

**ADDIS ABABA UNIVERSITY  
SCHOOL OF GRADUATE STUDIES  
INSTITUTE OF POPULATION STUDIES**



**DETERMINANTS OF ABORTION PRACTICE IN ADDIS ABABA**

**By; Mehiret Habte**

**July 2010**

**Addis Ababa**

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**By; Mehiret Habte**

A Thesis Submitted to the School of Graduate Studies of Addis Ababa University in Partial Fulfillment of the Requirement for the Degree of Master of Science in Population Studies

*(Specialization in Reproductive Health)*

**Advisor ; Mengistu Asnake ( MD, MPH)**

**July 2010**

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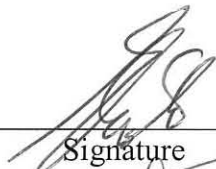
***Determinants of Abortion Practice in Addis Ababa***

***By***  
**Mehiret Habte Begna**

**Institute of Population Studies  
College of Development Studies**

*Approved by the Examining Board*

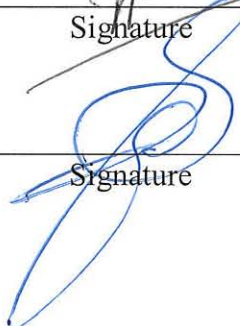
**Dr. Eshetu Gurmu**  
Chairman, Department Graduate Committee

  
Signature

**Dr. Mengistu Asnake**  
Advisor

  
Signature

**Dr. Negatu Regassa**  
Examiner

  
Signature

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## ACRONYMS

ARHB	Addis Ababa Regional Health Bureau
CAC	Comprehensive Abortion Care
CDS	College of Development Studies
CSA	Central Statistics Authority
D&C	Dilation and Curettage
DFID	Department for International Development
DHS	Demographic and Health survey
ESOG	Ethiopian society of obstetrician and gynecologists
FDRE	Federal Democratic Republic of Ethiopia
FGAE	Family Guidance Association
FGD	Focus Group Discussion.
HIV	Human Immunodeficiency Virus
HW	Health Workers
ICPD	International Conference on Population and Development
IPPF	International Planned parenthood Federation
IPS	Institute of Population studies
KAP	Knowledge Attitude Practice
LNMP	Last Normal Menstruation Period
MCH	Maternal and Child Health
MDG	Millennium Development Goals
MOH	Ethiopian Ministry of Health.
NGO	Non Governmental Organization.
PAC	Post Abortion Care
PRB	Population reference Bureau
RTI/STI	Reproductive Tract infection / Sexually Transmitted Infection
SDP	Service Delivery Points
SMC	Sharp Metallic Curettage
UNFPA	United Nations Fund for Population.
UNHCR	United Nations Human right Convention
WHO	World Health Organization

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## Abstract

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**Background:** World Health Organization (WHO) estimates that 42 million abortions take place every year around the world. Approximately 95% of unsafe abortions take place in poor countries, where access to family-planning services is limited. Unsafe abortion accounted for 17% of all maternal deaths in Eastern Africa. In Ethiopia 500,000 women suffer disabilities related to pregnancy and child health due to unsafe abortion related reasons. In Addis Ababa, unsafe abortion accounts for almost 54% percent of maternal mortality.

**Objective:** This study aimed to examine different socio-cultural, economic and demographic factors that are associated with their knowledge, attitude and practice of abortion .

**Methodology:** By applying multistage sampling method , 430 Addis Ababa reproductive age women were interviewed from five randomly selected health facilities which provide Comprehensive Abortion Care. Representative from three types of health providers (Government, private and NGO owned) were also interviewed in depth. Descriptive, Chi-square and multivariate analysis were done to figure out factors associated with their knowledge , a attitude and practice of abortion.

**Result :** Only 44% of the interviewed women can state the correct circumstances where abortion is permissible under Ethiopian abortion law. In terms of attitude 54 % of them are against the idea of abortion practice and 41% of them do not agree on legality of abortion. Respondent's religious affiliation indicates an association with respondent's attitude towards legality of abortion.

From the 414 ever pregnant women 65% of them have had abortion practice in their life time. Of which 66% of the abortion was induced. Taking the confounding effects of each variable, marital status, parity, abortion attitude, unwanted pregnancy history, birth place and occupation were found to be the major predictor variables that related with women abortion practice.

**Conclusion:** Women who are married, less than 30 years old, employed and who were born outside Addis Ababa mirrored relatively higher level of abortion practice than their counterparts. Giving due attention for effective family planning utilization , post abortion care , women empowerment, awareness on abortion legality , proper training and medical supplies are the major themes which needs to be considered for further interventions on abortion in general and unsafe abortion in particular.

**Key words :** Abortion , attitude , practice , unwanted pregnancy

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# CHAPTER ONE

## INRODUCTION

### 1.1 Background

Health and development have a direct link and are also interdependent. Different reproductive health indicators have been developed and utilized to distinguish one nation's socioeconomic status since it has direct correlation with social service availability as well as accessibility. Of the various reproductive health indicators Maternal and Child Health (MCH), Family Planning ,Management of abortion problems and Prevention & treatment of RTI/STI including HIV/AIDS are the major reproductive health components which have attracted the attention of national and international concern .

Maternal and child health is the primary component which encompasses and concern about more than half segment of the population. Of the various indicators maternal mortality and morbidity is the major indicator that also imply the availability and quality of health service in general and maternal health care in particular.

Global evidences indicate that obstetric complications are the leading cause of death for women of reproductive age in developing countries today, and constitute one of the world's most pressing and intractable health problems. It has been widely documented that consequences and complications from unsafe abortion cause a large number of maternal deaths. One in eight pregnancy-related deaths worldwide is caused by unsafe abortion. (UNFPA , 2009)

Complications due to unsafe abortion procedures account for an estimated 13% of maternal deaths worldwide, or 67,000 per year. For every 1,000 women of childbearing age (15–44) worldwide, 29 were estimated to have had an induced abortion in 2003, compared with 35 in 1995( Guttmacher , 2007).

Many countries have endorsed the reduction of maternal mortality as a key development goal, and it is included in consensus documents emanating from international conferences such as the World Summit for Children in 1990, the International Conference on Population and Development in 1994 and the Fourth World Conference on Women in 1995 and their respective

five-year follow-up evaluations of progress in 1999 and 2000, and the Millennium Declaration in 2000 .

The incidence of unsafe abortion is affected by legal provisions governing access to safe abortion, as well as the availability and quality of legal abortion services. Restrictive legislation is associated with a high incidence of unsafe abortion (WHO, 2004).

Increasing legal access to abortion is associated with improvement in sexual and reproductive health. Conversely, unsafe abortion and related mortality are both highest in countries with narrow grounds for legal abortion. More than 61% of the world's population resides in countries where induced abortion is allowed without restriction or for a wide range of reasons such as protection of the woman's life, preservation of her physical or mental health, and socioeconomic grounds. In 72 countries, most of which are in the developing world, 26% of the world's population lives where abortion is prohibited altogether or allowed only to save the woman's life (Grimes A David , 2006 ) Between 1995 and 2005, 12 countries increased access to legal abortion, including Albania, Benin, Burkina Faso, Cambodia, Chad, Ethiopia, Guinea, Guyana, Mali, Nepal, South Africa, and Switzerland.( Ibid)

Unsafe abortions affect women, their families and existing children, and their communities. Children, especially young children, of women who are hurt or killed by unsafe abortion suffer as well. Studies show, for instance, that among infants whose mothers die, fewer than 10% will live beyond their first birthday." When women die from unsafe abortion, communities lose productive as well as beloved members, and health systems incur tremendous preventable expenses ( Hord E. Charlotte , 2005) . In order to respond for such multifaceted problem, proper intervention and efforts need to be supported by reliable findings on factors associated with women's general knowledge , attitudes and practice of abortion and related health problems .

In this study, data from women age 15 – 49 who were available at MCH/FP service at five selected health facilities of Addis Ababa were used to study the determinant of abortion practice including knowledge and attitude. These two factors have been largely neglected in the problem of abortion but remained with important implications for safe abortion services.

## 1.2 Problem statement

Around the world, 42 million abortions take place every year. Worldwide, the estimates indicate that almost 20 million unsafe abortions were carried out in 2003, i.e. one in ten pregnancies ended in an unsafe abortion, giving a ratio of one unsafe abortion to about seven live births. For the period around 2000, 19 million unsafe abortions per year were estimated. Globally, 19–20 million unsafe abortions are estimated to have occurred each year from 1993 to 2003, as the transition to low fertility has advanced; contraceptive prevalence has increased, but so has unmet need for family planning as smaller families become the norm ( WHO 2007)

Approximately 95% of unsafe abortions take place in poor countries, where access to family-planning services is limited. Each year, close to 70,000 women across the globe die from unsafe abortions and countless others suffer serious injuries. Unsafe abortions affect women, their families and existing children, and their communities ( IPAS , 2004).

The decline in abortion incidence was greater in developed countries, where nearly all abortions are safe and legal (from 39 to 26 abortions per 1,000 women aged 15-44), than in developing countries, where more than half are unsafe and illegal (from 34 to 29) (Guttmacher , 2007).

The annual number of induced abortions in Africa rose between 1995 and 2003, from 5.0 million to 5.6 million. In 2003, most of the abortions occurred in Eastern Africa (2.3 million), Western Africa (1.5 million) and Northern Africa (1.0 million). Despite the increase in the number of abortions, the annual abortion rate declined between 1995 and 2003—from 33 to 29 abortions per 1,000 women aged 15–44. The decline in the rate was a result of the increase in the number of women of childbearing age (Guttmacher , 2009).

Unsafe abortion rates close to 30 per 1000 women of reproductive age are seen in both Africa and Latin America; however, because of the higher relative number of births, the unsafe abortion ratio for Africa is only half that for Latin America. However, the range of estimates for Africa is wide: Eastern Africa has the highest incidence rate of any sub region, at 39 per 1000 women aged 15–44, while Southern Africa has among the lowest, at 18 per 1000 (not counting legal abortions of 5 per 1000 women). In Eastern, Western and Middle Africa, where maternal mortality is high, the unsafe abortion- related mortality ratio is much higher than anywhere else – double that of Asia and more than 5 times that of Latin America. Morbidity is an even more

frequent consequence of unsafe abortion, and it is thus not surprising that the total disease burden for Africa is exceptionally high, threatening women's lives and health, and straining scarce resources ( WHO, 2007)

Table 1. Global and regional estimates of annual incidence of unsafe abortion and associated mortality, 2003.

	Number	Number of deaths	Percentage of all maternal deaths
<b>World</b>	19,700,000	66,500	13
<b>Developed countries</b>	500,000	<60	4
<b>Developing countries</b>	19,200,000	66,400	13
<b>Least Developed countries</b>	4,000,000	24,000	10
<b>Other developing countries</b>	15,300,000	42,400	15
<b>Sub Saharan Africa</b>	4,700,000	35,600	14
<b>Africa</b>	5,500,000	36,000	14
<b>Eastern Africa</b>	2,300,000	17,600	17
<b>Middle Africa</b>	600,000	5,000	10
<b>Northern Africa</b>	1,000,000	1,100	11
<b>Southern Africa</b>	200,000	300	9
<b>Western Africa</b>	1,500,000	11,900	13
<b>Asia</b>	9,800,000	28,400	12
<b>Europe</b>	500,000	<60	6
<b>Latin America and Caribbean</b>	3,900,000	2,000	11
<b>North America</b>	Neglibile	Neglibile	Neglibile
<b>Oceania</b>	20,000	<100	10

Source: WHO 2007

Unsafe abortion accounted for 13% of all maternal deaths in sub-Saharan Africa, where half of the world maternal deaths occurred. The consequences of unsafe abortion are not limited to mortality alone. The burden on women's livelihoods, their families and communities, and on the scarce resources of the health system is undeniably enormous. Yet few studies, if any, have tried to address the impact of morbidity from complications of unsafe abortion, including acute and chronic pelvic infection and infertility, and the cost implications of unsafe abortion for the health facilities ( WHO , 2007)

In Ethiopia, death and morbidity as a result of unsafe abortion is perhaps one of the least discussed health problems in the country. Every year, 25,000 Ethiopian women die due to complications of pregnancy, labor and child birth, this represents a total of 68 deaths per a day. 500,000 women also suffer disabilities related to pregnancy and child health. The maternal death rate associated with complications of pregnancy and delivery is among the highest in the world. The maternal mortality ratio for Ethiopia for the period 1998-2004 is 673 deaths per 100,000 live births (or alternatively 7 deaths per 1,000 live births ( UNFPA , 2009).

In recent study , it is indicated that 382000 induced abortions occurred in Ethiopia in 2008 . The medium national estimate of the 2008 abortion rate was 23 per 1000 women aged 15-44, the estimates ranges from 20-26 per 1000. An estimated 11-15 abortions occurred per 100 live births, depending on the multiplier used. Abortion rate in Addis Ababa ( 49 per 1000) was twice the national average likely the result of many factors among them a strong motivation on the part of couples to have small families that is not matched by a sufficiently high level of contraceptive use . (Singh Susheela etal 2010).

In Addis Ababa and other urban centers abortion is one of the major four causes of maternal deaths. In Addis Ababa the finding of Kwast etal, 1986 indicated , unsafe abortion accounts for almost 54% percent of maternal mortality. In a survey of illegal abortion in Addis Ababa showed abortion hospital occupancy rate among mothers represented 32.2% (MOH , 2006).

Legal restrictions on abortion do not affect its incidence. For example, the abortion rate is 29 in Africa, where abortion is illegal in many circumstances in most countries, and it is 28 in Europe, where abortion is generally permitted on broad grounds. The lowest rates in the world are in Western and Northern Europe, where abortion is accessible with few restrictions ( Guttmacher 2009).

The majority of countries in sub-Saharan Africa have allowed abortion to preserve the maternal life only. The Ethiopian Law which was restrictive and condemn abortion has been revised containing four grounds for getting abortion service( FDRE , 2005).

More than one-third of the approximately 205 million pregnancies that occur worldwide annually are unintended and about 20% of all pregnancies end in induced abortion. Of the 23 million

pregnancies that occur in developed countries, more than 40% are unintended, and 28% end in induced abortion.

Two-thirds of unintended pregnancies in developing countries occur among women who are not using any method of contraception. More than 100 million married women in developing countries have an unmet need for contraception, meaning they are sexually active; are able to become pregnant; do not want to have a child soon or at all; and are not using any method of contraception, either modern or traditional.(Guttmacher , 2007) When we look at the Ethiopian situation , in the 2005 demographic and health survey it was articulated that one in three currently married women has an unmet need for family planning (34 percent) ( CSA and ORC Macro , 2006).

According to Singn Susheela etal( 2010) there were 42% unintended pregnancy in Ethiopia in 2008 . Unexpectedly the unintended pregnancy of Addis Ababa it was higher 72% than the national average.

In response to mounting evidence on abortion-related maternal mortality, several advocacy efforts were done and the Ethiopian Parliament amended the penal code on abortion in 2004. The new law states that abortion can be performed legally in cases of rape or incest, if the woman has physical or mental disabilities, if it is needed to preserve the woman's life or her physical health, or if she is a minor who is physically or mentally unprepared for childbirth.

The Federal Democratic Republic of Ethiopia also recognized the need to expand access and improve the quality of reproductive health services in the country as indicated in the Health Sector Development Program (HSDP III) (2005/6-2009/10). In this document, reducing maternal mortality from 871 to 600 per 100, live births put as major objective of HSDP III. This document also clearly underlines that treatment of complications in pregnancy including abortion and treatment of abnormal menstruation including D&C as one of the key activities that has to be undertaken by health centers and hospitals respectively.

Changing the law is only the beginning, however, and by itself is no guarantee that unsafe abortion will cease to exist. For example, abortion has been legal in Zambia since 1994. However, safe services remain out of reach for most women there for several reasons: There is only one doctor per 8,000 individuals, a woman seeking an abortion must obtain the consent of three physicians, many doctors will not perform abortions for religious or moral reasons and, in the few hospitals where legal abortions are available, the cost is prohibitive. And in India, where abortion has been legal for more than 30 years, about three unsafe abortions take place for every two safe procedures. Therefore, even after legalization, more hurdles remain. Providers must be willing to step up and receive training. And then, the even longer process of changing cultural attitudes can begin, so that the stigma associated with providing and obtaining abortions can lessen and safe services can become normal and accepted ( Susan A. Cohen , 2009).

Of the various contributing factors cultural, traditional & economic factors restricting women from seeking services where permissible safe abortion services are the foremost (UNFPA ,2009).

Research in several countries has found that public knowledge about abortion law is often minimal and that subgroups of the population have tremendously varying levels of information. Public opinion can also directly affect access to safe abortion services. Conservative opinion may also influence women's own views. Public knowledge and opinions about abortion laws affect access to safe services ( Becker Davida , and etal 2002).

Within Ethiopian Context, there is a problem of getting well documented and recent assessment which focuses on peoples' knowledge, attitude and practice on abortion. The overall effect of revising the abortion law , the current knowledge , attitude and practice abortion among do not also clearly known. Accordingly the presence of standardized research finding allow us to assess the feasibility of the ongoing efforts and to determine if further efforts are needed on the identified but unfilled gaps .

### **1.3 Research Questions**

This study aimed to respond the following relevant research questions.

- Do women (reproductive age) know the meaning and implication safe and unsafe abortions? Do they know the outcomes of each type of abortion?
- Do they know safe abortion is legal under some circumstances in Ethiopia? What factors are associated with women's knowledge of about abortion law?
- What is the current attitude about abortion among women? What factors are associated with conservative and liberal opinions about abortion?
- Finally what does the abortion practice of women looks like ? What are the covariates and multivariate's that affects abortion practice of women?

### **1.4 Research Objectives**

The general objective of this research was to explore the determinants of abortion practice among reproductive age women of Addis Ababa. The specific objectives of this research were

- ➔ To assess the women's knowledge on abortion.
- ➔ To know the women's attitude towards abortion.
- ➔ To see the associated factors with their knowledge, attitude and practices of abortion
- ➔ Finally to indentify gaps about knowledge, attitude and practices on abortion and to forward feasible recommendations.

### **1.5 Significance of the Study**

Currently the attention of development partners has started to respond for the multifaceted problem faced by women with reproductive age. All such national and international intervention needs to be supported by feasible findings. Acquiring the associated factors behind knowledge , attitude and practice of abortion make the overall challenges ease. The researcher believes that

development partners primarily those who involve in maternal health can utilize findings and recommendations of this research for the betterment and advancement of the regional and national abortion related intervention of Ethiopia. Further policy makers and decision makers can also use the evidence of this findings to improve strategies , programmes policy.

## **1.6 Limitations**

The following are some of the drawbacks of this study.

- I. Since the study has retrospective content, recall error and lack of knowledge of dates may result in misreporting and underestimation of information.
- II. This study is based on women attending any MCH service. Thus this study may not be generalized to other populations of women who are not attending similar services.
- III. The theme of the research by itself is sensitive and therefore subjected to misreporting of abortion practice , number and type of abortion making calculation and generalization of the abortion rate difficult .

## CHAPTER TWO

### EMPRICAL LITERATURE REVIEW

#### 2.1. Reproductive Health Rights

Reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health ( UNFPA , 1995).

“In no case should abortion be promoted as a method of family planning. All Governments and relevant intergovernmental and non-governmental organizations are urged to strengthen their commitment to women's health, to deal with the health impact of unsafe abortion as a major public health concern and to reduce the recourse to abortion through expanded and improved family-planning services. Prevention of unwanted pregnancies must always be given the highest priority and every attempt should be made to eliminate the need for abortion. Women who have unwanted pregnancies should have ready access to reliable information and compassionate counseling. Any measures or changes related to abortion within the health system can only be determined at the national or local level according to the national legislative process. In circumstances where abortion is not against the law, such abortion should be safe.”(UNFPA, ICPD *Program of Action, Paragraph 8.25*, 1994)

#### 2.2 Types of abortion

##### a. Safe Abortion

Abortion is safest when performed early in a pregnancy. Safe methods of abortion used during the first trimester (12 weeks) of pregnancy are vacuum aspiration, dilation and curettage, and medication abortion. (The length of a pregnancy is measured from the first day of a woman's last menstrual period) (PRB, 2006).

## **b. Unsafe Abortion**

Where abortion is restricted by law, girls and women who can afford to pay often can find a private physician, or sometimes a nurse or midwife, willing to perform a safe abortion. Women who cannot afford or cannot access these services may try to abort the pregnancy themselves, or they may turn to unskilled practitioners (including traditional or religious healers, homeopaths, and herbalists) who use a variety of methods( PRB , 2006).

### **Unsafe methods include:**

- Swallowing large doses of drugs, such as anti malarial or oral contraceptives (birth control pills).
- Inserting a sharp object into the uterus.
- Drinking or flushing the vagina with caustic liquids such as bleach.
- Physical abuse such as jumping or falling from high places, vigorous dancing, or sustained and vigorous sexual intercourse over long periods.
- Prolonged and hard massage to manipulate the uterus, or repeated blows to the stomach ( PRB , 2006).

## **2.3. Types of Abortion Services**

According to FDRE (MOH, 2006), there are two types of care related to termination of pregnancy; women – centered abortion care and post abortion care.

Women – centered abortion care; is a comprehensive approach to providing abortion services that takes in to account the various factors that influence woman’s individual mental and physical health needs , her personal circumstances and her ability to access services. This care includes a range of medical and related health services that support women in exercising their sexual and reproductive rights.

Post abortion care is a comprehensive service for treating women that present to health care facilities after abortion has occurred spontaneously or after an attempted termination.

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### **Unsafe methods include:**

- Swallowing large doses of drugs, such as anti malarial or oral contraceptives (birth control pills).
- Inserting a sharp object into the uterus.
- Drinking or flushing the vagina with caustic liquids such as bleach.
- Physical abuse such as jumping or falling from high places, vigorous dancing, or sustained and vigorous sexual intercourse over long periods.
- Prolonged and hard massage to manipulate the uterus, or repeated blows to the stomach ( PRB , 2006).

## **2.3. Types of Abortion Services**

According to FDRE (MOH, 2006), there are two types of care related to termination of pregnancy; women – centered abortion care and post abortion care.

Women – centered abortion care; is a comprehensive approach to providing abortion services that takes in to account the various factors that influence woman’s individual mental and physical health needs , her personal circumstances and her ability to access services. This care includes a range of medical and related health services that support women in exercising their sexual and reproductive rights.

Post abortion care is a comprehensive service for treating women that present to health care facilities after abortion has occurred spontaneously or after an attempted termination.

