EXPLORING VIEWS AND PERSONAL VALUES OF HEALTH CARE PROVIDERS TOWARDS ABORTION AT SAINT PAUL HOSPITAL MILLENNIUM MEDICAL COLLEGE, ADDIS ABABA, ETHIOPIA

BY

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A THESIS SUBMITTED TO SCHOOL OF SOCIAL WORK, ADDIS ABABA UNIVERSITY PRESENTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF SOCIAL WORK

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SCHOOL OF GRADUATE STUDIES

This is to certify that the thesis prepared by Mahelet Desalegn, entitled: Exploring views and personal values of health care providers towards abortion at Saint Paul Hospital Millennium Medical College and submitted in partial fulfillment of the requirements for the degree of Degree of Master of Social Work complies with the regulations of the University and meets the accepted standards with respect to originality and quality.

Signed by the Examining Committee:

Examiner_____ Signature_____ Date _____

Examiner_____ Signature_____ Date _____

Advisor _____ Signature_____ Date _____

_____

Chair of Department or Graduate Program Coordinator

DECLARATION

I declare that "Exploring views and personal values of health care providers towards abortion at Saint Paul Hospital Millennium Medical College, Addis Ababa, Ethiopia "is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of reference and that the work has not been submitted before any other degree at any other institution.

Mahelet Desalegn

Signature: _____

Date: _____

Place: Addis Ababa University, Ethiopia

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First and foremost, I want to express my deepest gratitude to the almighty God, the mother of God, Saint Virgin Mary, and all of the aiding saints for everything. Next, I'd want to express my appreciation to my advisor and the School of Social Work for all of their assistance and insightful comments, as well as the Saint Paul personnel, who were gracious enough to provide me with all of the essential information. Finally, I'd like to express my sincere thanks to my loving family for their unwavering support.

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Acronyms

E and C Evacuation and Curettage

D and C Dilation and Curettage

D and E Dilatation and Evacuation

FIGO International Federation of Gynecology and Obstetrics

FGD Focused Group Discussion

IUD Intra Uterine Device

NICU Neonatal Intensive Care Unit

PTSDPost Traumatic Stress Disorder

WHO World Health Organization

Abstract

This study focused on safe abortion and explored the views and personal values of healthcare providers toward abortion at Saint Paul Hospital, as well as the knowledge of health care providers on legal criteria for abortion eligibility in Ethiopia. This was explored using case study design. The sampling technique used was purposeful sampling, and data were gathered through observation, in-depth interviews, and focused group discussions. The data were examined using thematic analysis, which helped in interpreting the data and structuring in to valuable information. The finding shows that majority of respondents have a negative view regarding abortion provision, with the majority of the reasons being based on religious prohibitions and moral judgments and also psychological and social influences. The study also examined the knowledge of health-care providers on legal criteria for abortion eligibility in Ethiopia as well as the experience of health-care providers in Saint Paul Hospital and Several of participants were aware of the abortion law and their obligations, This offers information on identifying the primary causes of health providers' negative views against abortion. It is advantageous for social work practice to intervene in pre- and post-abortion counseling and allay the worries of healthcare workers.

CHAPTER ONE

1. Introduction

Abortion is a deliberate method of terminating an unwanted and unintended pregnancy. The risk of abortion varies depending on the age of the pregnancy, whether it is in a proper medical setting or not, and the individual's expertise and competence. Safe abortion is defined as an abortion performed in a standard medical setting, by a skilled and trained professional, and in accordance with the WHO standard pregnancy age. When one of the requirements is not met, the danger increases (Sedgh et al., 2007).

Abortion has been widely done for a long time in most of the world, either legally or illegally, but it is a subject that arouses passion and debate since abortion highlights two essential problems, namely sex and life, which are commonly intermingled with religion and ethics. We have seen changes in laws as well as personal and professional attitudes around abortion during the last few years. Authorities and individuals' attitudes change as a result of social necessities. Statistics show that a substantial number of abortions are performed in many countries where abortion is illegal, yet authorities are indifferent, overlook or accept it, or even informally authorize abortion facilities (Arisi, 2003).

In 2003, 42 million abortions were reported to have been performed, compared to 46 million in 1995. In 2003, the rate of induced abortion among women aged 15 to 44 years was 29 per 1000, down from 35 in 1995. Western Europe had the lowest abortion rates (12 per 1000 women). In 2003, 48 percent of all abortions globally were unsafe, with developing nations accounting for more than 97 percent of all unsafe abortions. In 2003, there were 31 abortions for every 100 live births worldwide. Overall, the developing and developed worlds have

parallel abortion rates, although unsafe abortion is concentrated in developing countries (Sedgh et al., 2007).

The conditions that lead to a safe abortion are influenced by a variety of factors, including abortion laws and policies, socioeconomic situations, the availability of safe abortion providers, and the stigma associated with abortion. Stigma associated with seeking or providing abortion is widely recognized as having an impact on how and where women receive treatment, as well as who delivers care. During the 2010–14 periods, around 55.7 million abortions were performed worldwide (Sedgh et al., 2016).

There are studies that showed attitudes are not related to abortion services like on a study on attitudes and practice of private medical providers towards family planning and abortion in Nigeria showed that Private medical practitioners were willing to provide safe abortions and deal with the problems that come with unsafe abortions. The impact of attitudes on performing safe abortions was not substantial in the study, and they placed a strong emphasis on women's consent, with some believing that the mother should make the decision and have the right (Okonofua et al., 2005).

As Ethiopia encompasses a wide range of cultures and religions, the people's attitudes and values are paramount. According to one study, age and marriage were among the determinants in deciding on abortion, which was linked to unmarried women's cultural perceptions of appearing with any pregnancy outcome. Abortion rates increased with age, according to the finding. It indicates that as teenagers get older, they reveal abortion, which is uncommon at a young age, and that abortion occurs less frequently in low socioeconomic youths. In this study, both age and marriage had a similar impact on abortion(Gilano & Hailegebreal, 2021).

In 2005, Ethiopia liberalized its abortion laws, enabling midwives to perform abortions. Abortions were performed by the majority of midwives. This willingness was positively and

significantly related to clinical abortion experience, but negatively and significantly related to religion, belief in the right of providers to refuse services, and care of patients from urban rather than rural areas. There was no evidence of a link between abortion stigma beliefs, years of experience as a midwife, or legal knowledge. The result shows complex dynamics, such as tensions between professional norms and religious convictions, explain midwives' motivation to deliver services (Holcombe et al., 2015).

In general, abortion attitudes and personal beliefs affect not only woman who get abortion service, but also health care practitioners who must deal with their own personal values and moral judgments about whether or not to offer abortions. The views and personal values of health professionals about abortion were explored in this study in order to better understand the views and personal values of health providers in respect to abortion provision. This study revealed the tension of health care workers in providing abortion and the challenge of working at abortion site with having negative views on their work.

1.1 Statement of the problem

Abortion is widely practiced around the world, and several researches have been undertaken on topics such as unsafe abortion, that is a public-health and human-rights imperative, was investigated in relation to maternal mortality rates and reasons of death, such as hemorrhage, infection, and poisoning (Grimes, et al, 2006). It has been investigated in terms of impediments to competent care and legalization issues (Faúndes & Shah, 2015).The moral risk of abortion was studied based on arguments about abortion issues that were raised from various religion rules and conventions (Moller, 2011).Legal aspects of pregnancy terminations and various abortion management mechanisms like medical and surgical interventions depending on the age of pregnancy (WHO, 2018).

A study aimed at determining how personal and social attitudes are evolving in Europe showed a result that changes in laws, as well as personal and professional views toward

abortion, were discovered. Authorities and people' opinions are influenced by social demands. The study discovered that in many countries where abortion is banned, statistics showed that a large number of abortions were performed, yet authorities are unconcerned, overlook or accept the practice, or even informally license abortion clinics. Access to authorized facilities and staff, as well as resources to pay for abortions, may be constrained in other nations where abortion is nominally legal, resulting in more illicit abortions. Practice is evolving, and in some circumstances, it is becoming independent of the lawit was concluded that, due to the efforts of governments, women, professionals, and non-governmental groups, Europeans are transitioning from an abortion culture to one of contraception and abortion prevention (Arisi, 2003).

According to a study on Trends in Public Attitudes Toward Abortion among the American public, abortion approval is highest when the woman's health is seriously endangered (87.0 % across all years, 1972-2012), followed by pregnancies caused by rape (78.3 %), and a serious defect in the fetus (78.3 %). However, majorities oppose abortion when the family cannot able to accept another child (45.0 %), when a married woman does not want more children (42.1 %), when the woman is unmarried and does not want to marry the prospective father (42.0 %), and when the woman wants the abortion for "*any reason*" (42.0 %). The findings revealed that there is little variation in attitudes toward abortions between men and women, with males being slightly more favorable of legalization. Gender differences are less significant than age disparities. Those above the age of 65 are the least supportive of abortion However, the youngest age group (under 35) receives the most support, followed by those in the intermediate age groups (35-49 and 50-64) on average(Smith & Son, 2013).

Healthcare providers' knowledge and attitude towards abortions in Thailand: a pre-post evaluation of trainings on safe abortion (Sanitya et al., 2020).This study looked into the training course participants in order to assess their knowledge and attitudes about safe

abortions, and look into the factors that influence their knowledge and attitudes. A pre-and-after study design was used. Among the various categories of health professionals, changes in attitude were notably varied. Positive attitudes toward unintended pregnancies, unsafe abortions, and abortion scenarios grew significantly. The type of health professional's position played a big role in altering attitudes.

A study was undertaken on midwives' knowledge and views about legal and religious commandments on induced abortion, as well as their association with specific demographic variables in Iran (Afhami et al., 2016). The majority of the participants had very poor to moderate expertise of abortion rules. Their views on the effective application of abortion rules ranged from severely negative to reasonable. There was no link found between knowledge, age, work experience, or education. There was, however, a link between the level of understanding about abortion rules and the service location. There was no statistically significant link between attitude and demographic factors.

Röhrs, (2017) studied the impact of norms and values on the provision of abortion services in South Africa. He discovered that the nurses' performance is based on their personal opinions, and they classified the women as deserving of assistance or not. Furthermore, nurses are emotionally connected to their clients, and their personal judgment interferes with the client's decisions. Some nurses do not agree with the idea of abortion, and they are only involved in the work because they have no choice but to work in order to survive, and they believe that abortion and nursing are completely contradictory.

Research also conducted at a regional level hospital in Ghana on the responsiveness of health providers to post-abortion care. According to the findings, more than three-quarters of the women were satisfied with the facility's post-abortion care services. Overall, the women were pleased with the hospital's delivery, due to the courteous approach of health professionals

toward them and the fact that they were assisted in their financial need for a free service (Adde et al., 2018).

