Addis Ababa
University
(Since 1950)

ADDIS ABABA UNIVERSITY

COLLEGE OF SOCIAL SCIENCES

DEPARTMENT OF SOCIOLOGY

THE INTERFACE BETWEEN THE LIVED EXPERIENCE OF WOMEN PRACTICING ABORTION AND ATTITUDE OF THE COMMUNITY TOWARDS ABORTION IN A SOCIOCULTURAL CONTEXT: THE CASE OF WOLDIA TOWN, NORTH WOLLO ZONE, AMHARA NATIONAL REGIONAL STATE

BY

ANTEHUNEGN BIRHANU

June 2017

ADDIS ABABA, ETHIOPIOA

THE INTERFACE BETWEEN THE LIVED EXPERIENCE OF WOMEN PRACTICING ABORTION AND ATTITUDE OF THE COMMUNITY TOWARDS ABORTION IN A SOCIOCULTURAL CONTEXT: THE CASE OF WOLDIA TOWN, NORTH WOLLO ZONE, AMHARA NATIONAL REGIONAL STATE

A Thesis Submitted to the School of Graduate Studies of Addis Ababa University in Partial Fulfillment of the Requirements for the Degree of Master of Arts in Sociology

BY:
Antehunegn Birhanu

Advisor: Getnet Tadele (Prof.)

June, 2017
Addis Ababa, Ethiopia

Declaration

I hereby declare that this thesis is my original work and has neither been presented in any other University nor was published before and that all sources of material used for the thesis have been duly acknowledged.

Antehunegn Birhanu Bishaw

Signature------------------------

Addis Ababa University

June, 2017

Addis Ababa University

School of Graduate Studies

Department of Sociology

This is to certify that the thesis prepared by Antehunegn Birhanu entitled: *The Interface between the lived experience of Women Practicing Abortion and Attitude of the Community towards Abortion in a Sociocultural Context: The Case of Woldia Town, North Wollo Zone, Amhara National Regional State* and submitted in partial fulfillment of the requirements of the Degree of Master of Arts in Sociology compiles with the regulations of the University and meets the accepted standards with respect to originality and quality.

Approved By Boards of Examiners and Advisor

Examiner (Internal) ______________________________Signature __________Date_________

Examiner (External)_______________________________Signature__________Date________

Advisor ____Signature__________Date_________

Acknowledgements

First of all, I would like to thank the Almighty God for helping me to pass all difficult times of my life and making possible the successful completion of my study regardless of the obstacles I encountered in my ways.

I would like to express my heartfelt thanks, deepest gratitude and sincere appreciation to my Advisor, prof. Getnet Tadele for his scholarly and constructive comments and suggestions to accomplish this thesis work from the beginning to the end. It is unconceivable without his constructive comments. Really, I learned a lot about research from the insightful comments and critics he made available and experiences he shared.

Moreover, I would like to thank Woldia Town FGAE staff members, kebele officials and health extension workers. Above all, health extension workers I have no words to thank their priceless contribution to accomplish my thesis work. And also I did not forget the contribution of my staff particularly Chanyalew, Balew and Ermiyas and Tewodros at Woldia University for their moral support and data collection activities.

My heartfelt thank is also to my field assistants, particularly Tewodros Asefa, interviewees, key informants, respondents and participants of group discussions of this study for allowing me to access all the necessary data.

I am also indebted to my friends who were beside me. A special thanks to Genetu Desalew, Mathewos Abebe, Molla Yismaw, Menberu Bekabill, Kelemu Fenta, Dereje Wondie, Habtamu Nebere, Alelign Ewnetu, Dagnachew Adefris, Abduselam.M, Ambaye Tilahun and others who were supporting me.

My deepest gratitude is also to my family members especially to my mother Hibsie Asress. I have no words to express her sacrifice for my success. Long live Mam!

Last but not least, I would like to thank Addis Ababa University for providing the financial assistance needed for the study.

Table of contents

Contents **page**

Acknowledgements i
Table of contents ii
List of Tables vi
List of Figures vii
Acronyms viii
Abstract ix
CHAPTER ONE: INTRODUCTION 1
1.1 Background of the Study 1
1.2 Statement of the Problem 3
1.3 Objectives of the Study 7
1.3.1 General Objective of the Study 7
1.3.2 Specific Objectives of the Study 7
1.4 Hypothesis 7
1.5 Significance of the Study 8
1.6 Delimitation of the Study 9
1.7 Conceptualization Concepts 9
1.7.1 Conceptualization of Terms 10
1.8 Organization of the Thesis 11
CHAPTER TWO: REVIEW OF RELATED LITERATURE 12
2.1 General Overview of the Concept of Abortion and Practice 12
2.2 Incidence and Practice of Abortion in Africa 13
2.2.1 Abortion Incidence and Practice in Ethiopia 15
2.3 Socio-cultural Discourses on Abortion 15
2.3.1 The Social Context of Abortion 15
2.3.1.1 Religious Views on Abortion 16
2.3.1.2 Moral Discourses on Abortion 17
2.3.1.3 Legal Discourse on Abortion 19
2.3.2 Medical Discourses and Health Care Services on Abortion 24

2.3.2.1 Medical Ethics and Acceptability of Medical Abortion 24
2.3.2.2 Reproductive Health Policies on Abortion 25
2.3.2.3 Health Risks of Induced abortion 26
2.4 Gender Roles and Abortion 27
2.5 Abortion Stigma and Social Support 27
2.6 Abortion and Public Attitudes 29
2.7 The Lived Experience of Women Practicing Abortion 32
2.7.2 Contextual and Personal factors on Women's Abortion Experience...................... 32
2.7.3 The Emotional Impact of Abortion on Women 34
2.7.4 Resilience Mechanism of Women Practicing Abortion... 36
2.8 A Guiding Theoretical Framework of the Study 37
2.8.2 Structuration Theory 37
2.8.3 The Relevance of Structuration Theory to This Study 42
CHAPTER THREE: RESEARCH METHODS 44
3.1 Description of the Study Area... 44
3.1.1 Justification for study Site Selection 44
3.1.2 The study population 45
3.2 Research Approach 45
3.3 Study Design 47
3.4 Sources of Data and Methods of Data Collection.. 47
3.4.1 Methods of Qualitative Data Collection 48
3.4.2 Methods of Quantitative Data Collection 51
3.5 Sampling Design 53
3.5.1 Probability Sampling Design 53
3.5.2 Non-Probability Sampling Design.. 55
3.6 Procedures of Data Collection 56
3.7 Operationalization of Concepts.. 57
3.8 Methodological Triangulation 58
3.9 Method of Data Entry and Analysis.. 59
3.9.1 Qualitative Data Analysis 59
3.9.2 Quantitative Data Entry and Analysis.. 59

3.10 Field Challenges, Experiences and limitations from the Study 60
3.11 Ethical Considerations 61
CHAPTER FOUR: DATA PRESENTATION, ANALYSIS AND INTERPRETATION 63
4.1 Socio-Economic and Demographic Characteristics of the Respondents 63
4.2 The Practice of Abortion in the Study Area: Knowledge/Awareness, Context and Circumstances 65
4.2.1 Knowledge and Awareness of the Community towards Induced Abortion 65
4.2.1.1 Knowledge of Respondents on the 2005 revisions of the country's abortion law 70
4.2.1.2 Legalization of Abortion 72
4.2.2 Abortion Decision, Practice and Contextual Factors 76
4.2.2.1 Barriers to Abortion Practice 77
4.2.2.2 Gender Roles and Abortion Decision 78
4.2.2.3 Circumstantial Conditions in the Preference of Pregnancy Termination 81
4.2.3 Experience of the Community towards Abortion Practice 82
4.3 The Influence of Socio-Cultural Discourses on Community Attitude towards Abortion practice 89
4.3.1 The Relationship between stigmatizing attitudes, beliefs and actions and Community Attitudes towards Abortion Practice 89
4.3.2 The Relationship between Socio cultural Discourses and Community Attitude towards Abortion Practice 92
4.3.3 Sex Differences on the Attitude of Head of Households towards Abortion 96
4.3.4 Attitude of Community towards Abortion... 97
4.4 Abortion Experience and Negotiating Strategies of Women: Agency and Structure in Focus 98
4.4.1 Women's Negotiating Strategies Having Induced Abortion within Multiple and Competing Discourses 99
4.4.2 Lived experience of Women in abortion practice: before, during and after............. 101
CHAPTER FIVE: DISCUSSION, IMPLICATION AND CONCLUSION 111
5.1 Discussion 111
5.1.1 The Practice of Abortion: Knowledge, Experience of the Community and Context of Abortion 111
5.1.2 The Influence of Sociocultural Discourses on Community's Attitude towards Abortion 116

5.1.3 Women's Abortion Experience and Negotiating Strategies: Agency-Structure in Focus 118
5.2 Implications of the Study for Policy, Theory and Research 119
5.2.1 Implications for Policy 119
5.2.2 Implications for Theory 121
5.2.3 Implications for Research 122
5.3 Conclusion 122
References 127
Appendix 1: Instruments 136
Appendix 2: Profile of Study Participants 144
Appendix 3: Additional Tabular Presentations of Data 145

List of Tables

Table 3.1: Operationalization of Core Concepts of the Study 57

Table 3.2 Methodological Triangulation 58

Table 4.1: Socio-economic and Demographic characteristics of Respondents 64

Table 4.2: Knowledge and Awareness of Sample Respondents about Abortion 70

Table 4.3 Respondents' Awareness of the Recently Revised Abortion Law of Ethiopia 75

Table 4.4: Respondents' Opinion about Legalization of Abortion.. 75

Table 4.5: Contextual Factors in Abortion Decision Making and Practice 81

Table 4.6: Respondents' Preference of Pregnancy Termination in the Given Situations............ 82

Table 4.7: Experience of the Community towards Abortion Practice 88

Table 4.8:- The correlation between stigmatizing attitudes, beliefs and actions and community attitudes towards abortion 89

Table 4.9 : The Impact of Stigmatizing Attitudes, Beliefs and Actions on Community Attitude towards Abortion Practice.. 91

Table 4.10: The correlation between socio-cultural discourses and peoples attitude towards abortion practice.. 92

Table 4.11: The Impacts of socio-cultural discourses on the attitude of community towards abortion practice.. 93

Table 4.12: Respondents' Attitude towards Abortion Practice 96

Table 4.13 sex difference of respondents and attitude towards abortion practice 97

Table 4.14 Sex of Respondents and Attitude Towards Abortion Practice 97

List of Figures

Fig 1: The dimension of the duality of structure (Giddens 1984).. 41

Fig 2: Own Construction based on Giddens's Dimension of the Duality of Structure (1984)..... 42

Figure 3.1: Map of Study area 45

Acronyms

AGI	Alan Guttmacher Institute
CRR	Center for Reproductive Rights
CSA	Central Statistical Agency
FGAE	Family Guidance Association of Ethiopia
FGD	Focus Group Discussion
HIV/AIDS	Human Immune deficiency Virus/Acquired Immune Deficiency Syndrome
IDIs	In-depth Interviews
IUD	Intrauterine Device
KIIs	Key Informant Interviews
MDGs	Millennium Development Goals
PAC	Pregnancy Advisory Center
PRB	Population Reference Bureau
RH	Reproductive Health
RTI	Reproductive Tract Infections
SES	Socio-Economic Status
TBAs	Traditional Birth Attendants
UNFPA	United Nations Population Fund
WHO	World Health Organization

Abstract

The issue of abortion is as old as human existence. People since distant past to the present day have used it as a fertility control mechanism. The existing socio cultural factors influence women's abortion experiences despite they have their own desires, intention and rationale .Nonetheless, little has been done regarding lived experience from the women's perspective by integrating the community attitude towards abortion practice. Therefore, the main objective of this study was to examine the interface between the lived experience of women and attitude of community towards abortion in Woldia Town, North Wollo Zone. Mixed research approach was employed so as to collect and analyze data obtained from household survey, KIIs, IDIs and FGDs. The data obtained from survey and informants were analyzed by using descriptive and inferential statistics (SPSS version 20) and thematic analysis respectively. Household heads (n=310) with mean age of 41.33 to assess the practice of abortion and community response within a socio cultural context. Besides, women (n=12) were interviewed to explore the negotiating strategies and lived experiences in practicing induced abortion. The finding of this study showed that induced abortion is evidently practiced in the study area in spite of negative attitudes of community towards abortion but most people did not know abortion law of Ethiopia. Socio-economic and socio-cultural factors were the main reasons in pregnancy termination. The multiple regression test of socio *cultural discourses indicated that there was a statistically significant at $p<0.01$;($p=0.000$) on community attitudes towards abortion. Hence, strict community values and norms found to have a predominant influence up on the decision making process and abortion practice as well as the community response towards abortion so that 73% of community had negative attitude. As a result, the social stigma was still pervasive. As the qualitative result showed, women experiencing induced abortion faced complicated life challenges and double sufferers as they are responsible for their living situation and managing the societal reactions/stigma. Consequently, most women experienced psychological and emotional impacts, social stigma and even social rejection and reactions. Finally, this study suggests some of the policy implications such as re-visiting the existing abortion law, community based interventions and awareness rising, multi-stakeholder approaches and women empowerment approaches that should consider the interface between abortion practice and community response.*

Key words: abortion practice, lived experience, community attitude, socio-cultural discourses, structuration theory

CHAPTER ONE: INTRODUCTION

1.1 Background of the Study

The practice of abortion, which constitutes a global and local phenomenon, has been presented since the beginning of the history of humanity (Gilbert 2013). Unwanted pregnancy and abortion have existed and embedded across countries for a long period of time. Egyptians, for example, were the first to apply abortion techniques through herbal products (Kumar *et al.* 2009). Later on, the practice has been transferred to Greek, Rome and other parts of the world (Lopez 2012). The root of induced abortion is, no doubt, unwanted pregnancy; where frequently occurred in modern society than traditional societies-who believed that bearing a child, is God's gift. This is perhaps because in modern societies most people social, cultural, economic and including health situations matters to post postpone their births (Tsehai 2008).

In fact, abortion is one of the commonly used methods for controlling fertility and has been used in all societies at all times to terminate unwanted pregnancy (Alex and Hammarstrom 2003). As a result, the practice has existed throughout the world since time immemorial. For example, women throughout the world, both in the distant past and in the contemporary societies, have always turned to abortion as a last resort to prevent unwanted births (Warriner and Shah 2006; Rossier 2007) due to various reasons such as for timing and spacing of child births, health and /or age of pregnant and other related factors especially in Eastern Africa (Lauro 2011).

As universal as its practice is, whether or not abortion is a correct human practice is highly debatable. There are competing and conflicting views that predominantly influence the practice of abortion. It is one of the most keenly debated issues in local, national, and international

politics and religious communities. Societal attitudes, religious beliefs, cultural interpretations and socio economic reasons are playing significant role and, hence, making it debatable with regard to the decision of terminating unwanted pregnancy (Balkin 2007; Pickles 2012).

Religious view, for example, as an influential discourse, which underlies the sacredness of life of the fetus, affects the lived experience of women practicing abortion and the public attitude towards abortion which, in turn, profoundly affects sexual behavior (Henshaw 2006; Adamczyk 2009). The practice of induced abortion has been influenced not only by religious perspectives but also by a range of moral and ethical issues. These, perspectives, play a decisive role in making decisions of a woman in relation to abortion and a reciprocal effect on the public attitudes towards abortion practice. In fact, these ethical and moral values greatly vary across individuals who try to terminate pregnancy. In other words, some women might believe abortion as unethical and immoral while others insist on it as an option to a way out of difficulties (Atkins 1994). Mostly, moral discourses are interchangeably used with religion and religiosity because some people hold a view that abortion is an immoral act and sin by many religions across the world unless a mother's health is risky (Komut 2009).

As far as the literatures reviewed, most studies focused on the epidemiological dimensions of abortion. However, little has been done regarding lived experience of women and attitude of the community towards abortion. Thus, the intention behind carrying out this study is to examine the interface between the lived experience of women practicing abortion and the community's responses within the existing socio cultural context in Woldia Town, North Wollo Zone. This is made in a belief that we can lessen problems related to induced abortion if we could understand abortion in the context of a given society and culture.

1.2 Statement of the Problem

Abortion or the deliberate termination of pregnancy is one of the most controversial issues that need multiple considerations including social and cultural values that are embedded in the society. Despite varying degree of controversy, socio cultural values and existing discourses have a profound effect on the practice of abortion worldwide. This is due to the fact that induced abortion occurs at the interface of cultural attitudes, stigma, and the private arena of pregnancy and reproductive rights (Reardon 2013; Agrawal 2008).

Contextualizing women's abortion experiences by exploring historical, cultural, political, emotional, and social factors is vital because it may affect the ways women make meaning of their sexual and reproductive decisions, including abortion itself (Welter 2015). However, these realities and actual experiences of women are rarely considered, and the general public consequently has little understanding of the complex and diverse ways of its impacts on women's lives (Balkin 2007).