## 2.4 Abortion Methods and Procedures

According to the Ethiopian Ministry of Health, technical and procedural guidelines for safe abortion ( 2006) , there are two methods where pregnancies can be terminated .

1. **Medical abortion** ; Medical abortion (sometimes referred to as the abortion pill) terminates a pregnancy through the use of medicines. An alternative method to surgical abortion and vacuum aspiration, it does not require the insertion of any instruments into the uterus, thus reducing the risk of infection and other complications such as the tearing of the uterus. Several drugs can be used for medical abortion; the most commonly used and most effective regimen is the combination of mifepristone and misoprostol.( Ipas. 2003)

This procedure is applied to a pregnancy up to nine completed weeks since the last normal menstrual period ( LNMP). First Mifepristone 200 mg will be provided followed 36-48 hours later by misoprostol 800 ug vaginally ( insert misoprostol deep in to vagina or instruct the woman to do so herself). Unless clinical evidence of incomplete abortion is present, routine surgical evacuation is not necessary ( MOH 2006).

2. **Surgical Methods ;**

- a. *Vacuum Aspiration* ; vacuum aspiration is an alternative safe method of terminating an otherwise uncomplicated pregnancy up to 12 completed weeks of gestation from the first day of the LNMP.
- b. *Sharp Metallic Curettage* ; Where vacuum aspiration is available , dilation and curettage and SMC are not recommended. SMC is to be used for termination of pregnancy , it should be done by a trained health officer medical doctor of gynecologist under well equipped room for providing general anesthesia.

## 2.5 . Theoretical overview; Ethical Debates over Abortion

The subject of abortion requires exploration into multiple moral, social and religious values. Some may argue that abortion also requires an exploration of political views and legal perspectives, as the concept and subject is often shaped by multiple dynamics including those in the political realm. It has long been argued among politicians, sociologists, humanists and citizens. It remains controversial because it involves one's definitions of life and values as a human, the subject of abortion is one that legal analysts have reviewed over decades.

On one side are pro-choice supporters individuals who favor a woman's reproductive rights, including the right to choose to have an abortion. On the other side are the pro-life advocates, who may oppose abortion for any reason or who may only accept abortion in extreme circumstances, as when the mother's life would be threatened by carrying a pregnancy to term. This combination of medical ambiguities and emotional political confrontations has led to considerable hostility in the abortion debate. For many people, however, the lines between pro-choice and pro-life are blurred and the issue is far less polarized. ( Microsoft Encarta , 2009)

**a. Pro-Life**

Since life begins at conception, abortion is a kin to murder as it is the act of taking human life. Abortion is in direct defiance of the commonly accepted idea of the sanctity of human life. No civilized society permits one human to intentionally harm or take the life of another human without punishment, and abortion is no different ( Lowen Linda , 2007).

Many women who consider themselves pro-life supporters are concerned about possible threats to reproductive rights and the danger of allowing the government to decide what medical options are available to them. Other human rights that are closely associated with the right to liberty and security of the person include the right to private and family life, which some constitutions explicitly refer to as the right to decide on the number and spacing of one's children. National courts have applied these rights to require governments to reform restrictive abortion laws or to remove barriers to access to abortion services, such as partner authorization requirements(J. Cook Rebcca 2006).

**b. Pro-Choice**

Pro-choice defenders believe that the fetus is only a potential human being when it becomes viable, that is, able to survive outside its mother's womb. Until this time the fetus has no legal rights—the rights belong to the woman carrying the fetus, who can decide whether or not to bring the pregnancy to full term (Lowen Linda 2007).

According to pro choice activist's abortion is not used as a form of contraception. Pregnancy can occur even with responsible contraceptive use. The ability of a woman to have control of her body is critical to civil rights. Teenagers who become mothers have grim prospects for the future. They are much more likely to leave of school; receive inadequate prenatal care; rely on public assistance to raise a child; develop health problems; or end up divorced. Like any other difficult situation, abortion creates stress (Lowen Linda 2007).

Many pro-choice individuals are also deeply saddened by the act of abortion and seek to minimize its use through better education about birth control, and, in particular, emergency contraception, birth-control methods that prevent pregnancy after unprotected sexual intercourse ( MicrosoftEncarta ,2009).

Pro-choice advocates argue that illegalization of abortion increases the incidence of unsafe abortions, as the availability of professional abortion services decreases, and leads to increased maternal mortality. According to a global study collaboratively conducted by the World Health Organization and the Guttmacher Institute, most unsafe abortions occur where abortion is illegal ( Wikipedia , 2009).

### **c. Feminist**

The abortion debate has polarized women, putting them against each other in the binary of pro-choice and pro-life. This leads to a destructive division between women, one that is detrimental to the furthering of women's rights.

According to feminist activist , abortion has become a double-edged sword for women's rights. Without the right to choose women would be locked into their role as mothers, but being given the right to choose also acts to bypass the greater issues of patriarchy, such as the lack of support for women as mothers within our society. Pro-choice feminism views the right to an abortion as integral to a women's right to sovereignty. Without abortion, women would unjustly be forced into motherhood. From a feminist standpoint, denying the right for women to choose to have an abortion forces them into submissive roles in society (Pomeroy Claire , 2008).

Gaining the access to safe and legal abortions finally allowed a woman to have the basic right of controlling her own body. Prior to legal abortion, women had two options: to undergo an unsafe, illegal abortion that put their bodies at risk or to continue their pregnancy, even in situations that were disadvantageous to both the woman and the unborn fetus. From the pro-choice standpoint, the implication that an unborn fetus, which is unconscious and without thoughts, has rights equal to or superior to a woman's, serves only to diminish the recognition of women as living, breathing people who are able to consciously make their own decision about their pregnancy. Feminism is pro-woman rather than pro- or anti- abortion. This is where the pro-life and pro-choice groups can begin to relate to one another (Pomeroy Claire 2008).

Some feminists oppose all forms of violence, including abortion, because they are inconsistent with the core feminist principles of justice, non-violence and non-discrimination. Another group object to abortion because they see it as a male plot. They argue that men see the risk of pregnancy as something that stops men having sex when they want it. If men are to achieve full sexual freedom (i.e. the freedom to have sex without responsibility) it is essential that abortion be freely available to backup contraception. So abortion on demand is vital if men are to be able to have women on demand, and thus men are arguing for abortion so that they can continue to exploit women( BBC , 2010).

#### **d. Religious view on Abortion**

The abortion debate has heavy religious dimensions. All the religions have taken strong positions on abortion; they believe that the issue encompasses profound issues of life and death, right and wrong, human relationships and the nature of society, that make it a major religious concern. People involved in an abortion are usually affected very deeply not just emotionally, but often spiritually, as well.

But if we approach the question from more of a religious angle, then it becomes more problematic. The Roman Catholic Church, for example, teaches that the soul is implanted at the moment of conception. Other traditions teach that the soul enters the body during quickening, the point in pregnancy (usually around week 20) when the fetus begins to move. The Bible's position on abortion, like its position on so many other issues, can be described as extremely ambiguous.

It treats the death of a fetus as a non-homicide and makes no attempt to punish women who have abortions, nor does it mention the widely-practiced abortion that was contemporaneous to the period during which the relevant texts were written. On the other hand, it does not suggest or imply that personhood begins at the moment of birth. This is why the Judeo-Christian tradition has long struggled with the question of abortion. A theological approach to abortion, if it is to be found at all, cannot explicitly be found in the text of the Bible (Head Tom , 2010).

Although there are different opinions among Muslim scholars on the topic of Islam and abortion, most agree that the termination of a pregnancy after four months - the point at which, in Islam, a fetus is thought to become a living soul is not permissible. Many Islamic thinkers contend that in cases prior to four months of gestation, abortion should be permissible only in instances in which a mother's life is in danger or in cases of rape (Wikipedia , 2010).

## **2.6 Socio- Cultural Context of Abortion**

Based on the variation of socio cultural setting, abortion has been perceived differently. Some societies condemn abortion based on traditional and religious values, but others see abortion as a better option than carrying an unwanted pregnancy to term. In many Asian societies, e.g. Korean and Chinese, there is strong social stigma against single or unwed motherhood. In fact, abortion is much more acceptable from a societal perspective in Asia than it is in Latin America or the USA. This explains, in part, the growth of sex-selective abortion in some Asian countries where couples abort a female fetus hoping that the next pregnancy will be a boy. The law condemns this practice, but it is still pervasive in several countries, including India (Axel I. Mundigo , 2006).

Abortions are sought also by married women who have completed their desired family size and for whom another child may mean less care for the children they already have. In many cases, unintended pregnancies result from the use of less effective methods, e.g. withdrawal (coitus interruptus), which require a greater degree of user self-control. Among populations that have a strong preference for traditional methods, there is often a certain degree of indifference with respect to the adoption of more effective modern contraception, a situation commonly found in Turkey. Withdrawal is the most commonly utilized method by married couples, and abortion is sought when the method fails. It was found that, culturally, women expected men to make the

decisions concerning family size and thought the man should choose the contraceptive method. The strong patriarchal authority of men in this culture also leads to their using a male controlled method that is thought to be efficient and inexpensive ( Ibid) .

Cultures resistant to women's equality with men have perpetuated women's subordination and powerlessness as a "natural" condition of family life and render women's disadvantage invisible. Where women's subordination and powerlessness are perceived, they are considered not just a feature but a necessary condition of social order and stability. Family and social discipline are seen as dependent on men's authority to make decisions ( J. Cook Rebecca and Bernard M. Dickens ,2003).

A large number of African women resort to unsafe abortion in order to respect the values of their community. The reasons that render a pregnancy 'unwanted' may include, for instance, to avoid the social stigma of pre-marital sex and pregnancy. In such a case, even if the law permits abortion, a woman may still resort to unsafe abortion in order to keep her transgression of social values secret. Even if laws were liberalized, poverty would still pose an important obstacle to access to abortion services, unless the state ensures that abortion services are not only available, but also affordable and accessible. ( Kibrom I. Teklehaimanot , 2002) They may fear being identified as abortion patients by neighbors at a community clinic, for example, and instead go to a traditional healer in another village to avoid recognition, rumor and consequent social isolation (Marystopes and IPAS , 2007).

## **2.7 . Knowledge Attitude and Practice of Abortion; Underlying Factors**

Based on the general social, cultural, political and economic setting of the country the knowledge, attitude and practice of abortion among women and health professionals varied accordingly.

Public opinion can directly affect access to safe abortion services. In communities where the prevalent attitude toward abortion is conservative, medical providers may be unwilling to perform abortions, and spouses or other family members may forbid a woman to seek an abortion if they hold strong negative opinions about the practice. Conservative opinion may also influence women's own views. Women seeking induced abortion may feel guilty about doing so

and consider themselves deserving of punishment. These feelings may lead them to seek clandestine, unsafe services. If complications result, women may delay seeking assistance. An exploratory study based on a convenience sample of 134 women with complications of induced abortion at a hospital in Mexico City found that poverty was a key factor leading women to seek unsafe abortion (Becker Davida, And etal , 2002).

Provider attitudes and knowledge also affect the provision of legal abortion services. Providers holding conservative attitudes toward abortion have been known to refuse women services and to treat women they suspect of having had induced abortions poorly. Lack of correct information about abortion laws among medical professionals may further affect services. Several studies have found low levels of information about abortion laws among medical professionals, with many believing that abortions are always illegal( Ibid) .

According to Pathfinder study ( 2007) on community opinion survey on abortion in Ghana, out of 994 women and 102 men , 46 percent of the women and 49 percent of the men believed women should not practice abortion, and 44 percent of women and 50 percent of men believed it to be a sin. These findings reveal pervasive disapproval of abortion within the population. Despite the recognized risks, women continue to seek abortions under unsafe conditions because of cost and privacy issues . Knowledge of abortion law is also found to be minimal, with the vast majority of both women and men thinking it is wholly illegal. Though the government has promoted safe abortion under certain conditions as part of reproductive health, they are under pressure from the pervasive social stigma which reduces public impetus to promote knowledge of the law and access to services ( Pathfinder , 2007).

In Ethiopian context, though there is inadequate research on these three particular issues there are some findings which relatively similar perspective with other countries. With regard to knowledge of women on abortion law of the country, the recent study done by Engenderhealth ( 2009) show that small proportion of the interviewed women ( 2480) who can state at least one reason of where abprtion can be permissible; Addis Ababa women relatively have good knowledge followed by women who reside in other urban areas followed by women at rural areas.

Knowledge among health workers was found to be minimum in Ethiopia, according to ESOG study ( 2005) on 30 hospitals and 56 referring centers only 29% of the health workers stated the correct provision of the penal code for termination of pregnancy. The social stigma and religion was found to be strong in influencing the attitudes of women towards abortion and according Meaza Ashenafi ( 2004) during the advocacy period to revise abortion law in Ethiopia strong opposition were flowed from the religious groups which also would like to mold their followers. With regard to abortion practice, it is appear to be highest but showing declining rate after the law revision ( 2004) ( Yirgu Gebrehiwot and Tippawan Liabsuetrakul , 2008). Based on ESOG ( 2002) and Yirgu Gebrehiwot and Tippawan Liabsuetrakul facility Bases study at 2003-2007 , women whose age are below 30 years old , married and with some secondary education are those who are found have high abortion cases.

## **2.8 Legal status of Abortion; a continuum of progress**

Political attention to the issue of abortion has evolved through three stages of development: first, the law was used to enforce the "moral prohibition of abortion" in the 19th and early 20th centuries. Then, starting in Europe, public health arguments were put forward focusing on women's health and welfare. More recently, safe abortion has been advocated within a human rights and social justice framework, in order to oppose the consequences of criminal barriers to safe abortion ( Kibrom I. Teklehaimanot, 2002).

Existing data and a growing number of studies, seem to indicate that slow but steady progress is being made to reduce unsafe abortions and to reform abortion law, policy and practice to benefit women's health and lives around the world .

Governments, international treaty-monitoring bodies and others increasingly recognize abortion as an intrinsic human right, integral to women's ability to make their own decisions about the number and spacing of their children: The United Nations Human Rights Council (UNHRC), the Committee on the Elimination of Discrimination against Women, the European Court on Human Rights, and Colombia's Constitutional Court are some examples of global, regional and national bodies that have called for liberalization of laws criminalizing abortion on human rights grounds ( Marystopes and IPAS , 2007).

In Africa, the 2005 approval of the Protocol on the Rights of Women in Africa marked the first time that an international human rights agreement explicitly recognized abortion rights. In 2006,

Ministers of Health and delegates from 48 African countries had recognized the multiple reproductive health problem of the continent and have include addressing unsafe abortion in their short term plan of action (2006-2010) ,as one of nine action areas essential for achieving the Millennium Development Goals ( African Union Comission, 2007).

In 2007, the world's leading human rights advocacy organization, Amnesty International, adopted a policy supporting women's right to information and services for safe legal abortion in cases of unwanted pregnancy resulting from rape or incest or posing serious risk to the woman's life or health. Activists and others working to protect women from unsafe abortion need to make greater use of human rights treaty-monitoring bodies, national judicial systems and other mechanisms to hold governments accountable to citizens and to international human rights commitments ( Marystopes and IPAS , 2007).

According to Jane T. Bertr and etal ( 2002), there are five possible degrees of abortion laws .

- 1) Abortion is permitted without restriction as to reason;
- 2) Abortion is permitted on socioeconomic grounds (such laws allow consideration of a woman's economic resources, her age, her marital status, and the number of her living children)
- 3) Abortion is permitted to protect a woman's mental health, as well as her life and physical health (interpretation of mental health. may vary across countries, but it may encompass, for example, the psychological distress suffered by a woman who is raped or the severe strain caused by socioeconomic circumstances);
- 4) Abortion is permitted to protect a woman's life and physical health (such laws may permit abortion on health grounds that may require the threatened injury to health be either serious or permanent); and
- 5) Abortion is permitted only to save a woman's life, or the procedure is banned entirely.

China was the first large developing country to enact a liberal abortion law—in 1957. The Soviet Union and the central and western Asian republics enacted similar laws in the 1950s. Over the next 50 years, abortion become legal on broad grounds in a wide range of less developed countries, including Cuba (1965), Singapore (1970), India (1971), Zambia (1972), Tunisia

(1973), Vietnam (1975), Turkey (1983), Taiwan (1985), Mongolia (1989), South Africa (1996) and Cambodia (1997). Indeed, the worldwide trend in abortion law has continued to be toward liberalization. And since 1997, another 21 countries or populous jurisdictions have liberalized their laws, including Colombia, Ethiopia, Iran, Mexico City, Nepal Portugal and Thailand. During this same period, only three countries El Salvador, Nicaragua and Poland have increased restrictions( Susan A. Cohen 2009).

In the decade since the ICPD programme of Action was approved and the Millennium Development Goals were written, a number of countries have successfully legalized abortion on broad grounds and begun training providers, thereby making abortion and abortion services safer for women. In other countries, less restrictive laws than in the past are being proposed or have already been passed ( Berer Marge, 2004).

Even though eminent progress has been observed in legalization and liberalization of abortion , it is also worthwhile to mention one of major challenges , Gag rule, that draw considerable attention at international level. The Global Gag Rule was reinstated by President George W. Bush on his first day in office in January 2001. Officially termed the Mexico City Policy, these restrictions mandate that no U.S. family planning assistance can be provided to foreign nongovernmental organizations (NGOs) that use funding from any other source to: perform abortions in cases other than a threat to the woman's life, rape or incest; provide counseling and referral for abortion; or lobby to make abortion legal or more available in their country. Two organizations that form the backbone of family planning service delivery in Ethiopia are the Family Guidance Association of Ethiopia ( FGAE) and Marie Stopes International Ethiopia (MSIE) refused to abide by the gag rule conditions in early 2002. As a result, FGAE lost 35 percent of its budget, while MSIE lost 10 percent. These funding losses forced both providers to scale back services and outreach efforts (Population Action International , IPAS , IPPF , Pathfinder , Engnder health , 2005 ) .

### **2.8.1 Safe Abortion law in Ethiopia**

According to the FDRE , criminal code of Ethiopia ( 2005) Article 551 ( p. 325 ) the following are the cases where terminating pregnancy is allowed by Ethiopian law;

1. Termination of pregnancy by recognized medical institution with in the period permitted by the profession is not punishable where
  - a. The pregnancy is the result of rape or incest
  - b. The continuance of the pregnancy is dangers the life the of the mother or the child or the health of the mother or where the birth of the child is a risk of the life to the health of the mother or
  - c. Where the child has an incurable and serious deformity
  - d. Where the pregnant woman owing to a physical of mental deficiency she suffers from or her minority is physically as well as mentally unfit to bring up the child

The law has started to come in to effect starting from 2006 after the Ethiopian Ministry of Health has released guidelines for safe abortion services, making major progress toward implementing 2005 revisions of the country's abortion law.

### **2.9 Abortion from Women Empowerment Perspective**

The issue of gender inequality can be considered as a universal feature of developing countries. Unlike women in developed countries who are, in relative terms, economically empowered and have a powerful voice that demands an audience and positive action, women in developing countries are generally silent and their voice has been stifled by economic and cultural factors. Economic and cultural factors, coupled with institutional factors dictate the gender-based division of labour, rights, responsibilities, opportunities, and access to and control over resources. Education, literacy, access to media, employment, decision making, among other things, are some of the areas of gender disparity that are observed in most developing countries including Ethiopia ( Ethiopian Society of Population Studies, 2008).

Barriers to improving women's reproductive health including access to safe abortion services are often rooted in social, economic, cultural, and legal conditions that infringe upon women's human rights. Women's vulnerability to sexual and other abuses, in and out of marriage, increases their exposure to unplanned pregnancy and unsafe abortion, and has been associated

with further deterioration of their health, including mental health. Studies show that forced first intercourse is prevalent in many communities, affecting as many as 32 percent of girls and women ( J. Cook Rebecca & Bernard M. Dickens ,2003 ;MUNDIGO I A. 2005) .

In Africa as in every other country, poor women are much less likely than those with wealth and social connections to find a solution to unwanted pregnancy that does not put their lives at risk. Typically, women with resources can safely terminate unwanted pregnancies either by paying fees charged by private but clandestine providers or by travelling to a place with more liberal laws and more accessible services. ( Hord Charlotte and Merrill Wolf 2004).

Continued gender inequality throughout Africa, particularly in more rural and traditional communities, has a significant effect on prevention of unwanted pregnancy and women's access to abortion-related care. Women's partners, spouses or other family members may discourage them from using contraception. In many communities, women cannot seek medical treatment without the permission of their husbands, mothers-in-law, or other family members, even when they may be experiencing severe complications. This practice often delays the woman's access to care and can lead to serious complications or death. Furthermore, women's limited economic resources also contribute to delays in seeking services ( Hord Charlotte, 2005).

In Ethiopia the persistent gender disparity that are well documented in different indicators including age at first marriage , gender gap in education attainment , participation of labor force , having seat at regional and parliament seat have a contributed effect on the overall socio economic enhancement of the nation and reproductive health in particular.

Positive trends have been emerged in narrowing gender disparity at national and international level. Convention on Elimination of All forms of Discrimination Against Women which was ratified on 1979 and come in to effect at 1981 can be taken the major international progress towards avoiding gender inequality ( Meaza , 2004) Ethiopia as one of the signatory of the Convention incorporate and amended its national laws towards ensuring women rights and avoiding some harmful traditional practices mainly at the national constitution ( 1995) , family code ( 2000) penal code ( 2005) .



## **2.10 The Association of Unsafe Abortion and Maternal Mortality**

An “unwanted pregnancy” can be unwanted at its outset, such as when due to inaccessible or failed family planning or rape, or can become unwanted when a woman finds that it presents an unacceptable risk to her life or health. Opponents of abortion choice sometimes claim that pregnancy is never “unwanted,” because, even though a woman may not want her pregnancy, her family, society, or government does. The claim that women should be compelled against their will to serve the wants of others is an instrumental denial of their human dignity and an abuse of their reproductive capacities (J. Cook Rebecca and etal , 2003).