Health care providers' perceptions of and attitudes towards induced abortions in sub-Saharan Africa and Southeast Asia was also studied(Loi et al., 2015).From Thirty-six studies, published between 1977 and 2014, including data from 15 different countries, nine elements were identified as impacting health care workers' attitudes toward induced abortions. according to a systematic literature review of qualitative and quantitative data, 1) human rights, 2) gender, 3) religion, 4) access, 5) lack of preparation, 6) quality of life, and 7) ambivalence 8) Care quality; 9) Stigma and Victimization. They discussed that most health-care providers in Sub-Saharan Africa and Southeast Asia oppose induced abortion for moral, social, and gender reasons.

In Ethiopia, a study on safe abortion care in health facilities found that health centers and clinics are staffed by mid-level providers (nurses, midwives, and health officers) who are enabled to perform early abortions and care for women who have experienced complications from an unsafe abortion using vacuum aspiration. Conscientious objection among Ethiopian providers was not mentioned in the technical and procedural guidelines paper, unlike in numerous other African countries where abortion laws have recently been amended or reinterpreted. Mid-level clinicians commonly provide post-abortion and abortion care, and technology, such as vacuum aspiration and medical abortion procedures, is both affordable and widely available in the public and private sectors (Abdella et al., 2013).

According to a study on Personal Beliefs and Professional Responsibilities of Ethiopian Midwives' and Attitudes about Providing Abortion Services alter Legal Reform. Approximately two-thirds of those polled opposed having parental or male partner approval for abortion. There were also smaller majorities in favor of allowing abortion on

socioeconomic reasons and in circumstances when contraception had failed. A smaller majority of respondents believe that health professionals should be forced to provide abortion services, even if it goes against their religious convictions. In contrast, more than half of midwives believe that providers should have the freedom to refuse to offer services. Respondents, on the other hand, had considerable gaps in their legal knowledge, particularly when it came to identifying the legal criteria for abortion eligibility (Holcombe et al., 2015).

A study on health care providers' perception towards safe abortion service at selected health facilities in Addis Ababa show that the majority of respondents were unwilling to participate in abortion services, despite knowing all of the risks associated with unsafe abortion and being unaware of the legal criteria for abortion eligibility. The study discovered that health providers avoid abortions due to religion, personal values, and a lack of training (Abdi & Gebremariam, 2011).

In general, there are a variety of issues that arise on abortion, and numerous researches have been undertaken. However, these studies primarily focus on people who have had an abortion, as well as their perspectives, moral, and legal values and also mechanism of managing abortion and its incidence. In Ethiopia, a few studies on health care practitioners' views and understanding of abortion have been conducted but mostly most of the studies focused on the effect of the health care professional's attitudes on the abortion provision rather than their views and voice of healthcare providers in related to their life and work, also this was a new study on Saint Paul Hospital health care professionals exploring on their views and values on abortion, this study focused on this constraint by investigating the views and personal values of abortion practitioners, as well as their knowledge on legal criteria for abortion eligibility in Ethiopia.

1.2 Research objective

1.2.1 General objective

The general objective of this research was to explore views and personal values of health care providers towards abortion at Saint Paul Hospital.

1.2.2 Specific objective

1. To explore views of health care providers towards abortion at Saint Paul Hospital
2. To explore personal values of health care providers towards abortion at Saint Paul Hospital
3. To assess the knowledge of health care providers on legal criteria for abortion eligibility in Ethiopia
4. To assess the experience of health care providers on the abortion service at Saint Paul Hospital.

1.3 Research questions

1.3.1. General question

- ✓ What are the views of health care personnel at Saint Paul Hospital concerning abortion?

1.3.2. Specific question

- ✓ What are health care providers value regarding abortion at Saint Paul Hospital?
- ✓ What are the psychological and social aspects of a safe abortion for a healthcare practitioner?
- ✓ What is the knowledge of health care providers' on legal criteria for abortion eligibility in Ethiopia?

- ✓ How is the experience of heath care providers on providing abortion at Saint Paul Hospital?

1.4Significance of the study

Health social workers work in a range of settings and play a variety of roles in the design, delivery, and assessment of health. They also facilitate connections between organizational systems and professions in order to improve health care for people and populations (Gehlert et al., 2019).People's attitudes against abortion may be influenced by a variety of factors, but as health care professionals, their beliefs and personal values toward abortion will have a substantial impact on both women and health care practitioners. If health-care providers' beliefs and personal convictions concerning abortion conflict with the country's law, it is essential to alter the law or find other solutions for health care providers. As a result, this study added to our understanding of health care providers' beliefs and personal values towards abortion. In addition, the knowledge of health care providers regarding the legal criteria of abortion eligibility in Ethiopia was looked into. since social workers' role in policy practice and its role in social issues is very important, this study offers information on health care practitioners' views and values in abortion provision in order to solve moral and psychosocial issues of abortion and its regulation regarding health care providers.

1.5 Scope of the research

This study focused on exploring views and personal values of health care providers specifically doctors in the obstetrics and gynecology unit and midwives at Saint Paul Hospital who were explicitly involved in abortion cases.

1.6Limitation of the study

Since the study is qualitative, the study's ability to generalize the findings for all is limited because qualitative research seeks answers to questions by examining various social circumstances and is interested in understanding behavior from the perspective of the people themselves (Berg, 2004).

1.7. Definition of terms

Gestational age: the number of weeks since the first day of the woman's last menstrual period.

Curettage is a surgical procedure that involves dilating the cervix with medical or pharmacological dilators, then scraping the uterus walls with sharp metal curettes.

Vacuum aspiration is a surgical technique to evacuate the uterus using either manual or electric aspiration after cervical dilatation.

Incomplete abortion: is the partial loss of the products of conception with in the first 20 weeks.

Intra-amniotic injections: injections administered by entering in to the innermost membrane that encloses the foetus.

Intra-cardiac injections: injections that are given to directly in to the heart muscle

CHAPTER TWO

2 Literature Review

This chapter includes literatures and finding on abortion and related topics that helped in understanding the issue and identify any gaps in understanding of the study's goal. In order to gain a fundamental understanding of the problem, it also includes prior literature on the definition of abortion, its management, and its prevalence. In order to distinguish between the known and the unknown, the other major subjects are related to those of this study.

2.1. Abortion and types

According to the condition of the procedure, there are two kinds of abortion. Safe and unsafe abortions, as the term implies safe abortion is an abortion performed by legally licensed health provider or in a set up that full fill the medical standard or both. In contrast unsafe abortion is the reverse which means abortion done by persons without professional medical skill or in environment that does not confirm minimal medical standard or both. Even both safe and unsafe abortions occur as a result of unintended pregnancy, there is a significant difference in regard to the health consequence. In which unsafe abortion can lead to life treating conditions and it is one of the major causes of maternal mortality, safe abortion has a few consequences (Leone et al., 2016).

There was also confusion on defining unsafe abortion when seen from the angle of outcome. This may consider all abortion that result in complication and death as unsafe abortion but the fact is not all unsafe abortion leads to complication or death. And this will be difficult to determine the severity of the complication. The WHO (World Health Organization) definition becomes the preferred definition that encompasses all the factors related to unsafe abortion (Warriner & Shah, 2006).

The other classification is based on the mechanism of termination. This is spontaneous abortion and induced abortion. Whereas induced abortion can alternatively be defined in the

form of safe abortion when it is performed legally but it includes an outside intervention for the termination of the pregnancy and the other is therapeutic abortion, which is medically indicated abortion for women whose life or health is threatened by continuation of pregnancy or when the health of the fetus is threatened by congenital or genetic factors Spontaneous abortion is the loss of a pregnancy without outside intervention before twenty weeks of gestations In most of cases the cause is unknown. Many of the very early losses are because of genetic abnormalities and the other possible causes of abortion may be due to infection, hormonal and anatomical abnormalities. If there is spontaneous loss of fetus more than two times, the cause is most likely immunological (Griebel et al., 2005).

2.2. Types of abortion procedures

The first trimester of pregnancy lasts from conception to week 12. Weeks 13 through 28 make up the second trimester. Medical abortion and vacuum aspiration are popular abortion options in the first trimester. Medical abortion is normally available until about 10 weeks after a woman's last period. It entails the administration of two different medications. After 10 weeks, surgical options like vacuum aspiration and dilation and evacuation become increasingly popular. A woman may have dilation and evacuation or a labor induction abortion in the second trimester. Abortion in the third trimester is uncommon; however, it can be done if a woman's life is in risk (Zara, 2020).

2.2.1. Medical abortion

Two drugs, mifepristone and misoprostol, are used to perform a medical abortion. These two drugs work together to put a stop to a pregnancy. This treatment is used until the first week of pregnancy, but not if the fetus is implanted outside of the uterus, if the woman has a bleeding problem or serious liver, kidney, or lung disease, if she has an IUD, or if she has been using corticosteroid medications. The procedure begins with the administration of mifepristone, a

hormone that suppresses progesterone, which the embryo needs to implant and grow in your uterus. Misoprostol will be given orally a few hours or up to four days after mifepristone has been given. As the pregnancy tissue is pushed out, Misoprostol causes the uterus to contract, causing cramping and heavy bleeding. Nausea and vomiting, diarrhea, tiredness, headache, and sweating are all common side effects(WHO, 2018).

Another alternative is to take methotrexate and misoprostol during the first seven weeks of pregnancy. Methotrexate is a cancer-fighting drug. It prevents embryonic cells from multiplying in the same manner that cancer cells are prevented from proliferating. The uterus contracts as a result of misoprostol, allowing the contents of the uterus to be expelled. Because it takes longer than mifepristone and misoprostol, this method is less popular. Doctors typically use it to treat women who are pregnant outside of their uterus. In the same instances where mifepristone and misoprostol are combined, this technique is contraindicated. It could take a few days or weeks to finish the abortion. Only 1% to 2% of people will benefit from the medication. The only other option is to have a surgical abortion if it doesn't succeed (Archer, et al. 2013).

Medical abortion is favorable since it does not require surgery, can be performed in the first trimester, and does not require anesthesia. However, the downside is the unpleasant cramping and the fact that it is rarely successful, being unavailable in the second trimester. However, the World Health Organization recently recommended misoprostol over surgical techniques such as D and E for second-trimester abortion (WHO, 2018).

2.2.2. Surgical abortion

Vacuum aspiration

It’s a sort of surgical abortion that involves ending a pregnancy using gentle suction. It's usually done during the first trimester. Medical practitioners perform the process by placing a speculum into the woman's vagina. Then numb the region with medicine or an injection. The cervix is then opened with small rods called dilators, and a tube is inserted into the uterus. The uterus is then emptied using a manual or mechanical suction device. The benefits include its availability during the first 12 weeks of pregnancy, the short duration of the procedures, and the fact that it does not require anesthesia. Antibiotics must be taken to prevent infection, and rest is required for full recovery. Bleeding and infection are two possible side effects of the operation (Archer, et al. 2013).