Religious, cultural, legal, ethical and, even, medical perspectives are central to abortion attitudes throughout the world. For example, major world religions including Christianity, Islam, Buddhism and Hinduism, for example, have similarity when abortion is, perhaps, allowed. Hence, it is generally allowed by various sects in the early stages of pregnancy if the health and/or life of woman is in danger. Thus, religion has a powerful influence on abortion attitudes, decisions, and lived experiences of those who practice abortion (Adamczyk 2009). Besides, religious and moral values, psychosocial considerations affect abortion decision of women and community's attitude towards induced abortion. To this end, such factors affect men and women, particularly women's lived experience such as abortion decision, psychological distress and

meanings attributed to induced abortion within a broader sociocultural context. Women, for example, are influenced not only by the internal pressures including moral and ethical values of an individual, social circumstances including familial, societal attitude, and religious and cultural considerations are quite significant (Gilbert 2013). Medical discourses also including healthcare policies, the perception of health providers and conscientious objections also have an impact on the decision making provided with pre and post counseling services on women to decide and practice abortion (Reardon 2003).

There is an interface among religious, ethical, and medical discourses on the legalization of abortion. Religious perspectives, for example, influence the pregnant woman's right to terminate pregnancy legally (Welter 2015). To this end, a number of religions such as Catholic, Buddhism, Islam, and Judaism have their own positions regarding legalization of abortion. Consequently, stringent religious perspectives limit the legalization of abortion across country (Tsehai 2008).

Abortion is widely researched around the world; however, little effort has been given for the affected women due to the societal reactions and other contextual factors. In other words, the feelings and decision-making processes experienced by women intending to end unwanted pregnancy are not fully explored (Shah and Ahman 2009).

There are various studies which have been conducted regarding induced abortion throughout the world. Yet, such studies are not only confined in Ethiopia despite the fact that they discussed few of its dimensions especially the interface between agents lived experience and community responses. For example, a study conducted in Argentina on women's experiences on the use of medical abortion by Ramos *et al.* (2014) which mainly focused merely on the clinical setting of accessing medical information and even the setting was quite different from Ethiopian context.

Gilbert (2013), in his study, on narratives of abortion focused only psychosocial, religious and ethical considerations which affect women, men and health professionals views on abortion, without assessing the community response with qualitative approach from few cases and samples so that it did not assess the community responses from multiple discourses. Besides, Aniteye and Mahyew (2011), in their study on attitudes and experiences of women in Ghana took samples at hospital and found out reasons why women experienced abortion. However, this study did not adequately address the impacts of various discourses on women's lived experiences and community attitudes towards abortion.

Another study conducted by Creswell *et al*.(2016) on women's knowledge and attitudes towards legalization of abortion in Zambia, only assessed the knowledge of women on abortion and their attitude towards abortion practice and access to services without giving due emphasis on the impacts of socio-cultural discourses on the lived experiences of women within the community responses and vice versa.

In the Ethiopian context, so far, a number of studies have also been conducted on abortion mostly focusing on the attitude towards abortion practice from the public health perspective and epidemiological dimensions and mainly on the prevalence and associated risk factors. Hence there are gaps which need to be addressed yet. Among others, Selamawit (2013) conducted a study related to abortion in Addis Ababa and explored the view of women with respect to the accessibility, time, cost and skills of providers from public health perspective. Besides, further studies have been conducted on the legalization of abortion. For example, a study conducted by Abay (2002), assessed the attitude of women and men towards legalization of abortion but failed to triangulate the lived experience and the societal reactions within multiple and competing factors. Such failures also extended to other studies which have been conducted about the

attitude of the legalization of safe abortion in a number of university students by Wogene and Fikre (2007); Worku and Biniyam (2014); Sintayehu *et al*.(2015). As well, these studies did not explore the strategies used by female students and the influence of moral, religious and ethical considerations in practicing abortion from women's life world. On the other hand, Kidst (2015) conducted a study on women's emotional experiences of induced abortion in Addis Ababa by focusing on women's psychological consequence and distress of abortion. The study also did not examine the interface between the lived experience of women and community attitude towards abortion.

As far as reviewed empirical studies are concerned, researcher did not find studies which endeavor to explore the lived experiences, strategies (resilience mechanisms so as to cope with difficulties and stressful situations) and community attitudes towards abortion in a sociocultural context. Methodologically, unlike most previous studies which employed quantitative research methods so as to study the incidence and prevalence of unsafe abortion practice in different parts of the country and social settings, this study employed mixed research approach in order to examine the lived experience of women having induced abortion and community attitudes towards abortion. Moreover, the basic assumptions of agency structure theory motivated the researcher to study the interface between the practice of abortion and community attitudes within the existing competing discourses and socio cultural values.

1.3 Objectives of the Study

1.3.1 General Objective of the Study

The main objective of this study was to examine the practice of abortion, lived experience of women practicing abortion and community's attitude towards abortion within the existing socio-cultural discourses in Woldia Town, North Wollo Zone.

1.3.2 Specific Objectives of the Study

More specifically, the study attempted to address the following objectives

- To assess the practice of abortion in the study area with particular reference to knowledge and experience of the community and contextual factors on abortion practice
- To examine the influence of socio-cultural discourses(religious, moral, legal and medical) on the attitude of head of households towards abortion practice
- To examine contextual factors that influence women's abortion decision and their negotiating strategies within the existing discourses
- To examine the lived experience of women before, during and after having induced abortion

1.4 Hypothesis

From the literature reviewed and personal observations of the researcher, the following hypotheses were formulated concerning the influence of sociocultural discourses on community attitude towards abortion practice.

H1: Stigmatizing attitudes and beliefs negatively influence community's attitude towards abortion practice.

H2: There is relationship between socio-cultural discourses and community attitude towards abortion practice.

H3: There is attitudinal difference between male and female respondents towards abortion practice

1.5 Significance of the Study

Studying the sociocultural context of abortion with a particular emphasis on the interface between the practice of abortion and community responses will lessen the problems of induced abortion. This could be possible by understanding the existing sociocultural discourses (medico-legal, moral and religious values) and personal factors upon the community's attitude and women's abortion practice. Because such an interface, will be helpful for the actors, service providers and the community in general to understand the dynamic nature of abortion stigma, community reaction and the role of women and men in abortion decision making process and practice by giving due emphasis for micro and macro level analysis of social realities.

Moreover, understanding abortion in a socio cultural context enhances our insights and knowledge regarding the multifaceted dimensions that promote or deter safe abortion practice. In doing so, the findings of this study will enable policy makers, researchers and health professionals to design and implement sexual reproductive health policies by identifying sociocultural barriers and gaps through community awareness towards safe abortion practice. As a result, it will have further improvements on safe abortion accesses and reducing the prevalence

of unsafe abortion. This will, in turn, decreases health and life complications of women practicing abortion and help healthcare providers understand the problem on the broader socio cultural, moral and religious contexts of women. Furthermore, the study will have a contribution for the potential feminists and policy makers who want to design policies and conduct further researches in the issue of abortion, the unintended and intended consequences of practicing abortion, the complex nature of structures as enabling and constraining factors, abortion stigma(which creates barrier to safe abortion and shadows policy /legal/environments) and public attitude towards abortion within the existing discourses in practicing induced abortion by advocating on behalf of women.

1.6 Delimitation of the Study

This study was delimited to the sociocultural context of abortion particularly at the interface between actors (women who had induced abortion) and community responses in practicing abortion. In doing so, the study participants were women performing medical abortion in healthcare institutions and the perspective /attitude of head of households towards abortion. Hence, the study mainly attempts to explore the lived experience of those women and assess the community attitude towards abortion within multiple and competing moral, religious, legal and medical discourses by using Giddens's structuration theory so as to address the issue under study. Spatially, the study was delimited to Woldia Town, North Wollo Zone.

1.7 Conceptualization Concepts

In this sub section, important concepts that were used throughout the study were defined both conceptually and operationally.

1.7.1 Conceptualization of Terms

Agency: is defined as the way actors purposefully act on, shape and resist the world around them in which an individual could, at any phase, in a given sequence of conduct, have acted differently (Giddens 1984:14).

Attitude towards Abortion: refers to the positive (favorable) or negative (unfavorable) attachments about abortion by the local community and women.

Discourse: Foucault (1977) in Chavez (2004) defined discourse as a complex system that structures and constrains the way we perceive reality or a mediating link between agency and structure.

Induced abortion: refers to a deliberate action with the intention of terminating pregnancy before viability through medical procedure (sell *et al*. 2015: 2).

Interface: the interplay between agents (women) practicing abortion and community attitudes within the socio-cultural settings

Lived experience: women's psychological responses and phenomenological experiences focusing on questions of meaning, discourses and structural relations on the lives of women w/c are deep rooted in the larger socio-cultural perspectives (Desjarlais and Throop 2011).

Morality: a code of conduct which is accepted by the members of the society

Practice: refers to the day-to-day enactment of social life- the contexts, understandings, knowledge, and experience of the community or agents about abortion across time and space (Giddens 1984).

Resilience: refers to the continuing growth and articulation of capacities, knowledge, skills, insights and virtues derived through meeting the demands and challenges of one's world, and ability to manage a complex world and the ability to bounce back from some form of disruption, stress, or change (Saleebey 1996:298).

Strategy: mechanism, techniques and ways that women employ in reconciling competing and multiple realities in abortion decision making process.

Stress: refers to any environmental, social, biological, or psychological demand that requires a person to adjust his or her usual patterns of behavior (Carr and Umberson 2013:2).

1.8 Organization of the Thesis

Contents of this thesis are organized into five chapters. The first chapter introduces the background and the significance of studying the issue in light of the stated objectives. The second chapter addresses literature substantiating the topic of the thesis. Chapter three presents approaches and methods underpinning the study. Chapter four mainly discusses the major findings in line with objectives of the study with fundamental topics such as the practice of abortion, sociocultural discourses and lived experience of women in practicing abortion. The final chapter deals with the validation /discussion/of the study with the existing empirical literatures and set implications of the major findings of the study.

CHAPTER TWO: REVIEW OF RELATED LITERATURE

There are scant studies conducted on women and abortion particularly on women's lived experience as compared to attitudes; that is, there is no enough emphasis on woman herself as a rational decision maker. Besides, the feelings and decision-making processes experienced by women intending to end unwanted pregnancy are not fully explored (Shah and Ahman 2009; Kimport *et al*. 2011). To the best of my knowledge, there is also a lack of empirical studies on the interface between practice of abortion and community responses. However, there are many studies that address abortion from public health perspective especially in western countries. In this chapter, I have tried to review existing literature related to abortion by giving due emphasis to Africa in general and the Ethiopian context in particular.

2.1 General Overview of the Concept of Abortion and Practice

Abortion, from the very beginning, has no a single definition. It can be defined depending on the type of the practice, that is, safe and unsafe abortions (PRB 2006) and time of gestation limit (Adler 1979 in McCulloch 1996). Literally, abortion can be defined as a deliberate termination of human pregnancy (Demirel 2011; Doherty 2013). However, in a broader sense, the most commonly accepted definition revolves around the termination of pregnancy by the removal or expulsion from the uterus of a fetus or embryo before 20 weeks gestation (WHO 1970). Similarly, another definition is also congruent with the above one except the duration where the termination of human fetus should be during the first 12 weeks of gestation (Agyekum 2014). In the case of Ethiopia, abortion can be defined as the termination of a pregnancy before fetal viability, which is conventionally taken to be less than 28 weeks from the last normal menstrual period (MoH 2006).

The very nature of abortion remains controversial since it concerns with moral, religious, legal and medical and even human right issues. This, in turn, attracts the attention of many disciplines and scholars to study the issue from diverse dimensions (Reardon 2013). In this regard, abortion as a broader concept can have various types depending on its nature, characteristics and practice in relation to medical procedures. Thus, it can be classified into two major types: namely, spontaneous which is happening naturally in which a mother has no control over it and induced, that is, intentionally performed (Grisanti 2000).

Historically, abortion is the oldest and the most commonly used method for controlling fertility and has been used in all societies at all times to terminate an unwanted pregnancy (Alex and Hammarstrom 2003). Thus, the practice has been experienced by women in every parts of the world to end their unwanted and unintended pregnancy. Abortion is one of the highly effective birth control mechanisms though the issue is contested (Schwartz 1972). Women, for example, all over the world choose to terminate unwanted and untimed pregnancy through abortion due to various socioeconomic reasons and socio cultural beliefs (Grimes *et al*. 2006). That is why a number of conferences were held in Cairo and Beijing in 1994 and 1995 respectively so as to reduce maternal mortality and ensure women's right to control their fertility upon request (Malhotra *et al*. 2003).But, unfortunately, abortion unlike other reproductive and fertility control mechanisms attracts moral and religious condemnations and societal reactions and/or stigmatizations (WHO 1999).

2.2 Incidence and Practice of Abortion in Africa

According to AGI (2015), the annual number of induced abortion in Africa between 2003 and 2008 rose from 5.6 million to 6.4 million. The most abortion incidence and prevalence occurred

in 2008 in African regions. From these regions, Eastern Africa accounted 2.5 million, western Africa 1.8, Northern and Middle 0.9 and Southern Africa 0.2 million respectively due largely by women of reproductive age. Unfortunately, out of 6.4 million abortions in Africa, only 3 % were performed under safe conditions due to restrictive nature of abortion laws. Globally, roughly 39% of the world's population lives in countries with highly restrictive laws (those that prohibit abortion altogether, or allow the procedure only to save a woman's life, or to preserve her health) (CRR 2014). Similarly, in Africa in 2015, an estimated 93% of women of child bearing age lived in countries with restrictive laws. Even in 11 African countries, abortion is not permitted for any reasons. On the contrary, four countries such as Zambia, Cape Verde, South Africa and Tunisia, have relatively better abortion laws. Zambia, for example, permits abortion on the socio economic grounds, whereas others allow pregnancy termination without restrictions, but with gestational limit; that is first trimester abortion is completely allowed (AGI 2015). Accordingly, in these countries, abortion related deaths are to some extent declined due to legal frameworks and access to health and skilled practitioners providing the services. On the contrary, in situations are against the law, only rich segments of the society obtain safe abortion services but many of the poor and rural counterparts try to end their own pregnancies or turn to unskilled practitioners. Of the 600,000 women who die each year from pregnancy-related causes, an estimated one in eight die of complications from abortion. Thus, abortion-related deaths are hundreds of times more common in Latin America and Africa than in developed countries. Furthermore, experts believe that about one-third of women undergoing unsafe abortions experience serious complications, yet fewer than half of these women receive hospital treatment. In contrast, levels of maternal death and illness due to abortion have fallen dramatically in

countries that have liberalized their abortion laws as opposed to countries having restrictive laws (AGI 1999).

2.2.1 Abortion Incidence and Practice in Ethiopia

According to WHO (2008), every year, nearly 5.5 million African women have experienced unsafe abortion. As many as 36,000 of these women die from the procedure, while millions more experience short- or long- term illness and disability. Ethiopia is not an exception. Even it has the fifth highest number of maternal deaths in the world, that is, one in 27 women die from complications of pregnancy or childbirth annually. The rate and prevalence of abortion is higher in Ethiopia thereby out of 10 abortions six are performed in unsafe manner though the abortion law was revised since 2005. Moreover, in 2008, there were about 382,500 induced abortions performed in Ethiopia, for an annual rate of 23 abortions per 1,000 with women aged 15–44 (AGI 2010).

2.3 Socio-cultural Discourses on Abortion

2.3.1 The Social Context of Abortion

There are many factors that influence the attitude of abortion. Factors such as socio economic status, level of education, gender, religion, health care policies and etc. shape how people form their morals. The way individuals are being socialized and peoples around them significantly determine their values, social roles and morality (Konney 2009). Religion, culture and community values predominantly impact the perspective of those practicing induced and elective abortion. There is, for example, a relationship between religious beliefs and abortion attitude. In fact, studies indicate that religion is the most powerful indicator of abortion attitude, and in turn,

abortion attitude shapes abortion restrictions and access to medical abortions (Sarrah 2016). Such abortion attitude resulted from traditional values, social values and norms, religious teachings and lack of knowledge on the legal status of abortion in turn influence their level of stigma (Konney 2009).

2.3.1.1 Religious Views on Abortion

Abortion, which is a controversial concept and practice, is influenced by religious discourses since religion has taken strong positions on abortion; it is believed that the issue of abortion encompasses major issues of life and death, right and wrong, human relationships and the nature of society. As a result, by and large, people involved in abortion are usually affected very deeply not only emotionally but often spiritually, as well (Williams 2002). This is due to the fact that, abortion is perceived as the moral equivalent of murder and the practice is not acceptable by God almost in all religions throughout the world (Ellingsen 1990; McCulloch 1996).

Major religions in the world such as Christianity, Islam, Buddhism and Hinduism on the one hand and religious discourses and views on the other have a strong position on the sacredness and sanctity of life of the fetus (Adamczyk 2009). As a result, various religions having their own views on abortion believe that life starts at the conception and abortion is immoral and equivalent to murder (Larsson *et al*. 2015). However, most religions have some sort of similarity on the issue that when abortion is permitted even if only in limited circumstances, where the life of the mother is in danger or where there is a fetal abnormality (Hilton 2007).

