ to „Q323“ what was the subject(s) of the material? (Multiple answers Possible)	1. HIV/AIDS 2. Other STD 3. Abortion 88. Other(specify)	
Q312	During this visit, did the provider conduct any health examinations or procedures?	1. Yes 2. No 99. Don't know	If 2, 99-Q316
Q313	If „yes“ to „Q316“, did the provider explain the examinations before they were performed?	1. Yes 2. No	
Q314	Did the provider explain the results of the health examination procedures?	1. Yes 2. No	
Q315	Did the provider provided opportunity to ask questions about the abortion procedure?	1. Yes 2.No	
Q316	Did the provider order RH factor test?	1. Yes 2. No	
	Post-abortion contraception		
Q317	Did you volunteer to take family planning method this visit?	1. Yes 2.No	
Q318	If „yes“ Q329, what methods she wanted?	1. Depo-Provera 2.pills 3.nor-plant 4.IUD 88. other(specify)	

Q319	Did you get contraceptive method that you intended during this visit?	1. Yes 2. No	If 2 skip „Q321“
Q320	If „yes“ to „Q331“, Which method(s) did you accept today?	1.Oral Contraceptives 2. Injectable, 3. Implant 4.Condom, 88.other(specify)	
Q321	If „no“ to „Q331“, what is the main reason you did not obtain contraceptive method today?	1. No one raised the issue 2. Change my mind 3.Told to go to other health institutions 4. Other health reason 5. Method not available 88. Other (specify)	
Q322	Did the provider discuss the benefit of each method?	1.Yes 2.No	
Q323	Did the provider discuss the possible side-effect of each method?	1.Yes 2.No	
	Access to service		
Q324	How long did you wait till you get the service?	.....minutes	
Q325	How do you feel about the waiting time?	1.Reasonable 2.Too short 3.Too long 99.don't know	
Q326	Is the waiting place has adequate latrine?	1.Yes 2.No	
Q327	Do you believe that the information you shared with the provider will be kept confidential?	1.Yes 2.No 99.Don't know	
Q328	Were you offered any pain medication during the procedure?	1. Yes 2. No	
Q329	How is the cost?	1.Reasonable 2.Expensive 3. Cheap 99. Don't know	
Q330	Is the waiting place comfortable for you?	1. Yes 2. No	
Q331	Is the working time comfortable for you?	1. Yes 2. No	
Q332	Is the waiting place has adequate water supply?	1. Yes 2. No	
Q333	Did any service provider tell you when to come back for follow-up visit?	1. Yes 2. No	
Q334	If „yes“ to „Q327“, when did you appointed?	1.7-10 days 2. After 10days 99. Don't know	
Q335	Overall, do you satisfy with your visit?	1. Yes 2. No	
Q336	If you suggest one improvement to the services provided, what would it be?	_____	

**Annex III: Observation guide for safe abortion care in private for non-profit institutions in Addis Ababa, August 2009**

Health institutions

Questionnaire number \_\_\_\_\_

Patient code no. \_\_\_\_\_ (Same code with exit interview)

Date \_\_\_\_\_

Day\_ 1. Monday, 2. Tuesday, 3. Wednesday, 4. Thursday, 5. Friday, 6. Saturday,  
7. Sunday

Time observation began \_\_\_\_\_

**INSTRUCTIONS FOR CONDUCTING OBSERVATIONS:**

- ✓ You should get verbal consent from both the client and the provider before observing their interaction. Those clients unable to give verbal consent should not be included in the study.
- ✓ Try to minimize disruptions during the treatment of the patient.
- ✓ Explain to providers that the purpose of the observation is not to assess their personal performance, nor will information gathered through the observation be provided to their superiors to be used in a performance appraisal. The purpose of the study is for the observer to get a sense of how safe abortion services are provided overall at the health care institution.
- ✓ Always dress white coat.
- ✓ Before the session begins, find a place to sit or stand so that the patient-provider interaction can be seen clearly.
- ✓ During the session, you should remain quiet and still so as not to disrupt the patient and provider. Writing on the forms should be done as discreetly as possible.
- ✓ Allow the patients and providers to refuse to be observed at any time, or to discontinue the observation completely.
- ✓ Do not discuss your observations with anyone other than the study staff.

PRE-PROCEDURE

**Section I: interaction between patient and provider**

Sr. No	Questions	Response	Skip
1	Who examined the client	1.Obstetrician/Gynecologist (OB/GYN) 2. General Physician 3. Nurse or Nurse Midwife 4. Nursing assistant 5. Midwife(trained. untrained) 88.Other ( specify) ____	
2	Did the provider greet the patient in a friendly/ polite manner?	1. Yes          2. No	
3	Did the provider offer client a seat?	1.Yes          2.No	
4	Did the examiner introduce him or herself to the client by name?	1.Yes          2.No	
5	Confirm privacy and dignity?	1.Yes          2.No	
6	Assure confidentiality?	1.Yes          2.No	
7	Asked about last menstrual period?	1.Yes          2.No	
8	Attending the counseling session attentively?	1.Yes          2.No	
9	Support during counseling?	1.Yes          2.No	
10	Urine sample for pregnancy test?	1.Yes          2.No	
11	Order blood group and RH factors test?	1. Yes          2. No	
12	If pelvic exam was performed did the provider inform the patient what would happen before the exam?	1.Yes          2.No	
13	Did the client have the opportunity to ask questions before or after diagnostic examinations were completed?	1. Yes 2. No	
14	Did the provider respond to her questions?	1. Yes          2. No	
15	Provided opportunity to ask questions about the abortion procedure	1. Yes          2.No	
16	Provide emotional support during examination?	1. Yes          2. No	
<b>Section II. Information provision</b>			
17	Did the provider ask about STI/HIV?	1.Yes          2.No	
18	Did the provider ask any previous method use?	1.Yes          2.No	
19	Did the provider discussed the woman risk of pregnancy if not using contraception	1.Yes          2.No	
20	Did the provider offer the available method of contraception?	1.Yes          2.No	
21	(If yes) which method?	1. Condom	