Dilation and Evacuation

Other devices (such as forceps) are used in conjunction with suction to empty the uterus throughout the second trimester (between the 13th and 24th weeks of pregnancy). During a D&E, the cervix must be opened further to allow for the removal of bigger pregnancy tissue. Pre-dilation and softening of the cervix will be required. This procedure can take as little as a few hours early in the second trimester. Preparing the cervix later in the trimester can take as long as two days. Medication or sedatives might be used in addition to local anesthetic in the cervix to reduce pain. Mild pain and cramping may persist for a few days following the treatment, and some bleeding may persist for up to two weeks. Infection, severe bleeding, and uterine damage are all possible consequences (Newmann et al., 2010).

The recommended techniques for managing induced abortions, including missed and incomplete abortions, include vacuum aspiration and medicinal abortion. FIGO proposed that this be used instead of dilation and curettage to increase the safety and quality of abortion services (Zaidi et al., 2014).

A maternal Trans abdominal injection of digoxin is commonly used to achieve preoperative fetal a systole. Digoxin is used to cause fetal death prior to D and E. Although digoxin is commonly used to achieve preoperative fetal asystole, there are no evidence-based guidelines for achieving fetal asystole before D and E. With doses ranging from 0.25 to 2mg, digoxin has been delivered intracardiac, intrathoracic, and intra-amniotic ally. Digoxin is typically administered one to two days before to the D and E(White et al., 2018).

Labor induction abortion

This is a late-term procedure for terminating a pregnancy in the second or third trimester. This is a rare type of abortion that a doctor may approve if a woman's life is in risk. It includes inducing labor using medicines, which causes the uterus to empty over a period of 12-24 hours. The medicine can be taken orally, vaginally, or intravenously. Because the medication causes severe cramping, a pain reliever will be provided. Hemorrhage, cervical damage, infection, uterine rupture, and incomplete release of the pregnancy tissue are all possible complications (El-refaey & Templeton, 1995).

2.3 Abortion policy

Abortion regulation varies per country due to a variety of factors. These factors include the country's history as well as the people's cultural and religious values. Many studies point to restrictive abortion regulations as a contributing factor to abortion's high incidence. Some elements that are regarded an indicator or ground rules for approving safe abortion are influencing abortion regulations. Pregnancy stages, mother's age, number of children, and family status, which includes marital status, economic and medical circumstances, as well as varied indications for different countries. In developed countries back in 1971, Eastern Europe’s like Denmark and Finland consider the legal permission depends on stages of pregnancy, varying from 10 weeks to three months, depending on the country. In German if the women have more than 4 children and if the current pregnancy is less than 24 weeks,

abortion is permitted. These kinds of indicators were common among Europeans to grant legal abortion. Countries like Singapore emphasis on the economical and family status of the mother and consider this kind of statuses to be one of the indications to practice safe abortion legally. But as the same time these economic status does not consider being an indication for some of countries like United Kingdom in order to decrease the risk of health to the mother. The other factor is the women's age. For most of the European countries, if the pregnant women are below 16 and above 40, abortion is legally permitted. In USA some states including New York and Hawaii abortion is permitted for the following condition, women's full consent and "under a reasonable belief that the operation is necessary to preserve her life and the gestational age differs from one state to another, in most states it is up to 24 weeks and some states extended it up to 26 weeks, in developing countries like Tunisia, abortion is legally permitted if the woman have more than or at least five living children and if pregnancy does not exceeds 3 month of gestation in previous times(Wada, 2008).

In Ghana, there were certain conditions which abortion can be permitted if the pregnancy is a risk to the life of the mother and in case of rape and incest. It is legally permitted obviously if procedure will be done by medically registered professionals in hospital set up (Wada, 2008).

Abortion was legal in 98 % of the world's countries at the turn of the twentieth century to save a woman's life. Other reasons for abortion were: to protect a woman's physical health (63 %); to protect a woman's mental health (62 %); in cases of rape, sexual abuse, or incest (43 %); fetal abnormality or disability (39 %); economic or social reasons (33 %); and on the client request without telling her reason (27 %). In 65 % of developed countries, but only 14 % of developing countries, abortion was legal on demand, and in 75 % of developed countries, but only 19 % of developing countries, abortion was legal for economic and social reasons. Additional grounds for abortion are allowed in some countries, such as if the woman has HIV, is under the age of 16 or over the age of 40, is not married, or has a large family. A

few also enable it to protect current children or in cases when contraception has failed (Berer,2017).

In developed countries such as the United States, there are far more state laws restricting abortion in a broader range of ways than there were in the year 2000, and the trend toward restrictive legislation looks to be accelerating. Existing restrictive legislation includes gestational limits and restrictions on abortion coverage in private insurance plans(Beckman, 2017).

According to criminal code of the Federal Republic of Ethiopia (2004), article 551, proclamation no 414, abortion is legal in Ethiopia, as it is in most African countries, on six grounds: rape or incest, if the woman has physical or mental disability, if the woman's life is in danger due to medical abnormality, suspicion of fetal impairment, and for economic or social reasons.

After 2005, following the change in the abortion law, there were competing and ambiguous concerns, as well as hefty obligations, among health care practitioners on how to interpret and administer the law. They highlight their efforts to strike a balance between their religious faith and ideals and their professional commitments, as well as their worries for women's safety and well-being. This wrangling is most visible in the treatment of women who fall outside of the law's guidelines. Furthermore, many health workers are stigmatized by their coworkers who do not conduct abortions, so they keep their job a secret from their families and friends. Health practitioners in Ethiopia face ethical challenges as they strive to balance abortion law, personal values, and genuine care for women's health, indicating that more research is needed (McLean et al., 2019).

On the other hand, policymakers and policy implementers such as ministries, UN agencies, international and national NGOS, as well as religious organizations, adopted a strategy of silence in order to avoid inciting anti-abortion sentiments and politicization of the abortion

issue, which was seen as a threat to the revised law and policy, preventing dissemination of knowledge about the revised law and policy (Tadele et al., 2019).

The extant literature on the nature of abortion policies reveals that policies are only expressed in terms of a woman's right and legally permissible situations. However, the extent of performing abortion appears to have been overlooked, which will lead to confusion among health care practitioners about how to practice safe abortion in accordance with their personal values and willingness.

2.4. Pro -life and pro choice

Abortion should be forbidden because the fetus is a living being, according to the pro-life viewpoint. As a result, the pro-life movement bases its arguments on moral claims about the sanctity of life, claiming that the pro-life stance is ethically pure due to the moral weight it places on the protection of the unborn' existence. The pro-choice movement, on the other hand, rejects this argument by stating that the unborn is not a life, and that legislation should be geared toward safeguarding the mother's life (Smith, 2005).

Many pro-reproductive rights advocates have attempted to blur the lines between pro-life and pro-choice, depending on which side of the divide they fall on, in order to create their own point of view. Unfortunately, they are attempting to widen conceptions that are essentially built to exclude the bulk of women's experiences, notably the experiences of poor and disabled women (Smith, 2005).

The use of abortion pro-types, such as pro-life and pro-choice, in a study of abortion views revealed that people have different abortion attitudes and individual differences profiles than those who favor absolute abortion perspectives. It wasn't enough to just label abortion supporters as pro-life or pro-choice (Rye& Underhill, 2020).

2.5. Prevalence of abortion

Abortion is one of the common causes for maternal death. In spite of all the factors related to polices and insufficient data. The incidence of abortion worldwide differs for different reasons. In developing countries unsafe abortions is still an issue and in contrast in developed more than 90% is safe abortion. In 2003 the incidence of abortion worldwide has been studied. The result found that the rate of abortion has been decreased in spite of being influenced by different factors, the higher decrement has seen in developed countries. But in African countries, abortion rate increases in 2003 when compared that of the study done in 1995 (Singh et al., 2017).

In Ethiopia, "in 2014, an estimated 620,300 abortions were performed. This corresponds to annual rate of 28 abortions per 1000 women aged 15-49, an increase from 22 per 1000 in 2008(Singh et al., 2017).

2.6. Psychological and social impacts of abortion

Abortions are seen as a traumatic experience, even when they are carried out with the mother's desire. Post-traumatic stress disorder (PTSD) and depression are two psychological effects of abortion. Some women have mental health hazards after a period of time has passed prior to the abortion. Although PTSD is uncommon, depression is a frequent psychological response after abortion owing to guilt over ending the pregnancy. These post-abortion reactions are inversely proportional to the abortion's period. An unusual psychological reaction occurs shortly after an abortion. However, unfavorable psychological effects are discovered in some women after a period of time has elapsed. Because sadness and regret are virtually always present in the majority of women who have an abortion, this psychological response was not included as an impact(Major et al., 2000).

The gestational age of the pregnancy is linked to elements that influence psychological response following an abortion. Pregnancy terminations in the second trimester elicit a more

unfavorable reaction than those in the first trimester. Other factors include pro-abortion conditions, which can lead to depression in women who are faced with a difficult decision about whether or not to terminate their pregnancy. Support from family members, particularly from men, is critical in reducing negative psychological reactions (Adler et al., 1992).

Since their professional identity is linked to abortion, doctors' experiences of abortion stigma differ from women's because stigmatizing may be ongoing. The impacts of abortion stigma on abortion providers' well-being have not been widely explored, but stress, professional difficulties with anti-abortion colleagues; worries of disclosing one's work in social settings, and burnout have all been hypothesized. In addition to maintaining and strengthening training activities for providers, silence is a crucial technique for persons living with the abortion stigma (Heymann et al., 2021).

2.7. Moral and personal values

It is common for persons who have permissive views regarding abortion to believe that their moral deliberations are over once they have reviewed all of the reasons against abortion.They are aware of and concluded that they fail. This is because even the possibility of one of those reasons succeeding can produce a moral justification for the act. The more basic challenge that emerges is how to incorporate fallibilism in our decision-making when it comes to practical judgment. For instance, to create a countervailing risk, the case against gestating would have to establish that bearing a kid was comparable to killing an innocent person. However, we may be tempted to go even farther and point to the far more prevalent case of young moms whose lives are devastated by the responsibilities of premature motherhood. The burdens placed on the mother generate, at best, possibilities for abortion rather than requirements, for the same reason that someone can choose not to ruin his life in order to provide a modest pleasure to his child, but is not morally obligated to do so. The parent who destroys his life in order to provide a minor benefit to his child may be insane, but he is not

immoral. These arguments show that, in most cases, the net moral risk associated with abortion is overwhelmingly in favor of having the abortion. Because of this, the risk argument may be able to hold sway over abortion (Moller, 2011).

Medicine needs both reasons and values. Doctors, like everyone else, should have values that are reasonably aligned with what is right. Individual values should not dictate how health care is delivered at the bedside. Doctors can advocate for policy or legal changes. They can also offer sound counsel based on their ideals. They do not, however, claim any particular moral standing that would allow them to deny people medical care to which they are entitled (Savulescu & Schuklenk, 2017).