Religion, religious perspectives and beliefs play a pivotal role in reproductive health services including contraception uses and abortion in a way that such beliefs are very much related with the concepts and arguments of the morality of fetus and sexual relations. Therefore, religion and

religious beliefs influence the individuals' decision making regarding reproductive health services (Fowler 2013). Religiosity, for example, has a profound influence on abortion practice in different ways. Hence, it can affect people's behavior through sexual activity before marriage, contraceptive use, and choice of abortion to resolve unintended pregnancy (Henshaw 2006). Indeed, religion, therefore, played a decisive and powerful role on the abortion attitude and abortion debates (Adamczyk 2009; Komut 2009).

Consequently, religious and spiritual beliefs might play a role in how you understand pregnancy, fertility and birth control in general and abortion practice in particular. Hence, religious perspectives vary in their interpretations in a way that when life begins and the value of pregnancy that a women give an attachment. As a result, there are some religions which are pro-choice and still others are anti-abortionists (Atkins 1994).

Leaders of most countries justify that abortion law should be restricted especially in Latin America, Africa, the Middle East and South Asia (CRR 2005). Consequently, findings indicate that in most cases women's right to end and their religious affiliations appear to be conflictual in nature particularly when legal access to abortion and contraceptive use are taken into account. As a result, the relationship between personal freedoms of legal abortion and religious freedom influence each other (Casey 2014).

2.3.1.2 Moral Discourses on Abortion

Related religion but also somehow different discourse is the moral discourse of induced abortion. Abortion is a very sensitive and controversial issue in the modern times and hence people hold a wide diversity of views. By and large, there are two dominant arguments on the moral acceptability of the deliberate termination of pregnancy that dictate the moral status of the fetus

and the autonomy and the rights of the women (Hinman 2014). The former ones are advocating that the fetus is an innocent and a sacred being so that it is morally wrong to kill it in any aspect. Therefore, abortion is just equivalent to murder while the latter view abortion as the relief and a window for a woman who is oppressed in a patriarchal system and socio cultural realm (Jones and Chaloner 2007 in Hassan 2015).

Generally speaking, opponents of abortion put their justifications on the issue of the moral status of the fetus since the unborn has to be regarded as human being as does any person has so that they claim that abortion is a way of killing and terminating the human being's life. Therefore, abortion is definitely an immoral act (Patil *et al*. 2014). With the coming of secularization and modernity, some people accept abortion as a right of women (Klusendorf 2010; (Demirel 2011; Hassan 2015). However, still religion has a powerful influence in shaping people's attitude towards abortion. Moreover, religion and morality are inextricably linked concepts that influence abortion debate and attitude. There are people who think that abortion is immoral and sin in most major religions unless some obligatory reasons such as mother's health risk is involved (Komut 2009). In this regard, there are a range of moral and ethical issues which may arise about unplanned pregnancy and abortion. So, the moral and ethical perspectives, in fact, play a decisive role in making decisions of a woman in relation to unwanted pregnancy though such values prominently vary across individuals in practicing abortion. In other words, some women might believe that abortion is unethical and immoral while others claimed as the best option for difficulties (Atkins 1994).

2.3.1.3 Legal Discourse on Abortion

Abortion is still a controversial subject in politics of many countries. Thus, many competing groups, such as, political activists, religious organizations, state legislatures, and judges emerged either against or supporting the issue of abortion legalization (Williams 2002). To this end, there are two dominant but opposing groups of feminists who have fought each other in the legalization of abortion. The first group is anti-abortionists who strongly condemn the legalization of abortion since they argue that abortion is wrong because it kills human life as they believe that life begins at conception. But, pro-abortionists advocate that the essence and implication of the legalization of abortion because women are the victims of the problem not men in pregnancy so that women should have the right to control their own body and their life fate and goals (Williams 2002; Siegel 2012). In other words, proponents of abortion right argue that the embryo or fetus is not a person, so at least governments have no right to ban abortion while opponents of abortion rights argue that the embryo or fetus is a person or at least government has a responsibility to ban abortion until it can prove that an embryo or fetus is not a person. Thus, opponents of abortion often frame their objections in religious terms (Nalenga 2012).

From the legal point of view, abortion is considered to be one of the major social problems worldwide. As a result, some countries liberalize and accept it while others restricted in one way or another. The extent to be legalized is varied among countries because it depends on some legal requirements that are based on duration of gestation or number of weeks and the condition of a pregnant women including age, rape, threat to her life and child and the overall life plan of a woman (Doherty 2013).

A. Abortion Law Reform: A Human Rights Issue

A 'rights-based framework' is one that bases laws and policies on the principles and norms defined by the international human rights system in order to promote and protect human rights. Therefore, governments should endorse and enact laws and policies of abortion in the principles of international human rights so that women have the freedom to decide in the process of terminating their pregnancy (WHO 2011). This, in turn, ensures the autonomy of a woman to end pregnancy within her life circumstances and conditions. Because the nature of abortion is not only moral, religious and medical issue but also human rights since it involves the right of the women at the same time the right of the unborn or the fetus (Denbow 2005).

Human rights discourse examines the dual aspects of abortion discourse. The first one deal with the right to life of the unborn child on one hand and the second is the right of women to health and life. As a result, such argumentation is supported by two subfields such as legal and medical discourse (Larsson *et al*. 2015). Consequently, most countries especially the developed and western nations liberalize the abortion laws and access to abortion services in most cases (Lazdane 2005); nevertheless, some developing countries did not yet liberalize the abortion laws in their constitutions. Even the laws that allow abortions only in cases of "risk of serious harm to health" seldom define what constitutes such a risk, who decides, and what are the procedures for authorizing an abortion in the particular case. This, in turn, raises the issue of clarity so that it would expose abortion in the sense of secret, illegal and unsafe abortion outside formal health care system (Cook *et al*. 2003).

B. International Status of Abortion Law

The legal status of abortion is an important indicator of women's ability to enjoy their reproductive rights (CRR 2014). To this end, abortion is legal almost in all western countries except Malta and Andorra in which it is limited only to save the life of a woman (Lazdane 2005). Similarly, except some countries such as South Africa and Zambia which permit abortion on broader socio economic reasons, it is generally illegal in most African countries (Nalenga 2012).

As reports and empirical studies indicate, legal restrictions on abortion often cause high levels of illegal and unsafe abortion that leads to maternal mortality (CRR 2014). To this end, medical professionals also ask the international community to promote abortion policy reform and legalization due to the fact that unsafe abortion impacts the lives and health of millions of women, their families, communities, and nations (Crane and Smith 2006). In other words, restricting abortion in any manner would result multifaceted consequences not only women themselves but also in the wider social networks, community and the nation as whole. This fact is also consolidated by the assumption that abortion should be legalized otherwise women will be exposed to unsafe abortion and health risks. Due to restricted laws, over 70,000 maternal mortalities have occurred annually in developing countries (WHO 2011).

There are possible contending issues concerning with the legalization of abortion. Some believe that liberalizing abortion provides a woman full autonomy to terminate unwanted pregnancy and access to safe and legal abortion thereby it can save the women's lives and equality. This in turn provides to exercise their human rights relating personhood, dignity and privacy (Human Right Watch 2005). Moreover, some countries legalize abortion with limited conditions such as rape and incest, yet such laws are not sufficient conditions for autonomy of a woman because such

restriction disregards the lived experience of woman seeking abortions to limit child bearing, solve relational and personal problems and for socio economic reasons (Grimes *et al.* 2000). On the contrary, others argue that legalization has the social costs including the erosion of essential moral values such as sanctity of human life and decline of traditional sexual morality, increasing infanticide, murder and the like (Schwartz 1972).

Another striking concern in legalization of abortion would be its procedural and administrative nature that delay abortion process such as waiting times , biased counseling and durations of gestation that invite women to health risks and unsafe abortion even if most countries endeavor to legalize abortion laws (WHO 2003; CRR 2004 in Crane and Smith 2006). Especially in developing countries procedural requirements must be met before legal abortion is performed at health care centers for instance gestational limits, spousal or parental consent and doctors' permission under circumstances including counseling (Olukorede and Oluwaseun 2009).

C. Abortion policies and laws

Across countries, policies and laws regarding abortion are greatly varied based on some requirements. The parameters such as to save the life of women, to preserve physical health, mental health, socio economic grounds and upon the requests in considering abortion to be legalized or not also varied. In this regard, 61% of the world's people live in countries where induced abortion is permitted either a wide range of reasons or without restriction as to reason. On the contrary, 26% of the world population denied the right to terminate pregnancy regardless of any reason-prohibited altogether (CRR 2008). In this regard, most African countries did not acknowledge abortion law beyond to save the life of a pregnant woman. For instance in Nigeria, which is the most populous country in Africa, abortion is allowed only to save the life of the

women. Violating the due stated penal and criminal laws ensue for jail to sentence up to 14 years and highly opposed by traditional and religious groups. In this regard, unsafe abortion rate is high in Nigeria (Ilibinso 2007). In the case of Ethiopia, mental health, socio economic grounds and upon the requests were not given any attention as per the world's abortion law and human rights issue. Similarly, the above mentioned factors were not considered in Ethiopian criminal code of the year 2005 (Tsehai (2008). The criminal code of Ethiopia regarding safe abortion was came to in effect after the Ethiopian Ministry of Health has released guidelines for safe abortion services, making major progress toward implementing 2005 revisions of the country's abortion law. In doing so, according to the FDRE criminal code of Ethiopia (2005) Article 551 the following are the cases where terminating pregnancy is allowed by Ethiopian law; where termination of pregnancy by recognized medical institution within the period permitted by the profession is not punishable where;

a. The pregnancy is the result of rape or incest

b. The continuance of the pregnancy is dangers the life the of the mother or the child or the health of the mother or where the birth of the child is a risk of the life to the health of the mother

c. Where the child has an incurable and serious deformity

d. Where the pregnant woman owing to a physical or mental deficiency she suffers from or her minority is physically as well as mentally unfit to bring up the child

However, the above law has come to in effect on the basis of the FDRE (MoH 2006). Thus, there are two types of care related to termination of pregnancy; women – centered abortion care and

post abortion care. The former one is a comprehensive approach to providing abortion services that takes in to account the various factors that influence woman's individual mental and physical health needs , her personal circumstances and her ability to access services. This care includes a range of medical and related health services that support women in exercising their sexual and reproductive rights. On the contrary, post abortion care is a comprehensive service for treating women that present to health care facilities after abortion has occurred spontaneously of after an attempted termination.

2.3.2 Medical Discourses and Health Care Services on Abortion

2.3.2.1 Medical Ethics and Acceptability of Medical Abortion

In medical ethics, abortion is contested and frequently discussed issue because it was strongly opposed by Hippocrates, the founder of the medical ethics. From the stand point of obstetrics practice, ethics is the discipline which studies morality in providing services to clients. In this regard, Hippocratic Oath, the universal medical ethics, influences physicians develop negative attitude towards abortion and providing services for women (Patil *et al*. 2014). Besides, there are personal and contextual factors including moral agency, religious beliefs and societal stigma which affect abortion provision (Lamina 2013). This is perhaps typically linked with conscientious objection of physicians due to the incompatibility of healthcare providers' religious, moral, philosophical, or ethical beliefs. Many researches indicate that some healthcare providers refuse to provide services affect abortion procedure and the women's wide range of life situations. Yet, others develop conscience commitment to understand and help their clients' problems (Chavkin *et al.* 2013).

The acceptability of medical abortion can be looked at not only from health care providers' but also patients' perspective. Women usually used both medical and surgical types of abortions so as to end their pregnancy safely. The acceptability of medical treatments depend heavily on patients' expetations.To this end, comparative studies conducted in China, Cuba and India indicted that the expectation of women on medical abortion is lower than surgical one because of failure rate and complications such as frquent bleeding which is the worst feature of medical abortion than its counter part (Winikoff *et al.* 1997). However, 80% of women who underwent indcued abortion prefered medical abortion than surgical abortion due to its efficacy, safety, freedom from pain and absence of surgery and privacy (Winikoff 1994; Chung Ho 2006).

2.3.2.2 Reproductive Health Policies on Abortion

Legal, regulatory or administrative barriers determine not only healthcare service policy but also deter women from seeking safe abortion. For instance, access to information, third party authorization, waiting periods and conscientious objections play a significant role on safe abortion practice (WHO 2012). Moreover, the adequacy of hospital facilities, human personnel, and quality of health care services, willingness of medical providers and regulations play a pivotal role in providing abortion services. If such preconditions are not fulfilled, obviously it couldn't satisfy the demands of people who seek to end pregnancy at the right time. There are, in fact, social contexts that largely influence the willingness of physicians who provide abortion services especially in public health care centers. For example, religious affiliations and the legalization of abortion facilitate or delay abortion process (Smoller *et al.* 1973; Svanemyr and Sundby 2007). Moreover, countries designing restrictive reproductive health policies and discourses negatively influence people's attitude towards abortion and women's decision making process. This in turn imposes women unsafe and illegal abortion which causes risky health

outcomes and violation of women's reproductive rights. Conversely, conducive health policies and non-restrictive abortion laws promote safe abortion, hence, it declines maternal mortality (Crane and Smith 2006; Larsson *et al*. 2015). Furthermore, according to WHO (2008) social and cultural beliefs against abortion are the other barriers in accessing services. Whether legal or illegal, abortion is frequently censured by religious teachings and ideologies, hidden due to fear of reprisals or because of social condemnation and restrictive laws, whether de facto or de jure.

2.3.2.3 Health Risks of Induced abortion

In 2008, about 208 million pregnancies and 86 million unintended pregnancies occurred worldwide. This problem brings not only social but also health consequences on women, their families and society at large. Some studies suggest that women experience unintended pregnancy and abortion are faced with stigma from their families and communities and associated health risks such as depression, mortality and etc. (Singh *et al*. 2010). In abortion procedure, safety is the central and frequently raised issue for many women seeking medical and surgical abortion. It is common that complications are possible in any of medical or surgical procedures. Consequently, abortion is mostly associated with infections to health risks to death (Gale 2014).There are also studies that show women seeking medical abortion usually encounter health risks such as reproductive tract infections (RTI). A study in Vietnam, for example, indicated that induced abortion is one of the prevailing problems which cause RTI that comprises potential risk of pathogens from the lower reproductive tract into the upper tract. Besides, the prevalence of contradictions of medication abortion including cardiovascular disease, i.e. cerebro-vascular, ischemic heart or peripheral vascular disease; coagulation disorder; chronic adrenal failure just to name but a few are the common health risks and side effects appears to be in medical abortion procedures (WHO 1999; Hng *et al*. 2009).

2.4 Gender Roles and Abortion

Gender is one of the constraining or enabling factors in abortion practice. As many literatures and empirical studies indicated gender norms and roles prominently affect women's involvement in abortion practice. More importantly, gender role and relations between men and women plays an important role in determining not only the role and place of both sexes in society but also impacts the distribution of power between the sexes. This is particularly, true in societies where male dominancy is exercised. In any patriarchal system, men are believed to be dominant over women in terms of socially, politically, and even sexually. In a similar vein, gender relations, which resulted from gender inequalities, are expected to play an important role in influencing reproductive behaviors and decisions (Ndlovu 2006).

Moreover, according to Plous (1993) decision-making in whatever context is a complex issue as it encompasses personal desires, medical, moral, ethical, gender and other socio-cultural issues. Individuals approach decision-making processes from different social, cultural, interpersonal, and historical contexts. Hence, as Plous argues, there is no such thing as context free decision-making. The above scenario has been evidently practiced especially in African context. There are cultural norms among the African people which promote male dominance and treat women as subordinate to men (Ngubane 2010).

2.5 Abortion Stigma and Social Support

Practicing abortion and social stigma are inextricably linked concepts in every society and social structure. Thus, stigma, which is the social construction and reproduction of cultural, religious and societal values, plays an important role on women's abortion practice and experience (Berman 2008; Cockrill and Nack 2013). To this end, Berman (2008) further explained that there

are actors such as peers, family or the larger community label and stigmatize women so that women perceive or anticipate judgment or disappointment. In one way or another, abortion stigma affects social support that women receive from their immediate social networks, particularly their partners, mitigates the effects of abortion stigma. In other words, women who perceive community support for the right to terminate a pregnancy are less likely to feel guilt and shame than those who do not (Kumar *et al.* 2009). Thus, not only the woman herself but also the role players in abortion decision such as partners, family, and friends and significant others experience stigma. In other words, the level of social support is greatly influenced by stigma associated with various groups. The level and the extent of social support determined by the existing community values where sexuality, motherhood and wedlock are given due emphasis; violating such desirable societal values and norms would mean severe societal reaction. In this regard, abortion follows stigma and societal reaction.