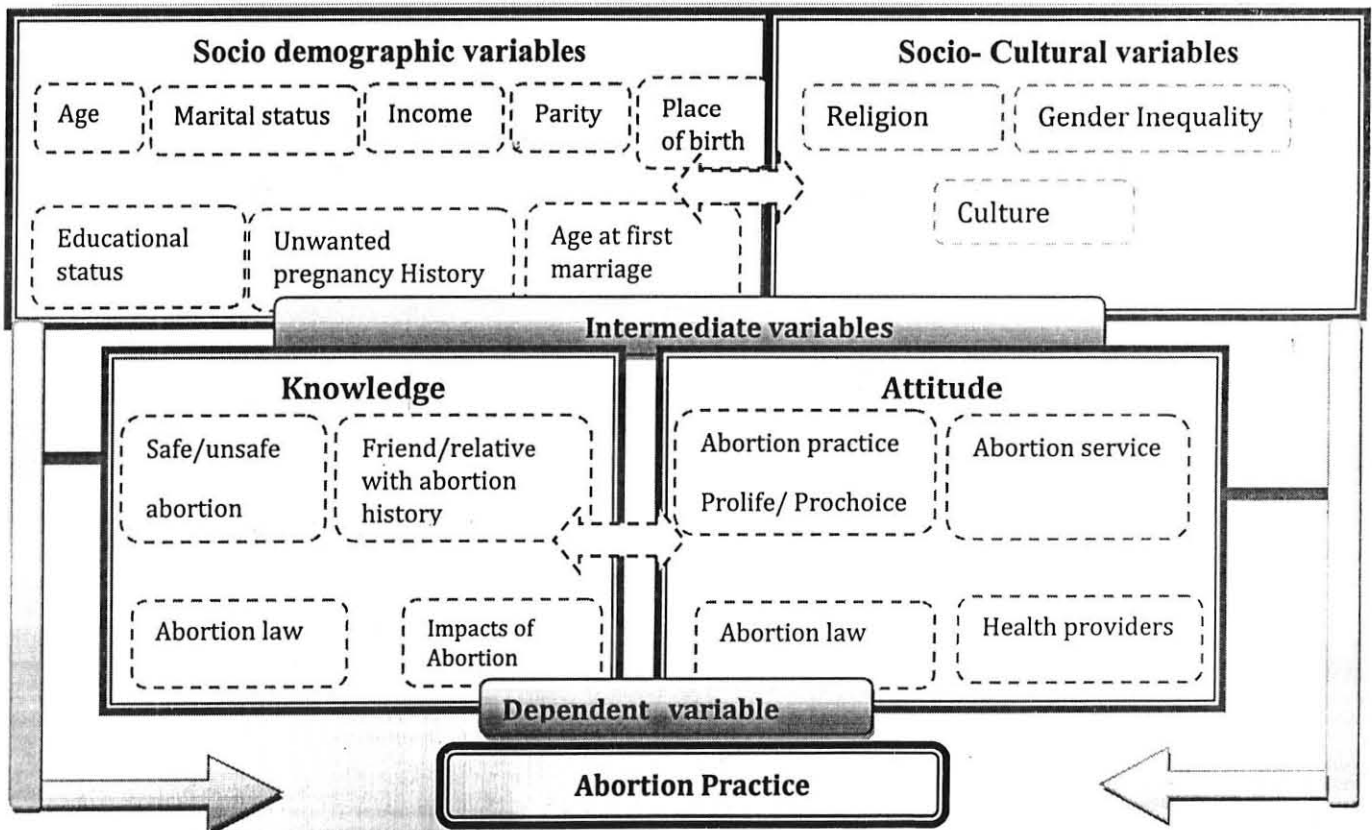
Maternal mortality, perhaps better understood in non-medical language as pregnancy-related death, includes deaths due to unsafe abortion, as well as death to women in and following childbirth. WHO defines maternal death as: The death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy but not from accidental or incidental causes ( WHO, 1992).

Nearly two thirds of maternal deaths worldwide are due to five direct causes: haemorrhage, obstructed labor, eclampsia (pregnancy-induced hypertension), sepsis, and unsafe abortion. The remaining third are due to indirect causes, or an existing medical condition that is worsened by pregnancy or delivery (such as malaria, anaemia, hepatitis, or increasingly, AIDS)( UNFPA , 2003).

Estimates of maternal deaths vary, depending on the sophistication of calculation, the time period of measurement, and classification practices. Calculation is difficult in countries that have no official registration of numbers or causes of deaths. However, Worldwide, an estimated five million women are hospitalized each year for treatment of abortion-related complications, such as hemorrhage and sepsis. Complications due to unsafe abortion procedures account for an estimated 13% of maternal deaths worldwide, or 67,000 per year. Almost all abortion-related deaths occur in developing countries. They are highest in Africa, where there were an estimated 650 deaths per 100,000 unsafe abortions in 2003, compared with 10 per 100,000 in developed regions. Approximately 220,000 children worldwide lose their mothers every year from abortion-related deaths ( WHO and Guttmacher , 2007).

The percentage of maternal deaths due to unsafe abortion will vary according to the circumstances in each country. Unsafe abortion accounted for 13% of all maternal deaths in sub-Saharan Africa, where half of the world maternal deaths occurred and among the regions, Eastern Africa have the highest, 17%. The mortality and morbidity risks associated with unsafe induced abortion depend on the facilities and the skill of the abortion provider, the method used, the general health of the woman and the stage of her pregnancy. Unsafe abortion may be induced by the woman herself, by a non-medical person or by a health worker under unhygienic conditions. Abortion attempts may involve insertion of a solid object (root, twig or catheter) into the uterus; a dilatation and curettage procedure performed improperly by an unskilled provider; ingestion of harmful substances; exertion of external force; or misuse of modern pharmaceuticals. In many settings, traditional practitioners vigorously pummel the woman's lower abdomen to disrupt the pregnancy; this can cause the uterus to burst, killing the woman (WHO, 2007).

**Figure1. Conceptual Framework;** interface of socio demographic determinants on Abortion practice.



*Source ; Developed by the researcher*

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## 2.11 Operational Definitions

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**Abortion:** termination of a pregnancy before fetal viability , which is conventionally taken to be less than 28 weeks from the last normal menstrual period. ( MOH , 2006

**Unsafe Abortion ;** The World Health Organization in 1992( Quoted in WHO , 2007) defines unsafe abortion as a procedure for terminating an unintended pregnancy carried out either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both.

**Post Abortion Care ( PAC) ;** is a comprehensive service for treating women that present to health care facilities after abortion has occurred spontaneously or after an attempted termination .

## CHAPTER THREE

### RESEARCH METHODOLOGY

#### 3.1 Study Area and the target population

This study was conducted in Addis Ababa city Administration. Based on the 2007 census , the population of Addis Ababa is estimated to be 3,459,145 extrapolated from a population of 2,738,248 on 2007 . As of 2007 , 2,738,248 total population consisting of 1,304,518 men and 1,433,730 women. From the 1,433,730 women 66.1% (948,784) of them are in their reproductive age , 15-49 age group. With an estimated area of 530.14 square kilometers, the city has an estimated density of 5,607.96 people per square kilometer (CSA and ORC Macro, 2006; CSA, 2008). In Addis Ababa there are 30 Hospital and 29 health centers that are owned by both government and private /NGO. (MOH, 2007).

This research target population were women whose age is between 15-49, and who come randomly for any Maternal child health care at the selected Health centers.

#### 3.2 Data source

On the basis of the study objectives, primary and secondary data were employed. The primary data have both quantitative and qualitative components. The primary data was originate from five selected health facilities which provide the comprehensive abortion care , getting the working certificate from Addis Ababa health bureau. Relevant local and international secondary data reviewed which were both published and unpublished. Majority secondary data was possessed from online publications store mainly Jstor , WHO, IPAS , MOH, Marystopes and etc

#### 3.3 Sample size Determination

This study takes abortion practice as dependent variable which requires proportion of Addis Ababa reproductive age women who undergo through abortion record. There is one recent study that deals with about abortion knowledge and attitude, it did not include the practice perspective.

As a result the researcher was forced to take following formula to determine sample size. (Cochran G. , 1977)

$$pq \left( \frac{z_{\alpha/2}}{E} \right)^2$$

The default value of (0.5) values of p and q are taken. The 95% confidence interval cut value of 1.96 of as  $Z_{\alpha/2}$  is considered. The study also made to tolerate the maximum standard error of 0.05 ( E value). Based on such calculation , the following process made the total sample size;

$$0.5 * 0.5 \left( \frac{1.96}{0.05} \right)^2$$

$$= 384.16$$

When 2% (8) questionnaire design effect and 10% (38) respondent effect added, the total sample size of the research turned as 430.

### 3.4 Research Design and Procedure

This research is a facility based cross-sectional, descriptive study, focusing mainly on knowledge, attitude and practice of abortion among women in reproductive age in Addis Ababa. Both quantitative and qualitative methods were applied.

Multi-stage sampling technique was employed. Using stratified random sampling the primary sampling units, which provides comprehensive abortion care (CAC) were selected. The homogeneity stratification was based on type of the facility. (Government, private or NGO). Efforts were exerted to get views from of all walks of life, by taking data from all types of health institutions ( from Government , Private and NGO). According to the information collected from the Family Health Department of Addis Ababa Regional Health Bureau , currently equal proportion of government and private health institutions ( 5 Hospitals and 10 Health centers/higher clinics ) are registered and are giving comprehensive abortion care based on the government abortion guideline which become operational starting from 2006. The department

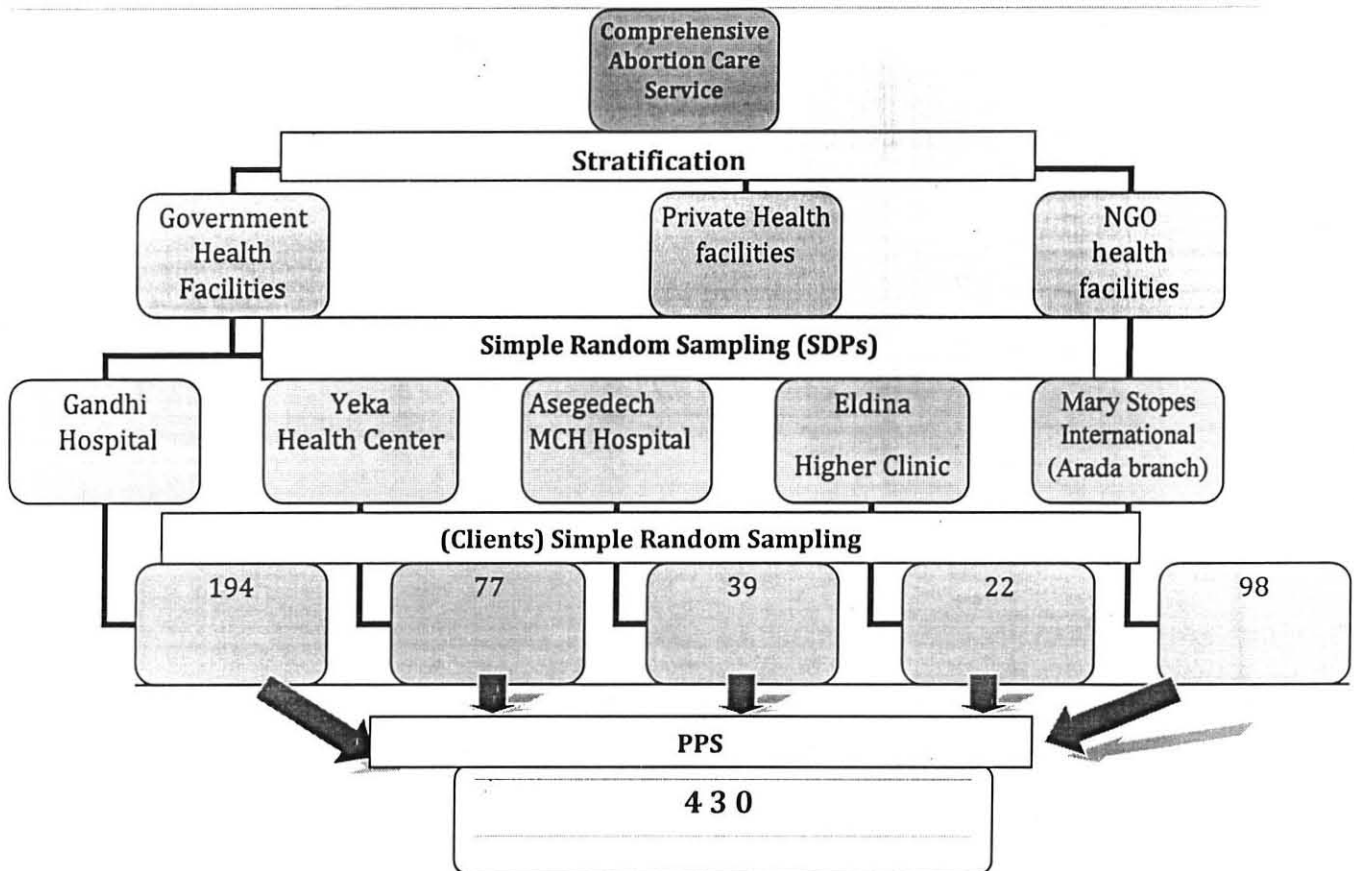
head also noted that the proportion of NGO owned health facility which are providing CAC are only three but these health facilities are preferable by the community and have been providing the service extensively.

Based on this, a total of five health facilities ( 45% (2)government , 45%(2) private and 10%(1) from NGO) were randomly selected. From government health facilities Ghandi Hospital and Yeka Health Center, from private Health Facilities Asegedech Mothers and Child Hospital and Eldina Higher Clinic and from NGO facilities Mariestopes, Arada Branch clinic were selected randomly .

After getting the necessary ethical approval to collect data from the selected Service Delivery Points (SDPs) from Addis Ababa Regional Health Bureau , the secondary sampling units which were women in their reproductive age who come to get MCH and FP service were interviewed. This last selection employed also simple random sampling procedure. The sample size was allocated with in proportional to each of the five facilities based on their monthly and annual report of 2009 on how many clients they serve in MCH/FP service.

These places were made available the researcher to get women who have been going through different reproductive health services which might include abortion and related complications. The possibility of getting women who are in their reproductive health from these sites age were also high.

**Figure 2. Sampling Procedure; illustrative Presentation**



### 3.5 Data collection

The quantitative data was collected through structured and pre-coded questionnaire. The survey questionnaire was first prepared in English and translated into Amharic. It was also pre-tested by a pilot survey among 30 women (15-49 years) in three SDPs of the selected health facilities to ensure its clarity, ordering, and acceptance. After the necessary corrections, the final questionnaire was finalized. The questionnaire contained four parts. The first part was designed to collect socio-demographic characteristics of the respondents; the second part of the questionnaire dealt with questions regarding the general abortion knowledge of the respondents; the third and fourth parts were concerned about the respondents' attitude and practice-related questions respectively.

Five female interviewers, who had former experience in data collection, were deployed to administer the questionnaires. Before the actual data collection, a three-day training was given focusing on the objectives of the study, major steps to collect quality data, approaching and

polite interviewing methods ,questionnaire filling methods and on other related matters. The quantitative data was collected in March 2010 . The data collection was closely followed and supervised by the researcher, so that anything that was unclear or ambiguous and incomplete could be corrected as early as possible.

The qualitative data was collected though open ended questionnaire that was developed for in depth interview with three representative ( from government, private and NGO) health workers who have more than three years of experience in providing comprehensive abortion care and counseling of the selected health facilities. The topic guide contained five parts ; general background of the health worker , knowledge , attitude , practice of the clients and finally service quality & challenge questions. The in-depth interview was conducted in April 2010.

### **3.6 Data Analysis**

#### **3.6.1 Quantitative data**

The collected data from the survey were encoded in to latest version of SPSS (15.0) . Data were edited and some internal inconsistency check was done to assess the quality of the data . These was done though running univariate frequencies and cross tabulating among different variables.

The analysis part which consists of descriptive statistics ( frequency and percentage) was done to know the general socio demographic characteristics of the respondents. In order to assess the existence of association between the socio demographic and the respondent's knowledge, attitude and practice bi-variate analysis was done and association was indentified though chi – square test.

At the multivariate analysis, since the dependent variable is dichotomous, a binary logistic regression model was fitted to estimate the likelihood of the occurrence abortion. Logistic regression was applied to examine the relationship between abortion practice and a set of predictor variables. The logistic regression model, the natural logarithm of odds ratio is expressed as a linear function of various independent variables.

$$\ln(p/1-p)= \beta_0+ \beta_1x_{1i}+ \beta_2x_{2x}+...+ \beta_kx_{kx}$$

The corresponding multiplicative model for the odds is

$$(p/1-p) = \exp (\beta_0 + \beta_1 x_{1i} + \beta_2 x_{2x} + \dots + \beta_k x_{kx})$$

$\beta_i$  = regression coefficients. (are partial coefficients, controlling for other variables in the model.)

$x_i$  = set of independent variables.

$p$  = probability of a woman to end pregnancy in abortion .

$1-p$  = probability of a woman to continue her pregnancy .

The logistic model are re-written in terms of the odds of an event occurring. The odds of an event occurring are defined as the ratio of the probability that it will occur to the probability that it will not.

### 3.6.2. Qualitative data

In Qualitative Data analysis, analysis of the in-depth interview was done by reading the transcripts, the observational notes and listening the tapes. The themes were identified in the responses to the key questions and categories were developed. Then quotes and narratives were sorted out, comparisons relations has been made and used to substantiate the quantitative study.

## 3.7 Variables

### A. Dependent variable

The dependent variable in this study is abortion practice of women. It is measured by whether a woman has had abortion record or not. To measure her abortion practice, woman who has ever been pregnant is also asked to describe their number of pregnancies and children ever born. Those who report a varied result are asked to explain the variation which automatically turns to be either still birth or abortion. The Women who practiced abortion were considered as “yes” and women who did not have abortion practice and have still birth together were considered as “no”.

#### **b. Intermediate variables.**

Two major themes of this study, knowledge and attitude of abortion, utilized as proximate variables to abortion practice. Women's knowledge with regard to safe and unsafe abortion, abortion law and abortion impacts were included . Women's attitude towards abortion practice, service and legality were also considered.

#### **c . Independent variables**

Effort is exerted to identify the influence of different socio- demographic and socio cultural variables on both intermediate and dependent variable of this study. Age , Marital status , educational status , parity , occupation , income , age at first marriage , place of birth , and unwanted pregnancy history have been considered with in socio demographic category. From the socio cultural factors – religion has been used to observe its effects on proximate and dependent variable while culture and gender inequality are considered to interpret the findings of certain results.

### **3.8 Ethical Considerations**

The study's proposal first got official approval from the Institute of population Studies (IPS) research team , College of Development studies (CDS). Since the research is undertaken in Addis Ababa , Addis Ababa Regional Health Bureau was the primary body which was informed and requested for an official approval . After the research team has approved the proposal , letter of collaboration was sent to all selected health facilities.

As it is known reproductive health problems in general, abortion and related cases in particular are to some extent uncommunicative issues in communities like Ethiopia. As a result it was critical to take into account different ethical issues while this research was underway especially during data collection .Moreover verbal consent and written consent was prepared and read to the respondents to get their consent before the interview. For those who were not comfortable to participate in the study, their right was respected. Confidentiality and privacy were maintained for all the respondents. Detail explanation about the objective and importance of the study was given verbally to all respondents, name and other identifiers remain undisclosed in the study.

They were also ensured that their response was only to be utilized for research purpose. Data collectors were also informed and trained to approach women in friendly manner so that they can develop trust and when they express their feelings and ideas freely.

## CHAPTER FOUR

### RESULTS

#### 4.1 Descriptive Analysis

In this study it was proposed to collect data from 430 women and the response rate was found to be 100%. The interviewed women are between age 16 and 47. All collected data were entered in to the data base and analysis was done accordingly

##### 4.1.1 Background characteristics of respondents

**Age:** Table-2 details selected socio-demographics of the women interviewed. The combined mean age of respondents was 29.62 years. The majority (30%) was in the age category of 25-29 followed by age group of 20-24 ( 22%) and 30-34 ( 21.86%).

**Literacy and educational status:** Overall, 12 % of the respondents ( N=50) are illiterate and 89 % of (N=380) the women are literate with some level of education. Consistent with existing data, they were asked to describe the highest grade they have accomplished of which 25.5 % and 50% and 24.7 % of the 380 women answered that they have some or completed primary and secondary and tertiary education respectively .

**Marital status:** Two-third of the respondents reported being married and living with a man at the time of the interview (i.e. —currently married). Never married, divorced / separated and widowed women comprised nearly 23% , 9% and 2% of the total respondents respectively.

**Age at first Marriage ;** Women whose current marital status are married / living together , widowed , separated/ divorced were asked in what age they got married.92% ( 301) of 327 women reported that they were 18 and above years old when they first got married. Among these women who got married 18 and above, 141 of them (47%) of them were married lately while they were 25 and above years old.

**Table2. Background characteristics of women interviewed (Determinants of Abortion practice, Addis Ababa March 2010)**

Age	N=430	%	Respondents literacy	N=430	%	
15-19		11	2.56	Illiterate	50	12
20-24		95	22.09	some or complete junior primary	68	16
25-29		129	30	some/complete middle primary	29	7
30-34		94	21.86	some/complete pre high school	103	24
35-39		58	13.49	some/complete full high school	86	20
40-44		39	9.07	some/complete tertiary education	94	22
45-49		4	0.93	Total	430	100
Total	430	100				
Marital status	(N=430)	%	Age at First Marriage	(N=327)	%	
Never Married	103	23.95	10-17	26	8.0	
Married/Living together	278	64.65	18-24	160	48.9	
Widowed	10	2.33	25 and above	141	43.1	
Divorced/Separated	39	9.07		327	100	
Total	430	100	Total			

Source; Field Data (March 2010)

**Religion:** The major religious affiliation of respondents is found to be orthodox Christianity composing 53% of the total respondents. Respondents who follow Islam and Protestant religions show relatively equal proportion 22.1 and 21.2 percent respectively. The rest category of religious affiliation is reported as Catholic and other traditional religions.

**Ethnicity ;** As it indicated in the following table , 31.2 % of the respondents are from Amhara , followed by women whose ethnic group are Oromo ( 27%) and women from south and southern nationalities are ( 26%).

**Occupation ;** women were requested about their current occupation and 44 % of them are unemployed being ( housewife , students etc) followed by , 41.4% who are employed and working for government , private or NGO. The remaining women reported that they are currently working as daily laborer or housemaid.