Findings imply that nurses who perform induced abortions are subjected to personal ethical judgments, cultural beliefs, and emotional concealment. Nurses who had to deal with fetal death and assisted with induced abortions devised a way to keep their emotions hidden. Front-line nurses are not encouraged to talk about their personal issues with induced abortions in hospitals. When the fetus had no defects and was already formed, nurses felt more mental tension and shame. Study found that dealing with abortion in the second trimester is more mentally distressing than dealing with abortion in the first trimester. When numerous nurses had long-term experience with abortion and had accepted abortions for chromosomal abnormalities, they claimed they felt sympathy for the women. Nurses, on the other hand, reacted with emotion and outrage when the fetus was normal, particularly when teenagers had recurrent abortions or adult women had undesired pregnancies, while continuing to provide contraceptive and postpartum care (Yang et al., 2016).

2.8. Attitudes towards abortion

In developed countries, abortion has become a common surgical practice. Abortion takes up the majority of gynecologists' time in the United States, following caesarian section (surgical technique for delivering a baby) and hysterectomy (uterus surgery). However, the number of

abortion procedures is increasing in the United States doctors are less interested in providing abortion services (Norton, 2011).

The study aimed to determine whether exposure to abortion training increases future practice of safe abortion in USA. Reported that most of the doctors were exposed to abortion training previously but still neglect to practice it, most are trained and some of them were providing the service to abortion. But for the most of the cases the reasons for avoiding abortion were because of attitudes and personal beliefs against abortion. The study identifies training as one of the benefits in provision of abortion but does not address the influence of attitudes and personal values towards abortion which was the significant role to avoid the practice (Steinauer et al.,2008).

A qualitative study of health-care providers' attitudes toward abortion in South Africa found that complex patterns of service delivery were common throughout many health-care facilities, and disorganized levels of service provision operated to satisfy health-care providers' willingness to participate in various aspects of abortion provision. Some providers provided abortions and some assisted with the procedures or provided pre and post abortion counseling. This was related the different reasons the participant mentioned mainly moral reason and religious beliefs. Many physicians expressed a desire for separate, stand-alone abortion clinics, resulting in a more welcoming environment for both women and health care providers. And it is founded that there was a general lack of understanding concerning the circumstances in which health care providers were entitled to invoke their right to refuse in providing, or even assist in abortion services (Harries et al., 2009).

The study on doctors' perspectives about creating safe abortion in Ghana focuses on medical professionals' attitudes on safe abortion, safe abortion provision, and the national legal situation on abortion. According to the findings, some of the participants were willing to participate in counseling but not in safe abortion. While near to half of them were willing to

participate in both counseling and termination and few were unwilling to participate in both counseling and termination. In terms of national legal policy, the majority of the professionals (about half of the client) are familiar with the national abortion policy, while the others are unsure. This concludes that, despite their thorough understanding of the law, there were experts who were unwilling to participate in both counseling and termination. This indicates that several elements must be studied in order to determine the cause for the refusal. Although the study identifies medical professionals' awareness of the national law of abortion and the provision of abortion, it is limited in discussing the major reasons for professionals to avoid safe termination and the involvement of policymakers regarding clear justification of the prior to the enactment of health providers, prompting the current study to focus on these issues (Morhe et al., 2007).

A recent study in Zimbabwe on health care providers' and abortion experts' knowledge and attitudes toward abortion found that health care providers and abortion experts' knowledge of the legal provisions for abortion is incomplete and often inaccurate, and the majority of them suggested liberalizing the abortion law to reduce unsafe abortions (Madziyire et al., 2019). Medical professionals have their own perspectives, ideas, and moral judgments regarding abortion. And the value of this variable varies from person to person. In order to assess the possible reasons, the research of opinions about induced abortion in Sub-Saharan Africa and Southeast Asia found nine primary descriptive themes. Health care professionals' attitudes toward abortion were explored, with religion being the most relevant component; majority of them considered that an induced abortion was a mortal sin, the majority of nurses, particularly midwives, considered abortion as incompatible with their profession, feeling that their purpose is to assist during birth and life, not to terminate pregnancy. As a result, they are vulnerable to anxiety. Other issues that influenced attitudes regarding abortion were human

rights, gender, access and unpreparedness, quality of life, stigma, and victimization (Loi et al., 2015).

In Ethiopia, A study on health care providers' perception towards safe abortion at selected health facilities in Addis Ababa, (2011) was conducted. According to the study's findings, the majority of health care providers were unaware of the existing legal right to abortion, and a lack of abortion training was the primary reason for not conducting abortions. On the other hand, individuals who were trained in abortion were found to perform abortions once every six months, and just a fifth of them were willing to work at a location where safe abortions are performed. However, due to religious and personal views, more than a quarter of the workers declined to work on facilities where safe abortions are performed. This finding indicates that the study considers the impact of health-care providers' opinions on the provision of safe abortion. It recommends that changing health-care workers' views toward abortion could help to reduce the risks of unsafe abortion (Abdi & Gebremariam, 2011). This study was conducted in support of safe abortion access, yet the results suggest that most people are unwilling to work in abortion facilities. Even though policy implications and many aspects should be studied, the reasons for the health professionals' condition were not briefly examined. This information aided the current study in identifying the important variables of health-care providers' attitudes regarding abortion

Another study in Ethiopia on the knowledge, attitude, and practice of health care providers toward safe abortion provision in Addis Ababa health centers (Assefa, 2019), found that most health care providers are aware of the revised abortion law, particularly midwives, and that half of the respondents provide post-abortion family planning services, with the majority of them providing safe abortion services. Providers' knowledge of abortion was explained in part by their profession and years of practice. Being a man and knowing about abortion care and law had a substantial impact on providers' attitudes toward safe abortion.

2.9. Abortion and social work

As competent practitioners alter their ideas and approaches in response to their clients, social workers must rely on guidance from professional social work organizations, as well as other resources like evidence-based practice, to make decisions in their daily practice contexts. Given the finding indicating a potential unwillingness to provide abortion referrals and a lack of understanding about abortion, social workers must clarify their own personal, spiritual, and religious attitudes, as well as their levels of knowledge and the potential impact of such on clients (Ely et al., 2012).

While the social work profession agrees on a human rights ethos, it does not agree on when life begins and, therefore, when the social work commitment to preserve that existence arises. The medical field has confirmed that a unique individual is formed at the moment of conception and that this individual is genetically and biologically defined as a fully functioning organism- a human being. This newly formed human being is constantly generating and growing throughout his or her lifetime. The fetus possesses intrinsic human rights, which are formalized in different international declarations, conventions, and professional norms. As a result, social workers have a professional obligation to act on behalf of the human person from conception to death and using social work knowledge, skills, and experience to protect the unborn human being's life from conception through birth and to help it grow up in dignity (Rainford & Thyer, 2019).

2.10. Complications of abortion

Complications from abortion, in any form, are a common cause of morbidity among women in underdeveloped nations, despite the fact that it is well known that the incidence is high. Morbidity data connected with unsafely induced abortion is frequently even more difficult to get than mortality statistics. Infertility, chronic incapacity, transfusion-related infections, and

emergency treatment for the effects of unsafe abortion are all issues that must be addressed in the quest for safe motherhood (WHO, 1995).

Women who had medication abortion had the highest rate of difficulties compared to other procedures including second trimester abortion, according to a study that looked at post-abortion complications for up to six weeks. The vast majority of the issues were modest and predictable, and they were managed with blood transfusions in the majority of cases. The most prevalent problems were incomplete abortions and unsuccessful abortions managed with uterine aspiration (Grimes, 2008).

When performed in a legal setting and under safe settings, abortion is a very safe and effective procedure with little complications. Most abortions can be performed by a diverse range of primary care practitioners, and major complications such as transfusion-dependent hemorrhage, infection, and uterine perforation are infrequent. Despite this, approximately half of the estimated 55.7 million abortions performed annually around the world are deemed unsafe, resulting in a high prevalence of complications and maternal deaths(Cameron, 2018).

2.10. Prevention of abortion

Safe abortion used to be a serious public health issue that caused the majority of pregnancy and morbidity, with the bulk of instances occurring in developing countries. In light of the situation, the World Health Organization (WHO) developed clinical guidelines for the management of unsafe abortion complications, which include expanding access to care, modifying primary care services, and providing managers with guidelines for identifying additional supplies, drugs, and equipment. Guidelines for policymakers were also produced to determine training needs for various types of health workers. It also creates contraception guidelines after an unsafe abortion (WHO, 1993).

Induced abortion should be discouraged, and unsafe abortion should be avoided through family planning. Health-care practitioners, women, and the general public must be aware of the risks of unsafe abortion and the advantages of contraception as a safer alternative. Increased access to family planning services and accurate information for women, health care providers, and the general public can significantly reduce the prevalence of unintended pregnancies, induced abortions, and the associated maternal morbidity and death. Family planning is fully integrated into maternity and child health services as part of the WHO's commitment to improve primary health care for all people (WHO, 1995).

Unsafe abortion is a primary cause of maternal mortality and serious morbidity in countries with restrictive abortion laws. The International Federation of Gynecology and Obstetrics (FIGO) has recommended several levels of prevention, the first of which is primary prevention of unintended pregnancy and induced abortion, the second of which is secondary prevention to ensure the safety of an abortion procedure that cannot be avoided, and the third of which is tertiary prevention of further complications from an unsafe abortion. Finally, quaternary abortion prevention is achieved through post-abortion family planning counseling and contraceptive measures (Faúndes, 2012).

A study looked at specialized contraception counseling and provision after a pregnancy was terminated to determine if long-acting methods could be used more broadly. According to the findings, women who received expert counsel and superior treatment were more likely to use long-acting contraception than women who received regular care. The data show that after two years of exposure, the intervention group has more abortions than the control group. Despite the fact that the trial was small, it confirmed that professional contraceptive advice and expanded provision are unsuccessful in avoiding recurrent abortion(Cavallaro et al., 2020).

Preventing unsafe abortions helps on avoiding unplanned pregnancies. This entails focusing on expanding and improving family planning options. It is strongly advised that special programs and trainings on human reproductive health and safe motherhood initiatives be implemented (Mason, 2007).

These literatures are significant in understanding the types of abortion, their incidence, the history of abortion laws and its provision, and, most importantly, the attitudes and personal opinions of health care providers concerning abortion and its relationship with social work. This provided a basic idea of the study's goal and the mechanisms that should be followed in this investigation. It also aided in the comparison of this data with the findings of this study and in reaching a conclusion.

CHAPTER THREE

3. Research Methods

This chapter consists of mainly researcher stance, research design, research area, methods of data collection, sampling techniques and analysis of the data. This briefly showed how and where and on whom the research conducted and also the purpose of the research.

3.1. Research design

Individuals, as a member of a social group construct subjective meanings for their experiences, meanings that are directed at certain objects or things. These meanings are diverse and multifaceted, prompting the researcher to focus on the diversity of perspectives rather than categorizing them into a few categories or ideas. Social constructivists are aware of such viewpoints. This type of viewpoint is accepted by social constructivists. This study looked at how people, specifically health care providers, see abortion and the subjective interpretations those health care providers build. The researcher's goal was to make sense of (or interpret) the meanings that health care providers have about abortion, hence social constructivism were the best choice. The focus of this study was on health care providers' views and personal values toward providing abortions. In our country, there has been little research done on this. Explorative qualitative research is important when an idea or phenomenon has to be investigated because little study has been done on it (Creswell, 2014). Thus, this study used exploratory qualitative research based on purpose of the research.