Consequently, there are three categories of people who are being affected by abortion stigma; namely, women seeking and having abortion, health workers who provide abortion services and those people who are working with abortion area such as advocates, researchers and activists (Cockrill and Nack 2013). As a consequence, abortion stigma adversely affects women and adolescents' life in several ways such as stereotype which labels women as if they were sinful, dirty and heartless just to name a few, and over discrimination which is a direct denial of various services and benefits which has to be given by the community. Due to the nature of stigma, people who feel being stigmatized can change behaviors and decisions, and suffer influences that impact their physical, mental health, and personal and professional welfare. In this regard, both stereotypes and overt discriminations could be located within the individual, community, organizational and structural levels (Schuster 2005; Machado *et al*. 2016). In many countries

including Kenya, Ghana, and Ethiopia, researchers found that women deliberately keep their decision-making and abortion experiences secret from peers, family members and partners for fear of damage to reputations due to social stigma (Cockrill *et al*. 2013). The decision to terminate a pregnancy is highly contextual in terms of culture and community, but also within an individual's life trajectory. The decision to terminate a pregnancy does not take place in a vacuum; instead it is a result of a particular set of often quite complex circumstances (Kumar *et al* .2009). Abortion stigma has several consequences up on those who are believed to involve. For instance, various labels such as promiscuous, sinful, selfish, dirty, irresponsible, heartless or murderous are applied to women who abort in different contexts. In other words, stigma diminishes or destroys a lived value and these values vary widely across cultural contexts. Therefore, secretiveness is one strategy that women use to avoid the social consequences of having peers and community members know about their abortions (Norris *et al.* 2011). There is a relationship between stigma or community-level stigma and the norms, prejudicial attitudes and negative behaviors toward abortion that exist in communities (Cockrill *et al*. 2013).

2.6 Abortion and Public Attitudes

With no doubt abortion debate is the direct fabric of our society in which it attracts many researchers and policy makers. This phenomenon, in turn, leads to legalization of abortion debate within the contested and controversial moral, religious, legal and medical perspectives. Social, cultural, political and economic settings play a pivotal role on the knowledge, attitude and practice of abortion among women and health professionals. Public opinion can directly affect access to safe abortion services. Conservative opinions and societal responses influence not only women who seek and practice abortion but also health care workers who provide medical services (Becker *et al*. 2002). Public opinions regarding abortion are not easy as such expected

because the decision to end pregnancy and access to legal and safe abortion requires multiple and contextual circumstances such as personal beliefs, socio-cultural and environmental factors, gender and political views of being pro-choice or pro-life etc. influence people's attitudes and opinions towards abortion (Butler 2015).

The contested nature of abortion lends itself for public debate since time immemorial. To this end, there are various factors that predominantly influence the wider public attitude and perception about abortion. Among other things, demographic variables for instance, age, education, marital status, income, religious affiliation, political ideology etc. determine the public attitude towards abortion. Commonly there is a correlation between abortion and demographic variables such as marital status, age, sex on the attitude of the community towards abortion. According to CDE (1995), this is typically true that marital status, unintended pregnancy, and abortion are more closely linked than is generally recognized; over 80 percent of all abortions in the U.S., for example, are to unmarried women. Conversely, a study conducted in USA by Narendra (2010) indicated that that sex has no significant impact on abortion attitudes.

In addition, situationality of morality, peer pressure and mass media influences the legality of abortion (Jones *et al*. 2011). In a similar vein, abortion has been strongly opposed by those who frequently attended church programs and services. This phenomenon is indeed quite varying from one religion to another. For instance, the difference is visible in catholic and protestant followers and others (Jones *et al*. 2011).

The community attitude towards abortion varies significantly from person to person. Thus, stigma, which is the main manifestations of the community towards abortion, varies from one community to another. The empirical studies found in Australia revealed that over 80 % of the

population accepts the women's right to abort (Durey 2010). On the contrary, religious family members, significant others especially anti-abortionists, peer friends and the like have played a negative attitude towards women who have abortion experiences. So, most women feared disclosing their abortion practice by fearing the responses of community level stigma including labeling, stereotyping, separating, and discrimination (Cockrill and Nack 2013).

Moreover, there are complexities of attitudes towards abortion worldwide. For example , an empirical study conducted in America showed that abortion attitude is constantly changing even between the dominant groups of pro-life and pro-choice proponents which have no rigidity due to the changing nature of abortion attitude is ambivalent because people's values and beliefs are prominently influenced by social networks, media and religious organizations (Strickler and Danigelis 2002).

In a similar vein, the issue of abortion attitude is complicated almost in all African countries even if some countries such as Zambia, South Africa and Cape Verde attempted to liberalize abortion laws. Yet, the community stigmatized and ostracized women as murderers and they also have strong beliefs regarding the immorality of abortion (Marlow *et al*. 2014; Creswell *et al*. 2015). Another empirical study conducted in Uganda, Zimbabwe, Burkina Faso and other African countries, men do not support and want women to have abortion because of socio cultural beliefs for instance they believe that children are resources and important for society and view abortion as a sign of illicit sexuality as a result woman do abortion secretly by fearing the consequence of their partners and the reaction of the wider community. Another reason why men have resistant and negative attitude towards abortion is fear of dying of their wives and even fear of arrest since there is no legalization of abortion in most countries (Moore *et al*. 2010). In this aspect, Ethiopia is not exception, as most people have negative attitude towards abortion. For

example, empirical study conducted in university students show that some had positive while most had negative attitudes and reactions towards abortion practice in general and abortion laws in particular (Abay 2002; Worku and Binyam 2014). Moreover, a study conducted by Mihret (2010) in Addis Ababa revealed that over 54% of respondents were against the practice of abortion.

2.7 The Lived Experience of Women Practicing Abortion

In the first place defining the term experience is paramount for the sake of understanding the whole research. From the phenomenological perspective, experience especially lived experience comes from the German word 'Erlebnis' which means the subjective feeling whether emotional, physical, and spiritual and /or intellectual level; so life is based on an individual's experience of things both real and non-real (Burch 1990 in Jackson 2014). The lived experience can be looked at not only the psychological responses but also the phenomenological experience focusing on questions of meaning, discourse, structural relations on people's lives which are deep rooted in the larger socio cultural perspectives (Desjarlais and Throop 2011).

2.7.2 Contextual and Personal factors on Women's Abortion Experience

According to Ahmed and Ray (2013) there are various types of determinants such as woman's characteristics, husband's characteristics, household characteristics and contextual variables that influence a woman to decide and perform abortion. Having this in mind, there are various contextual factors and reasons such as societal attitudes, religious beliefs, cultural interpretations and socio economic reasons and failure of traditional and modern contraceptives, women, for example, in US and Netherlands have faced unintended pregnancy. Therefore, they might be enforced to terminate their pregnancy through abortion (AGI 2006; Goenee *et al*. 2014).)

Moreover, most women , for example reported that due to personal and social situations, social stigma, diseases conditions, for instance HIV positive and the willingness of health providers influences their decision making process in terminating safe abortions in health care centers (PicKles 2012). Moreover, more often than not, in choosing to end pregnancy, women are constrained by structural factors such as poverty and socio cultural influences of stigma, and shame in view of familial, religious, and cultural sanctions against pregnancy and abortion (Gilbert and Sewpaul 2014).

As many empirical findings showed that deciding to have an abortion is rarely an easy process as it is a non-reversible decision that affects many areas of a woman's life and many contradictory feelings may come into play. In the decision- making process about whether one wants or is able to have a child at that particular point in time, a woman may question her relationship with her partner, her family values and her future on the one hand and societal reactions and responses on the other (McCulloch 1996).

Women's decision of abortion experience is also influenced by opposing and contradictory views of feminists. Hence, anti-abortion and pro-abortion feminists overwhelmingly influence the understanding of the abortion decision-making process including reasons, relationships and emotions that are mostly felt by women. As a result, the prevailing arguments create dilemma on women who want to terminate their pregnancy (McCulloch 1996; Madeira 2014). In addition, women experiencing unwanted pregnancy experience dilemma within conflicting beliefs, desires, uncertainties, and fears on one hand and the existing cultural, legal and religious and medical stands on the other (Reardon 2003). Even if abortion decision is complex, nevertheless still there are some women who easily decide to terminate their pregnancy. However, in reality it

does not eliminate the pervasive effects of abortion on the future women's social, cultural, emotional, spiritual and even physical and economic life (Reardon 2003; Kimport *et al*. 2011).

Generally, women as rationale actors try to resolve the complexity of decision making process to end pregnancy through various strategies and resilience mechanisms including cognitive, social and symbolic despite the fact that the ways they handle the situation greatly varied from women to women; some find it easy while others have to struggle to find ways to express and deal with the situation they faced. In doing so, there are common strategies such as detaching, meaning making, world view and social strategies-sharing the experience with others to gain acceptance (LiljasStalhandske *et al*. 2011).

2.7.3 The Emotional Impact of Abortion on Women

Pregnancy is one of the pleasant and respected reproductive values that a society acknowledges. Unfortunately, this is not always the case because unplanned pregnancy would produce higher levels of stress. Accordingly, empirical studies revealed that 1 in 10 women experience troubling feelings (PAC 2016).The abortion process induced existential thoughts and feelings in many women. Psychologically women suffer more mental illnesses than men, women tend to show into depression faster and twice than men do. Twice as many women suffer from something called Post Traumatic Stress Disorder, which occurs when the person has suffered a tremendous loss (Mappes and Zembaty 2002). Be it, spontaneous or induced abortion, women experience, responses ranging from emotional relief to severe emotional grief, guilty and distress. Thus, some women may experience trauma immediately after the abortion, while others might not experience trauma until ten years later. But the degree of stress and trauma depends on the type of induced abortion in which those who undergo. Hence, second trimester abortion experience

has more physical pain than women who abort in the first trimester. Perhaps most significantly, women who obtain second trimester abortions are more likely to perceive the fetus as a baby that can and does feel pain (Pacillo 1997; Curley 2010).

The ways that a woman experiences her abortion are diverse and complex. They potentially include both positive and negative outcomes, and appear to be highly dependent on the socio cultural context surrounding her decision and her personal coping mechanisms. Thus, emotional experiences following an abortion can be both positive and negative, and are often mixed, with many women reporting both relief and guilt (Miller 1998 cited in Dollar 1997). Nonetheless, anti-abortionists argued that sex, marriage and bearing child are the sacred acts and gifts of God so that women should adhere and respect the traditional roles so disrespecting and violating such values would ultimately cause a woman a feeling of regret, stress, guilt and remorse (Madeira 2014).

As of empirical studies are concerned, women faced emotional experiences after induced abortion. For example, a study conducted in Sweden revealed that 42% of women experienced no psychological reaction at all; 55% experienced remorse or emotional distress of shorter or longer duration; 16.1% still had slight emotional problems at the time of the interview 3.9% had a deeper depression (for 2.3% this persisted for a longer time. This finding in fact, shows where abortion law is freely enacted and public opinion is not actually anti-abortionist in nature (Soderberg *et al*. 1998 in Davis 2007).

Conversely, for pro-choice feminists, abortion is an option and a way of getting relief from the complicated personal, social, cultural, moral, religious and related factors. As a result, this argument or perspective provides autonomy and freedom for women who want to experience

abortion regardless of the aforementioned factors (Madeira 2014). Some empirical studies indicated that abortion allows women to exercise their free will regarding the direction of their lives. In doing so, some women experience relief following abortion in which, abortion is "a window of relief''; in an unequal and difficult situations from which there is no exit (Pacillo 1997, Kimport *et al*. 2011).

Even though women experience stress, guilt and emotionality after abortion; the situation is quite different in legal and first trimester abortion. Thus, most women report that after the first trimester medical procedure they showed relief and happiness. For example, in Sweden 72% of respondents having induced abortion narrated that they were benefiting from the abortion practice rather than harm; hence abortion brought relief and satisfaction as a normal stress (Adler *et al*. 2007). Likewise, teenagers and adolescents believed that abortion reduces tensions and reactions from their parents and communities (Lee *et al*. 2014). In other words, only few women experience clinically significant psychological distress after abortion practice (Royal College of Obstetricians and Gynecologists 2011).

2.7.4 Resilience Mechanism of Women Practicing Abortion

Resilience is usually correlated with stress, trauma and adverse life events. It consists of basic concepts that revolve around stressful events (exposure to significant stressors or risks), and positive outcomes (demonstration of competence and successful adaptation) (Luthar *et al.* 2000 in Anghel 2015). Although resilience has not been linked with the concept of structuration theory in many literatures, structuration theory implicitly expresses the dynamic relationship of structure and agency in both constraining and generative senses. This entails resilient performance of actors in their daily activities and life situations enhance the prospects for

resilience aspect (Hunte *et al. n.d*). However, resilience is just more than dealing with stress; rather, as negotiation, coping requires agency that may be seen as life conduct in which individuals respond to and cope with demand and opportunities in an active way. Agents are not necessarily passive entities that are always constrained by discourses and structural forces. To cope with adverse life situations, individuals use their social capitals (social networks, groups, trust, personal attributes, cultural and religious values that shape the possibility and forms of resilience) to resist difficulties though they are constrained by contextual and structural forces (Eyles *et al*. 2015).

2.8 A Guiding Theoretical Framework of the Study

2.8.2 Structuration Theory

According to Giddens (1984) the aim of social science theory is to develop explanatory concepts in order to analyze the rationale of social actors, intentions and motives that underpinning social actions (Giddens 1984). He divided the sociological analysis into two major intellectual camps: strcturalists and functionalists and interpretive sociologies. The former advocates the macro structure and social behavior where behavior is explained and constrained by the social structures. The later, mainly emphasizes on the human agent as a primary actor and interpreter of the social phenomena. However, in structuration theory, Giddens rejected these two extreme debates; rather he integrated structure and human agency as the duality of the structure and action (Giddens 1984). In other words, structuration theory as an integrated theory concerns with duality and dialectical interplay of agency and structure. Therefore, both cannot be separated and conceived as dualism rather; they are two sides of the same coin in which all social actions involve structure, and all structure involves social action. In other words, structure and agency

are interrelated concepts having an effect to each other and he calls this concept as the duality of structure (Ritzer 2011). Structuration theory clearly explains how people react to societal demands by manipulating the system to their perceived advantages and vice-versa. This theory conceptualizes the linkage between (societal and personal contexts) and processes in the society. Thus, the researcher employed structuration theory because it mainly provides an insight to a deeper understanding of the interface between the women's abortion experience and the responses of community which is embedded in the broader sociocultural context. Now let's have a look at the overall aspects of structuration theory and its implication to the current study at hand.

Basic Concepts of Structuration Theory

A. The agent and Agency

Human agency is a social agent that is primarily a reflexive actor capable of providing a rational justification for ones actions. Agency basically refers to knowledge and skill. It is basically what individuals do on a daily basis and basically refers to micro level and at the same time the (macro) collectives that act together. Thus, qualified agents as human agents being individuals and at the same time organized groups, organizations and nations (Ritzer 2011). As far as rationalization and reflexivity are concerned, agents are continuously involved in action, motivations and having potentials for action. Motivations provide overall plans for action, but most of our actions, in Giddens's view, are not directly motivated. Although such actions are not motivated and our motivations are generally unconscious, motivations play a significant role in human conduct (Ritzer 2011). Furthermore agency is closely linked to power as human actors have the opportunity to intervene in their environments but actions might have both intended and

unintended consequences (Rose 1998 in Thorseng 2008). Power is highly linked with agency in which agents have the ability to make a difference in the social world since actions are embedded in all human beings and it is taken with knowledgeability and consciousness (Ritzer 2011). This reflexive nature and consciousness enable individuals to monitor their actions and reacts to a situation and rationalizes their actions and decisions on their daily basis and social structure. Though actors are constrained by lack of resources, Giddens believed that actors have choices and make difference within the system (Ritzer 2011).

B. Structure

Giddens (1984) defines structure as the totality of all social institutions such as family, religion, education, gender, government and the like having their own rules to govern. Structure is not just always as large scale social structures, but that determine the conditions in which individuals are to react. This is because structure is flexible and constantly being modified, structure ought to be considered in systemic form. That is to say, structure is made up of properties (rules and resources), and the only thing bonding structure together is the structuring properties that allow the binding of time- space in social systems (Giddens 1984 in Ritzer 2011). In other words, structure is highly dependent on the moment in time that it exists. Social phenomena have the capacity to become structured so that situations and outcomes are the result of human actions which refer to micro structures involved in human interaction. Structures can therefore be created and recreated through human agency.

C. System

According to Giddens(1984) social systems can be defined as systems of social interaction that reproduced social practice between actors or collectivities organized as regular social practice.

These systems are patterns of relations in groupings of all kinds, from small, intimate groups, to social networks and large organizations. Social systems are, therefore, not independent of the actor but they depend on social practices which are enduring cycles of reproduced relations that form social systems. Moreover, social systems could be families, peer groups, and communities, which can either be at a face to face level or existing via networks over space and time or be media or face to face interaction that forms encounters that contribute to systems (Giddens 1984 cited in Ritzer 2011).