**Table 2a. Socio Demographic characteristics of women interviewed (Determinants of Abortion practice, Addis Ababa March 2010)**

Religion	N=430	%	Ethnicity	N=430	%
Orthodox	228	53.0	Oromo	118	27.4
Muslim	95	22.1	Amhara	134	31.2
Protestant	91	21.2	SNNP	112	26.0
others( traditional , catholic)	16	3.7	Tigre	61	14.2
<b>Total</b>	<b>430</b>	<b>100</b>	Others	5	1.2
			<b>Total</b>	<b>430</b>	<b>100</b>
Occupation	N=430	%	Type of earnings for work	N=240	%
Unemployed ( House wife and students)	190	44	Not paid	16	6.67
Employed( at private, gov. or NGO)	178	41	paid	224	93.33
daily laborer and housemaid	62	14	<b>Total</b>	<b>240</b>	<b>100.00</b>
<b>Total</b>	<b>430</b>	<b>100</b>			
Respondents place of Birth	N=430	%	Place of birth ( out side Addis)	N=235	%
Addis Ababa	195	45.35	city	72	30.6
Out side Addis	235	54.65	Rural Kebele	163	69.4
<b>Total</b>	<b>430</b>	<b>100</b>	<b>Total</b>	<b>235</b>	<b>100.0</b>

Source; Field Data (March 2010)

**Place of birth** ; the respondents were asked to report their place of birth and 54%(N=235) reported that they were born outside Addis Ababa of which 70% (163) of them were born in rural kebeles.

**Respondents pregnancy history** ; respondents were asked about their pregnancy history and 414 (96%) of them have been pregnant at least once.

#### 4.1.2 Abortion Knowledge

As a knowledge measurement parameter, women were asked the question “*Have you ever heard about terminating an unwanted pregnancy (abortion)*”. Overall, 97% of the women interviewed responded affirmatively. When they were asked whether they are informed about safe abortion or not, nearly 30% of them responded that they did not know . In the same manner they were requested whether they know unsafe abortion or not which shows that 93.5% of them know

about it. Respondents were also asked to indicate where abortion services are available in which 97% of them reported that they know different service providers including government, non government as well as traditional providers. Consequences of abortion were also the other question that the women were asked and 96% of the respondents mentioned major consequences of abortion.

**Table 3. Respondents knowledge on safe abortion service (Determinants of Abortion practice, Addis Ababa March 2010)**

Likelihood of facing problems after getting the service at health center/hospital		Likelihood of facing problems after getting the service outside health center/hospital		
		N=430	%	298
always face problems	141	32.7	102	23.72
sometimes face problems	188	43.7	11	2.56
no problem	69	16.0	19	4.42
I do not know	32	7.4	430	100
<b>Total</b>	<b>430</b>	<b>100.0</b>	<b>298</b>	<b>69.30</b>

Source; Field Data (March 2010)

In this study the respondents were asked how much they are aware of the possibility of facing severe abortion consequences as a woman gets an abortion service outside health institutions or unsafe places. As indicated in the above table (table 3) 43.7 % of the women answered that a woman might sometimes face abortion problems if she gets the service at hospital /clinic where as 69.3% of them agreed that a woman who acquired abortion services outside health institutions ‘ unsafe places’ might always face abortion problems.

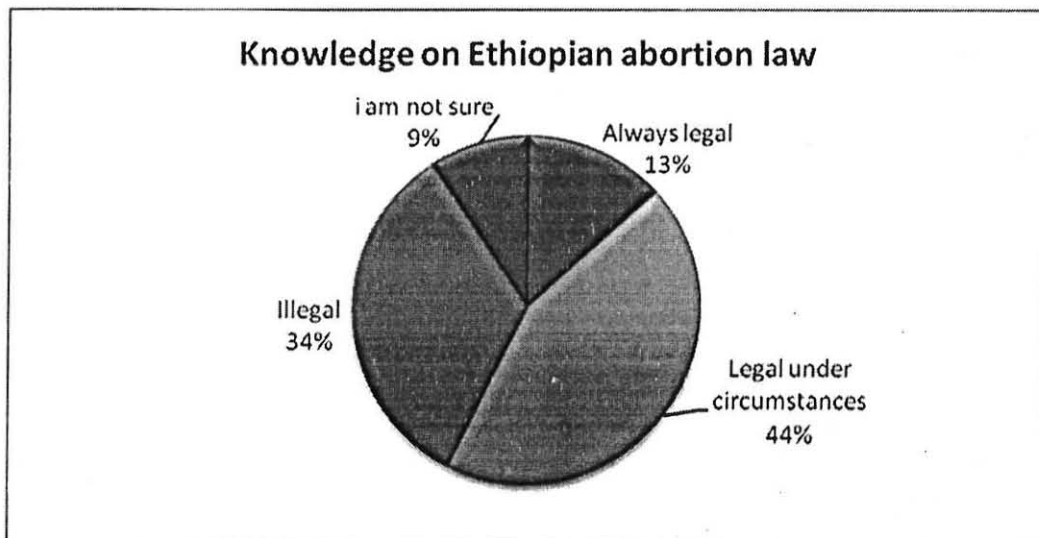
**Table 4. knowledge A person with Abortion case (Determinants of Abortion practice, Addis Ababa March 2010)**

Do you know a woman who has terminated her pregnancy? aborts her pregnancy?	Frequency	Percent
yes	300	69.7
no	130	30.2
Total	430	100

Source; Field Data (March 2010)

Regarding abortion knowledge , it was important how much the respondents are familiar with abortion issues by asking them whether they have friends or relatives who have abortion history. As the above table (table 4) indicates almost 70% ( N=300) of the respondents reported that they know a friend or a relative who have had abortion before.

**Figure 3. Knowledge of Respondents about Ethiopian ; Abortion KAP survey, Addis Ababa, March 2010**



Source; Field Data (March 2010)

The other abortion knowledge parameter that was forwarded to the respondents was to state their current information on abortion law of Ethiopia. As one can observe from the pie chart above ( fig 3) only 44% of the respondents mentioned that abortion is legal under some circumstances while 34% of the respondents answered that abortion is illegal . ( 13%) of them also understand the current abortion law is legal , while the rest (9%) are not sure about the law.

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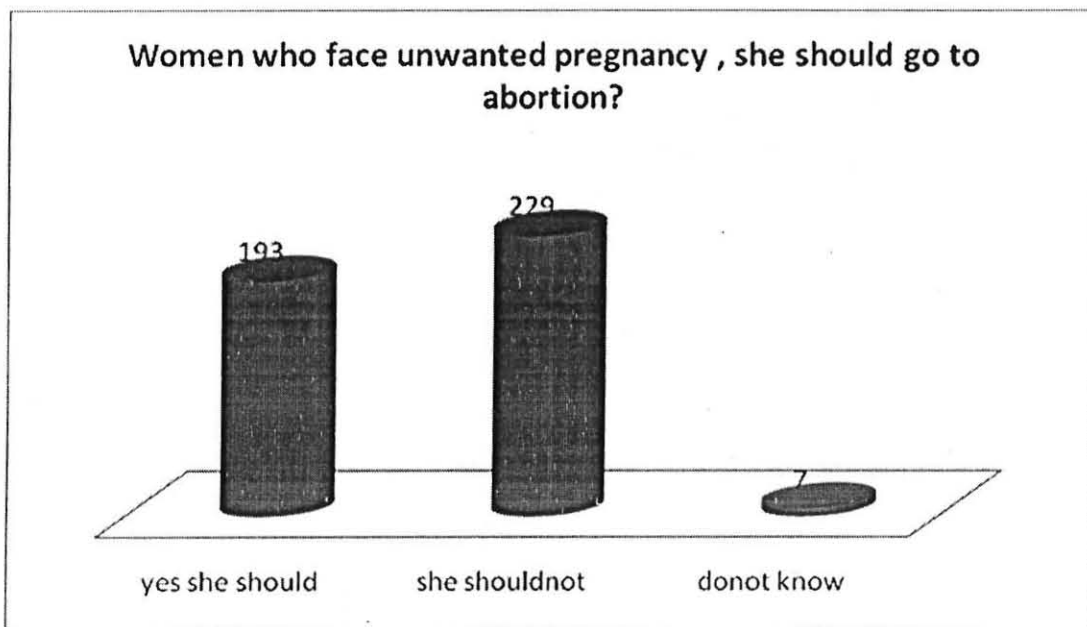
*The in depth interview result with health workers of the selected organization revealed that most women who come to have abortion services do not have prior information about the Ethiopian abortion law , they explained that they inform them during the service.*

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#### 4.1.3 Attitude Towards Abortion

Different questions were put forward to find out the attitude of respondents with regard to abortion. The first question was whether a woman who faces unwanted pregnancy should undergo abortion and as indicated in the bar chart below (fig 2), 53.2%( N=229) of them negate the idea of going to end the pregnancy through abortion and 44.8% ( N=193) of them support the idea of ending the unwanted pregnancy with abortion.

Figure 4. Respondents attitude towards abortion practice (Determinants of Abortion practice, Addis Ababa March 2010)



Source; Field Data (March 2010)

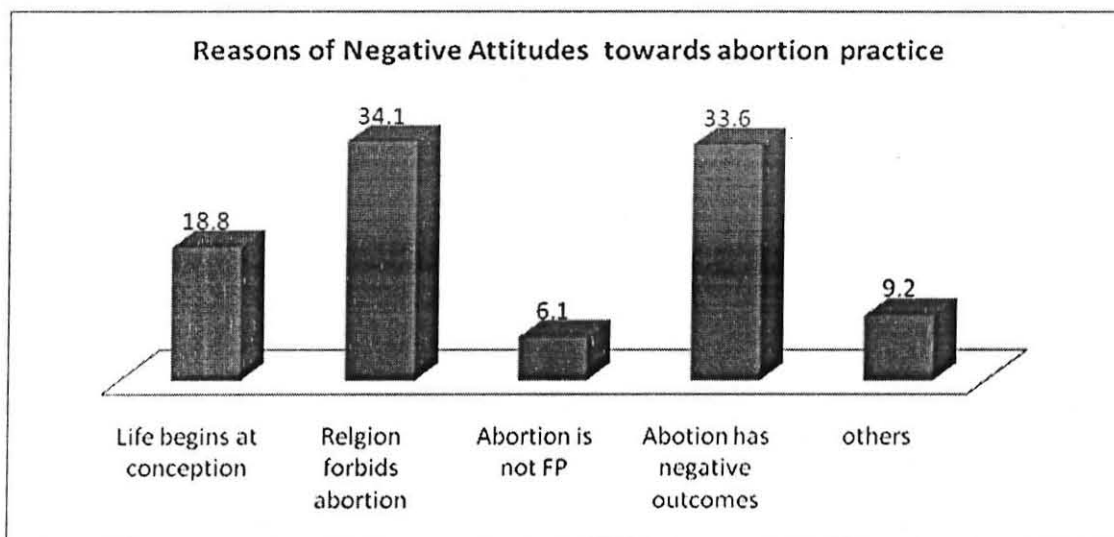
Based on the above attitude response the respondents were allowed to justify their response for rejecting or supporting the idea of terminating an unwanted pregnancy with abortion. As indicated in the following table (table 5) 63.2% responded affirmatively reasoning that a woman should get abortion in any circumstances, and if a woman faces the unwanted pregnancy due to either rape or incest 29.1% view abortion as a sole choice.

**Table 5. Respondents reasons for having positive Attitudes towards abortion practices (Determinants of Abortion practice, Addis Ababa March 2010)**

Positive Attitudes towards abortion practices – reasons	Number	Percentage
under any circumstances women should get abortion service	122	63.2
Abortion a human right issue	8	4.1
abortion has no harmful consequences	3	1.6
if women face rape and incest , abortion is sole choice	56	29.0
if she is poor	3	1.6
if the pregnancy is deformed	1	0.5
<b>Total</b>	<b>193</b>	<b>63.2</b>

Source; Field Data (March 2010)

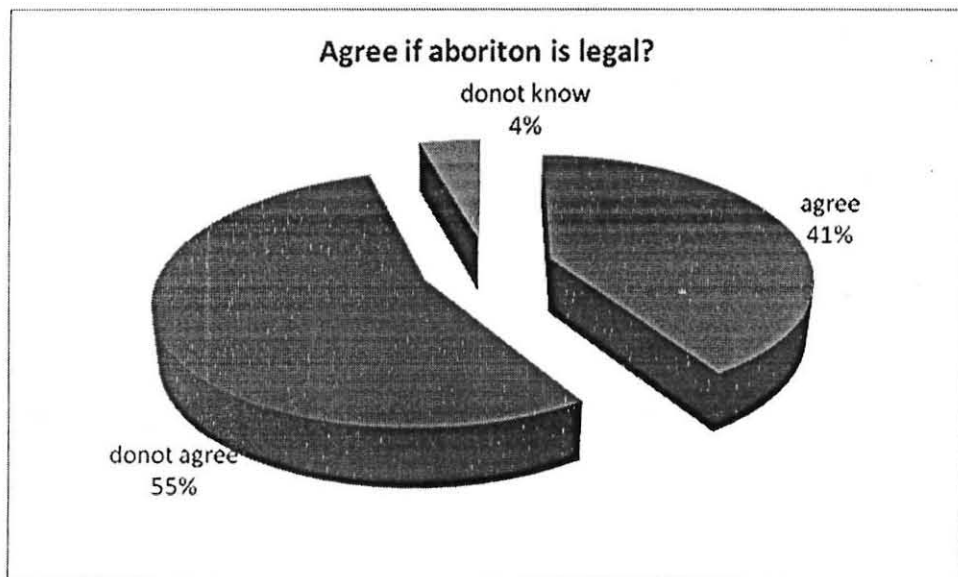
**Figure 5. Reasons of respondents for having Negative attitude towards abortion practice ; (Determinants of Abortion practice, Addis Ababa March 2010)**



Source; Field Data (March 2010)

Respondents who oppose the idea of terminating unwanted pregnancy were also asked to state their reasons. And as the above bar chart (fig 5) shows almost equal proportion of respondents (34.1% and 33.6% justify their stance because 'religion states abortion as a murder' and a 'woman after abortion will face severe health problems' respectively. There were also (17%) of the respondents who do not agree with the idea of abortion from pro-life or right of the unborn child point of view.

Figure 6. Respondents Attitude towards Abortion (Determinants of Abortion practice, Addis Ababa March 2010)



Source; Field Data (March 2010)

Participants of this survey were asked whether they agree if abortion will be fully legal (on request) in the future and as portrayed on the above pie chart (fig 6) 55% of them do not agree, 41% agree and 4% of them do not know what is their attitude about it.

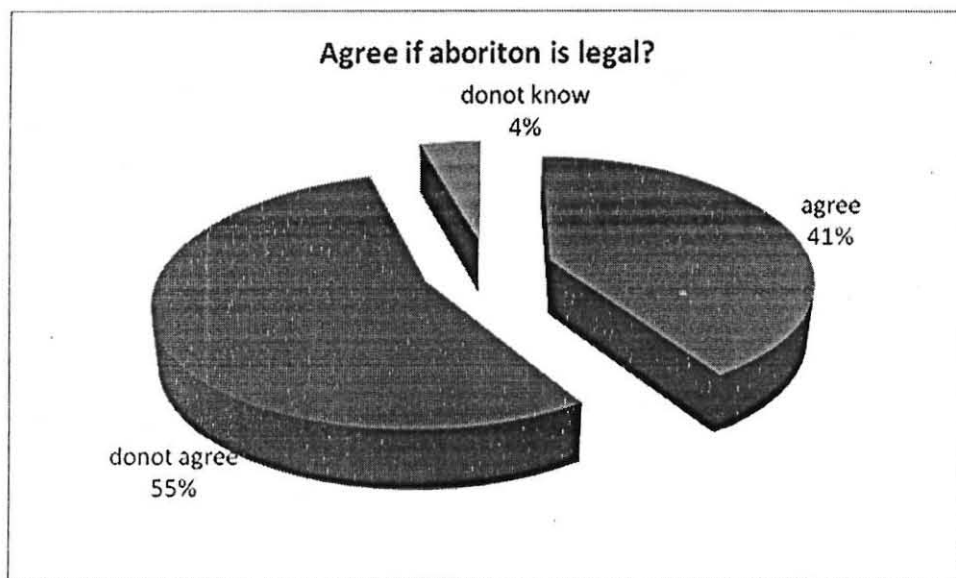
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*Result from in depth interview indicates that women prefer the Ethiopian abortion law to be broadened so that women with diverse socio economic background are entertained.*

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*Result from in depth interview indicates that women prefer the Ethiopian abortion law to be broadened so that women with diverse socio economic background are entertained.*

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Table 6. Respondents Opinion on outcomes of abortion law (Determinants of Abortion practice, Addis Ababa March 2010)

What result will happen if abortion is fully legal			
		Number	Percent
	abortion will increase	147	34.19
	unsafe abortion decrease	139	32.33
	nothing	144	33.49
	Total	430	100

Source; Field Data (March 2010)

Based on the attitude of abortion law , it was also important to understand the respondents attitude on legality of abortion by asking *what will happen if abortion becomes fully legal* . Respondents could be categorized in three categories according to their responses. About 34.2% of them expressed their fear that abortion might increase when it becomes fully legal , and 32.3% of them feel that unsafe abortion will decrease while the rest 33.5% do not see any change whether it becomes legal or not.

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*Findings from in- depth interview revealed that there is a change in the number and conditions of women coming for abortion before and after the revision of the law. The interviewee mentioned that before 2004, women who come with complications after trying abortion illegally were high. Daily a significant number of women come bleeding to death, with uterus infection and other related serious health problems. But now woman who need safe abortion care are becoming significant in number.*

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#### 4.1.4 Respondents practice on abortion

To know the abortion history of the respondents selected questions were sequentially presented. First they were asked whether they have been pregnant at least once, and then they were asked the number of pregnancies which ended in live birth , they were also asked to report on their current total number of children . Finally women whose number of pregnancy and number of

children vary were carefully asked why the discrepancy happened between their number of pregnancy and number of children.

**Table 7. Women pregnancy and Children Ever Born (Determinants of Abortion practice, Addis Ababa March 2010)**

<b>Pregnancy , total number of children and abortion related questions</b>		
<b>Have you ever been pregnant?</b>	<b>Frequency</b>	<b>Percent</b>
yes	414	96.28
no	16	3.72
<b>Total</b>	<b>430</b>	<b>100</b>
<b>Do you have any children</b>		
Yes	254	59.07
No	176	40.93
<b>Total</b>	<b>430</b>	
<b>Abortion Practice</b>		
Yes	271	65.4%
No	159	34.5%
<b>Total</b>	<b>430</b>	<b>100.00</b>

**Source; Field Data (March 2010)**

As can be understood from the above table 96% (414) of the respondents have ever been pregnant at least once of those 59% (254) of them have children. Out of 414 ever pregnant women 271 ( 65.4%) of them have had abortion in their life time. Women who declare that they have gone through abortion were asked on the type of abortion they 66.4% of them pointed out that the abortion was induced and the rest 33.5% of them that explained the abortion was due to miscarriage / spontaneous.

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*The interviewed health workers explained that when clients come to the centers with lots of bleeding they ask them why it happened; and most of them do not want to mention that they went to unsafe places , rather they just say ‘ I haven’t gone anywhere , I haven’t done anything; I just have the bleeding etc.*

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#### 4.1.5 Abortion Reasons

Women who have faced either induced or spontaneous abortion were asked the reasons of facing such problems and as indicated in the following pie chart ( fig7) 44 % of the reason were related with socio cultural reasons mainly being unmarried and having bad relationship with husband / fiancée or with their boy friend. Among the socio cultural factors ; rape accounted for 5.5% of the induced abortion reasons.

Women who forced to choose abortion due to health related issues (34%) stated that pregnancy deformity was the main problem. Women who mentioned economic reasons (15%) for their abortion decision explained employment and poverty as the major factors. Finally women who decided to had abortion due to demographic (6%) reasons, they have stated they have had enough family size .

**Figure 7. Reasons of women to choose Abortion ; (Determinants of Abortion practice, Addis Ababa March 2010)**



Source ; Field Data , March 2010

**Table 8. Marital status of women during abortion, (Determinants of Abortion practice, Addis Ababa March 2010)**

<b>Marital Status</b>	<b>Frequency</b>	<b>Percent</b>
Never married	92	33.94
Married/living together	155	57.19
Widowed/separated/divorced/	24	8.85
<b>Total</b>	<b>271</b>	<b>100</b>

Source ; Field Data , March 2010

As indicated in the above table (table 8) on marital status during abortion period of respondents , 57% of them were either married or were living with a partner followed by single and widowed/separated/divorced with 34% and 9% respectively.

**Table 9 Women’s abortion reasons per their marital status (Determinants of Abortion practice, Addis Ababa March 2010)**

<b>Marital status of respondents during abortion</b>	<b>Underlying factors</b>					<b>Total</b>
	<b>socio cultural reasons</b>	<b>Economic Reasons</b>	<b>Demographic reasons</b>	<b>health problems</b>	<b>others</b>	
Never married	68( 73%)	17(18.5%)	2( 2%)	5( 5.5%)	0	92
Married/living together	42( 27%)	16(10.3%)	13( 8.4%)	81( 52.3%)	3(2%)	155
Widowed/separated/divorced	10( 41%)	6( 25%)	1( 4%)	7( 29%)	0	24
Total	120( 44%)	39( 14%)	16( 6%)	93( 35%)	3( 1%)	271

Source ; Field Data ( march 2010)

As it indicated in the above cross table ( table 9) women who were single when they have aborted their pregnancy , 73% of them were due to different socio cultural reasons followed by economic reasons. Majority of married and living with a partner women have explained pregnancy related health problems ( 52%) as reason to have abortion followed by women who were influenced by socio cultural reasons ( 27%). Women who were widowed / separated / divorced were influenced by mainly socio cultural factors ( 41%) followed by health problems ( 29%) .