"*Qualitative research refers to the meanings, concepts, definitions, characteristics, metaphors, symbols and descriptions of things and quality. And it seeks an answer to questions by examine various social settings*" (Berg, 2004) (p, 7).In this study qualitative research design helped in making meanings and concepts out of the stories and experiences of health care providers towards abortion.

The study strategy was case study because case study allows the researcher collect detailed information over a period of time utilizing a variety of data collection approaches(Creswell, 2014).The health care providers were invited to tell their experiences regarding abortion and more of their personal values using case study, which is an appropriate choice for investigating on particular concept. Case study strategy encompasses different sections including various aspects of life from individual level to group level (Berg, 2004). This nature of case study guided the researcher to capture various patterns and significant determinants that could be valuable in the research in allowing to better understanding of intrinsic aspect of health care workers views towards abortion. Therefore,"*views and personal values as well as the experience of health care providers on abortion and their knowledge on the legal criteria of abortion legibility in Ethiopia*" was the unit of analysis that was analyzed using intrinsic case study. Since this study was only completed once, cross-sectional research was used to investigate health care professionals' perspectives at a specific point in time (Kreuger & Neuman, 2006).

3.2. Research area

Saint Paul Hospital Millennium Medical Collage was established in 1968 by the late Emperor Hail Selassie. It is governed by a board under the Federal Ministry of Health. In 2007, medical school joined the hospital. Now the hospital has more than 2800 clinical, academic and administrative and support staffs that provide services to patients who are referred from all over the country. While the inpatient capacity is more than 1000beds, the hospital sees an average of 1200 emergencies and outpatient clients daily. Since abortion is the topic of study in this research the researcher emphasis only on health providers providing abortion services. According to the comprehensive abortion care register book of Saint Paul Hospital data, currently with day-to-day schedule eleven women go through safe abortion daily and 55 weekly excluding the weekends this makes 2640 annually.

3.3. Sampling techniques

This research explored the views of health care providers towards abortion at Saint Paul hospital. This research used purposive sampling technique. According to Berg, in purposive sampling, the researcher uses its special knowledge or expertise about some group to select participants who represent a set of ideas. "*Researchers choose only those people who they think fit to participate in the research study*" (Berg, p, 36)(2004).

The participants were selected by the researcher based on work experience at Saint Paul Hospital and according to the comprehensive abortion care register book of Saint Paul hospital data, Saint Paul is one of the largest referral hospitals, providing over 2000 abortions annually.

The purposeful sampling technique refers to the deliberate selection of an informant depending on the informant's characteristics. It is a non-random sampling technique that does not necessitate any underlying ideas or a set number of informants. Simply said, the researcher identifies what information is needed and then searches out individuals who can and will provide it based on their knowledge or experience (Tongco, 2007). Therefore, purposive approach was used to include participants that fit and have high exposure to the work field of abortion in the health care of Saint Paul Hospital and eight health care workers from doctors in gynecology unit and midwives took part. Four of them were midwives and the other four are from gynecology resident and specialist.

3.4. Methods of data collection

The collection of data in qualitative research involves different techniques like observation, interviews, focused group discussions and reviewing documents as this can be divided as primary and secondary sources of data (Creswell, 2014).

3.4.1Observation

The researcher used observation as tool to evaluate the participant's behavior and actions and emotions. I gave an attention and observe their action and gestures that helped in making meaning and collect relevant information that showed an obvious positive and negative attitudes expression towards abortion and their experience. In the majority of in-depth interviews, participants were emotional and expressed various feelings, which supported the information obtained from the interview.

3.4.2In-depth interview

In-depth interviews with eight individuals were conducted using semi standardized interviews by adjusting the words at the level that participants able to understand it. The interview was recorded using both taking handwritten notes and audio recording. The major points of the questions were focused on to explain briefly on their views on abortion and also their personal values. The other questions were the psychological impact of providing abortion that most of them share and narrated their experience and the other question was on their awareness of the legal criteria of providing abortion in the country. The entire interview was conducted in a room with no other people present, and eight health care workers from doctors in gynecology unit and midwives took part.

3.4.3Focus group discussion

Focused group interviews provide a means for collecting qualitative data and intended to encourage subjects to speak freely and a far larger number of ideas, issues, even solution to a problem can be generated through group discussion (Berg, 2004). Two FGDs were conducted containing 12 FGD participants apart from interviews with individuals. Different level of experienced gynecologist and midwives were participated in order to capture different views

and information. Various issues were discussed and some of them helped in providing a relevant solution and recommendation.

3.5. Inclusion criteria

The participant in this study were specialists from gynecology department and fellow residents from gynecology department and, mid wives that specifically have an experience of providing abortion and still working at the site. Four mid wives and two residents and two specialists from gynecology took part. The study included professionals that have beyond one-year experience in order to fill information gap like an experience of being exposed to different medical and surgical procedures of abortion.

3.6. Exclusion criteria

Health care providers who did not have an exposure to abortion service did not take part in the study and first year residents and newly employed midwives less than one-year experience did not participate in the study.

3.7. Data analysis

Qualitative research uses concepts and different variables as measure of data to categorize on the basis of themes. Making meanings, definitions and assess the relationship between the themes is very significant in data analysis. "*Coding is two simultaneous activities, mechanical data reduction and analytic categorization of data in themes*" (Kreuger & Neuman, 2006)(p,56).This data reduction and analytic categorization was used in this study. After data collection completed, I read and heard all the data clearly and identify the major concepts to gain the general sense of the information. The raw collected data was translated from Amharic version to English. After transcription and translation, the researcher worked on formulation of codes. There were eight interviews with individuals, each was coded. Thematic analysis was done through coding. This was accomplished by discovering repeated

themes in text. These meaningful themes revealed key insights into data.The outcome of thematic analysis produced common categories from repeated themes. As the first question was on general view of healthcare providers on abortion, the repeated themes were mostly related with religious beliefs, moral reasons and personal judgment on the criteria of allowing abortion. The second was the psychological effects of providing abortion, that majority of them linked with second trimester abortion and surgical procedures that led them in feeling hopelessness in their job and sleeplessness and bad feelings. The other category was the social impact that most explain that they hide their job from their relatives and friends. The experience of the health care provider's was categorized as good and bad experience as most of them described it. The last was the participant knowledge on the legal indications to provide abortion that most of them mentions the six indications. There were two FGDs each containing six participants, the interview questions were applied in allowing them to discuss freely that most of them discussed it in a way of expressing the view of the majority of health care providers concern and need. This was also carefully transcribed and repeated themes were captured as a finding and their suggestions was also valuable in understanding the concept of the findings.

3.8. Quality assurance

Quality assurance was determined by using different reliability procedures through cross checking the transcription and the relation of the codes with data so that it will have consistent results (Creswell, 2014). In this research the transcription was cross checked and the codes used in forming categories were carefully analyzed. There were eight codes with the individual interviews and seven categories was formed in the process.The authenticity of the data and data triangulation are two important tactics for showing quality in qualitative research (Sargeant, 2012). In this study, data triangulation was used using multiple data sources such as in-depth interviews, focused group discussions, and observation. In this

study, I avoided individuals who were related to me, and in three interviews, an interview with one female midwife, another one specialist female gynecologist and male mid wife used a "*third party*" interviewer to decrease the impact on data quality.

3.9. Ethical consideration

Research ethics revolve around various issues of harm, consent, privacy and the confidentiality of data. These important ethical concerns are associated with researches (Berg, 2004) so this implies careful considerations of ethical issues is a top priority particularly in social work research

The participants were informed about the objectives of the study and all the data collection techniques and their involvement were based on their will and the participants were allowed to quit whenever they wanted too. The research was conducted using tape recording of in-depth interviews. The interviewer explained the purpose of the research and the potential risks and the benefits at beginning of the interview and was make sure that participants understand the information and their willingness to the interview.

CHAPTER FOUR

4. Findings

4.1 Back ground information of respondents

Age, sex, religion, professional status, and year of experience are all included in the demographic data.

Table 1: Demographic information of individual participant of in-depth interview

Respondents Code	Age	Sex	Religion	Professional status	Experience year
R1	27	M	OrthodoxChristian	Professional midwife	5
R2	30	M	Muslim	Professional midwife	8
R3	28	M	OrthodoxChristian	Gynecology resident	3
R4	25	F	Orthodox Christian	Professional midwife	3
R5	34	M	Protestant Christian	Gynecology resident	10
R6	32	F	Orthodox Christian	Gynecology Specialist	7
R7	26	F	Orthodox Christian	Professional midwife	4
R8	35	M	Muslim	GynecologySpecialist	12

Table 2: demographic data of focus group discussion participants

FGD1

Participant Code	Age	Sex	Religion	Professional status	Experience year
P1	27	F	Muslim	Professional midwife	4
P2	26	M	Protestant Christian	Gynecology resident	2
P3	28	F	Protestant Christian	Gynecology resident	3
P4	28	F	Orthodox Christian	Professional midwife	5
P5	25	M	Orthodox Christian	Professional midwife	5
P6	28	M	Orthodox Christian	Gynecology resident	2

FGD2

Participant Code	Age	Sex	Religion	Professional status	Experience year
P1	27	F	Muslim	Gynecology resident	4
P2	26	M	Protestant Christian	Gynecology resident	2
P3	28	M	Orthodox Christian	Gynecology resident	3
P4	28	F	Orthodox Christian	Professional midwife	5
P5	25	F	Orthodox Christian	Professional midwife	2
P6	28	M	Orthodox Christian	Gynecology specialist	7

4.2. Major findings

The following were the main themes: health care providers' overall view toward abortion, influencing variables such as psychological and social factors, health providers' experiences, and knowledge and awareness of the country's abortion regulations. The first important

subject was general view regarding abortion, which included religious beliefs, moral reasons, and personal judgment to allow safe abortion. Influencing variables, such as psychological and social issues, are the second primary theme. The third significant theme is health provider experience, which is separated into good and bad experiences, and the fourth important theme is abortion legislation information.

4.2.1 General view towards abortion

Religious beliefs

The findings reveal that the majority of participants associate the abortion service with their own value. Religious beliefs were cited as one of the reasons todevelop negative view to provide the service, and the majority of them believed that their activity was despised by God and that it was a major sin. This is how two female providers stated their beliefs.

> R4 said “I have been always exploring for other alternative services like working in labor units and maternity wards, it is really tough for me to work knowing that it is a tremendous sin and an act that is not allowed by God. I'm worried about my ability to follow my religion's laws because I'm not attending to church right now, and most of the time, if I do happen to be in church for some yearly event, I'll just be at the gate, afraid to get too close to the church. I don't believe God will answer my prayers, and situations like this make me regret taking this job. I had planned on how to be the greatest in my career when I was a student, and giving care to patients was my best motive and strategy; I never imagined being in this position.”