		2. Oral Contraceptives 3. Injectable 4. IUD 88. Other(specify)_____	
22	For a new method proposed, did the provider talk about any of these issues?	1. How to use method 2. Advantages 3. Disadvantages 4. Medial side effects 88. Other(Specify)_____	
23	Which IEC materials, if any, were used during the consultation?	1. Flipchart 2. Brochure/pamphlets 3. Contraceptive samples 4. Posters 88. Other: _____ 99. None	
	<b>Procedure</b>		
24	Primary staff member who performed	1. Obstetrician/Gynecologists (OB/GYN) 2. General Physician 3. Nurse or Nurse Midwife 4. Nursing assistant 5. Midwife(trained, untrained) 88. Other (please specify)---	
	<b>Section I: interaction and information provision</b>		
25	Assistant present?	1. Yes 2.No	
26	Did the provider explain the steps about the procedure?	1. Yes 2.No	
27	Did the provider give verbal support to client?	1. Yes 2.No	
28	Did the provider measure uterine size and position with uterine sound before the procedure?	1. Yes 2.No	
29	Did the provider give anti-pain before the procedure?	1. Yes 2.No	
30	Did the provider check the aspirator for negative pressure before the procedure?	1. Yes 2.No	
31	Did the provider respect for privacy of the client?	1. Yes 2.No	
32	Did the provider mention danger signs that may necessitate revisiting the facility?	1. Yes 2.No	
33	Did the provider mention when to revisit the facility?	1. Yes 2.No	
34	Was the patient asked if she was in pain?	1. Yes 2.No	

35	Did the provider check for sign of completion?	1.Yes 2.No	
36	Did the provider check for tissue?	1.Yes 2.No	
37	Did the patient have the opportunity to ask questions before or after procedures were completed?	1.Yes 2.No	
38	Did the provider assist the client to the recovery room after the completion of the procedure?	1.Yes 2.No	
	<b>Infection prevention</b>		
39	Did the provider follow no-touch technique?	1.Yes 2.No	
40	Did the provider wear : (circle the available one)	1.eye goggle 2.boots	
41	Did the provider clean the vagina and cervix before the procedure with swaps?	1.Yes 2.No	
	<b>Instrument reuse</b>		
42	Did the provider soak used instrument in decontamination solution?	1.Yes 2.No	
43	Did the provider draw the decontamination solution via the cannulae?	1.Yes 2.No	
44	Did the provider dispose medical waste properly?	1.Yes 2.No	

### Section III. Post-procedure

45	Did the client rest in the recovery room?	1. Yes 2. No	
46	Did the provider monitor vital sign?	1.Yes 2.No	
47	Did the the provider look for pallor?	1.Yes 2.No	
48	Did the provider performed abdominal examination and vaginal bleeding?	1.Yes 2.No	
49	Was the provider offered information on post-abortion infection and prevention?	1.Yes 2.No	
50	Was the provider foster counseling on sexually transmitted infection?	1.Yes 2.No	
51	Was the provider offer counseling on voluntary counseling and testing?	1.Yes 2.No	
52	Was the provider give information about other related issue?	1.Yes 2.No	
53	Did the provider administer tetanus toxoid for all eligible women before the client discharge?	1.Yes 2.No	
	<b>Post-abortion family planning</b>		
54	Did the provider offer post-abortion family planning	1.Yes 2.No	

	counseling?		
55	Did the woman express her desire for family planning method?	1.Yes 2.No	
56	If yes Q11, what methods she wanted?	1. Depo-Provera. 2. pills 3. nor –plant 4. IUD 88. other(specify)-----	
57	Did the provider offer for the woman choice of contraceptive methods?	1.Yes 2.No	
58	Did the provider discuss the availability benefits and risk of contraceptive methods?	1.Yes 2.No	
59	Did the provider foster the intended contraceptive method for the woman?	1.Yes 2.No	If 2 Q61
60	If yes Q59, what type of contraceptive method does the woman received?	1. Pills 2. Depo-Provera 3. nor- plant 4. IUD 88. other(specify)-----	
61	Why the woman didn't receive the intended contraceptive method?	1. Medical contraindication to alternative method 2.client wanted alternative method at later date 88. Other (specify)_____	
62	Did the woman referred for non-available methods?	1.Yes 2.No	
63	Did the client give an opportunity to ask question about contraceptive methods?	1.Yes 2.No	
64	Did the provider ask the client question if she had any concern?	1.Yes 2.No	
65	Did the provider give counseling for women of Rh negative?	1.Yes 2.No	
66	Did the client given follow-up appointment within seven to ten days?	1.Yes 2.No	

## **ANNEX IV: Questionnaire for service providers interview**

Addis Ababa University, Medical Faculty, School of Public Health

Hello dear colleague!