*During the in -depth interview, the health workers mentioned that women give different reasons for their decision to terminate the pregnancy. Married / those living with a partner decide to have abortion when they have enough children and cannot afford to have one additional child. Single/students who are living with their family primarily mention that it is a disgrace to the family if they have a child out of wedlock – called ‘ diqala ‘ in local language. Women who are housemaid and illiterate mentioned that they were raped / get pregnant from relatives. Young women also mention going to middle East for work as a factor to end their pregnancy.*

**Table 10 . Women Age when during abortion Period ; (Determinants of Abortion practice, Addis Ababa March 2010)**

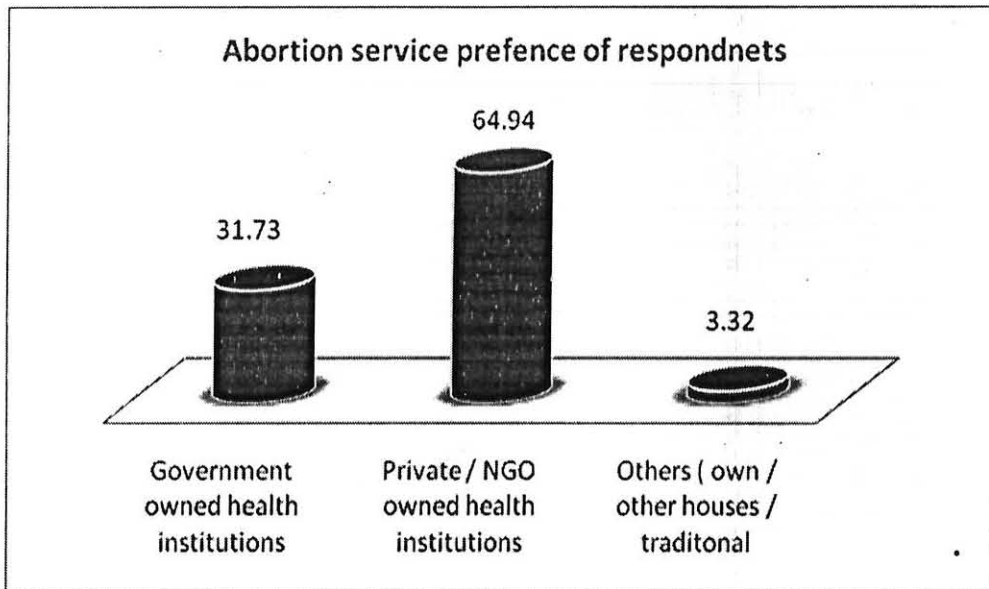
<b>Age of women during abortion</b>	<b>N=271</b>	<b>%</b>
<b>less than 20</b>	<b>103</b>	<b>38.1</b>
<b>20-29</b>	<b>138</b>	<b>51.1</b>
<b>30-39</b>	<b>26</b>	<b>9.6</b>
<b>40 -44</b>	<b>3</b>	<b>1.1</b>
<b>missing</b>	<b>1</b>	<b>0.4</b>
<b>Total</b>	<b>270</b>	<b>100</b>

As the above table (table 10) indicates, women whose age was between 20-29 are the highest percentage in practicing abortion followed by women whose age was below 20. About 89 % of abortion cases were also found among women whose age was below 30. The number of abortion cases also decreases as age increases.

#### **4.1.6 Abortion – Quality of care**

To assess facility preference women who terminate their pregnancy were asked where they went to get the service. The below chart (fig 8) illustrates that 65% and 32% of them went to private or NGO owned and government health institutions respectively. Those who went to private/NGO , more than 60% of them justify that they prefer the facility because of the service quality and confidentiality issues . Women who went to government health facilities , > 50 % of them explain that quality service and the fair fee make them prefer the facility .

Figure 8 . Abortion service preference of the respondents; (Determinants of Abortion practice, Addis Ababa March 2010)



*Findings from in depth interview with health workers revealed that women who have a relatively better education and income are inclined to seek safe abortion services at private health institutions. Even though they know that government health facilities provide the service with reasonable fees, they do not have the trust of getting quality service. Women who do not have the knowledge where safe abortion is available went to different unsafe places and try to terminate the pregnancy in unsafe methods (including at home) and start to face excessive bleedings which forces them to go to a nearby by government health center . Women who are poor but know place of safe abortion service they tend to go to affordable abortion service places ( NGO owned health institutions). The government health workers also explain that “single women are afraid to discuss and tell their history freely because they assume that the health workers will disrespect them or mistreat them.” More over they added that the number of women with repeated abortion cases cannot be neglected.*

**Table 11. Abortion complications of women who end their pregnancy in abortion ;  
(Determinants of Abortion practice, Addis Ababa March 2010)**

<b>Did face abortion effects after you terminate the pregnancy?</b>	<b>Frequency</b>	<b>Percent</b>
Yes	128	47.23
no	143	52.77
<b>Total</b>	<b>271</b>	<b>100.00</b>
<b>What did you when you had bleeding and other abortion effects</b>		
I went to health center/hospital	98	76.56
Others ( I did nothing , I went to traditional places	30	23.44
<b>Total</b>	<b>128</b>	<b>100</b>

Source ; Field Data ( March 2010)

As indicated in the above table (table 11) from the 271 women who had induced abortion in their life time , 47% of them have faced some health problems because of the abortion. Vaginal bleeding for a minimum of seven days was the main type of health problem they faced after the induced abortion. Among these women 76% of them have tried to get post abortion treatment from health center /hospital while the remaining women left their problems without seeking any treatment.

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*The health workers also explained that , women who went to other unsafe places face multiple short term and long term risks such as bleeding for long period of time , infection , abdominal pain Frequent abortion and infertility are the other long term and permanent problems women face due the unsafe abortion they had.*

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**Table 12; Social support of the respondents who end their pregnancy in Abortion :  
(Determinants of Abortion practice, Addis Ababa March 2010)**

<b>Marital status of women and their husband knowledge on abortion decision</b>			
	<b>Yes</b>	<b>No</b>	<b>Total</b>
Never married	31( 33.6%)	61( 66.3%)	92
Married/living together	133( 86%)	22( 14%)	155
Widowed/separated/divorced/	7( 29%)	17( 71%)	24
<b>Total</b>	<b>171( 63%)</b>	<b>100( 36.9%)</b>	<b>271</b>

<b>Husband / finacee / boyfriend attitude towards abortion decision</b>			
	<b>Support the idea</b>	<b>Reject the idea/No suggestion</b>	<b>Total</b>
Never married	26(84%)	5( 16%)	31
Married/living together	102( 76%)	31( 23%)	133
Widowed/separated/divorced/	4( 57%)	3( 43%)	7
<b>Total</b>	<b>130( 76%)</b>	<b>41( 24%)</b>	<b>171</b>

In order to know the existence and level of social stigma on women's who went through abortion ; women were asked what feedbacks they have received from their immediate social network. The boy friend / fiancée / of 61 single women ( 66% of 92 ) did not have the information about the women's abortion decision. From the rest informed men ( 34%, N=31), 84% of them have supported the idea.

Married women (N= 155) , 86% of them have announced their abortion to their husband / fiancée. From men who have prior information about their wife/ fiancée abortion decision 76% of them ( N=100) support the women's decision.

To know peoples attitude towards women who terminate their pregnancy in induced abortion, in this study the 271 women were asked what type of attitude and feedback they get from their immediate social network. Based on this 63% ( N=171) of the women's husband / friend / fiancée did know about their decision of which 130 of them ( 76%) support their decision. With regard to the attitudes of friends and family, most of them refrain from telling their decision ( 49% and 54% respectively).

Table 12 a ; Social support of the respondents who end their pregnancy in Abortion :  
(Determinants of Abortion practice, Addis Ababa March 2010)

Attitudes of respondent's friend during abortion decision				
	support the idea	reject the idea	Not informed / no suggestion	Total
never married	28( 30.4%)	1(1.1%)	63( 68.5%)	92
married/living together	62(40%)	10(6.5%)	83(53.5)	155
widowed/separated/divorced/	5(21%)	1(4.2%)	18(75%)	24
<b>Total</b>	<b>95(35%)</b>	<b>12(4.4%)</b>	<b>164 (60.5%)</b>	<b>271</b>
Family's attitude towards respondents abortion decision				
never married	7( 7.6%)	3(3.3%)	82(89%)	92
married/living together	54(34.8%)	7(4.5%)	94(60%)	155
widowed/separated/divorced/	2(8.3%)	3(12.5%)	19( 79%)	24
<b>Total</b>	<b>63(23%)</b>	<b>13(5%)</b>	<b>113( 42%)</b>	<b>271</b>

As can be comprehend from the above table, in all marital status category friends and families of majority women are either did not know or they have retreated from giving any suggestion about the abortion. 40% and 35% of married women were supported by their friends and their families respectively. Out of 92 single women 69% their friends and 89% of their families are either did not know about the abortion decision or they prefer to say nothing.

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*The interviewed health workers explained that, student and unmarried women tend to come with their best and trusted girl friends. Women who are single but have a promising relationship and married women are seen coming with their fiancée / husband and get the necessary information together.*

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*The interviewed health workers explained that, student and unmarried women tend to come with their best and trusted girl friends. Women who are single but have a promising relationship and married women are seen coming with their fiancée / husband and get the necessary information together.*

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**Table 13. Current pregnancy status and wantedness of the child ; (Determinants of Abortion practice, Addis Ababa March 2010)**

<b>Currently pregnant ?</b>	<b>Frequency</b>	<b>Percent</b>
No or unsure	300	69.8
Yes	130	30.2
<b>Total</b>	<b>430</b>	<b>100.0</b>
<b>Wanted the last child?</b>		
Wanted then	106	81.5
Wanted later/no more	24	18.5
<b>Total</b>	<b>130</b>	<b>100.0</b>
<b>Currently using family planning? ( to non pregnant respondents?)</b>		
yes	229	76.3
no	71	23.7
<b>Total</b>	<b>300</b>	<b>100.0</b>

Source ; Field Data , March 2010

Respondents of this survey were requested to report their current pregnancy status. And the above table (table 13) illustrates that, 70% of them reported that they are not pregnant or they are not sure about it. Those who report that they are currently pregnant ( 30%) were asked whether they wanted the child or not accordingly 82% of them answered they that they wanted the child and the remaining ( 18%) of them answered that they wanted the child but later or they wanted no more children.

**Table 14 . Unwanted Pregnancy History of Women (Determinants of Abortion Practice, Addis Ababa March 2010)**

<b>Have you ever faced unwanted pregnancy</b>	<b>Frequency</b>	<b>Percent</b>
yes	192	44.65
no	238	55.35
<b>Total</b>	<b>430</b>	<b>100.</b>
<b>Why did you face unwanted pregnancy</b>		
Absence of appropriate / adequate knowledge on contraceptives	82	42.7
I know but I did not use contraceptives	68	35.4
Contraceptive failures	36	18.8
health problems/deformed pregnancy	6	3.1
<b>Total</b>	<b>192</b>	<b>100</b>

Source; Field Data (March 2010)

about Family Planning methods , 35% of informed us that they did have unwanted pregnancy because they know family planning but they were not users.

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*As health worker from the private health institution mentioned that from the women who seek abortion services, majority of them have the FP knowledge but there is a huge problem in practice. Some of them reported that they are using emergency contraceptives frequently rather than using a regular FP method (often erroneous). Women who have infrequent /casual sexual relationship also use rhythm( withdrawal) method which make them vulnerable to unwanted pregnancy and consecutively with abortion.*

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## **4.2 Bi -Variate Analysis**

There are different methods for assessing bi variate association of the dependent variable and independent variables. Chi Square test is one way for examination of a bivariate relationship can measure the statistical significance of cross tabs cells of two categorical variables. It measures how different the values in the cells of a cross tab are from expected values. Since for this study all the variables were categorized, it is found that Chi Square test is suitable for the examination of the bivariate relationship . Based on this ; knowledge , attitude and practice of respondents were cross tabulated with socio demographic characteristics and the associated variables explained in each table below( table 15) .

Table 15. Factors associated with women knowledge of unsafe abortion; (Determinants of Abortion Practice, Addis Ababa March 2010)

Socio -demographic variables	know about unsafe abortion		Total	X <sup>2</sup>	P-value
	I know	I do not know			
<b>1 Work status</b>					
not working	175(92.1%)	15(7.8%)	190	1.1	0.3
working	227(94.5%)	13(5.4%)	240		
<b>2 Place of birth</b>					
Addis Ababa	185(94.8%)	10(5.1%)	195	1.12	0.29
Out side Addis	217(92.3%)	18(7.6%)	235		
<b>3 Marital status</b>					
Never Married	94(91.3%)	9(8.7%)	103	1.42	0.7
Married/Living together	262(94.2%)	16(5.7%)	278		
Widowed	9(90%)	1(10%)	10		
Divorced/Separated	37(94.8%)	2(5.12%)	39		
<b>4 Educational status</b>					
illiterate	47(94%)	3(6%)	50	19.404	0.001
some or complete junior primary	56(82.3%)	12(17.6%)	68		
some/complete middle primary	28(96.5%)	1(3.4%)	29		
some/complete pre high school	96(93.2%)	7(6.7%)	103		
some/complete full high school	82(95.3%)	4(4.6%)	86		
some/complete tertiary education	93(98.9%)	1(1.06%)	94		
<b>5 Religion</b>					
Orthodox	214(93.8%)	14(6.1%)	228	0.3	0.9
Catholic/protestant	98(93.3%)	7(6.6%)	105		
Muslim	88(92.7%)	7(7.3%)	95		
Others/traditional	2(100%)	0	2		

\*\* significant at P<0.001

In comparing the association of socio demographic characteristics of respondents with their knowledge about safe abortion , it is only their educational status which showed a strong association with at X<sup>2</sup>=19.4 and p value < 0.001. From those who have primary to tertiary education ( N=380) , 88% ( N=355) responded that they do know about unsafe abortion.



**Table 16 ; Factors Associated with women's knowledge about abortion complications ;  
(Determinants of Abortion Practice, Addis Ababa March 2010)**

Socio Demographic Characteristics		Know abortion consequences		Total	X2	P-value
		Yes	No			
Knowledge of a person with abortion cases	yes	298(99.3%)	2(0.7%)	300	9.85	0.002
	no	123(94.6%)	7(5.3%)	130		
educational background	illiterate	48(96%)	2(4%)	50	13.69	0.01
	some / complete junior primary	63(92.6%)	5(7.3%)	68		
	some/complete middle primary	29(100%)	0	29		
	some/complete pre high school	102(99.02%)	1(0.9%)	103		
	some/complete full high school	85(98.8%)	1(1.1%)	86		
	some/complete tertiary	94(100%)	0	94		
Know about safe abortion	I know	294(97.3%)	8(2.6%)	302	1.53	0.216
	I do not know	127(99.2%)	1(0.7%)	128		
know about unsafe abortion	I know	395(98.2%)	7(1.7%)	402	1.55	0.212
	I do not know	26(92.8%)	2(7.14%)	28		
marital status	Never Married	100(97.08%)	3(2.9%)	103	0.44	0.50
	Ever married	321(98.1%)	6(1.8%)	327		
have you ever face unwanted pregnancy	yes	188(97.9%)	4(2.08%)	192	0.0001	0.990
	No	233(97.8%)	5(2.1%)			
respondents occupation	Unemployed	185(97.3%)	5(2.6%)	190	4.58	0.101
	employed	177(99.4%)	1(0.5%)	178		
	daily laborer and housemaid	59(95.1%)	3(4.8%)	62		
Age 5-year groups	15-19	9(81.8%)	2(18.1%)	11	22.16	0.001
	20-24	86(95.5%)	4(4.4%)	90		
	25-29	135(100%)	0	135		
	30-34	86(96.6%)	3(3.3%)	89		
	35-39	65(100%)	0	65		
	40-44	34(100%)	0	34		
Have you ever been pregnant	yes	405(97.8%)	9(2.17%)	414		
	no	16(100%)	0	16		
age at first marriage	10-17	24(92.3%)	1(3.8%)	26	13.34	0.05
	18-24	157(98.12%)	3(1.8%)	160		
	25 and above	140(99.2%)	1(0.7%)	141		

Source ; Field data calculation ( March 2010)

As the above cross tab indicates there are four different socio demographic variables which indicate association with knowledge of complications of abortion.

**Knowing a friend or relative who has had abortion** shows a significant association with knowledge on the consequences of abortion with  $X^2 = 9.85$  and at  $p < 0.002$ . Women who do know a family (relatives) that has had an abortion (N=300) , 99% (N=298) of them recognized being familiar with abortion consequences.

**Education;** When we see the educational background of respondents with their knowledge about abortion consequences , the association turns to be significant with  $X^2 = 13.65$  at  $p < 0.01$ . From the literate respondents (n=380) , 98% of them answered they know the negative results of terminating pregnancy in abortion . When we see the illiterate respondents' knowledge on abortion effects, 4% of them answered they do not know the abortion consequences.

**Age;** Age is the other variable which shows a strong association with respondents' knowledge about abortion consequences with  $X^2$  value 22.16 at  $p < 0.041$ . As we can observe from table 12 those who report above 25 years old ( N=329) , 99% of them mention the consequences that result from abortion. In women whose age is below 25 years old ( N=101) , 6% of them report that they are not familiar with the negative result which comes from abortion.

**Age at first marriage** is also found to have a strong association with knowledge of abortion consequences with  $X^2$  value of 13.34 significant at  $p < 0.05$ . From the married 327 women 26 of them indicate that their age at first marriage is below 18 years old. From those women who married early, 4% of them haven't mentioned about the consequences resulting from abortion while 99% of women who get married after 18 years old were able to mention some of the negative effects of abortion.

#### **Factors associated with women attitude towards abortion**

To know which socio economic variables have an association with attitude towards abortion cross tabulation and chi square test was done and it was found out that it is only marital status that had a significant relationship with abortion attitude.

Table 17 . Factors associated with respondents attitude towards abortion law ;  
(Determinants of Abortion Practice, Addis Ababa March 2010)

Socio Demographic characteristics		do agree if abortion becomes fully legal		Total	X2	P value
		agree	Do not agree			
age at first marriage	10-17	5(19.2%)	21(80.7%)	26	5.4	0.0644
	18-24	57(35.6%)	103(64.3%)	160		
	25 and above	60(42.5%)	81(57.4%)	141		
know legal status of abortion	No	68(28.2%)	173(71.7%)	241	36.6	0.000
	yes	108(57.1%)	81(42.8%)	189		
Knowledge of person with abortion cases	yes	143(47.6%)	157(52.3%)	300	18.6	0.000
	no	33(25.3%)	97(74.6%)	130		
educational background	illiterate	10(20%)	40(80%)	50	25.0	0.0001
	some or complete junior primary	33(48.5%)	35(51.4%)	68		
	some/complete middle primary	11(37.9%)	18(62.1%)	29		
	some/complete pre high school	56(54.3%)	47(45.6%)	103		
	some/complete full high school	24(27.9%)	62(72.1%)	86		
	some/complete tertiary education	42(44.7%)	52(55%)	94		
	know about unsafe abortion	I know	165(41.04%)	237(58.9%)		
	I do not know	11(39.28%)	17(60.7%)	28		
respondents religion affiliation	Orthodox	103(45.1%)	125(54.8%)	228	8.8	0.030
	Muslim	40(42.1%)	55(57.8%)	95		
	Protestant	31(34.9%)	60(65.9%)	91		
	others( traditional , catholic)	2(12.5%)	14(87.5%)	16		
marital status of women	never married	54(52.47%)	49(47.5%)	103	7.5	0.05
	married	88(36.97%)	150(63.0%)	238		
	living together	16(40%)	24(60%)	40		
	widowed/separated/separated	18(36.7%)	31(63.2%)	49		

When we test the socio demographic variables that influence women's attitude towards legality of abortion, as the above illustrative table (table 16) indicates five variables were identified having an association.

**Knowledge Ethiopian legal status of abortion ;** Having or not having the accurate information on the Ethiopian abortion law indicate a strong association with possessing liberal of conservative attitude on full legality of abortion. As we can see, having the information correlates with legality attitudes with chi square value 36 , being significant at  $p < 0.000$ . Women

who have the exact information on Ethiopia abortion law (N=189) , 108(57.1%) of them agree for it to be fully legal . Women who do not mention the exact circumstances of abortion law (N=241) , only 28% of them are positive about abortion being totally legal.

**Know a friend/relative who has had abortion ;** The second variable that shows a an association with respondents attitude towards the legality of abortion is their prior information from their friend / relatives about abortion with chi square of 18.6 being sign infant whenever p value is less than 0.000. Those women who know friend / relative with abortion case ( N=300) 47% them agree for abortion to be fully legal compared to 74% of 130 women who do not know a friend/relative with abortion case and disagree.

**Education ;** Educational status of respondents was the other important variable which influences the view of the women on legality of abortion. Women who have no education ( N=50) , 80 % of them do not agree on the idea of making abortion fully legal. Women who are literate and have education from primary to tertiary education ( N=380) 43.6 of them agree for abortion to be legal .

**Religion ;** Religion was the additional social variable which shows a significant relationship with women's attitude towards the legality of abortion with chi square value of 8.84 and significant when p value is less than 0.05. 53% (N= 228) of the women are Orthodox followers of which 45% of them have positive attitude towards legality of abortion. Muslim(N=95) and protestant (N=91) religions followers report that they do not support the idea of making abortion fully legal with 57% and 65% respectively.

**Marital Status ;** Marital status of the women is the other key variable which play a great role in molding their attitudes towards abortion law with  $X^2$  value 7.54 which becomes significant when p value is less than 0.05. As table 13 indicates women who have never been married are relatively liberal than ever married women. 52% of 103 single women and 37% of 327 married women support the idea of making abortion fully legal.