R6 stated, "*I understand that some people may think it is inappropriate to combine my personal values with my professional work, but my belief is that it is not like wearing your clothes off while working because deep down you believe it is a sin. This is not something you can compromise it and leave it. It is difficult*." Many participants in both focused group

discussions stated that abortion is prohibited in almost all religions and is regarded as a major sin.

Two Muslims, one Protestant Christian, and four Orthodox Christians participated in the first FGD. In the conversation, it is shown that religious beliefs were a major factor that is incompatible with their work. As the participants mentioned, in most religious norms, there are several reasons and circumstantial evidence that a safe abortion can be performed. Most of these grounds were agreed upon, such as if the mother's health is jeopardized by the pregnancy or if the baby has a development defect and also for pregnancies caused by rape or incest. But one participant coded P5 said, "*I may not know all the principles of my church, but I just met a girl who had been raped by her cousin yet refused to terminate the pregnancy. Even under these conditions, I do not believe my religion allows abortion*.

The second FGD, on the other hand, focused primarily on the relationship between their views and personal values and their day-to-day work. And the majority of them state that their religious rule is controversial, and that it is difficult to think about the rule while concurrently providing abortion services. However, a participant coded P1disagreed that personal value such as religious beliefs should not be a factor in the workplace, saying, *"It is not right for a professional to link their job to their religious convictions. Despite the fact that our professional ethics forbid it, I feel that no professional should judge or avoid providing the service to a client based on their religious beliefs*."

The findings from each participant's in-depth interview demonstrate that the majority of health care providers opposed to providing abortion services because it is incompatible with their religion. Two participants stated that they did not wish to associate personal values with their profession and that they support delivering safe abortions in accordance with national law. Furthermore, I watched their facial and body expressions during the interview, and

several participants, particularly health care practitioners with little expertise providing the service, appeared to be emotional.

Moral reasons

Abortion was a moral problem for most health care providers as most of them mentioned it. The health care workers stated that delivering abortion services is extremely difficult, and that most of them prefer not to participate in the procedure unless they are forced to. Some residents in gynecology did not want to practice or offer service.

R3 said of the situation. "*I despise having to sacrifice one life in order to save another; I wish gynecological education didn't include this service. I chose to work in the gynecology department because I am fascinated by obstetrics and labor management, as well as the most interesting aspect of infertility managing mechanisms these days. It's difficult to be in the middle of two opposing emotions, providing new life while also ending it."*

Midwives, on the other hand, claim that managers purposefully chose newly employed midwives and senior midwives who are in conflict with the management team to perform abortions because they claim that even mangers know that the abortion service unit not morally acceptable by most of health care workers. "*I have been working at Saint Paul Hospital for more than five years, I give service in the labor ward and emergency unit, but in between when I had a disagreement with directors, they transferred me to the abortion service unit because they knew most of us hated the work*," said R1.

On the other hand, I identified two participants R8 and R2 who stated that safe abortion should not be overlooked or despised as a service, but rather should be viewed as a means of protecting the life of a woman who may be put in risk during the process of unsafe abortion.

> R8 said "when I was a student in internship practice, I saw mothers who lost their lives owing to unsafe abortion, which changed my attitude about hating the service. I remembered that was the time, when the new abortion law was amended and there

were several critics raised from different peoples. Even though, I had been just a student on internship practice, it helped me know the worst side and complication of unsafe abortion at that time and understood the importance to amend the law*"*

Many respondents in focus groups stated that they are hesitant to administer safe abortion because they believe the unborn baby has a right to life and that providing safe abortion entails taking the baby's life. Two respondents claimed that the mother's life is also at risk because most mothers undergo unsafe abortions if the service is not provided safely.

Personal judgment

According to the findings, almost every health care provider's perspective was influenced by the mother's motivation for seeking abortion and most develops their personal justification and reason to decide whether the client need the abortion service or not. As most of them mentioned, legitimate reasons for abortion (rape, incest, and pregnancy at a young age, maternal medical risk, and fetal anomalies, social reasons) were acceptable and comfortable in providing the service, but a few still believed social and economic grounds are not clear for practice and mostly subjective.

On the other hand, several respondents stated that women did not initially disclose the true reasons for seeking abortion because most of them are aware of the accepted reasons for seeking abortion services; instead, they only disclosed one of them, but later revealed the true reason because they don't want to go to counseling stages, they already set their mind up for just safe termination and do not want to look to other solutions. As a result, health care providers are less likely to believe most women and have a negative view about them.

In light of this, R6 said, "*Sometimes people may be upset and decide to terminate a pregnancy abruptly; in these instances, health providers need to advise them effectively but the women didn't bother to come and tell you the true reason for seeking abortion and their condition."*

Also, according to R7, "*economic hardship in raising a child is an accepted reason to terminate pregnancy, but if a mother came for an abortion because she had a conflict with her husband, I don't think I should even consider it as a reason*."

Most of them in the focus groups agreed that the justifiable indication was a ground to terminate the pregnancy, but only a few felt that economic insufficiency was not. Various personal reasons were established as valid grounds for some of them, including being a student, social and economic obstacles, and familial circumstances.

4.2.2 Influencing factors

Psychological factors

Hopeless

The psychological effects of providing abortion were influenced by the provider's willingness to perform the service, the pregnancy's gestational age, and the rationale for terminating the pregnancy. Because the majority of them do not want to provide abortion, they believe that the psychological impact is significant. The majority stated that they are stressed and have negative feelings. Some have stated that if the reason for terminating the pregnancy is not approved by their moral judgment and if it is not in accordance with law limit, psychological impact increases.

> "At first, I used to have nightmares and difficulty sleeping peacefully," R2 said "My moods vary, especially if I provided service to clients in their second trimester pregnancy (13-28 weeks of gestation or four and five month of pregnancy) and clients who I strongly suspected of lying about the reason for seeking abortion. The baby's formed body is quite obvious, making it impossible to attend to this dead baby. It's a horrible feeling to touch the baby and provide dead body care.*"*

R3 said, "*I don't feel well and comfortable in my time of practice in this service unit, and even my family observed the reason for my bad mood at those times*."

In my in-depth interviews, I discovered that most health care providers are uncomfortable, and I noted that some of them make disgusting faces when they mention second trimester abortion. The information acquired from the E and C (evacuation and curettage) wards suggests that second trimester abortion is increasing day by day, and that everyone would prefer to deal with first trimester abortion (less than 13 weeks of pregnancy) over second trimester abortion.

> R7 stated," I fear going to second-trimester abortions; I felt like crying and despised myself when I received the dead baby and saw his face and full body. If he hadn't been sentenced to death, I imagined what he could have been. I believe that abortion is never appropriate, regardless of gestational age, but receiving a dead baby in the second trimester is the worst. And when this is your daily activity, you may feel hopeless in your profession, which is why I am considering changing my field to social science."

Sleeplessness

Few gynecologists have stated that terminating a second trimester abortion using medical medications is extremely difficult due to the method involving the intra-amniotic administration of digoxin utilizing ultrasound guidance. Most respondents believe that injecting digoxin and viewing the fetus move in ultrasound makes them feel awful because this technique is used at a gestational age of more than 24 weeks.

On the other hand, midwives expressed their dissatisfaction with second-trimester abortions. Most respondents said that aborting a 28-week fetus is similar to having a preterm baby, but the difference is that the abortion requires killing the fetus before the baby is born. "*To tell you the truth, I detest coming to work and I don't want to see or receive a dead baby. If I do end up receiving a dead baby, I might not get a regular sleep for the following few days,*" stated R4

When asked about second trimester abortion, the majority of participants became upset, and several also remarked that there are women who seek second trimester abortion on a regular basis, making it difficult for health care providers to deal with them. Since the second trimester of pregnancy, the fetus has finished the formation of all organs and has begun to move. Most medical professionals agree that terminating a pregnancy is a difficult and unpleasant experience. Some people have claimed that they have received a live baby and are unsure whether or not to give him oxygen and treatment. Receiving a fully grown newborn increases as the gestational age grows and this affects the majority of health care professionals.

The participants in the focus groups discussed the level of stress involved in performing abortions, with the majority emphasizing the psychological impact, particularly in the case of repeated abortions and second trimester abortions. Few also described painful moments while receiving a fully developed deceased baby and the majority of them stated that the psychological impact grows as the gestational age increases.

On the other hand, R8 stated that psychological influence is dependent on the provider's goal and motivation to do the work, which indicates that if health care practitioners recognize their position, he believes that psychological influence does not exist. In relation to second trimester abortion, he suggested that why second trimester abortion is difficult, even when it is recommended to terminate third trimester pregnancy (28 to 40 weeks or seven-, eight-, and nine-month pregnancy) for maternal indications such as if the pregnancy risks the life of the mother.

"*If someone understands the benefits of providing the service, safe abortion, whether in the first or second trimester, is not psychologically influenced; rather, he or she would be ware of they are saving the life of the mother that would be complicated by unsafe abortion."* R8 stated.

The majority of participants cited second trimester abortions and the administration of digoxin prior to abortion as influencing factors. Despite the fact that one respondent does not link psychological effects to the procedures, the majority mentioned psychological effects were linked to the abortion procedures that result development of a negative attitude about abortion.

Social features

The data from heath care providers shows that community's attitude and awareness of safe abortion, as well as the cultural and social norms were among the social influencing factors. According to this study, most health care practitioners keep their work role secret from most of their friends and relatives because they believe they will not comprehend it. Some of them claim that most people are against abortion, so they would rather hide the fact that they are offering a safe termination.

Some health care providers recall how their families reacted when they initially told them about their involvement in abortion services, according to findings from focus group discussions. Most of the participants mentioned that individuals missed the idea that a health care practitioner did not have the right to oppose abortion if the clients seek abortion based on the criteria on the criminal code of Federal Republic of Ethiopia article 551, proclamation 414. Because of their level of comprehension of such sensitive matters, it was suggested that staying silent is a better choice, especially for older people like parents.

A participant whose parents are from another city, stated that she had been silent about her work on abortion for the past three years. She explained that her family is highly conservative, and that if they found out she was offering abortion services, they would push her to leave. "*If my mother finds out, she will surely ask me to leave the job and come home,*" she claimed.

"*When I meet my friends and they talk about their jobs, like their patient conditions, I choose not to share my experience of doing safe termination because I know they wouldn't want to hear such things and would definitely see me as murder or something*," R3 said.

The information gathered from health care providers working on safe abortion provision revealed that the majority of respondents believe the community's attitude toward safe abortion is negative, which causes health care providers to remain silent about their work, and some of them have experienced stigmatization and isolation from their friends after sharing their experience. Few, on the other hand, believe that it is the responsibility of health care providers to dispel misunderstandings and unfavorable attitudes about safe abortion.