We are going to carry out a survey in health facilities that provide safe abortion services to find ways of improving the services. The purpose of this study is to assess quality of safe abortion service care in private for non- profit institutions in Addis Ababa. The information from the survey will be used to provide important comments to improve the quality of service in your and other private for non-profit institutions. Therefore, your genuine response for the questions will help to improve the quality of service in safe abortion care. We will be interested to know about your experiences, capacitated with special training, and your opinion towards in providing safe abortion care. Please be assured that, the information you provide will be strictly confidential, and your name will not being recorded. Also, you are not obliged to answer any question you don't want to answer, and you may leave filling the questionnaire.

Do you want to participate?                      Yes                            No     

Signature\_\_\_\_\_

Date\_\_\_\_\_

Thank you!!

1. How old are you?
  1. \_\_\_\_\_ Years
2. Sex
  1. Male                      2. Female
3. What is your current marital stat?
  1. Never married   2. Married   3. Cohabiting   4. Divorced   5. Separated   6. Widowed
4. What is your religion?
  1. Orthodox      2. Muslim      3. Protestant      4. Catholic
  88. Other \_\_\_\_\_ 99. No response
5. What is your qualification?
  1. Obstetrician/Gynecologist (OB/GYN)   2. General Physician      3. Medical Intern
  4. Nurse    5. Nurse midwife    88. Other (please specify) \_\_\_\_\_
6. How long have you been working here at this department?
  1. \_\_\_\_\_ Years (round to nearest year)
  2. < 6 months
  88. Don't know
  99. No response
7. How many years ago did you complete your basic training?
  1. \_\_\_\_\_ Years (round to nearest year)
  2. < 6 months
  3. Currently on basic training
  88. Don't know
  99. No response
8. Did your basic training cover (Circle all that apply)?
  1. ANC
  2. Safe abortion care; post abortion care
  3. Maternity care/delivery service
  4. Postnatal care
  5. HIV/AIDS counseling/IEC
  6. Other STD counseling /IEC
  7. Other STD diagnosis
  8. Other STD treatment
  9. Family planning
  10. MVA/EVA procedures (manual/electrical vacuum aspiration)
  88. Other \_\_\_\_\_
9. Have you attended any refresher or post-basic training course specifically on safe abortion, family planning & other reproductive health matters?
  1. Yes
  2. No
  99. No response
10. If „yes“ to Q9, did that training include? (Circle all that apply)
  1. General clinical skills in Family Planning
  2. Family Planning counseling
  3. STD risk assessment/ screening
  4. STD counseling

- 5. MVA/EVA procedures (manual/electrical vacuum aspiration)
  - 6. Safe/Post- abortion care
  - 7. ANC
  - 8. Postnatal care
  - 88. Other (specify) \_\_\_\_\_
  - 99. No response
11. In the last 3 months, have you yourself actually provided family planning to clients?
- 1. Yes
  - 2. No
  - 99. Don't know
12. If „yes“ to Q11, which methods have you yourself actually provided in the last 3 months? **(Circle all that apply)**
- 1. Condom (Male or Female)
  - 2. Spermicide (Foam, Tablet, Gel, Jelly, Film)
  - 3. Diaphragm or Cervical Cap
  - 4. Oral Contraceptives (Combined Oral Contraceptive, Progestin-only Pill)
  - 5. Injectable (Depo-Provera, Net-pellets)
  - 6. Implant (Norplant)
  - 7. IUD
  - 8. Female Sterilization
  - 9. Male Sterilization
  - 10. Lactational amenorrhea
  - 11. Periodic Abstinence (Rhythm/Calendar, Basal Body Temperature)
  - 12. Withdrawal
  - 99. No responses
12. In your opinion women with safe abortion should be denied services?
- 1. Yes
  - 2. No
  - 88. Don't know
  - 99. No response
13. In your opinion women with safe abortion do not provide equal attention?
- 1. Yes
  - 2. No
  - 88. No comment
14. In your opinion, are you comfortable to confront with safe abortion clients?
- 1. Yes
  - 2. No
  - 88. No response
15. In your opinion, do you think married women, unmarried and adolescent girls should be treated equally?
- 1. Yes
  - 2. No
  - 88. No

**ANNEX V. Essential equipment and supplies for safe abortion care in private for  
non- profit institutions in, Addis Ababa, August 2009**

Code of the health institution \_\_\_\_\_

I. Category of the health institution

1. Private Health Center
2. Higher Clinic
3. Medium Clinic

1. Health institution staff by category:

Category	Male	Female	Total
1.Technical			
Obstetric /Gynecologic Specialist			
General Practitioner			
Other Specialist			
Health Officer			
Midwifery Nurse			
General Nurse			
Junior Nurse			
Health Assistant			
Lab. Technician			
Pharmacist			
Other			
2.Administrative			
Cleaners			
Guard			
Other			
Total			