**Table 18 ; Factors associated with women abortion practice (Determinants of Abortion Practice, Addis Ababa March 2010)**

Variables		did have abortion practice			Chi Square	P-Value
		no	yes	Total		
Respondents religion affiliation	Orthodox	86(37.7%)	142(62.2%)	228	1.68	0.641
	Muslim	32(33.6%)	63(66.3%)	95		
	Protestant	33(36.2%)	58(63.7%)	91		
	others( traditional , catholic)	8(50%)	8(50%)	16		
educational background	illiterate	18(36%)	32(64%)	50	3.46	0.629
	some or complete junior primary	23(33.8%)	45(66.1%)	68		
	some/complete middle primary	13(44.8%)	16(55.1%)	29		
	some/complete pre highschool	38(36.8%)	65(63.1%)	103		
	some/complete full highschool	37(43.0%)	49(56.9%)	86		
	some/complete tertiary education	30(31.9%)	64(68.08%)	94		
Age of respondents	15-19	6(54.5%)	5( 45.5%)	11	6.1	0.40
	20-24	27(30%)	63(70%)	90		
	25-29	55( 41%)	80( 59%)	135		
	30-34	30(34%)	59( 66%)	89		
	35-39	26(40%)	39( 60%)	65		
	40-44	14(41%)	20( 59%)	34		
	45-49	1(17%)	5( 83%)	6		
Woman face unwanted, should she get abortion service?	yes she should	39(20.2%)	154(79.8%)	193	42.93	0.000
	she should not	117(51.1%)	112(48.9%)	229		
	donot know	3(42.8%)	4(57.1%)	7		
Place of birth	Addis Ababa	88(45.1%)	107(54.8)	195	10.17	0.001
	Outside Addis	71(30.2%)	164(69.7%)	235		
have you ever face unwanted pregnancy	yes	10(5.20%)	182(94.7%)	192	150.23	0.000
	no	149(62.6%)	89(37.3%)	238		
Current marital status	currently married	124(44.6%)	154(55.3%)	278	19.63	0.000
	currently not married	35(23.0%)	117(76.9%)	152		
Respondents occupation	unemployed	87(45.7%)	103(54.2%)	190	16.74	0.000
	employed	61(34.2%)	117(65.7%)	178		
	daily laborer and housemaid	11(17.7%)	51(82.2%)	62		
Do you know friend	yes	91(30.3%)	209(69.6%)	300	18.79	0.000

family who abort?	no	68(52.3%)	62(47.6%)	130		
Parity of women	once	66(40.9%)	95(59.0%)	161	9.38	0.025
	twice	53(36.5%)	92(63.4%)	145		
	three times	15(23.1%)	50(76.9%)	65		
	4 and above	10(23.2%)	33(76.7%)	43		
Age at first marriage	10-17	10(38.4%)	16(61.5%)	26	0.17	0.918
	18-24	68(42.5%)	92(57.5%)	160		
	25 and above	58(41.13%)	83(58.8%)	141		
Know legal status of abortion	No	99(41.07%)	142(58.9%)	241	3.96	0.047
	yes	60(31.7%)	129(68.2%)	189		
Respondents attitude towards attitude	liberal	41(23.3%)	135(76.7%)	176	23.93	0.000
	conservative	118(46.4%)	136(53.5%)	254		
Monthly income of respondents	< 500	33(28.4%)	83(71.5%)	116	12.69	0.002
	500-1000	19(23.4%)	62(76.5%)	81		
	>1000	16(59.2%)	11(40.7%)	27		

**Marital status ;** Respondents marital status appeared among the key variables which seem do have strong relation with their abortion history (  $X^2=19.6$  and  $p<0.000$ ). As we can understand from the table (table 18) there were 152 currently not married of which 117(76.9%) of them did have abortion history than currently married women who only 154(55.3%) of them had abortion history.

**Unwanted pregnancy History ;** Being faced with unwanted pregnancy shows a strong association with their previous abortion practice with chi square value of 150 and significant at  $p=0.000$ ). Women who report that they have faced unwanted pregnancy (  $N=192$ ) 94.7% of them report that they did have abortion history. Women who said they did not face unwanted pregnancy ( $N=238$  ) only ( 89) 37.3% of them had terminated one or more of their pregnancy through abortion.

**Occupation;** Occupation of the respondents is the economic variables which shows an association with their abortion practice with chi-square of 16.74 and significant at  $p 0.000$ . Women who report that they are currently unemployed (student, house wife and unemployed ,  $N=190$ ) 54% (  $N=103$ ) of them confessed that they have abortion practice. Women who are currently employed at government, private and NGO ( $N= 178$ ) 65.7% of

them 82 % of 62 women who are currently working either as daily laborer or house maid reported that they did have abortion record.

**Knowing a friend/a relative who has practiced abortion;** Women who report that they know a friend / a relative who underwent through abortion indicated a strong association with respondents abortion practice (chi square =18.79 and  $p=0.000$ ). As the above cross table (table 17) illustrates, women who know a friend/ a relative who have had abortion (N=300) 70% of them expressed that they themselves did also have practiced abortion. Women who did not know (not sure) a friend/ a relative who have abortion practice 60% of them have practiced abortion.

**Parity ; Parity ;** Number of pregnancy of women signals an association with their abortion practice with  $X^2$  9.38 and  $p= 0.025$ . Women whose pregnancy ranges between 1-2 ( N=306) 61% of them have abortion practice than women whose number of pregnancy is three and above ( N= 187) >80 % of them have had abortion record.

**Place of birth;** The association between Women's place of birth and abortion practice was checked and it was identified that there is an association between them with 42.9 chi-square and being significant at  $p=0.000$ . Respondents who were born in Addis ( N=195) 55% of them explained that they did have abortion practice than 70% of ( 235) women who said their place of birth is outside Addis.

**Attitude towards abortion;** From the major attitude questions that were forwarded two of them have identified having a strong relation with their abortion practice, attitude towards abortion decision and abortion legality (chi-square = 42.9 and 23.9 with  $p=0.000$  ). Respondents who support the idea of abortion for a woman with unwanted pregnancy ( N=193) 80% of them reported that they did have abortion practice. Woman who reject the idea of abortion (N=229) 49% of them confessed that they have underwent through induced/spontaneous abortion.

**Income;** Even though it is difficult to categorize the respondent's income as poor , middle and rich ; their income level was tabulated against their abortion practice and the level of association is chi-square value of 12.69 and being significant at  $p=0.002$ . Women whose monthly income is < 500 ( N=116 ) 72% , women whose monthly income is b/n 500-1000 77% of them and 41% of 27 women whose income is > 1000 of them did have abortion record.

The other socio demographic independent variables including age , age at first marriage , educational background , children ever born and religion fell short of showing a statistical significance relation with the dependent variable , abortion practice.

#### **4.3 Multivariate Analysis**

After the association of different independent variables was tested finally multivariate logistic regression which takes the effects of confounding variables into account was applied. Before fitting the model directly the following procedures were followed.

##### **4.3.1 Testing of Multi colinearity and Goodness of test**

The logistic regression analysis model was used to assess the relative effect of variables. Here the dependent variable is abortion practice and all the independent variables which show a significant association on the above chi-square test are entered.

Multicollinearity is the degree of correlation between the independent variables. A high degree of multicollinearity produces unacceptable large variance in regression coefficient estimates. A commonly given rule of thumb is that when the VIF is over 2.5 and the tolerance is under 0.40. In this study, multicollinearity does not appear to be a problem. Bivariate cross product correlation was also examined among independent variables to examine multicollinearity and age , educational status , age at first marriage , CEB , and religion were found to be very much correlated with other variables and therefore were eliminated since they were also found to be statistically insignificant and do not have an association with the dependent variable during chi-square test too .

Regarding goodness of fit of the model, there are various ways to assess the extent to which the model robustly fits the data. One way is Hosmer and Lemshow Test. It indicates the goodness of fit test of the null hypothesis that the model adequately fits the data. If the test is greater than 0.05 we accept that the model well-fit the data. In this study the test is 0.441 showing the model strongly fits the data.

All explanatory variables which were considered in the bivariate analyses were included in the logistic regression. The outcome variable was a binary one with two possible values, having or not having abortion. Accordingly, place of birth, marital status, number of pregnancies attitudes

towards abortion practice & law and occupation of the respondents remained to be significantly associated with abortion.

#### 4.3.2. Logistic regression Model

**Table 18 Result of Logistic Regression on abortion practice by selected Variables; (Determinants of Abortion Practice, Addis Ababa March 2010)**

Independent variables	B		Sig.	Exp(B)	95.0% C.I. for EXP(B)	
	Lower	Upper			Lower	Upper
Abortion attitude( Yes) ( Ref)			.069			
Abortion attitude(No)	-.735	.324	.023	.480	.254	.904
Abortion Attitude (Do not know)	-.098	.990	.921	.906	.130	6.309
Birth place ( Addis Ababa) (Ref)						
Birth Place ( Out Side Addis)	.698	.303	.021	2.010	1.109	3.642
Unwanted pregnancy ( Yes) (Ref)						
Unwanted pregnancy history( No)	-3.487	.423	.000	.031	.013	.070
Unemployed (Ref)			.110			
Employed	.624	.313	.046	1.866	1.010	3.449
Daily laborer and housemaids	.595	.519	.251	1.814	.656	5.014
Know friend /relative with abortion record (Ref)						
Do not know friend/relative with abortion record	-.697	.312	.025	.498	.270	.918
Women with one pregnancy (Ref)			.000			
Women with two pregnancies	1.285	.365	.000	3.616	1.768	7.395
Women with three pregnancies	2.108	.464	.000	8.235	3.319	20.429
Women with four and above pregnancies	2.270	.542	.000	9.684	3.345	28.037
Currently Married (Ref)						
Currently are not married	.853	.348	.014	2.346	1.186	4.642
Liberal to abortion law ( Ref)						
Conservative to abortion law	-.220	.298	.460	.802	.447	1.439
Constant	1.829	.511	.000	6.225		

##### 4.3.2.1.Abortion Attitude

Women who are against abortion , have 50% times lower risk to have abortion practice than those who support to terminate the unwanted pregnancy. Respondents who have preferred to say nothing on the opinion have no significant risk from the reference group.

#### **4.3.2.2 . Birth Place and Occupation**

People whose birth place is outside Addis Ababa have double risk to undergo through abortion practices than the reference group, women who were born in Addis Ababa.

Women who are currently employed, housemaid and daily laborer have witnessed that they have nearly two times higher risk of abortion practice than women who are unemployed.

#### **4.3.2.3.Parity and Unwanted pregnancy history**

Women with two numbers of pregnancies did have three times higher likelihood of practicing abortion than those women who have only one pregnancy. Women with three of pregnancies also did have eight times higher risk of abortion than those who have only one pregnancy. Women with four and above number of pregnancies did have nine times higher abortion record than those have only one pregnancy.

Women who did not face unwanted pregnancy have shown a slight lower risk of abortion practice with Odds ratio of ( 0.03) than their counterparts .

#### **4.3.2.4 Knowing a friend/a relative with abortion record**

Women who do not know a friend / a relative who had had abortion have indicated 50% lower risk to record abortion practice than the reference group , than women who know a friend/ a relative with abortion record.

#### **4.3.2.5 Marital Status**

Women who are currently not married have shown more than double higher risk with odds ratio ( 2.3) of recording abortion history than women who are currently married.

The other variables which shows an association at chi-square test including knowing legal status of abortion, income, knowing legal status of abortion did fall short of statistical significance here at the logistic regression model.

## CHAPTER FIVE

### DISCUSSION

In this chapter it has been tried to interpret some of the major findings of the research .Efforts are also exerted to support the findings with previous relevant national and international studies and with personal opinions.

#### **Knowledge on abortion law**

In countries where abortion is legal, access to safe abortion is also mediated by women's awareness of the law. In this study only 44% of women have stated correctly the abortion law in the country, while 56% of them did have incorrect information. Knowledge is found to be often poor, even in countries with longstanding liberal laws. Misperceptions about the specifics of the law are not uncommon, thus making women vulnerable to poor care, financial exploitation, and prosecution. Even where abortion is legal and widely available on request, misperceptions about the legality of minors having sexual intercourse delay some adolescents from seeking care (Grimes A. David, 2006).

From the informal discussion with health professionals many health care providers, law professional do not appear to be familiar with their own countries' abortion laws which inhibit health facilities and partners from giving appropriate and timely service for needy women. As ESOG ( 2005) study , only 29% of the health practioners were able to sate the correct and legal provision of safe abortion .

In a recent Knowledge and Attitude study on abortion in Addis Ababa , similar findings are reported on abortion law knowledge among women with reproductive age. From the interviewed 620 women, little over a fifth (21%) of the women in Addis Ababa reported at least one reason, this was followed by 17.1% in other urban areas and the lowest was recorded at 4.3% in the rural. In terms of the specific reasons, rape and incest were reported by 4.1% and 4.5% of the women, respectively. In Addis Ababa and other urban areas, a little over a tenth (10.5%) of the women reported that the Ethiopian penal code allows abortion if a pregnancy occurs as a result of incest. Rape was reported as a reason by 10.3% and 7.6%, respectively, of the women in

Addis Ababa and other urban areas. Other reasons were rarely reported in any of the three domains ( EngenderHealth , 2009).

### **Attitude towards abortion legality and its outcomes**

In this study women (34.1%) have negated the idea of ending unwanted pregnancy justifying that their religion regards abortion as murder. We also found in further analysis of the result that other than orthodox religion followers , more than 50% of other religion followers ( Muslim , protestant and catholic ) have reported that they do not agree if abortion becomes fully legal. As Meaza Asehnafi explained in her Advocacy for Legal Reform for Safe Abortion ( source 2004) , the strongest opposition to liberalizing the abortion law in Ethiopia comes from religious groups, which also likely oppose family planning and do not seem to offer women any options for ensuring their reproductive well being.

Women were also allowed to express their opinion about the possible outcomes of legalizing the abortion law. As we already understood from the result section of this study almost equal proportion of women answered as abortion will increase, unsafe abortion will decrease and as nothing will happen in 34% , 32% and 33 % respectively.

In a five year consecutive study at Tikur Anbessa Hospital here in Addis Ababa the abortion rate, after the revision of abortion law, decreased significantly. Even though absolute number of abortion and Abortion related Maternal Mortality Rate (AMMR) fell substantially, the proportion of severe complications did not change while the case fatality rate increased (Yirgu Gebrehiwot and Tippawan Liabsuetrakul 2008).

The effects of the revision of the abortion law on abortion-related maternal mortality varied among countries. According to Yirgu G. and Tippawan Liabsuetrakul five year ( 2003-2007) study, the point estimate of trend of abortion-related maternal mortality has declined after the revision of the abortion law, although it is not impressive and needs to be observed for a longer period.

On one international study , based on data from 165 countries it clearly indicated that the legislation that allows abortion on broad grounds is associated with a lower incidence of unsafe

abortion and much lower mortality from unsafe abortion, as compared to legislation that greatly restricts abortion (Berer Marge , 2004).

Legal abortion prevents the problems of the unwanted child and economic burden of rearing large families. Liberalization was also argued to minimize the cost related to treatment of unsafe abortion, to provide safe and high quality abortion services and expanding safe abortion services. It also addresses human right & empowers women. Nationally, liberalization was expected to bring economic, social & demographic harmony (WHO, 2004).

### **Abortion Incidence and Type of abortion**

In this study 66.42% of the 271 women with abortion cases, they have reported that their abortion was induced and the rest 33.5% of them explain that the abortion was due to miscarriage / spontaneous. In one facility based research which was conducted all over Ethiopia , among women who were accepted due to abortion and related complications, three fourth of patients had spontaneous abortion and one fourth (25.6%) of them had induced abortion.( ESOG , 2002). In similar study done at northern west Ethiopia on 2003 ,it was described that two hundred fifty six women from 1266 (19%) had abortions and the prevalence rates of spontaneous and induced abortion were computed as 14.3% and 4.8%, respectively.( Elias Senbeto etal 2005)

As can be understood from the above discussion there is an apparent variation in abortion rate as well as on induced abortion rate among this research and other previous researches. The researcher has identified multiple possible explanations that contribute for such kind of discrepancy. The research period of the two studies and the current study have a big landmark event between them, revision of the Ethiopian abortion law. The revision of abortion law and subsequent programs might attributed to increase number of women coming to health facilities seeking safe abortion services which might also decrease their skepticism of reporting their abortion history. The variation between North West study and the current study might also be explained by the very difference of the study area itself. The current study is conducted in Addis Ababa , urban where as the North west study was conducted both in rural and urban parts. Rural areas are usually go together with strong socio – cultural circumstances where women might face difficulty to decide and to access safe abortion . Abortion service accessibility is also the other

variation that is not available proportionately in urban and rural parts of the country. The finding variation could also be attributed to the interviewing technique of the current study that enabled the women to report their pregnancy and abortion history consistently.

The current life style of women especially in urban areas is in a great process of change. Age at first marriage is significantly rising. The relative costs of housing and the desire for consumer goods are rising faster than are income opportunities; causing longer delays in marriage. The financial cost of increasingly elaborate and expensive weddings is another possible reason for delaying marriage. What appears to be unique in the Ethiopian context is that the prevalence of out of wedlock births has not increased; in fact, it has declined. The social and economic incentives to avoid non marital births also remain powerful in Ethiopia. Abortion and increased access to contraception are the possible immediate mechanisms by which out of wedlock births are being averted among single women in Addis Ababa ( Sibanda A. 2003).

### **Quality of Care**

As we have seen in the result section of this study, 65% of women with abortion record explained that they have got the abortion service from a private or NGO owned health facility. Availability of quality service, and confidentiality was their main reasons to decide and prefer to get the service from that health facility. The health workers at government health hospitals also stated that the clients do not have positive attitude towards them, fearing mistreatment and neglect. The same interview also mentioned the shortages of medical supplies (sterilization and trained human power) to give timely service to the women who are mostly poor and in pain. They have also added the poor quality of post abortion care with high number of repeated abortion cases.

Making abortion safe and accessible to the full extent of the law, requires trained health personnel so that they are conversant with national laws regulation as well as with technical procedures , ensuring equipments and supplies and designing protocols, regulations and policies that promote access to quality abortion services. Given that abortion is legal for certain indications in most countries of the world there is a considerable scope in almost every country both developed and developing ( WHO, 2002).



These and other related obstacles , barriers to mid level providers , insufficient supplies of technologies , have been also identified in one research which aimed to see the impacts of WHO safe abortion guidance on abortion towards the provision of abortion service ( Hessim Leila and etal , 2006).

### **Why Women Choose Abortion**

There are many reasons why women decide to terminate a pregnancy. In this study from 271 women who encounter either induced or miscarriage abortion, 44 % of the reason were related with socio cultural reasons, followed by health ( 34%) , economic reasons ( 15%) and demographic ( 6%) reasons.

Young women who end their pregnancy in induced abortion feel they are too young or too poor to raise a child. From the socio cultural factors the social stigma of raising a child outside marriage has been also mentioned by majority unmarried women. While women become pregnant but have unhealthy relationship with their husband / fiancée they prefer to have an abortion than having child. Married women are inclined to mention both economic and demographic reasons, having enough family size and inability to raise additional children. There were also women who mentioned their current employment status (probably not entitled to maternal leave) as a reason to have an abortion. In many Asian societies, e.g. Korean and Chinese, there is strong social stigma against single or unwed motherhood. In fact, abortion is much more acceptable from a societal perspective in Asia than it is in Latin America or the USA( Axel Mudingo , 2006).

As DFID practice paper states that the consequences of gender inequality, cultural norms, some religious beliefs and poverty on unwanted pregnancy for the most vulnerable are dire. For many it equates to social exclusion, expulsion from the family, abandonment and deepening poverty. For most the choices are limited risk of death from an unsafe abortion, or face destitution from isolation and extreme poverty (DFID's 2009 ).

By contrast, in more favorable economic environments, economic aspirations can also act as a determinant in the decision to end a pregnancy. This was clearly demonstrated in the study by Kwon and colleagues of young women working in three export-oriented industrial zones in the Republic of Korea. The study attributes the growth in numbers of young women postponing

marriage, while seeking employment opportunities to improve their own and their parents' economic wellbeing, to the rapid pace of industrialization. These changes have inevitably led to an increase in premarital sexual activity. In a society that strongly condemns out-of-wedlock pregnancy, this has also brought about a rapid increase in the number of abortions among adolescents and young adults (Axel I. Munidgo, 2005).

### **Abortion complications**

As we understand from the result section of this study from the 271 women who undergo through abortion, 47% of them have faced different forms of abortion-related health effects of which hemorrhage and sepsis are the most common complications reported, followed by uterine perforation, chronic pelvic pain and secondary infertility. Among these women 76% of them have tried to get post-abortion treatment from health center/hospital while the remaining women left their problems without seeking any treatment.

In a facility-based research on clients of women with abortion cases at five different Hospitals of Ethiopia, the major categories of complications that have been faced by women who undergo through unsafe abortion were infection (28%), genital tract injuries (12%), foreign bodies in the genital tract (1.6%) and organ failure (13.1%). There were 13 deaths, which made the overall procedure-related death 1,209/100,000 abortions. (ESOG, 2002)

In Addis Ababa maternal mortality research (1986) it was identified that the main cause of Maternal mortality was septic abortion, which accounted for 54% of direct obstetric deaths. Illegal methods were revealed in the majority cases (92%). As the transition from a traditional to developing society occurs and the risks of child birth diminish, more women face the risks associated with induced abortion. (E. Kwast et al 1986)

Currently some developing countries are making substantial, albeit varied, progress towards achieving MDG 5. Although only 23 countries are on track to achieve a 75% decrease in MMR by 2015, countries such as Egypt, China, Ecuador, and Bolivia have been achieving accelerated progress (Margaret C Hogan et al, 2010) whereas Ethiopia is in a difficult position to achieve its Maternal Mortality ratio reduction MDG goals if the current trend continues (Mulu W Abraha and Tilahun H Nigatu, 2009).

### **Unintended pregnancies and abortion**

From 430 women 120 of them have reported that they were pregnant during the data collection period. Among these pregnant women , 18.5 % of them do not want the child now. The possibility of these pregnancies ending in abortion by these is high since some of them even expressed that they came to that specific facility to request abortion counseling and service. In this study, 192 ( 45%) of the respondents confessed that they have faced unwanted pregnancies in their life time, and all of them reported that they have had abortion history but the data did not indicate whether all their unwanted pregnancies ended with induced abortion or not . 42% of these 192 women reasoned that they do not have contraceptive knowledge and 35% of them did know but were not users, 18% of the have faced contraceptive failures. In a study that was conducted at Harrar , two hundred twenty five (33.3 %) out of the 675 pregnant women reported that their most recent pregnancies were unintended. Of these, 112 (50%) had unintended childbirths while the rest 113 (50%) ended in induced abortions. A decline in desired family size over time leads to a rise in the proportion of women who are at risk of having unwanted pregnancies and its consequences, particularly where contraceptive use is not optimal ( Solomon W and Misganaw Fanatahun , 2006).

Moreover, of the 182 million pregnancies that occur in developing countries, more than one-third are unintended, and 19% end in induced abortion (8% are safe procedures and 11% are unsafe)(Gurrmacher 2007).

### **Determinant Characteristics of Women with Abortion History**

As it is indicated in the result section of this study, 51 % (N=138) of the respondents who have had abortion history ( N=271) reported that their age was between 20-29 when they terminated their pregnancy followed by 38% abortion cases among women whose age was less than 20 ( N=103). It was also indicated that around 89% of reported abortion records were with women whose age was below 30 years . Similar result was observed a study by ESOG in which among 1075 abortion cases, 58% of the cases were in the age range of 20-29 years. In Nigeria, for example, adolescents account for 80% of all women treated for abortion complications in hospitals . Adolescents also account for a disproportionately high number of abortion-related deaths( E. Hord , Charlotte, 2006).

In a study which focused on age patterns of unsafe abortion study, it was indicated that almost 60% of unsafe abortions in Africa were among women under age 25 and almost 80% are among women under 30 years old (Shah Iqbal and Elisabeth Ahman, 2004).