4.2.3 Experience

Good experience for health care providers

The study obtained a wide range of data from all participants since it included a variety of health care practitioners that specialize in abortion at varied levels of practice, ranging from one year to twelve years. Counseling, family planning, and safe termination with medical indication were all mentioned as good experiences by most of the participants. My two interviewees had very different experiences.

R6 presented her counseling experiences. Because senior gynecologists are the ones who must first receive medico legal issues such as rape and pregnancy at a young age, she stressed the importance of counseling them and suggested that every client should be effectively counseled so that health care providers are not stressed because they believe they are responsible for the client's decision and act.

> "Once I remembered a woman who came in for a second trimester abortion, she was extremely upset, and we talked for over half a day. She revealed that she has a husband, but she doesn't trust him, and she suspects that he has begun another affair. When I questioned her how she discovered it, she said she was just guessing and

> didn't have any proof. So, we spoke about how to talk honestly with her husband, as well as how to be patient and think things through. She returned home that day, intent on giving everything time. The surprising thing was that I met her in the labor ward after a few months, delivering her full-term baby."

R8 expressed his experience in sharing the clients' tension, despite the fact that most of them were unaware of their abortion rights. Counseling on family planning and ensuring clients when performing abortions were mentioned as important aspects of maintaining a positive attitude towards abortion and gaining pleasant experiences. And the presence of social workers in resolving financial issues associated to continuing the pregnancy makes full counseling and management more successful.

The gynecology residents with different level of experience narrated their most of their positive experience associating to first trimester abortion and family planning provision. Most of them remarked as good experience of decreasing the medical risk of the client by providing first trimester safe termination in case of fetal growth defect and maternal health risk. Few stated the importance of providing family planning after providing abortion as good experience.

On the other hand, the midwives mentioned their experience associating with spontaneous abortion with the point of saving the mother’s life. Counseling and treating raped and traumatized women were mentioned as one of good experiences of the job.

> R7 said “Since the majority of raped women are from rural areas and maids. Most of them were afraid to express their feelings and became quite emotional as a result. They only want you to get rid of the unwanted pregnancy and go to work without preparing emotionally or psychologically. However, in these circumstances, psychosocial therapy and a period of stability were required. Although our service

> lacked this type of recreational facility and therapy, providing them with care and monitoring their improvement on a daily basis brings me joy in my job."

The FGDs suggested the advantage of creating awareness to clients that came for abortion and reassuring clients while providing safe termination in developing good experience for health care providers. Few consider changing the mind of the mother in continuing the pregnancy as successful counseling and pleasant experience and mentioned that since abortion is not first line management, health care providers should take the whole step of counseling for continuation of the pregnancy.

Bad experience

The findings revealed that the majority of health care workers' bad experiences were entwined with moments of receiving a second trimester grown dead baby and instrumental aided abortion procedures. Because there are several types of care based on the situation and stage of pregnancy, participants selected a few procedures as an unpleasant experience. Specialists described the painful sensation of performing surgical procedures during second trimester abortions, mainly administering digoxin for fetal demise as well as the client's worry and pain, as a very awful experience.

According to information from mid-level health care personnel, the majorities of them do not want to conduct abortions and have expressed a desire to be transferred to other wards but are unable to do so. Experienced midwives shared their negative experiences with second trimester abortions, and the majority of them stated that regardless of the reason, it is not normal not to feel uncomfortable upon receiving a well-formed dead baby. They also said that having a medicinal abortion in the second trimester put them at risk of delivering a dead baby, with much of the responsibility falling on midwives because surgical procedures such as D and E are conducted by fellow gynecologists.

According to D and E ward midwives, receiving a live baby after a second trimester medical abortion was usual in the past, before the introduction of digoxin administration prior to misoprostol.

> R1 remarked, "I recall one occasion when I was on night duty and attending an abortion, but when the baby was delivered it was a live baby about 22 weeks old, I was shocked when I saw the baby gasping and immediately I transferred him to the NICU (neonatal intensive care unit). After I delivered him to the NICU, I was crying and it was difficult for me to return to work. And I had no desire to see him again. I was overcome with emotion, wondering what would happen if the baby survived, but I found out later that he dies after only a few hours."

R6 said “I recalled a 21-year-old woman who had returned for the third time for a safe termination. In fact, I knew her mother, who works in Saint Paul, and she was the one who brought her to safe termination two times previously, and we counseled her on family planning and started the program at that time. After all of this, she returned for her third safe termination.She came alone and didn't expect to see me there; she was surprised when she saw me at first, and I was surprised as well; however, we talked the infertility concerns for her future and phoned her mother, and she decided to continue the pregnancy. I remember her mother's expression when we told her about the issue. It's extremely difficult because I know women who become infertile after repeated abortion procedures″

In order to resolve negative experiences, the FGD suggested new policy restrictions on second trimester abortions and increased family planning provision, and a few suggested that health care providers should not be required to work on abortion provision without their consent, and a few suggested recreational programs as a method of reducing negative moments.

4.2.4 Knowledge of on legal criteria for abortion eligibility

According to criminal code of the federal republic of Ethiopia (2004), article 551, proclamation no 414; abortion is legal in Ethiopia, on six grounds: rape or incest, if the woman has physical or mental disability, if the woman's life is in danger due to medical abnormality, suspicion of fetal impairment, and for economic or social reasons.

In-depth interviews revealed that the majority of them are aware of the six indications for safe termination, with the practice at Saint Paul Hospital being cited as a successful comprehensive abortion provider. Still most have objected to the national abortion law, claiming that there is no way to verify the truth of the client's reason for seeking abortion, implying that the likelihood of women concealing the true reason is considerable.

Several FGD participants listed the indications and understood their legal obligations, but the majority disagreed with the rule that allows abortion for economic and social reasons, comparing it to allowing women to obtain abortions on demand because it is a popular justification.

"*Economic and societal difficulties are rampant in Ethiopia,"* stated one gynecologist. *"Allowing pregnancy termination as a cause is the same as offering safe termination without seeking permission*."

The majority of others remarked the increment of safe terminations in hospitals, which few attributed to the permeability of the current abortion law, and one senior respondent who had experience with the previous law mentioned the advantage of the current law, when compared to the previous law, the current law reduced unsafe abortions and their associated complications.

CHAPTER FIVE

5.1. Discussion

According to my findings, the majority of interviewees indicated that abortion services at Saint Paul Hospital have increased since the previous provision. According to comprehensive abortion care register book of 2011, only five clients per day got the service. When compared to the recent one, eleven cases per day. It shows increment of the service Despite the fact that the majority of the participants don't want to provide abortion, the abortion service appears to remain increasing This was a similar finding to that of research in developed nations in relation to the increased involvement of health care practitioners in abortion provision, despite the fact that the majority of them are still not believed in abortion services (Norton, 2011)Most research in underdeveloped countries; on the other hand, have only looked at influencing factors of safe abortion provisions that aimed reducing unsafe abortion complications(Röhrs, 2017).

The findings of this study revealed that health care workers' views were influenced by religious beliefs, personal values, and moral concerns and also psychological and social reasons. Religious beliefs are virtually always cited by health care workers as a basis for developing anti-abortion views. This appears to be the most common cause given in nearly every previous study (Loi et al., 2015). In previous studies on Ethiopia, religious and personal beliefs were found to be the most common justifications given by health care professionals (Abdi & Gebremariam, 2011). However, a recent study found that men health care practitioners and knowledgeable health care providers on abortion law enhanced abortion provision and reduced negative attitudes against abortion among health care providers (Assefa, 2019). In contrary, this study showed that midwives preferred to work in labor and maternity units rather than abortion-providing facilities due to moral considerations. Despite the fact that just a few doctors saw abortion as a way to save a woman's life from the dangers

of an unsafe abortion, the majority of providers considered that terminating a fetus' life were a morally questionable act and Religious beliefs were the first factor in the majority, as most people stated that abortion is never permitted because it ends a person's life and is an act that GOD clearly hates. That was a same finding in another study.(Yang et al., 2016)

Most experts appeared to have personal justifications for approving abortion, and most of them set distinct standards in determining who deserves the service. Although the particular legal grounds constitute the true reasoning, because the majority of women seeking abortion services do not disclose the exact reason, clinicians use personal justification to gain approval. As a result, the majority of them have developed an unfavorable view against abortion, as their justifications do not match the reasons why the mother wants an abortion. This emphasizes the contrast between the extent to which legal grounds can be used and the abortion provision, which has not been determined in other studies.

The psychological impacts of providing abortion were determined by the provider's readiness to provide the service, the gestational age of the pregnancy, and the rationale for terminating the pregnancy, according to my findings. Sad feelings, hopelessness, and hesitancy at work were also reported as signs of psychological effects, as were night mares and inability to sleep. Insomnia and regret were the same finding in pervious study; in fact it marked them as the common psychological features seen on health care providers (Adler et al., 1992).

In contrary, the psychological and social effects related to providing abortion on health care workers rare in previous investigations. Most psychological influences have been studied in regards to women who have had abortions in the literature(Major et al., 2000).This necessitates deeper research into the psychological effects of abortion among health care providers.

Most providers were found to be influenced by the social impact of abortion, with the majority stating that they kept their profession hidden from their social surrounds, and a few

stating that they face isolation and stigmatization from their peers. Stress, professional issues with anti-abortion colleagues, worries of disclosing one's work in social settings, and burnout were hypothesized in a previous study (Heymann et al., 2022). However, more research is required because health care providers are members of the community who engage and participate in any social scenario.

The care offered to circumstances such abortion due to rape, medically endangered women, and incomplete abortions was related with a good experience. Successful counseling to continue a pregnancy was noted by a few senior professionals as a pleasant experience, and post-abortion family planning was also mentioned as a good experience. The majority of unpleasant experiences, on the other hand, are linked to second-trimester abortion and surgical treatments. Medical abortion is common in second trimester abortion, according to the participants, and the history of receiving a live baby was common before the introduction of using digoxin prior to delivery. Because recent studies have shown that medical abortion and dilatation and evacuation are more effective than curettage, this appears to be the case in Saint Paul's abortion provision (WHO, 2018). In relation to this the majority of responders were bothered by second-trimester abortion, with midwives in particular hating receiving a fully developed dead baby. The challenges of gynecologists in providing digoxin for second trimester abortion were a new result linked to unfavorable opinions of the job, as one pervious study also recognized it (Adler et al., 1992) that called for further research.

The other finding was the knowledge of health care providers on abortion laws. This study shows an increment of awareness of the laws by health care providers in related to findings of other studies in Ethiopia (Abdi & Gebremariam, 2011). Previous research found a knowledge gap among health professionals regarding abortion legality, which was cited as one of the barriers to reducing abortion service. However, all of the participants in this study were completely aware of the law. Different arguments on specific abortion seeking reasons like

due to economic and social issues mentioned as ambiguous to practice. The providers complained about the difficulty of enforcing the legislation based on the right grounds due to the fact that most women conceal the true reason for requesting abortion. This was identified during research conducted following the passage of a new criminal code on abortion in 2005(McLean et al., 2019)The fact that there has been a more than ten-year gap since the law was revised, but issues are still unresolved at this time, demonstrates the necessity for further examination and revisions to the law.