## 2. Equipment and supplies checklist

<b>1.Facilities</b>	1.available 2.Not available
Toilet for clients	
Running water	
Visual privacy	
IEC materials displayed adequately	
Adequate waiting space	
Drinking water available	
<b>2.Basic supplies</b>	
Intravenous fluid	
Syringes and needles	
Sterile gloves of different sizes	
Cotton balls or gauze sponges	
Antiseptics solutions	
Antibiotics	
Pain medications	
Long needle holders	
Sterilizer	
<b>3.Instrument and equipment for first-trimester uterine evacuation:</b>	
a. Basic uterine evacuation	
Sponge forceps	
Uterine sound	
Pratt or Denniston dilators :sizes 13-27 French	
Medium self-retaining speculum	
500ml container for antiseptics	
Container for cleansing solution	

Clear glass dish for tissue inspection	
Single tooth tenaculum forceps	
b. Vacuum aspiration with electric pump	
Basic uterine evacuation supplies	
Vacuum pump with extra glass bottles	
Connecting tubing	
Cannulae (any of the following)	
.Flexible:4,5,6,7,8,9,10,12mm	
.Curved rigid: 7,8,9,10,12,14mm	
. Straight rigid:7,8,9,10,12mm	
c. Manual vacuum aspiration	
Basic uterine evacuation supplies	
Vacuum aspirators	
Adapters	
Flexible or semi-rigid cannulae, size 4-12mm	
d. Twelve –weeks plus	
Basic uterine evacuation supplies	
Pratt or Denniston dilators: sizes 29-43	
<b>4. Laboratory</b>	
Pregnancy test kit	
Blood group	
RH factor	
Hematocrit/Hemoglobin	



2. እባክዎን በጥናቱ ለመሳተፍ ፈቃደኛ ያልሆኑትን ተሳታፊ ዕድሜ ይመዝገቡ።

**ክፍል 2- እድሜያቸው ከ18-49 ለሆኑ ሴቶች የፈቃደኝነት መጠየቂያ ቅጽ።**

ከዚህ በታች ፊርማዬን ያኖርኩት እኔ የጥናቱ አላማ የተነገረኝ ሲሆን ለምጠይቀው ጥያቄ የማውቀውን መመለስ እንደምችል፤ እኔ የምሠጠው መረጃ ለዚህ ጥናት አገልግሎት ብቻ የሚውል ሲሆን ስሜንና የምሠጠው መረጃ በሚስጥር እንደሚጠበቅ ተነግሮኛል። ፍላጎት ከሌለኝ በጥናቱ ያለመሳተፍ፤ ጥያቄ ያለመመለስና በጥያቄው ወቅት ምላሹ መስጠት ማቋረጥ እንደሚቻል ተነግሮኛል- በዚህ መሰረት በጥናቱ በመሳተፍ ፈቃደኛ መሆኔን በፊርማዬ አረጋግጣለሁ።

ፊርማ ----- ቀን -----

**ማስታወሻ**

1. የጥናቱ ተሳታፊ በጥናቱ ለመሳተፍ ፈቃደኛ ከሆኑ መጠይቁን ይጀምሩ
2. የፈቃደኝነት መግለጫ የመልስ ሰጪው በቃል መስጠቱን የሚያረጋግጥ የመረጃ ሰብሳቢው

ስም ----- ፊርማ -----  
 ቀን ----- ስልክ -----

ማንኛውም ገለፃ የሚያስፈልጋቸው ነገሮች ካሉ መረጃ ሰብሳቢውን ሆነ ዋና ተመራማሪውን በአካልም ሆነ በአድራሻ ይጠይቁ።

**የዋናው ተመራማሪ አድራሻ : ተሾመ ሙሉጌታ**

አዲስ አበባ ዩንቨርሲቲ

በህክምና ፋኩሊቲ

የብረተሰብ ጤና ትምህርት ቤት

ፖ.ሳ.ቁ፣ 9086

ስልክ፣ 0911-80-80-47

አዲስ አበባ

**Annex Vii. እድሜያቸው ከ18 ዓመት በታች ለሆኑ ሴቶች የመረጃ መስጫ የበጎ ፈቃደኝነት ማረጋገጫ ቅፅ I አዲስ አበባ ዩንቨርሲቲ ህክምና ፋካሊቲ የህብረተሰብ ጤና ት/ቤት።**

**ክፍል 1 - የመረጃ መስጫ ቅፅ**

1. ጥናቱ የሚካሄድበት አካባቢ ስም (ክፍለ ከተማ) -----

2. የመጠይቁ መለያ ቁጥር -----

መግቢያ፡ እንደምን አደሩ/ዋሉ ? ስሜ ----- ይባላል። እኔ በአዲስ አበባ ዩንቨርሲቲ የድህረምረቃ ተማሪ ስሆን በህክምና ፋካሊቲ በህብረተሰብ ጤና ት/ቤት አስተባባሪነት በሚከናወነው ጥናት በእኔና በዕርሶ አጠር ያለና ከ30-35 ደቂቃ የሚወስድ ውይይት ይኖረናል።