The marital status of women as this study illustrated that, married or women who are currently living with their partner (57% of 271 women) have had abortion history. As the ESOG study also describe, 53% of 1075 women with abortion cases were housewives and 2/3 of them were married. (ESOG, 2002) Another study that were conducted at Tikur Anbessa Hospital between 2003-2007 revealed that both before legalization of abortion and after legalization, married women were the highest (53% of 598 and 64% of 175) proportion who have had abortion history than women with other type of marital status (Yirgu Gebrehiwot and Tippawan Liabsuetrakul, 2008). Though reason behind high number of abortion rate among married women needs further explanation, majority inclined to have enough family size and incapable to raise additional child.

With regard to educational status of women with abortion history, in this study it was described that 183 (67.5%) of them women with abortion cases have secondary and above educational level followed by women with primary education (20.7%) and with no education (11.8%). In one study at which was conducted in northwest of Ethiopia on induced abortion (2005), out of 64 women with induced abortion cases 40 (62.5%) of them have high school and above education (Elias Senbeto et al 2005).

As it indicated in the result section of this study women whose pregnancies ranges three and above (N=187), more than 80% of them confessed that they have had abortion record. Women whose pregnancies lie between 1-2 (N=306) 61% of them have had abortion. In the northwest Ethiopia induced abortion study (2005), it was described that as the number of pregnancies increased, there was a corresponding progressive increase in the number of induced abortion. This is generally true as women who had several pregnancies (which may indicate the presence of more children) would have the tendency of not having more and more additional new children. Due to this reason, they may tend to avoid unwanted pregnancies by conducting induced abortions (Elias Senbeto et al 2005).

The other demographic variable which shows a significant relationship with women's abortion practice was place of birth. At chi-square test indicated women whose birth place is outside Addis ( N= 235) nearly 70 % of them have had abortion practice than women who were born in Addis in where only 55% of 195 were underwent though abortion history . Though it was difficult to support this finding with previous researches, the researcher tries to relate with the same study by observing unwanted pregnancy history vs place of birth. Women who were born in Addis ( n=195) 37% of them have faced the unwanted pregnancy problem while 50% of women who were born outside Addis ( n=235) 51% of them have faced with unwanted pregnancy. This result can also be related with other socio cultural situation including gender inequality, religion and other related circumstances .In rural areas it is known that accepted norms and cultures have a prominent role in shaping the reproductive health in general and pregnancy situation of women in particular.

#### **The Association Between Abortion and Women Empowerment**

Even though it was difficult to get opinion from the interviewed women about the linkage between women empowerment and abortion; during in the in-depth interview the health worker have explained the relationship between these two important variables. According to the health workers it is the implications of problems in relation women low socio economic status that forced them to have an unsafe abortion. Women who do not have adequate knowledge on contraceptive methods make them susceptible for the root cause of abortion; unintended pregnancy. Poor economic condition in both marital union and outside marriage has been also raised as an additional implication of women economic disempowerment. Rural women and poor women are more likely than better-off and urban women to turn to traditional practitioners and unsafe methods, and therefore to experience health complications. However, they are less likely to receive the post-abortion treatment they need ( IPAS 2009).

The inability to cope with the strong influence of socio cultural factors towards child outside marriage also makes them to pay sacrifice their health for the sake of the community norms and values.

## CHAPTER SIX ; CONCLUSION AND RECOMMENDATIONS

### **a. Conclusion**

The interaction of unsafe abortion and maternal mortality and morbidity has long been recognized by program people and researchers. Making abortion safe and legal has gone through different stages of debates and still the dialogue and disagreement has sustained. Simultaneously, countries are making a progress towards liberalization of their abortion law. The developed countries are the prime agents in understanding abortion as integral part of women right issue. In Ethiopia, though it is not still recognized as right, there is a step forward in making abortion safe and legal under some situations. After 2004 some studies, even though not adequate, tried to indicate the downward trends of unsafe abortion and its complications which in turn indicated a decrease in abortion related maternal mortality ratio. Here the researcher wants to articulate that the prime agenda shouldn't be minimizing unsafe abortion through promoting safe abortion rather avoiding unwanted pregnancy and the subsequent decline in the number of abortion and related deaths.

In this study more than 90% women know unsafe abortion, and 70 % of them know about safe abortion . Women did seem to be short of identifying what safe and abortion implies. Women are also well informed where to find abortion service, knowing the impact of abortion.

Women's attitude towards abortion appear a little bit conservative ( 53% have negative attitude towards abortion practice) which indicates the presence of influential cultural and religious views in shaping women's understanding and views about abortion.

Significant number of Abortion cases were reported women among below 30 years old, married, with some or complete secondary education , employed and those whose birth place were outside Addis Ababa. Abortion practice which was observed in a significant number needs to be interpreted from different dimensions. The paradox of a rise of age at first marriage, the decrease number of birth outside marriage in Addis Ababa has been interpreted in two ways , increased number of contraceptive prevalence rate and increased number of abortion.

Married women also seem understand the benefit of limiting their family size and appear using abortion whenever they faced unwanted or unplanned pregnancy.

One can also raise reporting issue; currently there is relatively an improved attitude towards seeking safe abortion services than unsafe services . This trend might also decrease the fear to report abortion cases which in turn elevate the number of abortion number than the previous times where abortion was done in unsafe places and kept unreported. If there is substantial number of abortion practices, one cannot be uncertain on the presence of health and psychological related complications which can be either short term or long term.

In this study the researcher understood the existence of deviation among the three parameters, knowledge, attitude and practice. This report in general indicate that women have relatively better knowledge on abortion but relatively negative attitude but unexpectedly high number of abortion practice.

Finally the researcher want to emphasize that the collection of data on a highly stigmatized and sensitive topic is likely to under-represent the true state of KAP on abortion-related issues. Moreover, the lack of standardized measures for abortion-related data presents a challenge to the validity and conclusion of the survey findings on this topic.

### **B. Recommendations**

After analyzing the findings of the research, the researcher would like forward the following recommendations.

- ➔ As part of safe motherhood information campaigns on the danger signs of complications following pregnancy and birth, information on safe and unsafe abortion , the danger signs of abortion and complications and where to seek help should also be included.
- ➔ Different dialogue and debates need to be organized where women can contribute by openly giving their true attitudes and opinions about abortion.
- ➔ The prevalence rates of abortion in general and induced abortion in particular are very high requiring the attention of all concerned bodies. Family Planning is an urgent global priority. Women and men are entitled to determine the number, timing and spacing of their children, with access to the appropriate contraceptive methods and health information and services, as affirmed at the International Conference on Population and

Development (ICPD). The findings of this study and the results of different studies done in Ethiopia underscore the importance of addressing the unmet need of young adults by providing access to basic reproductive health information and youth friendly services that would enable them to take control of reproductive health decisions. Married women also have to get the appropriate family planning service and avoid using abortion as marital contraceptive.

- ➔ Ethiopian women have not reached at a stage where they can fully exercise their reproductive health right including preventing unwanted pregnancy. They are the primary victims from any kinds of consequences that are resulting from avoiding unwanted pregnancy such as abortion or giving birth in unwelcoming environment. To prevent poverty arisen abortion cases (often unsafe); broad actions need to be taken to empower women in every aspect of their lives but especially in control of their reproductive lives. Women must be able to make their own fertility decisions and have access to and know where to find safe abortion services in their communities. Men must get involved and learn to support the women in reproductive health and choice issues. Since strong and accepted culture and norms limit a woman's ability to seek safe abortion services , abortion related programs are required to adopt strategies as to how to address aforementioned cultural issues.
- ➔ Better knowledge and implementation of existing laws would go a long way toward reversing the tragic toll of unsafe abortion. Better disseminating the conditions under which abortion is currently permitted and making abortion available to the full extent of existing laws can have numerous benefits, including:
  - permitting services to be visible, accessible and affordable for all women
  - helping health professionals feel protected in providing compassionate abortion services
  - allowing women to choose among providers
  - better enabling women to take legal action when their rights are violated
- ➔ Alternative Campaigns are needed among health professionals to sensitize them as to why women have abortions, and to expose and denounce unacceptably cruel and punitive behavior, including towards women who are in hospital for complications of unsafe abortions. Campaigns among health professionals are also needed to reduce the stigma of

providing abortion, and to recruit those who are sympathetic to women's need for abortion and to train as providers and to make abortion provision an acceptable career path.

- ➔ As can be understood during data collection and interview with health professionals , Medical abortion is not widely practiced in Addis Ababa. Except Mariestopes international both government and private hospitals did not start to implement medical abortion. Since scientific researches indicated the overshadow benefit of using medical abortion over MVA , SMC and D&C , women are missing the opportunity of minimized health risks of abortion complications. As a result it needs government's attention to record the necessary medical supplies along with essential drugs and facilitate its availability at all levels of health facilities including public hospitals
- ➔ During the interview with health professionals, it was found out that public hospitals are in scarce of appropriate trained human power with particular to abortion ( MVA application) which inhibited the facilities to provide quality and timely service . Women are forced to undergo through a long period of pain and are wasting considerable amount of time in waiting the service. Shortage of medical supplies has also been observed which aggravates the aforementioned problems. Such bottlenecks require the efforts of all responsible including development partners.
- ➔ The number of women with repeated abortion cases should not be neglected. Women with frequent number of abortion are facing habitual abortion or secondary infertility and other complications. This large number of women with more than one abortion cases forced the researcher to question the quality of post abortion care especially family planning counseling and service provision . As a result improving the quality of post abortion care services at all levels of health facilities needs to be enhanced.
- ➔ Finally similar studies should be undertaken in different parts of the country to see the trends, magnitude and the determinant factors of safe and unsafe abortion. Policies, strategies, working guidelines and intervention programs should be supported and emanated from such feasible and updated research. In order to achieve MDG 5 , reducing maternal mortality by three quarters, the researcher wants to call for a systematic and organized effort by all concerned to address the multifaceted problems of abortion, especially unsafe abortion.

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Appendice 1. English Quantitative questionnaire

ADDIS ABABA UNIVERSITY  
SCHOOL OF GRADUATE STUDIES  
INSTITUTE OF POPULATION STUDIES  
KNOWLEDGE , ATTITUDE AND PRACTICE OF ABORTION IN ADDIS ABABA

**Introduction and Consent**

My name is \_\_\_\_\_. I am a data collector to one of MSc student at Addis Ababa University , Population studies Department. Who is conducting an assessment about termination of pregnancy knowledge, attitude and practice in Addis Ababa. I would very much appreciate your participation in this survey. I would like to ask you about pregnancy , child birth, and related issues. This information will help the governmental and non - governmental organizations to plan provision of comprehensive pregnancy and related services. The questionnaire usually takes between 20-30 minutes to complete. Whatever information you provide will be kept strictly confidential and will not be shown to other persons. Participation in this interview is entirely on voluntary basis and you can choose not to answer any individual questions or all of the questions. However, we hope that you will participate fully in this assessment since your views are important. Do you have any questions about the survey? May I begin the interview now?

**VERBAL CONSENT GIVEN TO INTERVIEW, CHECK BOX**

	Research objectives	<ul style="list-style-type: none"> <li>• To assess the knowledge, attitude and practice of women 15-49 on termination of pregnancy</li> <li>• To see the associated factors with their knowledge, attitude and practices.</li> <li>• Finally to see the gap among their abortion knowledge attitude and practices and to forward feasible recommendations.</li> </ul>
	Research questions	Do women (reproductive age) know what safe and unsafe pregnancy termination are and its benefit / consequences? Do they know safe pregnancy termination is legal under some circumstances in Ethiopia? What is the current attitude about abortion among women? What factors are associated with conservative and liberal opinions about abortion? Finally, is knowledge of the abortion law associated with attitude and practice about abortion? <input type="checkbox"/>
	Personnel	Interviewer _____ Interviewer code [   ] Field Supervisor _____ Supervisor code [   ] Data Entry Clerk _____ Data entry code [ ]
	Questionnaire Number	
	Result code	<ol style="list-style-type: none"> <li>1. Completed</li> <li>2. Postponed</li> <li>3. Refused</li> <li>4. Partly completed</li> <li>5. Other _____</li> <li>6. (SPECIFY)</li> </ol>

Part I. IDENTIFICATION/ General Information			
	Questions	CODING CATEGORIES	Skip to
101	Address	Sub city _____ Kebele _____	
102	What is your current marital status ?	Currently married ....1 Widowed .....2 Divorced .....3 Separated .....4 Living with a man .....5 Never Married ....6 →	104
103	How old were you when you first got married?	Age at first marriage _____	
104	Can you read or write?	Yes .....1 No .....2 →	107
105	Have you attended formal school?	Yes .....1 No .....2 →	To no 108
106	What is the highest grade you completed?	Grade <input type="text"/> ..... 1-10 Technical /vocational Certificate 13.....11,12,13 University College / Diploma ..... 14 University / College / Degree..... 15 University / College / Masters ..... 16	
107	In what month and year were you born ?	Month <input type="text"/> Don't Know month 9998 Year <input type="text"/> Don not Know year 98	
108	How old were you at your last birthday? Compare and correct 6 if inconsistent	Age in completed year _____	
109	Religion	Orthodox .....1 Catholic .....2 Protestant .....3 Muslim .....4 Traditional .....5 Others [specify] _____ 6	
110	Are you working that generate income to you/your household ?	a. Yes .....1 b. No.....2 →	115
111	Do you do this work for a member of your family, for someone else, or are you self-employed?	FOR FAMILY MEMBER.....1 Employed in Gov .....2 Employed in private .....3 Employed in NGO .....4 SELF-EMPLOYED .....5	
112	Are you paid in cash or kind for this work ?	Yes .....1 No .....2 →	114

113	If you are paid how much do you get per month	< 100 .....1 100-500.....2 500-1000 .....3 1000-1500.....4 1500-2000.....5 2000-2500.....6 >2500.....7	
114	Do you usually work at home or away from home?	HOME.....1 AWAY.....2	
115	Were you born in this district Addis Ababa (Sub city)?	Yes .....1 No ....2	
116	If no where did you born	Town .....1 Rural kebele .....2	
	For How many years did you live here? KAP survey on abortion at Ghana	<1 year 1-3 years 3-5 years >5 years	
	What is your ethnicity?		

**Part II. Knowledge related Questions**

	Questions	Coding catagories	Skip to
201	Have you ever heard about terminating pregnancy (abortion)?	Yes .....1 No .....2	
202	Have you ever heard about safe and unsafe termination of unwanted pregnancy (abortion)?	Yes .....1 No.....2	
203	Have you ever heard unsafe termination of unwanted pregnancy (abortion)?	Yes .....1 No.....2	
204	Do you know places/persons where unwanted pregnancy is terminated?	Yes .....1 No.....2	→ To Q. 206
205	What are the different places that a woman in this or near by community can go to terminate an unwanted pregnancy?	M = mentioned, NM = not mentioned) Circle all mentioned answers  M-1 NM 2 . a. Gov. hospital .....1 2 b. Gov. health center .....1 2 c. Gov. health station/clinic .1 2 d. Gov. health post .....1 2 e. NGO hospital .....1 2 f. NGO health center .....1 2 g. NGO clinic .....1 2 h. private hospital .....1 2 i. private health center.....1 2	

		j. private clinic.....1 2 k. Private doctor .....1 2 l. Pharmacy .....1 2 m. Drug vendor.....1 2 n. Other, Specify .....1 2	
206	Who are all the different people who can help a woman in this or nearby community to terminate an unwanted pregnancy?	<ul style="list-style-type: none"> <li>• TBA/Trained TBA .....1</li> <li>• Physician .....2</li> <li>• Health Officers .....3</li> <li>• Nurses .....4</li> <li>• A Health worker (in his/her house premise .....5</li> <li>• Traditional healer .....6</li> <li>• Health workers working in private health facilities ..7</li> <li>• Don't know/remember .....8</li> <li>• Other specify)_____</li> </ul>	
207	What problems can happen in a woman after terminating pregnancy ?	NM M = mentioned, NM = not mentioned) M=1 NM=2 Vaginal bleeding .....1 2 Other vaginal discharge .....1 2 Abdominal Pain .....1 2 Fever .....1 2 Other (specify)_____	
208	How likely is it that a woman who went to a <b>health center</b> or a <b>hospital</b> to terminate an unwanted pregnancy will experience a serious health problem afterwards?	Always experience the problem.....1 Sometimes experience the problem.....2 Do not experience the problem.....3 Don't know.....8	
209	How likely is it that a woman who went <b>somewhere other than to a health center or a hospital</b> to terminate an unwanted pregnancy will experience a serious health problem afterwards?	Always experience the problem.....1 Sometimes experience the problem.....2 Do not experience the problem.....3 Don't know.....8	
210	Do you think that the nearest hospital /health center has sufficient equipment and supplies to help women safely terminate an unwanted pregnancy?	Yes.....1 No.....2 Not sure.....3 Do not know.....8	
211	Do you think that the staffs at nearest <b>health center</b> treat women who want to terminate an unwanted pregnancy there with respect?	Yes.....1 No.....2 Not sure.....3 Do not know.....8	

212	Is it legal for a woman to terminate an unwanted pregnancy according to the government of Ethiopia?	Yes for all reasons.....1 Yes with some specific reasons.....2 No.....3 Not sure.....4	
213	From where did you get the information ?	Media ( Radio , Television , News paper) .....1 Friends.....2 Family .....3 Health centers .....4 School.....5 Religious places .....6 At work place .....7 Other , specify _____	

**Part III. Attitude related Questions**

	Questions	Coding categories	Skip to
301	If a woman becomes ( face) unwanted pregnancy can she go to abortion services ?	1. Yes 2. No $\longrightarrow$ 3. Do not Know	To Q. 303
302	If yes why ?	a. A woman who does not want to give birth on whatever reason should get abortion services .....1 b. Abortion is a human right issue .....2 c. Abortion is a safe medical procedure .....3 d. In case of incest or rape , abortion is a best alternatives.....4	
303	If you no why?	Circle all mentioned answers a. Life begins starting from conception .....1 b. Abortion is taking human life.....2 c. Abortion should not be considered as contraception....3 d. Unwanted pregnancy can be solved by adoption.....4 e. "A child can up bring by his/her opportunity".....5 f. A woman who undergo abortion will face negative outcome .....6	
304	Do you agree if abortion is liberal and legal?	Strongly agree .....1 agree .....2 Fair .....3 Don't agree .....4 Do not know .....5	
305	What do you think would be the out comes of making abortion legal?	It aggravates abortion .....1 It minimizes unsafe abortion .....2 It neither aggravates abortion nor minimizes unsafe abortion.....4	

306	If you had a friend or family member experiencing an unwanted pregnancy do you advice her to a health facility for a doctor or nurse to help terminate the pregnancy?	Yes .....1 No .....2 Not sure.....8	
307	If you have faced ( will face) unwanted pregnancy due to rape , incest ,... what would be your decision?	a. Giving birth .....1 b. Abortion .....2 c. Dismissed from the village .....3 d. Suicide .....4 e. Other specify .....5	

**Part IV. Practice related Questions**

	Questions	Coding categories	Skip to
401	Have you ever been pregnant ?	1. Yes .....1 2. No .....2	
402	How many times	_____	
403	How many pregnancies ended in live births?	_____	
404	What was your age when you have given birth for the first time	a. 15-19.....1 b. 20-24 .....2 c. 25-29 .....3 d. 30-34 .....4 e. 35-39.....5 f. 40-44.....6 g. 45-49.....7	
405	Number of children	Total _____ Boys _____ Girls _____	
406	Check number mentioned in 402=405 , if number mentioned in 415is less than number mentioned in 403 , ask What happen to the remaining pregnancy ?	1. Abortion .....1 2. Still birth .....2	
	How many pregnancies ended in abortion ?	_____	
407	If abortion what was the nature of the termination /miscarriage/abortion?	Spontaneous.....1 Induced .....2	
408	When this last abortion happen?	During last year .....1 During the last 1-5 years .....2 Later than 5 years .....3	
409	What was your age when you terminated your pregnancy for	a. 15-19.....1 b. 20-24 .....2	

	the last time? ( recent)	c. 25-29 .....3 d. 30-34 .....4 e. 35-39.....5 f. 40-44.....6 g. 45-49.....7	
410	If you terminate your unwanted pregnancy , what was your reason to do so?	Desire of small family size.....1 Education . employment .....2 Poverty .....3 Having enough children .....4 A relationship with friend .....5 Being unmarried .....6 Urban rural migration .....7 Rape .....8	
411	If you terminated your pregnancy where did you go to get the services	a. Health center/Hospital .....1 b. Other than health center/hospital .....2	
412	Did you face any outcome after you went through the abortion process?	a. Yes.....1 b. No.....2 →	415
413	If you have faced negative outcomes after the abortion you went through can you mention some of <i>MULTIPLE RESPONSES POSSIBLE CIRCLE ALL MENTIONED</i>	Vaginal bleeding .....1 Other vaginal discharge .....2 Abdominal Pain .....3 Fever .....4 Other (specify) _____	
414	What did you do when you faced negative outcomes after the abortion?	a. I went to health center /Hospital.....1 b. I abandoned it .....2	
415	If you terminated your pregnancy , did your husband, fiancée , friend know your termination of pregnancy ?	Yes .....1 No .....2	
416	If you terminated your pregnancy , what feedbacks did you get from your family/friends ?	a. Supported / encouraged .....1 b. Neglected/rejected.....2 c. Neutral .....3	
417	If your husband/friend/fiancée know about your pregnancy termination what was his attitude towards abortion?	Conservative .....1 Liberal .....2 Do not know .....4	
418	Are you pregnant now?	Yes .....1 No .....2 Unsure .....8	
419	How many months pregnant are you?	Months <input type="text"/> <input type="text"/>	

420	At the time you became pregnant did you want to become pregnant then, did you want to wait until later, or did you not want to have any (more) children at all?.	1. Then .....1 2. Later .....2 3. Not at All .....3	
421	Are you currently using any contraceptives ?	1. Yes .....1 2. No .....2	
	If yes what methods are you using ?	Pill .....1 IUD ...2 Injectables ....3 Foaming tablets ....4 Condom .....5 Female sterilization .....6 Male sterilization .....7 Implants .....8 Rhythm Methods .....9 LAM.....10 Withdrawal.....11 Other[specify] _____	
422	Have you faced unwanted pregnancy ?	1. Yes .....1 2. No .....2	
423	If you faced unwanted pregnancy what the reason ?	a. I did not know contraceptives b. I know but I did not use contraceptives c. I know and used contraceptives but I faced unwanted pregnancy	
424	Do you know a family member/friend /neighbor who had terminated pregnancy during the last year (12 months)	1. Yes 2. No →	426
425	If so,	how many were they? _____	
426	Have you ever heard about or known a woman who died immediately or with a few weeks after terminating an unwanted pregnancy?	Yes..... 1 No.....2 Not sure.....3	
427	Have you heard about or known a woman who died immediately or within a few weeks after terminating an unwanted pregnancy in the last 12 months?	a. Yes.....1 b. No.....2 c. Not sure.....3 d. Do not know.....8	

Appendice 2. Amharic Quantitative Questionnaire

<b>አዲስ አበባ ዩኒቨርሲቲ</b>
<b>የሰነ - ሕዝብ ጥናት</b>
<b>በአዲስ አበባ ጽንሰ ስለማቋርጥ ያለ እውቀት ፣ አመለካከት እና ልማድ</b>
<b>መግቢያ እና ፈቃድ</b>
<b>ጤና ይስጥልኝ!</b>

ስሜ \_\_\_\_\_ የሚባል ሲሆን በአዲስ አበባ ዩኒቨርሲቲ በድህረ ምረቃ ክፍል በሰነ ሕዝብ ጥናት ትምህርት ክፍል እርግዝና እና ተያያዥ ጉዳዮች ላይ የመመረቂያ ጥናቷን እየሰራች ላለችው ምህረት ሀብቷ መረጃ እየሰበሰበኩ ነው። ስለዚህ ስለእርስዎ እርግዝና እና ተያያዥ ጉዳዮችን መረጃ እንዲገኙን በትህትና እጠይቃለሁ። ጥናቱ እርግዝና እና ተያያዥ ጉዳዮች ላይ ለሚሰሩ መንግስት እና መንግስታዊ ላልሆኑ ደርጅቶች ጥራት ያለው እና ሁሉን አቀፍ አገልግሎት እንዲሰጥ ያግዛቸዋል። መረጃውን ለመሰብሰብ ከ 15-20 ደቂቃ የሚወስድ ሲሆን በዚህ ጥናት መሳተፍ በፈቃደኝነት ላይ የተመሰረተ ነው። የሚሰጡት መረጃ በጥብቅ ሚስጢር የሚጠበቅ ሲሆን (የግል መረጃዎች የቤት ቁጥር ፣ ስልክ ቁጥር እና ስም ስለማይጠይቅ ምንም ስጋት አይግባዎት) መረጃውም ለማንኛውም ሶስተኛ ወገን የማይተላለፍ ነው። የጥናቱን አላማ በመረዳት በጥናቱ ላይ ለመሳተፍ ሙሉ ፈቃድዎትን እንደሚሰጡ እተማመናለሁ። ማንኛውም ጥያቄ ካለዎት ማንሳት ይችላሉ። ቃለ መጠይቁን መጀመር እችላለሁ?