5.1.1Strength of the study

The study's topic has not been thoroughly researched in Ethiopia, and only a small study of health workers' attitudes toward safe abortion training and practice with an emphasis on safe abortion provision has been conducted. Despite the fact that this is a qualitative study focused on a specific subject, the findings revealed similar beliefs among most health workers, as well as their challenges and experiences, which have been examined in detail. The additional benefit is that, when compared to earlier research, the study found that there is an increase in awareness of the legal criteria of abortion eligibility and their responsibility as health care providers, despite the fact that this does not represent the entire professionals.

Researchers have looked into the psychological and social effects of abortion, but most of the studies have focused on the clients who get abortion services rather than the providers. This research assisted in gathering information from providers, which aided in determining the impact of establishing a negative attitude toward abortion. The study's findings on social consequences are also useful for further research on community attitudes about abortion. Earlier studies evidenced the impact of stigma and isolations on abortion providing health worker, this study also discovered the social impact is high in most of the respondents and it is related with developing negative view towards abortion

In general, participant’s experiences and comments from focus group discussions will be valuable in developing new ideas and policy changes. Despite the fact that other studies have focused on safe abortion provision, this study focused on health providers' opinions and perceptions, particularly their challenges and positive experiences, which will undoubtedly be useful in determining how to make the service more pleasant and sustainable.

5.1.2Limitations

The study concentrated on extracting meanings and concepts from the stories and experiences of health-care personnel' views toward abortion at Saint Paul Hospital. This restricts the study's ability to look into the views of health care practitioners in other areas.

The other flaw is the inability to locate more experienced experts who can serve as a model for discussing on the flaws and strengths of previous abortion laws in comparison to current ones. Regardless of the fact that I was able to find one senior gynecologist to discuss about the changes that have occurred as a result of the current abortion policy, it is insufficient to fully complete the information gap in relation to views toward abortion under the present law. And Gender and age were not shown to play a role in health-care providers' attitudes toward abortion in this study. As a result, more research into the effects of these factors on abortion is still needed.

5.2 Conclusion

A thematic analysis of the data revealed that the majority of participants have a negative view regarding abortion provision, with the most of the reasons being based on religious prohibitions and moral judgments and also psychological and social influences. Despite the fact that few respondents make an argument for separating religion and personal values from their work, many do. Another reason for opposition to providing abortion was moral reasons;

most of them considered it was morally reprehensible work that involved ending the life of the fetus and pressing his right to leave.

Moreover, the majority of them found the reasons for the client's abortion to be unacceptable, and while most agreed to work based on the abortion law, the women' failure to disclose the true reason caused them to develop a negative attitude toward the job.

The psychological impact of providing abortion was discovered to be as a result of late gestational age, such as second trimester abortion, and the negative attitude towards to the procedure itself, which was indicated as a psychological influencing element. Only one respondent disagreed with its psychological effects and instead saw safe termination as a benefit for preventing unsafe abortion that does not affect psychologically. Among the social influencing factors that were described by participants were the community's attitude and understanding of safe abortion, as well as cultural and social norms.

The health-care providers' good and bad experiences were utilized to assess their view. The majority of good experiences was linked to pre-abortion counseling and medically indicated first-trimester abortions to save the mother's life, with only a few mentioning family planning and post-abortion counseling as pleasant experiences. One of the pleasant aspects of the job was being able to help raped and traumatized women. Abortion in the second trimester and surgical intervention were viewed as bad experiences

Several of participants were aware of the legal criteria for abortion eligibility and their obligations, despite having a thorough understanding of the legal criteria, some people consider that a few factors, such as social and economic concerns, are subjective and confusing to implement. And the majority of them mentioned the law's inability to offer advanced regulations for health care practitioners taking into account their values and moral difficulties, with the most emphasis on second trimester abortion, psychological and social impacts, and community perspectives. Policy modifications to the law regarding health care

providers, with a special focus on the abortion provision, were offered as ways to improve this. Despite the fact that this study is limited in drawing conclusion for all health care professionals, this abortion law appears to have caused no change in the views of health care providers until now.

5.3. Implications

According to the findings of this study, the majority of participants have negative views toward abortion and most experience issues with their day-to-day activities. This implies a more enhanced system for resolving the issue while taking into account the perspectives of health care providers. As most of the professionals suggested that family planning is one of the ways to reduce abortion. However, as a few participants mentioned that there are women who are unaware of using family planning and mistake abortion for family planning, more work on awareness of family planning provision is required.

This study revealed a limitation of a potent counseling mechanism and routine follow-up program, particularly for women seeking abortion for economic and social reasons. Because the majority of participants consider this reason to be the most common, there needs to be a program that continues more needed professionals such as social workers and government bodies. This means that in order to resolve the issue, health institutions should consider a relevant function routine programs in collaboration with government agencies. Furthermore, concerns relating to economic and social difficulties are not only managed by governments, but international assisting facilities also play a significant role in problem resolution.

5.3.1Implications for social work education, policy and practice

Social work is a profession dedicated to assisting people in functioning as well as possible in their environments, assisting people in solving and coping with problems in their daily lives. One of social work's commitments is to advocate for social and economic justice for all members of the community; this includes abortion issues, which are linked to social and

economic issues. This study gives information on abortion views, personal values, and understanding of abortion law among Saint Paul's health care providers, which may be valuable to the social work department as a mechanism to understand the problem related to abortion.

Since social issues and financial problem is one of the reason most clients seek abortion and one of the criteria to abortion eligibility, this rationale was vague and subjective to practice in relation to the difficulties of measuring the problem, as most of the health care providers noted. As a result, the role of social work in this situation is valuable. Despite the fact that few health care providers say that clients are occasionally communicated to social workers, additional interventions will be useful in resolving the situation. At the micro level, this can be done by working directly with individuals to assist them cope with their economic and social challenges. Working with fundraising groups, governmental and non-governmental entities on a larger scale helps to find better and more long-term solutions.

According to the findings, the psychological and social effects of offering abortion were linked to the attitudes and lack of understanding about abortion in the communities and bad experience of the work. This suggests that social workers involve in creating awareness on the community and mediate on discussing psychological issues of health care providers and assist them in overcoming these obstacles. According to the findings, the majority of health care practitioners advocated for the involvement of social workers as one of the solutions to the problem. Working with groups of diverse health care professionals to find solutions is also one way that may be done at the mezzo level.

This study is also beneficial to social work education since it adds knowledge to the preparation of new standard guide lines and expands the scope of social work counseling in abortion concerns. New counseling mechanisms for health care professionals in relation to

sensitive issues in their working environment considering the psychological effect of providing abortion can be one of the solutions.

Recommendations from healthcare providers on policy revisions concerning abortion regulations will contribute to the social work policy database. Since most mentioned negative views on abortion, the policy may consider an amendment in related to the concern of health care providers. A few health-care providers suggested that they should be able to choose whether or not to give the service relating it on the advantage of working what you love and believed on, so the legislation surrounding it is important to the provision. The importance of this study in bringing information on health care practitioners' views and experiences at Saint Paul Hospital, as well as ideas and suggestions from focus groups is valuable to consider policy amendment.

This research has ramifications for future studies as well. The findings of this study reveal health care providers' views, experiences, personal values, and understanding about abortion law. Social workers' perspectives on abortion, in particular, have been lacking. Future studies into the attitudes of social workers may be useful in determining the impact of social work in the abortion provision and assessing the role of social work in the provision.

5.3.2Recommendations

The following recommendations are based on a number of issues raised by the health care providers contacted for this study and implications from findings.

For clients who seek abortion for reasons that are not illegible under the law, effective pre-abortion and post-abortion counseling has been suggested. Because most clients do not disclose the true reason for seeking abortion, employing effective counseling and giving alternative management has been recommended by health care providers.

It was also suggested that family planning services and counseling be expanded in order to reduce the number of safe abortions and infertility concerns. Health care experts

recommended access to training and extra opportunities, as well as recreational programs, to decrease the psychological burden of performing abortion.

It has been argued that social workers and supporting agencies should do more to address the topic of abortion seeking in relation to economic and social challenges. Because the majority of the clients' complaints were related to economic and social difficulties, further productive capacity and interventions is another solution. Interactions between hospitals and fundraising organizations and private agents are recommended as a better alternative, as is the establishment of a more organized team that includes social workers and psychologists in the administration of safe abortions, in order to enhance first line management in which that is a means to continue the pregnancy and providing abortion will be the last management in medically illegible conditions so that negative views and bad experience of health care providers, as well as the psychological effects in related to it, get resolved.

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Zara, I. Overview on Abortion.

APPENDIX I

Informed consent

The purpose of this study to explore the attitude and personal values of health care providers to wards abortion that thought to be beneficial in solving issues related to abortion among health providers This set of form is a contract that will be signed between the researcher and the client. The client should reveal all the necessary information that the researcher requests. If the questions are thought to be have a negative effect on emotion or without giving any justification; it is the right of the respondent to discontinue the interview process. During the process, the researcher will use audio visual materials and will take note, the information that the client gives will be kept confidential and the participant will remain anonymous. When the researcher finished with this study the researcher will write a report about what was learned. This researcher will ensure confidentiality by not citing your name with in the study and this is a voluntary participation and there is no any payment or any special benefit from your participation in the study. If you have a willing to participate in this study, I sincerely appreciate your interest. Please sign to be legalized.

Name_____

Signature_____

Date_____

Name of the researcher: Mahelet Desalegn

Contact 0911060491

APPENDIX II

In-depth interview guide

Socio demographic data:

Age: _____

Sex: _____

Religion: _____

Professional status: _____

Year of experience_____

Interview guide

1. What is your attitude towards abortion?

2. How is providing abortion related to psychological issue?

3. What are the social consequences of a safe abortion for a health care provider?

4. What is Ethiopia's present legal status in terms of safe abortion for health-care providers?

5. How would you describe your experience working at Saint Paul Hospital as an abortion provider?

APPENDIX III

ክፍልአንድ

<u>የተሳታፊመረጃ</u>

I. **ኮድ** _____

II. **ዕታ** _____

III. **ሀይማኖት** _____

IV. **የሙያደረጃ** _____

V. **የስራልምድ** _____

ክፍልሁለት

<u>ቃለመጠይቅመመሪያ</u>

1. **ስለፅንስማቋረጥያለህ/ሽ/ አመለካከትምንድንነው?**
2. **የፅንስማቋረጥስራከስነልቦናጋርያለውግንኙነትምንድንነው?**
3. **በፅንስማቋረጥስራላይየሚሰሩየጤናባለሙያዎችበማህበራዊህይወታቸውላይያ ለውተፅዕኖምንድንነው?**
4. **አሁንበኢትዮጵያላይያለውየፅንስማቋረጥህግምንይላል?**
5. **በቅ/ጳውሎስሆስፒታልበፅንስማቋረጥስራላይያለህን/ሽን/ልምድግለፅ /ግለጭ?**