D. Duality of structure

Giddens(1984) argues that structure consists of rules and resources that are created through the actions of individuals thorough practices and daily routines. In this regard, duality emerges through when the existing structure constrains actions at the same time actions serve to maintain and modify structure. This is because in the sense of duality, Giddens meant that structural properties of social systems are both medium and outcome of the practices they recursively organize or the moment of production of action is also one of reproduction in the contexts of the day–to-day enactment of social life. In other words, structuration involves a dialectical relationship between agency and structure which neither can exist independently (Giddens 1984). Structuration, therefore, highlights this link between social formation and the individual actor that social life is constituted through social practices. These social practices are the mediating concept between agency and structure and between individuation and society. As a result, structuration reproduces social structures which both enables and constrain each other (Giddens 1984). The following well known diagram in fig 1 depicts the dimension of the duality of structure.

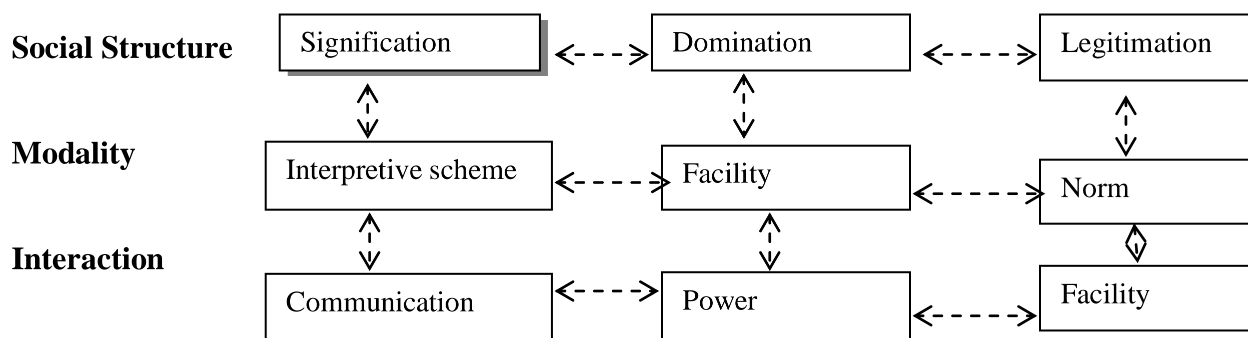


Fig 1: The dimension of the duality of structure (Giddens 1984)

Under here, Giddens breaks down the social structure and human action into three dimensions: signification, domination and legitimation which are interlinked by the three modalities such as interpretive scheme, facility and norm of the society. Signification refers to the norms and resources to the rules that constitute meaning, while legitimation refers to the norms and resources that determine relations of domination. Giddens also introduces modalities of structuration in a way that knowledgeable capacities of agents to structural feature. To this end, there are three modalities relating to signification, domination and legitimation are interpretive schemes, norms and facilities respectively. According to Giddens, interpretive schemes are the stocks of knowledge that enable actors to understand things through their daily experiences. Norms are rules for understanding how to act. Actors use rules as standards of morality to sanction or legitimate their actions as appropriate conduct.

Briefly, duality of structure therefore becomes important when discussing abortion practice because women's abortion practice and the community response are located at the interface of structure and action. In this regard, the researcher modified dialectical relationship in fig 2 to better understand the interface between abortion practice and attitude of community towards abortion. Hence, the diagram illustrates human beings as reflexive actors on the one hand have a

capability to decide on matters of pregnancy termination due to various contextual and personal factors. And this, in turn, influences the existing normative structure of a society and also these normative structures particularly religion and morality both influence women's decision on abortion and the attitude of community towards abortion practice and societal stigma towards women having induced abortion on the other hand. In this manner, the reaction of the community which is being influenced by the existing sociocultural discourses determines the overall lived experience of women practicing abortion.

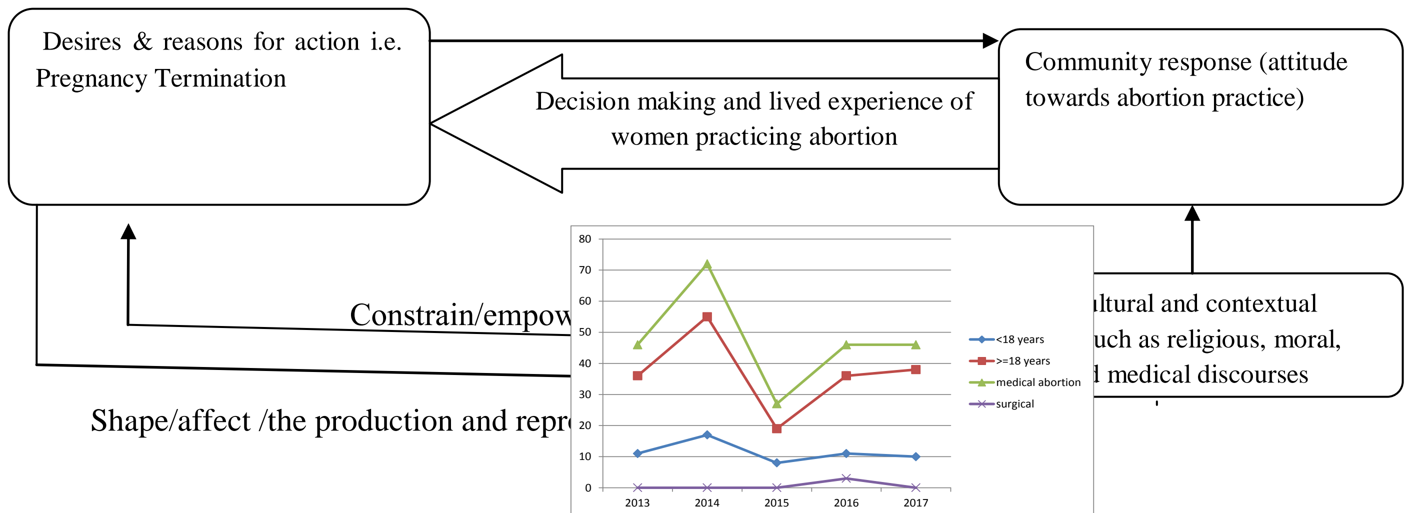


Fig 2: Own Construction based on Giddens's Dimension of the Duality of Structure (1984)

2.8.3 The Relevance of Structuration Theory to This Study

There are so many sociologists who tried to conceptualize practice theory in the field of social science such as Perie Bourdieu. However, this study used Giddens's structuration theory since that has suited to feminist perspective and allowed the possibility that individuals may change their own circumstances (Charrad (2010) in Read 2014). In other words, it gives equal importance to structure and agency. Individuals as actors develop their own rational justifications to their actions and forming their life world and, in turn, created the social structure. Using

structuration theory also benefits us to connect micro-social practices and macro-structural considerations and thus allows us to situate our understanding of abortion within wider social processes. Therefore, the researcher found this theory as congenital because it enable to analyze and examine the socio-cultural and contextual factors (moral, religious, legal and medical values and gender roles) that shape attitude of community towards abortion practice and the lived experience of women before, during and after practicing induced abortion on one hand and women's choice and autonomy on pregnancy termination which is being implicated within the larger social structure on the other hand. Women having induced abortion are constrained or empowered by the social system in which they are living. Therefore, structuration theory might help us to better understand the interface between women's lives and community responses. This means, women as social agents (experiencing abortion) affect the moral order of the community and in turn their abortion decision are affected by the socio-cultural values and beliefs which are prevailing in the society in which they are living especially in the patriarchal system. For example, the decision to terminate pregnancy cannot be considered in isolation from contextual factors (religion, gender roles and the existing healthcare system etc.). The existing normative structures such as moral order, religion, medico-legal and patriarchy as structural properties reinforce or constrain people's attitude towards abortion practice and women's lived experience. Similarly, women's abortion practice (rationalization, practical consciousness and their motives, be it intended or unintended consequences, affects the normative structure of community values regarding womanhood. Hence, structuration theory can also be a useful lens to view the dynamics of the existing socio-cultural contexts of abortion and the women's agency from their inner life world.

CHAPTER THREE: RESEARCH METHODS

3.1 Description of the Study Area

The setting of this study was delimited to Woldia Town in North Wollo Zone, in Amhara National Regional State. This zone is one of the ten zones in Amhara Regional State. Based on the 2007 census, the zone has a total population of 1,500,303 of whom 752,895 are men and 747,408 are women. Out of this total population, 155,273 are urban inhabitants. This zone has 355,974 households with an average of 4.21 persons per household. Thus, Woldia, which is the Capital of North Wollo, has a population of 46,139 of which 23,000 are men and 23,139 are women (CSA 2007). It is found 521 KMs away from Addis Ababa to the North East. In terms of religion, 82.74% (37,125) practice Ethiopian orthodox Christianity and 17.08% (8519) of the population practiced Islam. But, according to CSA (2013) population projection, the current population of Woldia Town is 68,352, of which 35,154 are males and 33,198 females.

3.1.1 Justification for study Site Selection

Woldia Town is purposively selected owing to the researcher's exposure and familiarity to the area as well as is his work place too. Creswell (2009) also says that a study site can be selected purposively based on the researcher's intention such as his or her familiarity to a place. To this end, Woldia Medium Sexual Reproductive Health Center (WMSRHC) or FGAE Woldia branch, which provides SRH for 98,736 reproductive age groups, was another motive for the researcher to select the area

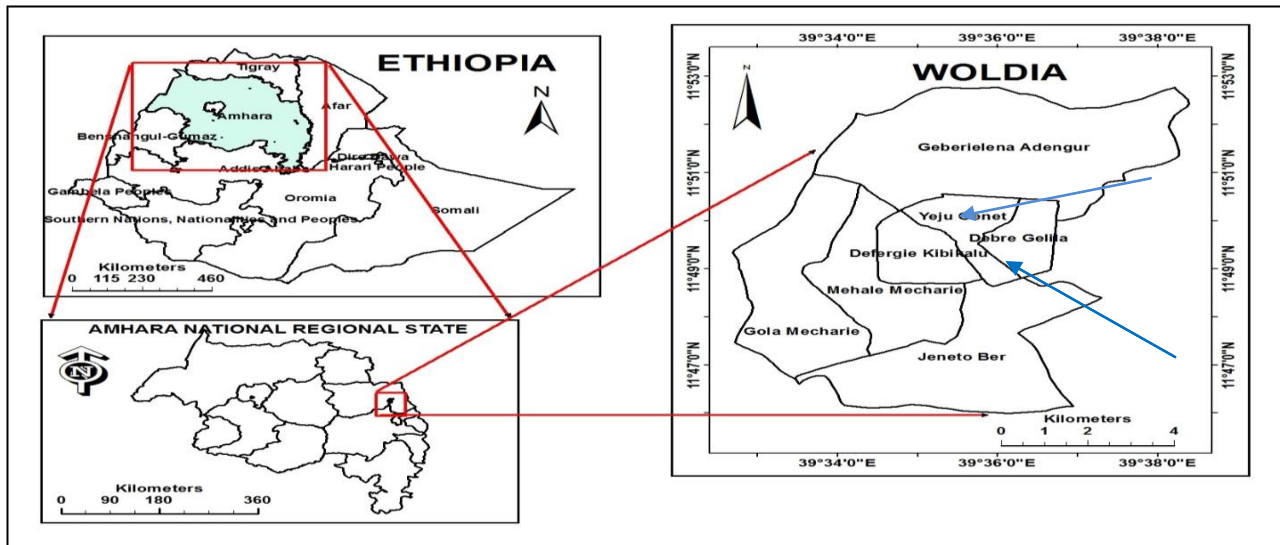


Figure 3.1: Map of Study area ***(Source: North Wollo Finance and Economic Development, 2017)***

3.1.2 The study population

Woldia Town, has three sub-cities (Debre Gelila, Yeju Genet and Deferge) and a total of seven kebeles- five urban and two rural. Of which large population lives in Debre Gelila and Yeju Genet. Moreover, FGAE Woldia branch is located at Yeju Genet kebele where it provides SRH services for the surrounding community. In this manner, the target population of this study included women experiencing induced abortion in the surrounding community, sampled urban head of households, health professionals, religious leaders, community elders and zonal court office and Town administration women and children office.

3.2 Research Approach

This study employed mixed method approach: qualitative and quantitative. The reason behind employing mixed research approach is that both quantitative and qualitative research can support each other towards a better understanding of the issue under study (Creswell 2009). It is believed

that combining multiple theories, methods, and empirical materials in social science researches can hope to overcome the weakness or intrinsic biases and the problems that come from single method and single-theory studies (Yeasmin and Rahman 2012). Creswell (2009) indicates that when we are dealing with collection of both qualitative and quantitative data at the same time, we have to use concurrent procedural design. In this study, concurrent procedural design was used: qualitative and quantitative forms of data were collected at the same time during the study and the integration of both forms of data was also mainly made in the analysis and interpretation of results. Some of the qualitative themes were analyzed separately in order to explore the agents' conscious and deliberate action despite the structural properties and normative order.

Qualitative Research Method: This method provides detailed description and analysis of a quality, or a substance of the human experience (Marvasti 2004:16). This study is interested in using phenomenology and case study, among other qualitative research techniques, because the researcher describes the lived experiences of individuals about a phenomenon as described by participants (Creswell 2014). Phenomenology method tries to describe social reality from the diverse subjective perspectives of the participants and in their life world to extract hidden meanings (Finlay 2009; Bhattacherjee 2012). Thus, this approach is important to explore the women's perception of abortion and healthcare providers, negotiating strategies on abortion decision, community level stigma on women practicing induced abortion and resilience mechanisms within the existing discourses.

Quantitative Research Method: This research strategy explores human experience through numerical or statistical data so as to measure attitudes, behaviors and perceptions (Bryman 1998; Abiy *et al*. 2009). As a result, this study employed survey method so as to examine the

knowledge, experience and contextual factors and the impact of socio-cultural discourses on the attitude of community towards abortion practice.

3.3 Study Design

The study employed a cross-sectional research design in order to obtain data concerning the issue under study. A cross sectional design entails a collection of data at a single point in time from a sample selected to describe some large population at that time (Bryman 1998). Since the aim of this study is a single-time description of the issue under investigation (assessing the attitude of community towards abortion and the lived experience of women practicing abortion in Woldia Town), a cross-sectional survey has been found to be the most important research design for this study particularly to examine the interface between women's agency in practicing abortion and community response towards abortion practice.

3.4 Sources of Data and Methods of Data Collection

Qualitative research is used to gain insights concerning with perceptions, beliefs, motivations and behaviors of individuals to explore a social or human problem by using focus groups, in-depth interviews and case studies whereas the quantitative research concerns with the measurement of attitudes and behaviors through household surveys (Abiy *et al*. 2009). To this end, both primary and secondary data sources were used in this study where secondary source of data entails valid and relevant data so as to document clinic based reports which show the trend of safe abortion practice at FGAE Woldia branch from 2013-2017. On the contrary, primary source of data generated by the investigator from the subject of the study or observation units for the purpose of this research project through, in-depth interviews, case studies/narrative interviews/ key informant interviews and focus group discussions and household survey.

3.4.1 Methods of Qualitative Data Collection

Qualitative research was used in this study, to explore the factors influencing decision on abortion, negotiating strategies and the societal stigma attribute to women having induced abortion. Moreover, the impacts of various sociocultural discourses upon abortion practice in general and women's abortion decision in particular were discussed accordingly. Regarding to the selection of participants under the qualitative approach, samples were selected through non-probability (purposive) sampling techniques based on availability, and the assumption that they can better explain the issue at hand. To this end, the following methods of qualitative data collection were applied in this study to gather the required qualitative data.

In-Depth Interview: This method enables the researcher to explore issues in detail with the interviewee, using probes, prompts, and flexible questioning styles (Henn *et al*. 2006). Such an interview would provide insights into a relationship between structure and agency in the women's lived experience (psychological response such as distress and life challenges ingrained within the existing structures and community responses like factors affecting decision making process in relation to motives, practical consciousness (action) and discursive consciousness (meaning). Moreover, the existing discourses such as religion, morality, gender roles and the like which influence the women's abortion practice. In so doing, the researcher explored all the detail information required from participants [women practicing abortion] about negotiating strategies in abortion decision and resilience mechanisms.

First, the researcher made a close relationship with healthcare providers which enabled him to develop rapport and intimacy with clients. Then, **nine** informants i.e. women having induced abortion after two weeks in FGAE and private clinics in Woldia Town based on the assumption

that in phenomenological research, the sample size ranges from 3-15 participants (Finlay 2011). Thus, clients were purposively and conveniently selected based on availability and the assumption that they can provide sufficient information. Then, the researcher continued interviewing the informants until reaching on a saturation point in which necessary data that can adequately addresses the objectives of the this study were collected. In this regard, the interview guide was used to conduct in-depth interview (see appendix 1 part III) which took an average of one hour for each meanwhile note taking techniques and tape recording(only one informant due to fear of confidentiality) were used to capture the information acquired from interviewees. Based on this, rough notes were prepared in Amharic and transcribed to English.

Key Informant Interview: According to Mikkelson (2005), KIIs are interviews aimed at obtaining special knowledge on a given issue. Key informant is someone who has particular position in the society, knows a great deal about the subject of the research (Payne and Payne 2004).