ለዚህም ውይይት እንዲተባበሩኝ በትህትና እጠይቃሁ። ወደ ውይይቱ ከመግባታችን በፊ ስለጥናቱ አላማና ጠቅላላ ሁኔታ ስለማነብልዎት በጥምና እንዲያዳምጡኝ እጠይቃለሁ። በመቸረሻም በጥናቱ ስለመሳተፍ መስማማትዎን ወይም አለመስማማትዎን ይነግሩኛል። የዚህ ጥናት አላማ በአዲስ አበባ ደረጃውን (ንጽህናውን) የጠበቀ የውርጃ አገልግሎት አጠቃቀም ሁኔታ ምን እንደሚመስል ለማወቅ ሲሆን ጥናቱ የሚካሄዱበት መንገድ በመረጃ ሰብሳቢው በሚቀርብ መጠይቅ ይሆናል። መጠይቁ የራስዎን ሁኔታ በተመለከተ ይሆናል።

እርሶዎ የሚሠጡት መረጃ ንጽህናው (ደረጃውን) የጠበቀ ህጋዊ የውርጃ አገልግሎት በአዲስ አበባና በሀገር አቀፍ ደረጃ ለማስፋፋት ይረዳሉ። በቆይታዎ ሁሉ ሚስጥር እንደሚጠበቅ እያረጋገጥኩኝ ለእያንዳንዱ ተሳታፊ የተለየ መለያ ቁጥር የሚኖረው ሲሆን ስምም አይጻፍም። ለማንኛውም ጥያቄ የሚሰጡት ምላሽ ለሌላ ሰው ተላልፎ የማይሰጥ ሲሆን የጥናቱ ሪፖርትም ስር እርስዎ አይገልጹም። በተጨማሪ የጥናቱ ሪፖርት ቢታተም የሚወጣው ስለ አጠቃላይ ተሳታፊዎች መረጃ ብቻ ይሆናል። መጠይቁ በፈቃደኝነት ላይ የተመሠረተ ሲሆን የእርስዎ መሳተፍ ወይም አለመሳተፍ እንዲሁም ጥያቄዎችን ለመመለስ ፈቃደኛ አለመሆንና በጥያቄው ወቅት አቋርጦ መውጣት አሁንም ይሁን ወደፊት እርሶም ይሁኑ ቤተሰብዎ በሚያገኙት አገልግሎት ላይ ምንም አይነት ተፅዕኖ አይኖረውም።

በጥናቱ ለመሳተፍ ፈቃደኛ ነዎት ?

2.   2 አይደለሁም አመሠግናለሁ!!!

ማስታወሻ፤

1. የጥናቱ ተሳታፊ በጥናቱ ለመሳተፍ ፈቃደኛ ከሆኑ ወደ ፈቃደኝነት ማረጋገጫ ቅፅ ይለፉ።
2. የአገልግሎት ተጠቃሚዎች በጥናቱ እንዲሳተፉ ማስገደድ አያስፈልግም።
3. እባክዎን በጥናቱ ለመሳተፍ ፈቃደኛ ያልሆኑትን ተሳታፊ ዕድሜ ይመዝግቡ።

**ክፍል 2- እድሜያቸው ከ18 ዓመት በታች ለሆኑ ሴቶች የበጎ ፈቃደኝነት ማረጋገጫ ቅጽ።**

ከዚህ በታች ፊርማዬን ያኖርኩት እኔ የጥናቱ አላማ የተነገረኝ ሲሆን ለምጠይቀው ጥያቄ የማውቀውን መመለስ እንደምችል፤ እኔ የምሠጠው መረጃ ለዚህ ጥናት አገልግሎት ብቻ የሚውል ሲሆን ስሜንና የምሠጠው መረጃ በሚስጥር እንደሚጠበቅ ተነግሮኛል። ፍላጎት ከሌለኝ በጥናቱ ያለመሳተፍ፤ ጥያቄ ያለመመለስና በጥያቄው ወቅት ምላሹ መስጠት ማቋረጥ እንደሚቻል ተነግሮኛል በዚህ መሰረት በጥናቱ በመሳተፍ ፈቃደኛ መሆኔን በፊርማዬ አረጋግጣለሁ።

ፊርማ ----- ቀን -----

ማስታወሻ

1. የጥናቱ ተሳታፊ በጥናቱ ለመሳተፍ ፈቃደኛ ከሆኑ መጠይቁን ይጀምሩ
2. የፈቃደኝነት መግለጫ የመልስ ሰጪው በቃል መስጠቱን የሚያረጋግጥ የመረጃ ሰብሳቢው ስምና ፊርማ

ስም ----- ፊርማ -----  
ቀን ----- ስልክ -----

ማንኛውም ገለፃ የሚያስፈልጋቸው ነገሮች ካሉ መረጃ ሰብሳቢውን ሆነ ዋና ተመራማሪውን በአካልም ሆነ በአድራሻ ይጠይቁ። የዋናው ተመራማሪ አድራሻ፡ ተሾመ ሙሉጌታ