<b>የቃል ፈቃድ ከሰጡ የ √ ምልክት ያስቀምጡ</b>			
	የሰው ሃይል	ቃለ መጠይቅ ያደረገው የሰጠው ኮድ [   ]	
		መረጃ ወደኮምፒዩተር ያስገባው ሰው ኮድ [   ]	
	የቃለ መጠይቁ ቁጥር	_____	
	የጤና ተቋሙ ስም	_____	
	አድራሻ	ከ/ከተማ _____ ቀበሌ _____	
	የቃለ መጠይቁ ውጤት	1. ተጠናቋል	
		2. ተላልፏል	
		3. በከፊልተጠናቋል	
		ሌላ ካለ ይጥቀሱ _____	

<b>ክፍለ አንድ 1. መለያ / ጠቅላላ መረጃ</b>			
	ጥያቄዎች	ኮድ አሰጣጥ	ወደ--- ጥ.ይለፉ
101	አድራሻ	ክፍለ ከተማ _____ ቀበሌ _____	
102	የትዳር ሁኔታ	*ያገባ .....1 *የሞተበት .....2 *የተፋታ .....3 *የተለያየ .....4 *የወንድ ጋር የሚኖር .....5  ያላገባ ....6 →	ወደ ጥ. 104
103	ለመጀመሪያ ጊዜ ሲያገቡ ስንት አመቶት ነበሩ?	*እድሜ _____	
104	ማንበብ እና መጻፍ ይችላሉ?	*አዎ .....1  አልችልም .....2 →	ወደ ጥ. 107
105	መደበኛ ትምህርት ቤት ገብተዋል ?	*አዎ .....1  አልገባሁም .....2 <input type="checkbox"/>	ወደ ጥ. 108

106	ያጠናቀቁት የመጨረሻ የትምህርት ክፍል ስንት ነው	*ክፍል ..... 1-10 *ቴክኒክ እና ሙያ/ሰርተፍኬት.....11,12,13 *የኒቨርስቴ/ ኮሌጅ / ዲፕሎማ..... 14 *የኒቨርስቴ/ ኮሌጅ / ዲግሪ..... 15 *የኒቨርስቴ/ ኮሌጅ / ማስተርስ..... 16	
107	በምን ወር እና ዓ.ም ነው የተወለዱት?	*ወር <input type="text"/> *ወሩን አላውቀውም 9998 *ዓ/ም <input type="text"/> *ዓ.ም ሀረቴን አላውቀውም 98	
108	አሁን ስንት አመቶት ነው? ከቁጥር 107 ከተጠቀሰው ጋር በማነጻጸር ስኬተት ካለ ያስተካክሉት	*አመት _____	
109	የምን ሀይማኖት ተከታይ ነዎት ?	*አርቶዶክስ .....1 *ካቶሊክ .....2 *ፕሮቴስታንት .....3 *ሙስሊም .....4 *ባህላዊ.....5 *ሌላ ካለ ጥያቄ _____	
110	የሥራ ሁኔታ	ተማሪ-----1 የመንግስት ተቀጣሪ-----2 የግል ተቀጣሪ-----3 የቀን ሠራተኛ-----4 የቤት ሠራተኛ-----5 ሥራ የሌላት-----6 የቤት እመቤት-----7 ሌላ /ይገለጽ/-----88	ወደ ጥ. 115
111	ስራውን የሚሰሩት የት ነው?	*ለቤተሰብ .....1 *በመንግስት ስራ .....2 *በግለሰብ ስራ .....3 *በመያድ .....4 *የራስ ስራ .....5 ሌላ ካለ ይጥቀሱ .....	
112	ለሚሰሩት ስራ ይከፈሉታል ?	አዎ .....1 አይከፈሉኝም .....2	ወደ ጥ. 114
113	የሚፈሉት ከሆነ በወር ስንት ይከፈሉታል ?	* < 100 .....1 *100-500.....2 *500-1000 .....3 *1000-1500.....4 *1500-2000.....5 *2000-2500.....6 *>2500.....7	
114	ስራውን የሚሰሩት የት ነው ?	*ቤት .....1 *ከቤት ውጪ.....2	
115	የተወለዱት የት ነው ?	*አዲስ አበባ .....1	

		*ከአዲስ አበባ ውጪ.....2	
116	ከአዲስ አበባ ውጪ ከተወለዱ የት ተወለዱ ?	*ከተማ .....1 *የገጠር ቀበሌ .....2	
117	አሁን ያሉበት ቦታ ስንት አመት ኖረዋል?	*<1 ዓመት.....1 *1-3 ዓመት.....2 *3-5 ዓመት.....3 *>5 ዓመት.....4	
118	ብሄርዎት ምንድነው ?	*አሮሞ .....1 *አማራ .....2 *ሶማሌ .....3 *ትግራይ.....4 *ሲዳማ.....5 *ጉራጌ.....6 *ወላይታ.....7 *ሀድያ.....8 *አፋር.....9 *ጋሞ .....10 *ሌላ ካለ ይጥቀሱ .....	

**ክፍል 2 . እውቀትን የመለከተ ጥያቄዎች**

	ጥያቄዎች	ኮድ አሰጣጥ	ወደ---- ጥ.ይለፉ
201	ጽንሰ ስለማቋረጥ ሰምተው ያውቃሉ?	*አዎ .....1 *አልሰማሁም .....2	
202	ጉዳት የማያስከትል ጽንሰ የማቋረጥ ሂደት ያውቃሉ ?	*አውቃለሁ .....1 *አላውቅም .....2	
203	ጉዳት የሚያስከትል ጽንሰ የማቋረጥ ሂደት ያውቃሉ ?	*አውቃለሁ .....1 *አላውቅም .....2	
204	ጽንሰ የት እንደሚቋረጥ ያውቃሉ ?	*አውቃለሁ .....1 *አላውቅም .....2	ወደ ጥ. 206
205	ጽንሰ ማቋረጥ አገልግሎት የሚሰጥባቸው ቦታዎች የት ናቸው ?	ተ = ተጠቅሷል , አል = አልተጠቀሰም *የመንግስት ሆስፒታል ...1 2 *የመንግስት ጤና ጣቢያ...1 2 *የመንግስት ጤና ኬህ/ ክሊኒክ..1 2 የተጠቀሱ መልሶችን ይክክብ *የመንግስት ጤና ኬህ/ .....1 2 *የመያድ ሆስፒታል ...1 2 *የመያድ ጤና ጣቢያ...1 2 *የመያድ ክሊኒክ...1 2 *የግል ሆስፒታል...1 2 *የግል ጤና ጣቢያ .....1 2 *የግል ኪሊኒክ.....1 2 *የግል ዶክተር .....1 2 *ፋርማሲ .....1 2 *መድሃኒት መሸጫ.....1 2 *ሌላ ካለ ይጥቀሱ .....1 2	
206	በአካባቢዎ ጽንሰን ለማቋረጥ እርዳታ የሚሰጡ ሰዎች ማን ማናቸው;	*የልምድ አዋላጆች.....1 *ዶክተሮች.....2	

	የተጠቀሱ መልሶችን ይከከብ	*የጤና መኮንኖች.....3	
		*ነርሶች.....4	
		*የጤና ሰራተኞች( በቤታቸው ውስጥ).....5	
		*ባህላዊ ሃኪሞች .....6	
		*በግል ጤና ተቋማት የሚሰሩ ሰራተኞች.....7	
		*ሌላ ካለ ይጥቀሱ _____	
		*አላውቅም .....8	
207	አንድ ሴት ጽንሰ ካቋረጠች በኋላ ምን ምን ችግር ሊያጋጥማት ይችላል	ተ = ተጠቅሷል , አል = አልተጠቀሰም	
		ተ-1 አል 2	
		*ከማህጸን ደም መፍሰስ.....1 2	
	የተጠቀሱ መልሶችን ይከከብ	*ከማህጸን ፈሳሽ መኖር..1 2	
		*ከፍተኛ የሆድ ህመም .....1 2	
		*ትኩሳት .....1 2	
		*ሌላ ካለ ይጥቀሱ _____	
208	ጤና ጣቢያ / ሆስፒታል ጽንሰ ያቋረጠች ሴት ችግር ውስጥ የመውደቅ እድሏ ምን ያህል ነው?	*ሁልጊዜ ችግር ያጋጥማታል.....1	
		*አንዳንዴ ችግር ያጋጥማታል.....2	
		*ምንም ችግር አያጋጥማትም.....3	
		*አላውቅም.....8	
209	ከጤና ጣቢያ / ሆስፒታል ውጪ ጽንሰ ያቋረጠች ሴት ችግር ውስጥ የመውደቅ እድሏ ምን ያህል ነው?	*ሁልጊዜ ችግር ያጋጥማታል .....1	
		*አንዳንዴ ችግር ያጋጥማታል.....2	
		*ምንም ችግር አያጋጥማትም.....3	
		*አላውቅም.....8	
210	በአቅራቢያዎት ያለው የመንግስት ሆስፒታል /ጤና ጣቢያ ሴቶችን ጽንሰ በማቋረጥ ለመርዳት በቂ ቁሳቁስ አለው ብለው ያምናሉ ?	*አዎ.....1	
		*አላምንም.....2	
		*እርግጠኛ አይደለሁም .....3	
		*አላውቅም .....8	
211	በአቅራቢያዎት ያለው የመንግስት ሆስፒታል /ጤና ጣቢያ የሚሰሩ ሰራተኞች ሴቶችን ጽንሰ በማቋረጥ ለመርዳት በአግባቡ ያስተናግዳሉ ብለው ያምናሉ ?	*አዎ.....1	
		*አላምንም.....2	
		*እርግጠኛ አይደለሁም .....3	
		*አላውቅም .....8	
212	በአቅራቢያዎት ያለው የግል/መንግስታዊ ያልሆነ ሆስፒታል /ጤና ጣቢያ /ክሊኒክ ሴቶችን ጽንሰ በማቋረጥ ለመርዳት በቂ ቁሳቁስ አለው ብለው ያምናሉ ?	*አዎ.....1	
		*አላምንም.....2	
		*እርግጠኛ አይደለሁም .....3	
		*አላውቅም .....8	
213	በአቅራቢያዎት ያለው የግል/መንግስታዊ ያልሆነ ሆስፒታል /ጤና ጣቢያ /ክሊኒክ ሴቶችን ጽንሰ በማቋረጥ ለመርዳት በአግባቡ ያስተናግዳሉ ብለው ያምናሉ ?	*አዎ.....1	
		*አላምንም.....2	
		*እርግጠኛ አይደለሁም .....3	
		*አላውቅም .....8	
214	ኢትዮጵያ ውስጥ ጽንሰ ማቋረጥ ህጋዊ ነው?	*በማንኛውም ምክንያት ህጋዊ ነው.....1	
		*በተወሰኑ ምክንያቶች ህጋዊ ነው .....2	
		*በምንም ምክንያት አይደለም .....3	
		*እርግጠኛ አይደለሁም .....4	
215	ከላይ ያለውን መረጃዎን ከየት ነው የሰሙት/ያወቁት?	*በመገናኛ ብዙሃን(ራዲዮ ,ቴሌቪዥን ,ጋዜጣ).....1	
		*ከጓደኞች.....2	
		*ከቤተሰብ.....3	
		*ከጤና ተቋማት.....4	
		*ከት/ቤት.....5	

		*ከሃይማኖት ተቋማት.....6	
		*ከስራ ቦታ .....7	
		*ሌላ ካለ ይጥቀሱ	
<b>ክፍል 3 .አመለካከት ተኮር ጥያቄቶች</b>			
	<b>ጥያቄዎች</b>	<b>ኮድ አሰጣጥ</b>	<b>ወደ---ጥ.ይሰፉ</b>
301	አንድ ሴት ያልተፈለገ እርግዝና ቢያጋጥማት ጽንሱን ማቋረጥ አለባት ?	* አዎ *የለባትም * አላውቅም	ወደ303
302	መልሶት አዎ ከሆነ ለምን	*በምንም ምክንያት መውለድ ያልፈለገች ሴት ጽንስ የማቋረጥ አገልግሎት ልታገኝ ይገባል .....1	
	የተጠቀሱ መልሶችን ላይ ያክብቡ	*ጽንስ ማቋረጥ የመብት ጉዳይ ነው .....2	
		*ጽንስ ማቋረጥ ጉዳት የሌለው የህክምና ሃይት ነው .....3	
		*ተደፍራ ወይም ከቅርብ ዘመድ ካረዘች ጽንስ ማቋረጥ ትክክለኛ አማራጭ ነው .....4	
		ሌላ ካለ ይጥቀሱ	
303	የለባትም ካሉ ለምን	*ሀይወት ከመጀመሪያው የጽንስ ቀን ስለሚጀምር .....1	
		*ሃይማኖት ጽንስ ማቋረጥ ነፍስን ማጥፋት ነው ስለሚል .....2	
	የተጠቀሱ መልሶችን ላይ ያክብቡ	*ጽንስ ማቋረጥ እንደ እርግዝና መከላከያ መታየት ስለሌለበት.....3	
		*ያልተፈለገ እርግዝና ወልዶ ለማደግ መስጠት ስለሚቻል.....4	
		*ልጅ በእድሉ ስለሚያድግ.....5	
		*ጽንስ ያቋረጠች ሴት ጥሩ ያልሆነ ውጤት ስለሚያጋጥማት .....6	
304	ጽንስ ማቋረጥ ያለገደብ ቢፈቀድ እና ህጋዊ ቢሆን ይስማማሉ?	*በጣም አስማማለሁ .....1	
		*አስማማለሁ .....2	
		*መካከለኛ .....3	
		*አልስማማም .....4	
		*አላውቀውም .....5	
305	ጽንስ ማቋረጥ ያለገደብ ቢፈቀድ እና ህጋዊ ቢሆን ምን ውጤት ያመጣል ብለው ያምናሉ;	*የጽንስ ማቋረጥ ቁጥር ይጨምራል.....1	
		*ህጋዊ ያልሆነ ጽንስ ማስወረድ ይቀንሳል.....2	
		ምንም ለውጥ አያመጣም .....4	
306	ከቤተሰብ ወይም ከጓደኛዎች ያልተፈለገ እርግዝና ያጋጠመው ሰው ቢኖር ጽንሱን እንዲያቅርጡ ይመክራሉ	*አዎ .....1	
		*አልመክርም .....2	
		*እርግጠኛ አይደለሁም .....8	
307	እርስዎ በተለያዩ ምክንያት( በመደፈር ወይም ከቅርብ ዘመድ ) ቢያረግዙ ምን ይወስናሉ	*የትም ሳልሄድ እወልዳለሁ.....1	
		*በአካባቢው ባለ ጤና ተቋማት ጽንሱን አቋርጣለሁ.....2	
	የተጠቀሱ መልሶችን ላይ ያክብቡ	*ከአካባቢው ጠፍቼ እወልዳለሁ .....3	
		*ከአካባቢው ርቄ ጽንሱን አቋርጣለሁ.....4	
		*ራሴን አግድላለሁ .....4	
		*ሌላ ካለ ይጥቀሱ .....5	

ክፍል 4 . ልማድ እና ተያያዥ ጉዳዮች

	ጥያቄዎች	ክፍል አሰጣጥ	ወደ----- ጥያቄ ይለፉ
401	ከጓደኛ/ከቤተሰብ/ከጎረቤት ጽንሰ ያቋረጠ ሰው ያውቃሉ	*አዎ .....1  *አላውቅም .....2	ወደ ጥ.403
402	የሚያውቁ ከሆነ ስንት	* _____	
403	ጽንሰ አቋርጣ በሳምንት እና ከሳምንት በኋላ የሞተች ሴት ያውቃሉ	*አዎ ..... 1 *አላውቅም .....2 *እርግጠኛ አይደለሁም .....3	ወደ ጥ.405
404	ለ ጥያቄ 403 መልሱ አዎ ከሆነ ስንት ሰው ያውቃሉ;	_____	
405	ባለፈው አንድ አመት ውስጥ ጽንሰ አቋርጣ በሳምንት እና ከሳምንት በኋላ የሞተች ሴት ያውቃሉ	*አለ..... 1 *የለም .....2 *እርግጠኛ አይደለሁም .....3 *አላውቅም .....8	ወደ ጥ.407
406	ለ ጥያቄ 405 መልሱ አዎ ከሆነ ስንት ሰው ያውቃሉ;	_____	
407	እርጉዝ ሆነው ያውቃሉ?	* አዎ .....1 * አላውቅም .....2	
408	በአጠቃላይ እድሜዎት ስንት ጊዜ ነፍሰጡር ሆነው ያውቃሉ?	* _____	
409	ስንቶቹ እርግጠኛዎችን በሕይወት ያለ ልጅ ወለዱ?	* _____	
410	ለመጀመሪያ ጊዜ ሲወልዱ ስንት አመቶት ነበሩ ?	*15-19.....1 *20-24 .....2 *25-29 .....3 *30-34 .....4 *35-39.....5 *40-44.....6 *45-49.....7	
411	ስንት ልጅ አለዎት	*ድምር _____ *ወንድ _____ *ሴት _____	
412	ከ405 እስከ 409 ያለውን ጥያቄ ተመልሰው በማየት ለጥያቄ 405 ላይ የተመለሰ መልስ እና ለጥያቄ 409 የተመለሰው መልስ ቁጥር ልዩነት ካለው ( 409 የተጠቀሰው ቁጥር ካነሰ) በቀሪው እርግጠኛ ላይ ምን እንደተከሰተ በትህትና ይጠይቁ	*ጽንሱ ተቋርጦ .....1 *ሀይወቱ ያለፈ ልጅ ወልደው.....2	
413	ስንት እርግጠኛዎችን /ጽንሶች ተቋርጠዋል	_____	
414	የተቋረጠው ጽንሰ እንዴት ነበር	*በራሱ/ድንገት.....1 *በፍላጎት ጽንሱን አቋርጠው.....2	
415	የመጨረሻው ጽንሰ መቼ ነው የተቋረጠው ?	*ባለፈው አንድ አመት ውስጥ.....1 *ባለፈው አምስት አመት ወስጥ.....2 *ከአምስት አመት በፊት.....3	

### Appendice 3. Interview questions guide with health workers selected health facilities

#### 1. General

- What is your profession?
  - Respondent category: Mark [  ]
    - Medical Director [  ]
    - Medical Doctor [  ]
    - Nurse [  ]
    - Counselor [  ]
    - Other, specify \_\_\_\_\_ [  ]
  - Specialization \_\_\_\_\_
- Sex of respondent Male [  ] Female [  ]
- How long have you been working in this profession? [  ]
- How long have you been working in this facility? [  ] Months (convert it to months)
- How long have you been working on abortion and related issues in this facility? [  ]
- What is your responsibility in this organization ? What jobs do you do here?
- How many years did you work in your profession?
- How many years did you work in on RH and related Mat Health: How many on abortion?

#### 2. Background about women ;

- How did you see the educational background of women who are coming to get CAC or PAC service? / How would you compare abortion service utilization
  - *proportion are secondary level, primary level, illiterate?*
  - *What socio-economic class are they: proportion higher class, middle, and lower class?*
  - *between older and younger females?*
  - *educational level affect use of the service*
  - *marital status affect service utilization*
  - *economic status affect service utilization*
  - *distance to the health facility*
- How did you see the parity of women? *How do you see the women 's marital status? Be careful with generalities. Divide women into analytical categories, like unmarried, divorced, widowed, polygamous, etc.*

## Declaration

The Thesis is my original work , has not been presented for a degree in any other university and that all sources of material used for the thesis have been duly acknowledged .

Mehiret Habte

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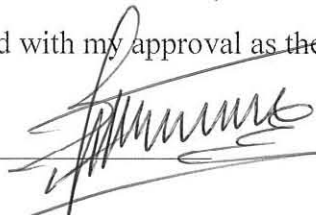
Student

Signature

Date

I confirm that this thesis has been submitted with my approval as the supervisor of the same.

Mengistu Asnake( MD, MPH)

  
\_\_\_\_\_

02/08/10

Advisor

Signature

Date