In this regard, some knowledgeable individuals who can best explain the issue under this study were purposively selected by snowball technique especially lawyers, community elders and religious leaders to generate data concerning abortion practice and attitude of community towards abortion in the town.

Generally sixteen key informants were contacted including one key informant from Woldia University teaching staff (lawyer), four community elders, three religious leaders (including one from Orthodox, one from Muslim and one from Protestant), healthcare providers(two from FGAE and one from private clinic), two HEWs(one from each selected study kebels), two professionals from women and children office (1male 1 female) and one from North Wollo court

office were selected and interviewed on their views about abortion practice of community, the contextual factors upon the abortion practice of women and decision making and the associated social stigma of abortion. Then, key informant interview guideline was prepared in line with the objective of this study and used by the researcher during key informant interview (see appendix 1 part IV). Note taking was used for recording data during the interview process and the average duration of the interview was 40 minutes.

Focus Group Discussion (FGD): FGDs serve to generate interactions that can produce comprehensive data that is unlikely to be obtained from individual interviews to supplement the survey data (Smithson 2000 in Williams 2003). This method is good for understanding the discourses which shape practices of everyday life, and as such, to understand attitudes related to abortion practice. Therefore, non-sensitive issues such as the awareness of people towards the 2005 revised abortion law of Ethiopia, the community's perception, the perceived social support and attitudes towards women having abortion, the impacts of discourses regarding abortion were discussed. FGD supplements and substantiates data that was obtained from key informant interviews and household surveys regarding the practice of abortion and community's response towards abortion. Discussants were purposively selected based on their age, sex, and main livelihood activities and marital status. No FGD participants were less than 18 years with household level except the youths whose age ranges from 15-29. The participants from youth leagues were recruited based on their awareness of abortion and sexuality issues as they work in theatre amateur clubs. To this end, 3 FGDs i.e. two from household level (Yeju genet and Debre gelila) and one from youths in Yeju genet purposively selected based on availability and interest to freely express and share their ideas and experiences; helped to gain more insights about the socio-cultural values and discourses towards abortion practice. The selection of the participants

from youth clubs was helped by the kebele's youth league officer. Each consisted of eight participants with average duration of one hour.

Case study: It is a method of inquiry which provides a detailed account of individuals over a period of time. In this regard, it entails the phenomenon within its real life context, particularly when the boundaries between phenomenon and context are not clearly evident (Yin 1994). Moreover, case study is conducted into three phases. The first one, retrospective phase, refers to the past life experiences and histories. The second one is prospective phase which refers to the present status of the case and finally the conspective phase which refers to the future remedies that are to be done to reverse what has happened (Singh 2006). Accordingly, in this study, case study approach was conducted by selecting three women having induced abortion ,that is, two from FGAE Woldia branch and one from one of the private clinics (on the basis of second trimester abortion-surgical abortion) in Woldia Town) via convenience and purposive sampling technique during family planning service guided by nurses at the clinic on the basis of repeated abortion experience, the type of abortion procedure- first and second trimester and availability and capacity to respond the interview raised by the researcher concerning the overall lived experiences of women before, during and after practicing induced abortion.

3.4.2 Methods of Quantitative Data Collection

Household Survey: A survey is a method of obtaining a large amount of data, usually in a statistical form, from a large number of people in a relatively short time (Mcneill and Chapman 2005:39). In other words, survey is the only way we can measure motivation, attitudes, beliefs, feelings, perceptions and expectations by asking research participants (Corbetta 2003:126).

Moreover, the household survey enables the researcher to collect information about the process, experience and context of abortion from the larger society in order to generalize to the broader population. In developing countries where information recording and keeping is very fragile and unreliable, household survey is an important tool (Edmeades *et al.* 2010; Ansah and Jackson 2013). Therefore, this study employed the household survey which is a major tool used to collect facts and information. The household survey tool principally assessed the knowledge of the community regarding type of abortion, reason and consequence of abortion and abortion law, contextual factors that determine abortion decision and attitudes of the community towards abortion. The questionnaire also employed Likert scale method having five item responses of "strongly agree", "agree", "undecided", "disagree", and "strongly disagree" (Crano and Brewer 2002). Hence, responses to these items are summed up to create an overall score for each respondent. Then, according to Kothari (2004), cutoff point of the total score of respondents' was set based on neutral value. In other words, 10 items x 5 highest score, 10x3 medium score and 10x1 lowest score. If the score happens to be bellow neutral value, it shows unfavorable opinion towards a given point of view whereas if the score falls above, it shows favorableness towards an object whereas the neutral value remains the same.

SABAS developed by Shellenberg *et al.* (2013) was used to measure community level stigma towards abortion. The tool applied in Ghana and Zambia to measure negative stereotypes about people associated with abortion and people having induced abortion (Cockrill 2013). Further testing is going on in Uganda, Kenya and Mexico. This scale consists of three important dimensions of abortion such as negative stereotypes about men and women who are associated with abortion, discrimination/ exclusion of women who have abortion, and fear of contagion as a result of coming in contact with a woman who has had an abortion (IPAS 2011). Then, the

response categories of SABAS scale (stigmatizing attitudes, beliefs and action scales) was set to form based on Likert scale ranging from strongly agree to strongly disagree. There is no cut off point for stigma scale (IPAS 2011).

For the sake of validity of the study, besides triangulation of various methods, pilot test was conducted prior to data collection with 20 respondents from the community members after the questionnaire was translated into Amharic and then the survey instrument was corrected by adding, deleting and/or rephrasing some items.

Moreover, internal consistency reliability test (Cronbach alpha) of the instrument of attitudinal scale was checked through SPSS with coefficient alpha of 0.7. Finally, the necessary data for the survey was collected by employing interviewer administered questionnaire as it explores important information from research participants by the trained data collectors.

3.5 Sampling Design

3.5.1 Probability Sampling Design

Quantitative research was used to understand the attitude of the community towards abortion and women having induced abortion. Therefore, sample survey was conducted to collect quantitative data regarding the attitude of the head of households towards abortion.

In this case, probability sampling technique was employed in the sample survey for quantitative data collection from sampled head of households. The type of sampling technique employed in survey part under the current study was a multistage stage (two stage sampling). In the first stage, two *kebeles* i.e Yeju Genet (04) and Debre Gelila (03) were selected out of five urban *kebeles*) through lottery method. Due to shortage of time and cost it was impossible to cover the

whole five kebeles. In the second stage sampling, households in the two selected kebeles in the first stage were sampled as follows: First, sample size was determined by Yamane's sample size determination formula of $n=N/1+ N (E)^{2}$ at 95% confidence interval for the total population of 1360 households where 560 for Yeju Genet and 800 for Debre Gelila respectively yields a sample size of 310 households. Finally, 128 and 182 households were selected through a multiple proportion of each *kebele* (P) calculated through n/N *sample size. Then, by using SPSS random sampling method, head of households were selected from the given sample frame. Accordingly, a structured questionnaire which includes both closed ended and open-ended, and items of likert scale were prepared and distributed among sampled households whereby heads of each households filled the questionnaire with the help of the researcher and data collectors (4 in number), who collected the required data, for 24 days by using interviewer administered questionnaire. For this study head of household is defined as a person who economically supports or manages the household or for reasons of age or respect, is considered as head by members of the household or declares himself as head of a household (CSA 2012). Moreover, this study applied the definition of household head as the one who is currently living together with the family and has an authority to control them, on whom the rest members of the family assumed to be depend and generally, who the family members were considering as their representative. The data collectors used HEWs to show the selected heads of households during door to door visit. However, due to absent or unwillingness of husband/male household heads, most female household heads replaced their male household heads and responded the questions provided in this study.

3.5.2 Non-Probability Sampling Design

The informants for the qualitative research were recruited by purposive sampling technique. In doing so, participants were selected based on characteristics they possess or their availability to participate (Vanderstoep and Johnston 2009). In this regard, purposeful sampling was employed to select participants (women who experienced induced abortion) during post abortion care and cases with individuals during family planning service guided by healthcare providers (nurses) to explore deeper meaning of the subject. The close relationship with healthcare providers enabled the researcher to develop rapport and intimacy with clients. Finally, the researcher set inclusion criteria to recruit participants. In doing so, in terms of marital status, married, unmarried and divorced and widowed clients were included since the study considered the attitude of community towards abortion practice and it enables the researcher to get rich and diverse data from different perspectives. Moreover, both first and second trimester abortion procedure was considered to examine the effects across clients. Finally, samples were selected through non-probability (purposive) sampling techniques based on availability, and the assumption that they can better explain the issue at hand. However, the there are no fixed rules for sample size in qualitative research because sampling is determined when data is saturated i.e when the researcher is no longer see or hear no new information or when it adequately address the study objectives (Simon 2011).

Finally, key informants based on their willingness, availability and knowledge of the issue and the community's sociocultural values on abortion and motherhood, healthcare providers (nurses), community elders, HEWs, religious leaders, lawyers working in courts and officers in women and children affair were selected purposively.

3.6 Procedures of Data Collection

Before going to field and directly starting data collection, the researcher delivered the letter of cooperation given by Department of Sociology of AAU to Woldia Town Administration office and Woldia FGAE branch. Upon the consent of the respective offices, the researcher and four data collectors, where three of them were university teachers and the one was from Woldia Town having an experience in data collection, oriented and trained by the researcher and they collected the data from respondents on the due date from Feb 21/06/2009 E.C up to March 15/07/2009 E.C. However, the overall data collection was held from Feb 21/06/2009 E.C up to March 29/07/2009 E.C. The qualitative data was exclusively collected by the researcher since the issue is complex and sensitive; nevertheless, the quantitative data was collected by trained data collectors at household level guided by the researcher. Despite an effort was made to perform audio recording during data collection, but only four of the informants were willing to be recorded. While the rest were unwilling though they were informed about the purpose of the study.

The timing of data collection from women having induced abortion varies from one researcher to another. For some, data collection is done while women were undergoing abortion procedure while others employed from two weeks up to three months after the abortion is performed (Michault and Pellet 1975 and Miller 1992 cited in Dollar 1997) respectively. Based on this, this study took the position of Miller (1992) to examine the factors affecting women's decision on abortion and lived experience before, during and after abortion through IDIs during post abortion care. However, the researcher employed case study with individuals so as to explore the overall lived experience during family planning service so as to get those women experienced abortion in the previous times. As such, this enabled the researcher to explore the lived experience of

women with diverse time frame. In doing so, the researcher contacted the head of FGAE Woldia branch with letter of cooperation in order to get permission and consent on the issue under investigation. Work with the healthcare providers (nurses) closely helped the researcher to create intimacy with the clients in order to get trust from them. Through the help of healthcare providers and by using convenient sampling technique in post abortion care and family planning service, the researcher approached clients by introducing the purpose of the study and then interview was held at a separate room provided by the institution about the overall lived experiences of clients with an average of one hour.

3.7 Operationalization of Concepts

Table 3.1: Operationalization of Core Concepts of the Study

Concept	Variable	Indicator	Measurement
	Independent variables		
Age	Age	Age of respondents in years	Age in years ▪ Interval /ratio
Marital status	Marital status	Marital status of respondents	Married, unmarried, divorce, widowed ▪ Nominal scale
Sex	Sex	Sex of respondents	Male/female ▪ Nominal scale
Religion	Religious affiliation	Religion of respondents	Naming types of religions ▪ Nominal scale
Family size	Family size	Actual family size in the household	Count the number of responses ▪ Interval and ratio
Social class	SES	Total annual income+ level of education attained +type of profession/occupation	Lower, middle and upper SES ▪ Ordinal scale
Socio-cultural discourses	Moral, religious medico-legal discourses and stigmatizing beliefs	Based on total scores on certain statements reflecting the attitude of the respondent (Likert-scale to measure attitude	Likert scales ▪ Ordinal scale
Dependent variable			
Attitude towards abortion	Attitude of people towards abortion practice	Likert scale to measure the attitude towards abortion practice and experience or own rating of the respondents	Likert scale ▪ Ordinal scale

3.8 Methodological Triangulation

Abortion is one of the complex and dynamic phenomenon to be dealt in terms of its sociocultural context. Triangulating data sources of a study is used for seeking convergence across qualitative and quantitative data. Hence, to better achieve the objectives of this study, it is plausible to triangulate using primary data collection methods. Accordingly, summarized and triangulated version of primary data collection methods, with their respective specific objectives, unit of analysis and data sources was indicated in the table below.

Table 3.2 Methodological Triangulation

No	Objectives of the study (For what purpose?)	Unit of Analysis (About what?)	Unit of observation (From whom?)	Method of data collection How?	Method of data analysis
1	To assess the practice of abortion in the study area with a particular reference knowledge and experience of community	Knowledge, context and experience of community	A. Sample household, B. health workers C. FGD discussants	I. Household survey II. secondary sources III. FGD	• Descriptive statistics (mean frequency distribution percentage etc.) ▪ Thematic analysis
2	To examine the influence of socio-cultural discourses on the attitude of head of household towards abortion practice	Socio-cultural discourses [religious, moral, legal, medical]	A. Sample households B. Elderly C. Health professionals D. Women's affairs E. Courts F. FGD discussants	I. Household survey II. KIIs III. FGD	1. Descriptive statistics and inferential statistics (multiple regression) 2. Thematic analysis
3	To examine factors that influence decision on abortion and negotiation strategies of women within the existing discourses	structural factors and negotiating Strategies	i. Women ii. Health care providers	IDIs KIIs	Thematic analysis
4.	To examine the lived experience of women before, during and after having induced abortion	Lived experiences	Women	I. Case study II. IDIs	Thematic analysis

3.9 Method of Data Entry and Analysis

Data analysis is a systematic search for meaning. Analysis means organizing and interrogating data in ways that allow researchers to see patterns, identify themes, discover relationships, develop explanations, make interpretations, mount critiques or generate theories (Hatch 2002 in Nalenga 2012).

3.9.1 Qualitative Data Analysis

The qualitative data which were collected through KIs, IDIs and FGDs were summarized and analyzed using thematic analysis. That means, qualitative data analysis involves organizing data, breaking it into manageable units, synthesizing it, searching for patterns, discovering what is important and what is to be learned, and deciding what you will tell others (Bogdan & Biklen 1982 in Simon 2011). As a result, about 46 pages of the qualitative data resulted from note taking activities and audio records were transcribed, categorized and organized based on pre-coded and emergent themes (as per study objectives) and changed into meaningful patterns. Finally, according to Finlay (2011) the qualitative data was analyzed through such steps like reading and re-reading the original transcripts, reconstruct the content into significant statements, extract significant statements- identify themes (emergent or pre-coded themes), make meaning and integrate results with the essence of the phenomenon and then triangulated concurrently alongside with the quantitative data.

3.9.2 Quantitative Data Entry and Analysis

On the other hand, the quantitative data collected through the use of questionnaire was entered into SPSS version 20 after cleaning and recoding (non- pre-coded) and then analyzed

descriptively and inferentially between and among variables. To this end, both descriptive and inferential statistics were used. Descriptive statistics was employed to describe, the background information of respondents, the knowledge, experience and contexts of community towards abortion practice by using frequency distributions, percentages, mean and measure of dispersions. Finally, inferential statistics was computed to draw conclusions about the target population. Accordingly, correlations and regressions were computed so as to address the objectives of this research and to predict the socio cultural discourses upon the dependent variable.

Finally, the results of the quantitative and the qualitative data were compared (identify and merge common data sets, sort out differences, and work out transformation of data sets wherever it deemed logical) with each other so as to ensure depth of analysis across methods and data sources. However, negotiating strategies of women in abortion decision, lived experience before, during and after abortion and resilience mechanism of women obtained from IDIs and case studies were put separately and analyzed through narration method to provide detailed and further explanations about the issue of induced abortion from the women's unique perspective. Moreover, qualitative data triangulation method was employed in order to enrich the finding of the study.

3.10 Field Challenges, Experiences and limitations from the Study

While conducting this study, I have faced some field challenges as a novice researcher. The first challenge comes from the researcher himself. The interview skill regarding sensitive issues like abortion especially with women during and post induced abortion; the way they express their feeling and want to withdraw disturbed and shocked me. At that time, I interrupted the interview

session and let them withdraw from it. But later on, I learned lessons how to manage the situation by consulting healthcare providers. Concerning the survey, initially most respondents especially elders were unwilling and dislike the issue of abortion as it is believed to be abnormal and immoral. Then, the researcher just went with HEWs to get rapport and familiarity. The researcher could not use audio materials and recording in both qualitative interview and survey since most participants feared and suspected then the researcher was compelled to jot down important field notes and later on I have tried to organize them systematically based on their order of importance and contents. Despite challenges, I got good lessons and conducted this study successfully.

Regarding the limitation of the study, it is difficult to generalize the finding of the study to the whole population by taking two kebeles and few participants experiencing abortion within a single point in time studies about the practice of abortion and community response. As a result, the study did not explore the long term effects of abortion upon women's lives. Theoretically, I failed to integrate agency structure with psychological theories to explore the lived experience of women before, during and after abortion experience with regard to their level of stress and traumatic disorder.