አዲስ አበባ ዩንቨርሲቲ በህክምና ፋኩሊቲ የህብረተሰብ ጤና ትምህርት ቤት

ፖ.ሳ.ቁ ፣ 9086  
ስልክ: 0911 80 80 47

አዲስ አበባ

**Questionnaire for client Exit interview (Amharic Version)**

ክፍል 1: ማህበራዊና ነባራዊ ሁኔታ

ተ.ቁ	ጥያቄ	መልስ	ወደ- ይዝለሉ
101	እድሜዎ (በአመት) ስንት ነው?	----- አመት	
102	የጋብቻ ሁኔታ	<ol style="list-style-type: none"> <li>1. አግባታ የማታውቅ</li> <li>2. በአሁኑ ወቅት ጋብቻ ላይ ያለች</li> <li>3. የፈታች</li> <li>4. ባል የሞተባት</li> <li>5. የተለያየች</li> <li>6. ጋብቻ ሳይፈፀሙ አብረው የሚኖሩ</li> </ol>	
103	በአሁኑ ወቅት ያላቸው ሃይማኖት	<ol style="list-style-type: none"> <li>1. ኦርቶዶክስ</li> <li>2. ሙስሊም</li> <li>3. ካቶሊክ</li> <li>4. ፕሮቴስታንት</li> <li>88. ሌላ(ይጠቀስ)_____</li> </ol>	
104	የስራ ሁኔታ	<ol style="list-style-type: none"> <li>1. ተማሪ</li> <li>2. የቤት እመቤት</li> <li>3. የመንግስት ሰራተኛ</li> <li>4. ችርቻሮ ንግድ</li> <li>5. የግል መስሪያ ቤት ተቀጣሪ</li> <li>6. የግል ስራ</li> <li>7. የወጥ ቤት ሰራተኛ</li> <li>8. የቤት ሰራተኛ</li> <li>88. ሌላ(ይገለፅ)_____</li> </ol>	
105	ብሔር	<ol style="list-style-type: none"> <li>1. ኦሮሞ</li> <li>2. አማራ</li> <li>3. ጉራጌ</li> <li>4. ትግሬ</li> <li>88. ሌላ(ይገለፅ)_____</li> </ol>	
106	የትምህርት ደረጃ	<ol style="list-style-type: none"> <li>1. ያልተማረች</li> <li>2. ማንበብና መጻፍ የምትችል</li> <li>3. 1-8ኛ ክፍል የተማረች</li> <li>4. 9-12 ክፍል የተማረች</li> <li>5. ከ12ኛ ክፍል በላይ የተማረች</li> </ol>	

ከፍል 2. የሰነ ተዋልዶ ሁኔታ በተመለከተ

ተ. ቁ	ጥያቄ	መልስ	
201	እስከ አሁን ለምን ያህል ጊዜ አርገዘዋል?	-----	
202	በመጀመሪያ እርግዝናዎ ወቅት እድሜዎ ስንት ነበር?	.....	
203	በህይወት የተወለዱ ልጆች ብዛት	_____	
204	ከአሁን በፊት ውርጃ ነበረዎት?	1. አዎ 2. የለም	2- 206 ይዘለሉ
205	ለጥያቄ ቁጥር 204 አዎ ካሉ ስንት ግዜ?	1. _____ 99. መልስ የለም	
206	የተረገዘው ልጅ የተፈለገ ነው?	1. አዎ 2. የለም	2- 208 ይዘለሉ
207	ለጥያቄ “206”አዎ ካሉ, ለማስወረድ የወሰኑበት ምክንያት ምንድን ነው?	1. የገንዘብ ችግር ስላለብኝ 2. በጤና ችግር 3. የጓደኛ ግፊት 4. በጣም ብዙ ልጆች ስላሉኝ 5. ተማሪ ስለሆንኩና ትምህርቴን ለመጨረስ 6. ከጋብቻ ውጪ ስለሆነ 88. ሌላ (ይገለጹ) _____	
208	ለጥያቄ“206”የለም የሚሉ ከሆነ ያልተፈለገበት ምክንያት ምንድን ነው?	1.ተደፍራ ነው 2. ከዘመድ ነው 3.የወሊድ መቆጣጠሪያ ስላልተጠቀምኩ ነው 4.የወሊድ መቆጣጠሪያ መድሃኒት አለመስራት ነው 5.ችግሩን ካለመገንዘብ ነው 6. የወሊድ መቆጣጠሪያ መድሃኒቱን በትክክል ሳልወሰድ ቀርቼ ነው 88. ሌላ (ይገለጹ) _____	
209	ወደፊት ለማርገዝ ፍላጎት አለዎት?	1.በፍፁም አልፈልግም 2.አዎ በ3ወር ጊዜ ውስጥ 3.አዎ በ2ዓመት ገዜ ውስጥ 4.አዎ ከ2 ዓመት በኋላ 88.ሌላ (ይገለጹ) _____ 99. አላውቅም	
210	እርስዎ ግብረ ስጋ ቢያደርጉ በቅርቡ	1. በሁለት ሳምንት ጊዜ ውስጥ 2. በአንድ ወር ጊዜ ውስጥ	

	መቼ አረግዛለሁ ብለው ያስባሉ?	3. በ3 ወር ጊዜ ውስጥ 4. በ6 ወር ጊዜ ውስጥ 88. ሌላ (ይገለጹ)_____ 99. አላውቅም	
211	እርስዎ ያልተፈለገ ወይም ያለ እቅድ የሚመጣ እርግዝናን ለመከላከል የሚጠቅም የወሊድ መቆጣጠሪያ ያውቃሉ? (ከእንድ በላይ መልስ ይቻላል)	1.ኮንዶም የወንድ /የሴት 2.በአፍ የሚወሰድ እንክብል 3.በመርፌ የሚሰጥ 4.ክንድ ላይ የሚቀበር 5.በማህፀን የሚገባ መቆጣጠሪያ 6.ማህፀን ማስቋጠር 7.የወንድ የዘር ፍሬ መውጫ ማስቋጠር 88.ሌላ (ይገለጹ)_____ 99. አላውቅም	
212	እርስዎም ወሊድ መቆጣጠሪያ ተጠቅመው ያውቃሉ?	1. አዎ 2. የለም	2- 214 ይዘለሉ
213	ለጥያቄ 212 «አዎ» ካሉ ምን አይነት መቆጣጠሪያ መንገድ ተጠቅመዋል? (ከንድ በላይ መልስ ይቻላል)	1.ባህላዊ 2.በመርፌ የሚወሰድ 3.በአፍ የሚወሰድ እንክብል 4.ኮንዶም 88. ሌላ (ይገለጹ)_____	
214	እርስዎ በአሁኑ የእርግዝና ወቅት የወሊድ መቆጣጠሪያ ያልተጠቀሙ ከሆነ ለምን?	1.የአሁኑ እርግዝና የተፈለገ ነው 2.የግብረ ስጋ ግንኙነት ለማድረግ ስላላሰብኩ 3.የወሊድ መቆጣጠሪያ ስለሌለ 4.መክፈል ስለማልችል 5.ጓደኛዬ ስላልፈለገ 6.የወሊድ መቆጣጠሪያ የጎንጎር ስለፈራሁ 7.ሃይማኖቴ ስለማይፈቅድ 88. ሌላ (ይገለጹ)_____	

ክፍል 3 - የተጠቃሚዎች ጥራት እርካታን በተመለከተ

ተ.ቁ	ጥያቄ	መልስ	ወደጥያቄ ይዘት ለሉ
301	በጤና ድርጅት በነበረዎት ቆይታ በአገልግሎት ሰጪው ባለሙያ ትህትና እና አክብሮት የተሞላበት አገልግሎት የሰጥዎት ይመስልዎታል?	1. አዎ 2. የለም	
302	የምክር አገልግሎት ሊሰጥዎት ለምን ያህል ጊዜ ቆይቶ?	.....ደቂቃ	
303	የምክር አገልግሎት ሰአት እንዴት አዩት	1. በቂ 2. አጭር 3. ረጅም 99. አላውቅም	
304	በምክር አገልግሎት ሰአት ነፃነትዎ የተጠበቀልዎት ይመስልዎታል?	1. አዎ 2. የለም 99. አላውቅም	
305	እርስዎ ስለ ውርጃ የወሊድ መቆጣጠሪያ ወይም	1. አዎ	2-

	ስለ ሌላ የጤና ጉዳዮች ጥያቄ የጤና ባለሙያውን ጠይቀዋልን?	2. የለም	307 ይዘለሉ
306	ለጥያቄ <<310>> መልስዎ አዎን ከሆነ አጥጋቢ መልስ አግኝተዋልን?	1. አዎ 2. የለም	
307	ስለዚህ ስለ ጤና ድርጅቱ እንዴት ሰሙ? (ከአንድ በላይ መልስ ይቻላል)	1. በሬዲዮ 2. በቴሌቪዥን 3. ከገጽ 4. ከአገልግሎት ተጠቃሚ 5. ከጤና ባለሙያ 88. ሌላ (ይገለጹ)___	
308	የጤና ባለሙያው ለእርሶ በህይወት አስጊ የሆነና ጤና ድርጅት መምጣት የሚያስፈልጋቸው የህመም ምልክቶችን ገልፀውሎታል?	1. አዎ 2. የለም 99. አላውቅም	2/99-310 ይዘለሉ
309	ለጥያቄ <<321>> መልሱ አዎ ከሆነ እነዚህ ምልክቶች ምን እንደሆኑ ሊነግሩን ይችላሉ? (ከአንድ በላይ መልስ ይቻላል)	1. ደም መፍሰስ 2. የሆድ ህመም 3. ትኩሰት 4. ያልተለመደ ማህጸን የሚመጣ ፈሳሽ 5. 6 ሳምንት በላይ የወር አበባ አለመምጣት 88. ሌላ (ይገለጹ)___	
310	በአሁኑ የአገልግሎት ጉብኝት ወቅት እቤትዎ የሚነበብ ብሮሽር ወይም ሊፍሌት ተሰጥቶታል?	1. አዎ 2. የለም 99. አላውቅም	2/99-312 ይዘለሉ
311	ለጥያቄ "323" መልሱ አዎ ከሆነ ብሮሽሩ ወይም ሊፍሌቱ የያዘው መረጃ ስለምን ነበር? (ከአንድ በላይ መልስ ይቻላል)	1. HIV/AIDS 2. ሌሎች የአባልዘር በሽታዎች 3. ስለፅንሰ መቁረጥ 88. ሌላ (ይገለጹ)___	
312	በአሁኑ አገልግሎት ጉብኝት ወቅት የጤና ባለሙያው የጤና /የመሀጸን/ ምርመራ አድርጎሎታል?	1. አዎ 2. የለም 2. 99. አላውቅም	2/99- ወደ 316
313	ለጥያቄ <<316>> መልስዎ አዎ ከሆነ የጤና ባለሙያው ምርመራውን ከማድረግ በፊት ስለ ምርመራው ምንነት ገልጾሎታል?	1. አዎ 2. የለም	
314	የጤና ባለሙያው የጤና ምርመራ ውጤቱን አሳውቆታል?	1. አዎ 2. የለም	
315	የጤና ባለሙያው ፅንሱ እንዴት እንደሚቋረጥ ለእርሶ ጥያቄ እንዲጠይቁ እድሉን ሰጥቶት ነበር?	1. አዎ 2. የለም	
316	የጤና ባለሙያው የደም ወይም የሾተላይ ላብራቶሩ ምርመራ ታዘሎታል ነበር?	1. አዎ 2. የለም	
317	እርስዎ በዚህ ጉብኝት የወሊድ መቆጣጠሪያ ለመውሰድ ፈቃደኛ ነዎት ?	1. አዎ 2. የለም	2-319 ይዘለሉ
318	ለጥያቄ "329" መልስዎ አዎ ከሆነ ምርጫዎ የትኛው የወሊድ መቆጣጠሪያ መንገድ ነው ?	1. በመርፌ የሚሰጥ 2. በአፍ የሚወሰድ እንክብል 3. በክንድ የሚቀበር 4. በማህፀን የሚገባ 88. ሌላ (ይገለጹ)___	
319	በዛሬው የህክምና ጉብኝትዎ የወሊድ መቆጣጠሪያ መንገድ ወስደዋልን ?	1. አዎ 2. የለም	2-321 ይዘለሉ