3.11 Ethical Considerations

In research, the goal of ethics is to ensure that those participating in the research are not harmed or suffer adverse effects. Particularly, a sensitive issue like abortion needs careful considerations to ethical concerns. After obtaining formal letter from Addis Ababa University, department of Sociology, the researcher went to the study area contacted the Town Administration governing

body to get permission. As a result, prior to data collection, it was worth taking the consent of the FGAE and private clinics and other concerned bodies in the community.

Informed consent, therefore, was seriously considered where it is a process by which a study participant voluntarily confirms his or her willingness to participate in a particular trial/study, after having been informed of all aspects of the trial/study that are relevant to the study participant's decision to participate (Abiy Zegeye *et al.* 2009). In this regard, the objective and purpose of the research was clearly communicated to participants and also let them know to withdraw if they get discomfort in the process of their participation. Hence, the researcher and the study participants had a mutual trust and they were not misused each other.

Moreover, regarding anonymity and confidentiality, throughout the research process, the identity of the participants has been kept confidentially. In doing so, the actual names of the participants were never written on the audio tape and other related materials. Rather, the researcher used various mechanisms while coding such as demographic variables like age, sex, socio economic status and the so on.

The principle of no harm was considered despite no incentives to respondents and participants; nevertheless, there was refreshments given to FGD participants for tea breaks and financial support to three in-depth interviewees (100 ETB) each who were housemaids and could not to afford abortion fee.

CHAPTER FOUR: DATA PRESENTATION, ANALYSIS AND INTERPRETATION

As indicated hitherto, this study intended to examine the interface between practice (the lived experience of women having induced abortion) and the community response by using agency structure theory. To this end, the primary data obtained from household survey, key informant interview, FGD, in-depth interview and case studies were presented, analyzed and interpreted. The findings of the study were discussed in line with the specific objectives and then analysis and interpretation was done by using concurrent triangulation model though some qualitative themes were analyzed separately.

4.1 Socio-Economic and Demographic Characteristics of the Respondents

As table 4.1 below depicts, 137(44.2%) male and 173(55.8%) female respondents involved in the study. Due to unavailability and lack of interest to participate in the study on the males' side, female participants became more in number. With regard to age of respondents, majority of the respondents' age group was found to be from 35-45(46.1%) followed by 24-34 and 46-56 that comprised of 24.2 % respectively. while the remaining 57-67 and >=68 with 3.9 and 1.6 % respectively. The mean age of respondents' was 41.33 which are adult productive forces [1]in the country. With respect to marital status, majority of respondents, 210 (67.7%), were married followed by (23.5%) unmarried. The remaining 6.5 and 2.3 % were divorced and widowed respectively.

The study involved 226 (72.9%) Orthodox Christians followed by Islam (21.9%) and the remaining 4.2 % and 1 % were Protestant and Catholic respectively. This was perhaps because Orthodox Christianity is the most dominant than others in North Wollo Zone (CSA 2007).

[1] Age groups ranges from 25-59 represents adult age and productive force

Concerning the household family size, majority was found to be under the category of 3-4 (41%) followed by 1-2(28.1%).

As table 4.1 below depicts, 87(28.1%) were diploma holders, 73(23.5%) degree and above, 69(22.3%) secondary school completed, 41 (13.2%) read and write, 29(9.4) primary school completed and 11(3.5%) unable to read and write. Finally, regarding the main source of income, trade was the main livelihood strategy for most respondents followed by government employment.

Table 4.1: Socio-economic and Demographic characteristics of Respondents

Characteristics		**(N=310)**	**Percent**
Sex of respondents	Male	137	44.2
	Female	173	55.8
Age of respondents	24-34	75	24.2
	35-45	143	46.1
	46-56	75	24.2
	57-67	12	3.9
	68 and above	5	1.6
Marital status	Married	210	67.7
	Unmarried	73	23.5
	Divorced	20	6.5
	Widowed	7	2.3
Religious Affiliation	Orthodox Christian	226	72.9
	Islam	68	21.9
	Catholic	3	1.0
	Protestant	13	4.2
Household family size	1-2	87	28.1
	3-4	127	41.0
	5-6	73	23.5
	7 and above	23	7.4
Educational level	unable to read and write	11	3.5
	read and write	41	13.2
	primary completed	29	9.4
	secondary completed	69	22.3
	Diploma	87	28.1
	degree and above	73	23.5
Main source of income/livelihood	Trade	132	42.6
	Government employee	113	36.5
	daily laborer	15	4.8
	Remittance	22	7.1
	NGO/private employed	24	7.7
	Others	4	1.3

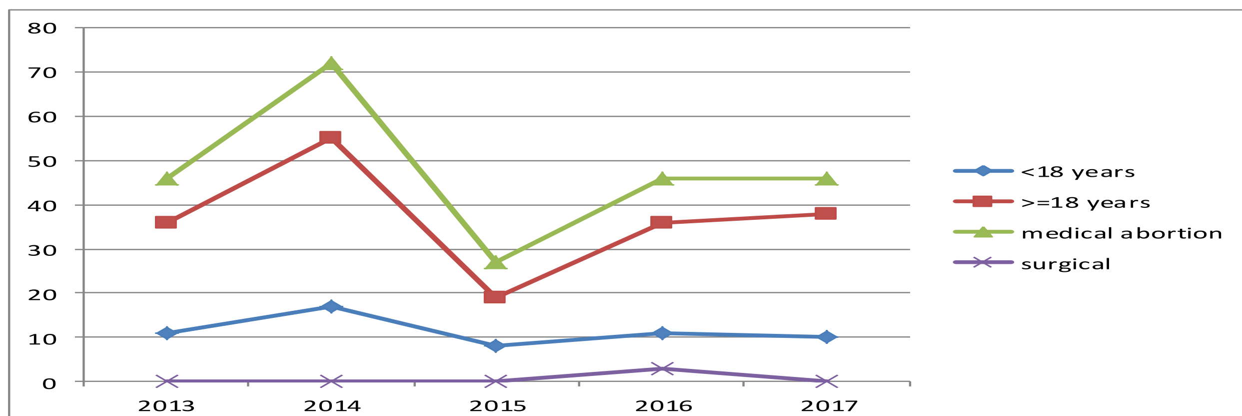
Source: Sample survey at Woldia Town, 2017

4.2 The Practice of Abortion in the Study Area: Knowledge/Awareness, Context and Circumstances

4.2.1 Knowledge and Awareness of the Community towards Induced Abortion

As table 4.2 below depicts, respondents were asked which kind of pregnancy termination they knew in the area. Accordingly, majority of the respondents 181 (58.4%) said that safe abortion practices performed in healthcare centers was the most common practice. Moreover, unsafe abortion practice which accounted for 101 (32.6 %) was still a common practice in the study area. Only 28 (9%) of the respondents knew about spontaneous abortion.

Regarding the people's preference of institutions (place of pregnancy termination), majority of the respondents said that most of the unwanted pregnancy was terminated in private clinic (50.8%) followed by traditional practitioners (35.3%), government hospital (34%), NGO health clinics (33.7%) and government health post (24.3%) respectively. Thus, safe abortion was a common practice in the study area. Moreover, the secondary data obtained from FGAE clinic consolidated the fact that safe abortion practice has been slightly increasing from time to time. Hence, the trend of abortion practice in FGAE clinic from 2013-2017 per month is illustrated in the following line graph.



Graph 1: Trend of Safe Abortion Practice from 2013-2017 at FGAE, Woldia Branch

From the above line graph one can understand that adolescents (<18 years) and adults and their preference of medical abortion slightly increased from time to time except in 2015, where the clinic was under construction. As a result, clients were not interested in the service provision of the clinic as they feared exposure and privacy. Besides, surgical abortion was getting to null because of logistic reasons (lack of standard equipment and trained professionals) in the clinic.

One of the kebele health extension workers said the following about safe abortion:

> *Though unsafe abortion is still performed secretly, most women terminate unwanted pregnancy in health centers especially in private and NGO health centers so as to get quality service and to escape from societal reaction. The reason behind is that most people get information about reproductive health and associated risks in various scenarios such as in health packages. As to my experience when I worked in private clinics, a lot of women terminated their unwanted pregnancy due to various reasons. Most people do not prefer hospital for two reasons: the first is they fear others [*not to be seen by others*] and the other is the service is not given in hospitals* (female Key informant, age 23).

The above quotation agrees with IPAS (2016) that says women's preference for a place of abortion largely depends on privacy, cost and an ability to control their image.

Respondents were asked reasons of pregnancy termination. The response was such that 52.8% of the respondents thought that the people terminated pregnancy due to fear of societal stigma/judgment/, 49% for economic reason, 39.5% for fetal abnormality and 37.5% for a health threat to mother. Thus, social stigma and economic reasons were found to be the most important factors to terminate pregnancy. Results of FGD with household heads also confirmed that societal stigma and reactions followed by economic reasons played a great role in pregnancy termination. One of my FGD discussant narrated:

> *There is a strong reaction by the community against induced abortion. They labeled women as 'dikkalawolaj' [giving birth illegitimately] in local language if they bear a child before wedlock and outside of marriage. Besides, most women terminated their pregnancy due to economic reasons. Imagine that a lot of babies were born and thrown in the back streets (ditches) mainly due to the fear of societal reactions and economic reasons* (FGD, Male).

One elderly key informant also added:

> *According to the real existing situations, abortion has been performed both by couples and non-couples -especially students and 'setegna adariwoch' [commercial sex workers]. One of the reasons towards terminating pregnancy is stringent socio-cultural values where bearing a child without marriage produces labeling such as illegitimate birth (dikalawolaj), 'yesetlij', 'balege'(indecent) , 'abatu yemaytawoq' (whose father is not recognized) and so on. As a result, induced abortion is the last resort to terminate unwanted pregnancy. Another most important factor is economic reason* (female, age 56).

On the contrary, the FGD results conducted with youths showed that economic reasons were the top pressing issues for women experiencing abortion. One of the participants in FGD put his suggestion as follows:

> *There are several factors that aggravate women to terminate unwanted pregnancy such as lack of trust between sexual partner, family reaction, economic reasons, bearing a child before marriage (wedlock) is the cause of societal reaction and labeling. Besides, most girls performed abortion because they believed that bearing a child at early age is an obstacle for getting a husband since men do not want to marry a woman having a child before marriage. However, the main reason is lack of economy followed by societal pressures against those who perform abortion* (male, age 22).

Generally, survey results and most women during the in-depth interview indicated that economy, family pressure and social reaction predominantly triggered women to end pregnancy. In this

regard, it was important to see cross tabulations across socio-demographic characteristics with possible reasons of pregnancy termination. In doing so, for instance, for age groups 24-34 and 57-67 social stigma followed by economy and for those in the range of 35-45 and 46-56 economic followed by societal reaction were the main factors in pregnancy termination. However, for the age group 68 and above health status and condition determines reason for termination. Females were more sensitive than males to the reasons of pregnancy termination. As a result, for males societal reaction was the most important reason while for females economic reason was found to be critical for pregnancy termination. With regard to marital status, for married and divorced economy and fear of social reaction and for unmarried and widowed fear of social reaction followed by economy determines reason for pregnancy termination. Finally, religious affiliation affects abortion. Hence, societal reaction and economy played a central role for Orthodox Christianity followers while health, economy and societal reaction equivalently impose Muslim religion followers to end pregnancy. For the remaining religions, it was more or less indifferent (see appendix 3.1).

Respondents were also asked about the problems (consequences) of abortion in general. Therefore, 66% and 54.5% of the respondents reported that abortion causes health problems and death respectively. The remaining 27.1 % said societal stigma (enacted stigma) and 7.7% did not know about the consequences of induced abortion respectively. For more than half of the respondents, abortion brings health problems and death followed by social stigma. One of the healthcare providers put his justification about why abortion causes health complications:

> *Abortion can be performed in safe or unsafe way. Though now a day people's practice towards safe abortion is better than the previous, there are still unsafe abortion practices that are performed in secret in unclean environment, unskilled personnel and*

less standard equipment. This might cause health complications and maternal mortality. Of course, safe abortion can also cause continuous bleeding (hemorrhage) and related health problems especially if the procedure is performed after 3 months. Indeed, repeated abortion and unsafe abortion exposes both short term and long term effects including bleeding, death and even infertility (male key informant, age 29).

Another health extension worker added:

If a pregnancy is more than three months and performed in an unsafe manner, it will be a health threat to mother such as may cause a serious bleeding, ectopic pregnancy and other related problems. As a result, spontaneous abortion may occur if the fetus gets infected (Female key informant, age 23).

Concerning the social dimension, abortion has a multiplier effect upon the woman's lives and the family in general. A woman who experienced induced abortion narrated about the societal stigma, stereotype and reactions in her own words as follows:

There are bad words from my neighbors and my work place. They insulted me as an arrogant, killer and murderer. I always felt embarrassed and sometimes I cry. Only God knows my situation. I am a housemaid (domestic worker). Life is miserable and I may not be married in the future because the community sees me in a bad manner (Unmarried and housemaid, age 24).

Moreover, the FGDs with household heads verified that most women practicing abortion faced societal reactions such as gossip, sometimes insulting despite no more discrimination. Now a day, discrimination from various social life activities is quite decreasing since abortion (safe) is common particularly at private and NGO health centers but people had more reaction to those who performed abortion clandestinely.

Table 4.2: Knowledge and Awareness of Sample Respondents about Abortion

Variables	Responses	F	%	F(multiple response)
What kind of pregnancy termination do you know currently in the area?	Safe	181	58.4	
	Unsafe	101	32.6	
	Spontaneous	28	9.0	
	Total	310	100.0	
In which place do women terminate unwanted pregnancy? **(Multiple response is possible)**		Frequency (N=310)	Percent of responses	Percent of cases
	government hospital	105	19.1%	34.0%
	government health post	75	13.6%	24.3%
	NGO health centers	104	18.9%	33.7%
	private health clinic	157	28.5%	50.8%
	traditional practitioner	109	19.8%	35.3%
	Total	550	100.0%	178.0%
What do you think that the reasons why women terminate pregnancy? (multiple response is allowed)		Frequency (N=310)	Percent of Responses	Percent of cases
	Economic reason	154	27.7%	49.8%
	Health threat to mother	116	20.9%	37.5%
	Fetal abnormality	122	22.0%	39.5%
	fear of societal reaction/stigma	163	29.4%	52.8%
	Total	555	100.0%	179.6%
What problems do you think that women face after terminating pregnancy? (Multiple responses is possible)		Frequency (N=310)	Percent of responses	Percent of cases
	Health Problems	205	42.5%	66.1%
	Death	169	35.1%	54.5%
	Societal Stigma and Reaction	84	17.4%	27.1%
	I Do not know	24	5.0%	7.7%
	Total	482	100.0%	155.5%

Source, sample survey of Woldia Town, 2017

4.2.1.1 Knowledge of Respondents on the 2005 revisions of the country's abortion law

As table 4.3 below depicted, 141(45.5 %) respondents had information about the revised abortion law whereas 169 (54.5%) did not have any sort of information. Thus, majority of the respondents were not aware of what abortion law says at all. Most of the participants in the FGD did not have any idea what abortion law and what it actually says. However, only few discussants had information about abortion law in general and the revised law which legalized

abortion when it is rape and incest, health threat to mother and fetal abnormality. Furthermore, the crosstab between sex of respondents and knowledge on abortion law showed that 58(137) male respondents and 83 (173) female respondents had information about the revised abortion law. This implies that men did not have any sort of information than women (see appendix 3.2).

Furthermore, those respondents who said they know the abortion law were asked their opinion concerning the revised law. As a result, out of 141, 67(48%) believed that it is sufficient, 23 (16%) said it violates the norms of the society and 51 (36 %) said insufficient/does not consider all social factors. This implies that most of the respondents believed that the existing law endorsed by the government is enough because if it were liberalized more, they claimed that it will violate the fundamental societal values and norms that bind the society together. In contrast, among those who believed abortion should be legalized (n=141), 51 (36%), of the respondents and most of the FGD participants, conversely reasoned out about the revised abortion law. Because most FGD participants of this study confirmed that regarding the health aspect, the law is sufficient and important that prevents maternal mortality. But concerning the economic and other social dimensions yet the law has the gap. Due to financial reasons and poor living standard and service unavailability and inaccessibility at government hospital and unwillingness of providers in giving the service, lots of babies were thrown in backstreets. Besides, restricting abortion law invites to some women perform unsafe abortion which causes maternal mortality. One of my FGD participants elaborated the issue as follows:

> *Women have the right to terminate unwanted pregnancy if they are not ready to continue it. Women are constrained by the existing normative structures such as patriarchal system, family pressure and societal values. Society believes that women are child bearers so that the revised abortion law should be re-considered. Otherwise,*

> *many women will be victims of unsafe abortion and miserable life situations* (female, age 45).