320	ለጥያቄ 331 መልሱ አዎ ከሆነ የትኛውን የወሊድ የመቆጣጠሪያ መንገድ ወሰዱ ?	1.በአፍ የሚወሰድ እንክብል 2.በመርፌ የሚሰጥ 3. በክንድ የሚቀበር 4. በማህፀን የሚገባ 5.ኮንዶም 88.ሌላ (ይግለፁ)_	
321	ለጥያቄ "331" መልስ የለም ከሆነ ለምን ?	1. ማንም ሃሳቡን ያነሳው የለም 2.ሌላ ጤና ድርጅት እንዲሄዱ ስለተደረገ 3. በጤና ችግር ምክንያት 4.የወሊድ መቆጣጠሪያ መንገድ ስለሌለ 88. ሌላ (ይግለጹ) _____	
322	የጤና ባለሙያው ስለወሊድ መቆጣጠሪያ መንገድ ጥቅም ገልጾልዎታል ?	1. አዎ 2. የለም	
323	የጤና ባለሙያው ስለወሊድ መቆጣጠሪያ መንገድ የጎን ችግር ገልጾልዎታል ?	1. አዎ 2. የለም	
324	ጤና ድርጅት ከመጡ በኋላ አገልግሎቱን ለማግኘት ምን ያክል ሰዓት ጠበቁ?	----- ደቂቃ	
325	አገልግሎት ለማግኘት የቆዩበት ሰዓት እንዴት አዩት?	1.በቂ 2. በጣም አጭር 3.በጣም ረጅም 99 አላውቅም	
326	አገልግሎት የሚሰጥበት ደርጅት በቂ መጻዳጃ አለው?	1.አዎ 2. የለም	
327	እርስዎ ለጤና ባለሙያው ያካፈሉት መረጃ ሚስትራቂ ነው ይጠበቃል ብለው ያምናሉ?	1. አዎ 2.የለም 99. አላውቅም	
328	የህመም ማስታገሻ ተሰጥቶታል ?	1. አዎ 2. የለም	
329	የአገልግሎት ክፍያውን እንዴት አዩት ?	1.ተመጣጣኝ ነው 2. ውድ ነው 3.ርካሽ ነው 99. አላውቅም	
330	አገልግሎት ከመሰጠቱ በፊት ያለው የመጠበቂያ ክፍል ለእርስዎ አመቺ ነው?	1. አዎ 2. የለም	
331	ጤና ጣቢያው /ክሊኒኩ/ አገልግሎት የሚሰጥበት የስራ ሰዓት ለእርስዎ አመቺ ነው?	1. አዎ 2. የለም	
332	አገልግሎት የሚሰጥበት ደርጅት በቂ ውሃ አለው?	1. አዎ 2. የለም	
333	አገልግሎት ሰጪው ባለሙያ የጤናዎትን ሁኔታ ለመከታተል ቀጠሮ ቀን ተሠጥቶታል?	1. አዎ 2. የለም	2-335 ይዘለሉ
334	ለጥያቄ "327" መልስ አዎ ከሆነ ለመቼ ተቀጠሩ ?	1.ከ7-10 ቀን 2. ከ10 ቀን በኋላ 99. አላውቅም	
335	በአጠቃላይ በተሰጠው አገልግሎት ረክተዋል?	1. አዎ 2. የለም	
336	የአገልግሎት አሰጣጥ ጥራቱን ለማሻሻል ምን መደረግ አለበት ይላሉ ?	_____	

የተቆጠረው ስም \_\_\_\_\_ ቀን \_\_\_\_\_

ፊርማ \_\_\_\_\_