Another key informant further added as follows:

> *The revised abortion law does not consider the women's right because women have their own valid reasons in economic, social and educational aspects. Limited grounds on which abortion may be allowed are not enough and in fact very stringent which deter women to exercise their rights. Therefore, the law is more of a conservative reflection of the society and against social dynamism at expense of the pregnant women's right of choice, privacy and liberty. It is not enough for the law to allow abortion in principle and only in some limited circumstances* (Lawyer, age 35).

The above quotes and survey results agree with Tsehai (2008) who says that the revised law disregards the social dynamism and segments of population at risk such as commercial sex workers, persons with HIV/AIDS and other victims.

4.2.1.2 Legalization of Abortion

Legalization of abortion is one of the contending issues. Some believe that liberalizing abortion provides a woman full autonomy to terminate unwanted pregnancy and access to safe and legal abortion thereby it can save the women's life and equality (Human Right Watch 2005). As the following table 4.4 shows, respondents were also asked whether abortion should be legalized. Majority of respondents, 183 (59%), believed that abortion should be legalized. Whereas 127(41%) of the respondents did not believe abortion to be legalized.

As FGD with male and female household heads and some key informant interviews with lawyers and women and children affair officers results showed, abortion should be legalized as unsafe abortion practice clandestinely practiced by most commercial sex workers, women with

poor economy and other victims. In doing so, unsafe abortion practice is still a stubborn problem. For example, one of my key informants from the elderly segments of the population narrated her opinion about the legalization of abortion as follows:

> *I personally believe that abortion should be legalized since unsafe abortion can be performed at any time. For example, there are situations other than rape and incest, health threat to mother that compels abortion such as economic and social/psychological reasons. At this time, legal abortion should be allowed. If abortion should not be allowed, most women will be vulnerable to various unwanted life experiences such as discrimination* (Female key informant, age 56).

Conversely, various religious positions more or less had negative reactions towards abortion and its legalization. In doing so, from the Islamic point of views, one of the Muslim religious leaders put his claims towards abortion as follows:

> *The issue of abortion is not directly addressed in Quran. It has been yet a point of debate among several religious leaders. Some believed that abortion is strictly forbidden in religion (Qur 77:21). Still some argued that abortion is permitted only when the life of the mother is in danger. However, in Hadis, the practice of abortion is allowed up to 120 days, where it is a threat to mother and difficult life situations, as the fetus is not a soul. Out of this due time, performing abortion is* ***haram*** *[forbidden in religion] and it is an act of killing an innocent person* (Male key informant, age 72).

Similarly, a 50 year-old key informant from Orthodox Church further added that

> *Abortion is strictly for bidden in our religion; it is clearly stated in Feteha Negest [2]article 47 about the act of killing an innocent person both consciously or unconsciously. Even, spilling sperm on the ground is strictly forbidden (Genesis 38:1)*

---

[2] **ፍትሐ-ነገስት** (Law of kings) is a legal code compiled around 1240 by the Coptic Egyptian Christian Writer, Abul Fadail Ibn AL-Assal and translated into Geez in Ethiopia.

and Exodus (23:26) there shall nothing cast their young, nor be barren in the land. So, legalizing abortion would invite the generation out of the religious doctrines and this induces them to follow western life styles. Rather the government should prohibit laws that promote abortion practice. In bible, even 'zimut' [fornication] is strictly forbidden. In our religion, conception starts at 40 days; so does the soul (male key informant).

Another key informant from Protestant church strengthened the above ideas as follows:

I am completely against legalization of abortion because God created man to be multiplied on earth. Killing an innocent person is an act of crime. And it is also sinful act. Human beings are respected creatures. In bible, Ezekiel 18:4 clearly indicated that "all souls are mine; as the soul of the father, so also the soul of the son is mine: the soul that sinneth (sinner), it shall die". Our church has a strong position not only abortion but also family planning because the soul of several babies is crying towards God (Male, age 58).

From the above quotes it can be understood that legalization of abortion is strictly forbidden except in Islamic religion where abortion is allowed up to 120 days. Hence, the practice of abortion and legalization is castigated and religiously forbidden. Moreover, cross tab was computed so as to see the relationship between sex of respondents and opinion of legalization of abortion. In this regard, 76(137) male and 107(173) females believed that abortion should be legalized. Hence, about 55% and 62 % of male and female respondents respectively believed in abortion legalization. This implies that more than half of the respondents believed that abortion should be legalized but females were more eager than their counterparts (see appendix 3.3).

Respondents were also asked under what conditions abortion should be legalized. In this regard, 88(48.4%) claimed that abortion should be legalized to prevent maternal mortality, 64 (35.2%) if a pregnant is a minor and approved by recognized officials, 57(31.3%) in case of rape that is legally approved and reported, 33(18.1%) were upon the desire and request of a woman,

17(9.3%) were not quite sure and 2(1.1%) stated other justifications. Thus, majority of the respondents believed that legalization of abortion was important to save the life of the women and decrease maternal mortality due to unsafe abortion practice followed by minor age and rape. The FGD results also showed that abortion should be legalized since there are a number of abortion practices at home by using traditional methods such as drinking Coka Cola and taking drugs such as ampicillin.

Table 4.3 Respondents' Awareness of the Recently Revised Abortion Law of Ethiopia

Variables	Responses	Frequency	Percent	Multiple response(F)
Do you have information about Ethiopian 2005(1997 E.C)) revised abortion law?	Yes	141	45.5	
	No	169	54.5	
	Total	310	100.0	
What is your opinion about the revised abortion law if yes?	I believe it is sufficient	67	48	
	I oppose as it violates norm of the society	23	16	
	I think it is insufficient/does not considers all social factors	51	36	
	Total	141	100	

Table 4.4: Respondents' Opinion about Legalization of Abortion

	Responses	F	%	
Do you believe that abortion should be legalized?	Yes	183	59.0	
	No	127	41.0	
	Total	310	100.0	
Under what conditions do you think that abortion should be justified? Multiple response is possible		F (N=183)	Percent of responses	Percent of cases
	In case of rape that is legally approved and reported	57	21.8%	31.3%
	to prevent maternal death	88	33.7%	48.4%
	if a pregnant is a minor approved by recognized officials	64	24.5%	35.2%
	up on the desire and request of a woman	33	12.6%	18.1%
	I am not quite sure	17	6.5%	9.3%
	other justifications	2	0.8%	1.1%
	Total	261	100.0%	143.4%

Source: sample survey at Woldia Town, 2017

4.2.2 Abortion Decision, Practice and Contextual Factors

Abortion decision is not an easy process and requires several steps to reach a decision as the decision that affects women's social, cultural, emotional, and spiritual and even physical and economic life (Reardon 2003; Kimport *et al*. 2011).

As depicted in table 4.5, there are factors that influence abortion decision in the study community. Accordingly, respondents were asked which factor mainly influenced their decision. As a result, 120 (38.7%) claimed that religion and morality, 69 (22.3%) said gender norms and relations/roles, 24 (7.7%) said legality issues and 97 (31.3%) said societal stigma and stereotypes. Majority of respondents claimed that religion and morality followed by societal stigma predominantly influenced abortion decision and practice. Moreover, my survey [respondents] identified factors that influence abortion decision such as religious commandments/teachings, societal reactions, health status/health threats to mother, for instance, hypertension, diabetes etc. and fear of death, income and economic status of a family or a woman, family socialization and so on.

A 22 year old woman having induced abortion during the in-depth interview narrated how her religion impacts on her abortion decision as follows:

> *First I checked up the pregnancy test; it was positive result which makes me nervous. It was very difficult to make a decision after checking pregnancy test. I was in tension in deciding to end my pregnancy. Above all else, my religion and morality of killing a baby worried me greatly [enklf nesagn]. I frequently attended church programs that make me more worried; because religious leaders frequently taught us about the sin of killing a baby and the dignity of celibacy. Moreover, both giving birth before wedlock*

and abortion are socially undesirable; I was stressed because I may be socially neglected and isolated.

Another woman during an in-depth interview added that:

> *My husband lives abroad. Unfortunately, I got pregnant without my husband (from another man). I was very ashamed of this. I was in trouble and worried and I don't know to whom I may share my problems. The pregnancy was more than 5 months and the doctor told me that I should continue the pregnancy otherwise it would be difficult to my life. But I decided to terminate it because if my husband knows this our relationship would end. Then I went to private clinic alone and consulted a doctor. However, another problem that worried me was financial problems. The fee for abortion was 4000 birr [ETB]. But, it was a must to perform it* (Married, age 34).

Another key informant interview with healthcare providers strengthened the impacts of structural factors upon the decision of women practicing induced abortion as follows:

> *I have been working as a healthcare provider for 23 years. Out of this, I have been working more than 10 years in providing abortion service. So, as to my experience, most women are interested to be okay for service provision in the first time they came to the clinic. However, some of the women are even in dilemma to decide pregnancy termination. There are situations that put them in dilemma such as economy, religion, societal reaction, fear of health complication, infertility and abortion myths. Particularly, most women get confused due to their religion especially those who are strict in observing their religion's order [akrari]. Yet, they terminated their pregnancy by considering the problems they face* (female key informant, age 58).

4.2.2.1 Barriers to Abortion Practice

Thus, as we can understand from the above quote, religion and morality followed by societal reactions played a decisive role in abortion decision process unlike other socio-economic factors. Religious, moral, legal and medical discourses and structural factors predominantly

influence abortion decision, abortion practice and people's attitude towards abortion. Induced abortion practice can be influenced by the structure and agency (personal factors). To this end, at the micro/personal level, 63(20.5%) respondents thought that conscientious objection of doctors (incompatibility of healthcare providers' moral, religious and ethical perspectives), 57 (18.5%) lack of confidentiality of healthcare providers to their clients privacy and at the structural levels, 100 (32.5%) said that availability of TBAs (unsafe abortion practice), 132 (42.9%) stringent values and norms of the society and 80(26%) cost of abortion fee were the barriers of safe abortion practice in the study population. Yet, strict societal values and norms followed by availability of unsafe abortion practice were the leading factors that deter the practice of safe abortion in health centers.

The FGD results also revealed that there are stringent societal values and discourses that stigmatize and discriminate women having induced abortion. Besides, the ethics of some health providers including conscious objections and lack of confidentiality matters affect the practice of safe abortion practice. Moreover, unsafe abortion is also practiced secretly by fearing reaction of the society.

4.2.2.2 Gender Roles and Abortion Decision

Regarding a decision making about reproductive matters in the family, table 4.5 showed that 237(76.5%) believed that husbands were responsible, 239 (77.1%) wives and 18 (5.8%) children in the decision making concerning when, how many and in what situation children should be born. Thus, women had slightly less decision making power than men. Moreover, respondents were asked whether women have the right of pregnancy termination or not. Nevertheless, only 99(31.9%) responded that women have the right to decide on matters of abortion and unwanted

pregnancy and 211(68.1%) responded that women have no right regarding abortion decision and practice. Besides, as the crosstab between sex of respondents and the right of a woman in pregnancy termination showed, out of 137 male respondents and 173 female respondents, only 48 and 51 respectively believed that a woman has a right to terminate pregnancy by their own interest. This implies that gender role /patriarchal system still dominates in exercising women's reproductive rights (see appendix 3.5). The finding agrees with Evens (2003) who argue the dominant discourses in which men are placed at the center of the universe and women are marginal and have meaning when they are fulfilling roles that are significant for men: as mothers, as partners, as daughters.

The respondents were also asked why women could not influence men in abortion decision and practice. As a result, 113 (53.3 %) believed that abortion is believed to be a sign of illicit sexuality (pregnancy outside of marriage) by women followed by 101(47.6%) male dominancy system (men's power to decision). The remaining 74(34.9%) and 5(2.4%) thought that women are perceived as not leaders in the community and other factors respectively. Concerning the gender roles and patriarchal system in abortion practice, one of the key informants working in women and children office of North Wollo Zone explained as follows:

> *Gender and gender roles are the reflections of the wider society. Still male dominancy is reflected. Men are dominating women in any aspects such as in abortion decision especially in married couples. Women are subordinate to men; hence, women are ashamed of influencing men in abortion decision and consider themselves as inferiors. As a result, the burden is usually on women having less voice than men* (male key informant, age 38).

Another key informant seconded this as follows:

> *Generally speaking, still there are fundamental problems in gender relations though a concerted effort has been done in empowering women and gender equality. However, women are victims in decision making especially in abortion practice and family planning. Only few women decide on such issues especially if a man does not want a child. There is a proverb that is still uttered in the society 'set biyawq bawond yalq', meaning, [no matter how knowledgeable a woman may be, it is a man's word that presides over her]* (female key informant, age 45).

One of my FGD participants explained the influence of a patriarchal system in a different manner; she expressed from her neighbors experience as follows:

> *Despite some improvements, yet women are double victims by the existing patriarchal system [yewondoch yebelaynet]. First and foremost, men are always suspecting women for illicit sexuality. Moreover, if women faced unwanted pregnancy they reject, deny and insulted them by saying 'ene wulej biyeshalehu'[I do not want any child; it is up to you to bear a child] and other similar touching slangs* (FGD, female, 38).

From the above quotes, it can be understood that gender role and the existing normative structure (patriarchal system) directly and indirectly influence abortion decision and practice in general and women's lived experience in particular.

Table 4.5: Contextual Factors in Abortion Decision Making and Practice

Items /variables	Responses	Frequency	Percent	Multiple response
1. Which factor mainly influence abortion decision in your community?	religion and morality	120	38.7	
	gender norms and relations/roles	69	22.3	
	Legality	24	7.7	
	societal stigma	97	31.3	
	Total	310	100.0	
2. What are the barriers in practicing safe abortion? (multiple response is possible)		Frequency (N=310)	Percent of responses	Percent of cases
	Conscientious objection of doctors	63	14.5%	20.5%
	availability of TBAs(abortionists)	100	23.0%	32.5%
	Lack of confidentiality of healthcare providers	57	13.1%	18.5%
	Stringent values and norms of the society	132	30.4%	42.9%
	cost of abortion fee	80	18.4%	26.0%
	other barriers	2	0.5%	0.6%
	Total	434	100.0%	140.9%
3. Who do you think that responsible for reproductive decision making in family? (Multiple response is possible)	Husband	237	47.9%	76.5%
	Wife	239	48.3%	77.1%
	Children	18	3.6%	5.8%
	Others	1	0.2%	0.3%
	Total	495	100.0%	159.7%
4. Do you think that females have the right to terminate pregnancy by their own?		Frequency	Percent	
	Yes	99	31.9	
	No	211	68.1	
	Total	310	100.0	
		Frequency (N=211)	Percent of responses	Percent of cases
5. What would be the possible reasons why women do not influence men in abortion decisions?(Multiple response is possible)	Male dominance system	101	34.5%	47.6%
	women are perceived as not leaders in the community	74	25.3%	34.9%
	abortion is a sign of illicit sexuality	113	38.6%	53.3%
	other factors	5	1.7%	2.4%
	Total	293	100.0%	138.2%

Source: sample survey at Woldia Town, 2017

4.2.2.3 Circumstantial Conditions in the Preference of Pregnancy Termination

Most researchers found that situational factors played a large role in determining subjects' abortion attitudes and decision of abortion. Moreover, numerous studies found prospective abortion decisions to be situationally dependent (Pickrell and Bardis 2002; cited in Crock 2007). Accordingly, table 4.6 showed the preference of the community in the given situations when

unwanted pregnancy occurred. As a result, respondents preferred their order of preferences from greatest to least as follows: 86(27.7%) preferred and might decide to terminate when unwanted pregnancy is the result of rape and incest, 72(23.2%) if the family is economically very poor and unable to raise a child, 62(20%) when the pregnancy affects physical, emotional and psychological aspects of a woman and her family, 45(14.5%) when there are no conditions under which abortion is acceptable, 27(8.7%) the pregnant women wants to control her body and terminate pregnancy for any reason at any time in pregnancy, and 18(5.8%) the father/husband/ does not want a baby. Therefore, majority of the respondents' preference was rape and incest followed by poverty or economic situation of the family and a woman. Conversely, the father does not want the baby accounted only 5.8% of the respondents' preference.

Table 4.6: Respondents' Preference of Pregnancy Termination in the Given Situations

Under what conditions you would agree or disagree if **someone else** experience unwanted pregnancy and wants to terminate (please put your preferences from the lists given bellow)			
Order	**Responses/statements**	**F**	**%**
2nd	If the family is very poor	72	23.2
1st	The pregnancy is the result of rape and incest	86	27.7
5th	The pregnant women wants to control her body and terminate pregnancy for any reason, at any time in pregnancy	27	8.7
6th	The father does not want a baby	18	5.8
4th	There are no conditions under which abortion is acceptable	45	14.5
3rd	When the pregnancy affects physical, emotional and psychological aspects of a woman and her family	62	20.0
	Total	310	100.0

4.2.3 Experience of the Community towards Abortion Practice

In the table 4.7 below, respondents were asked regarding the community's response towards induced abortion. Accordingly, 56(18.1%) respondents expected that the community had positive

or favorable response, 120 (38.7%) said moderate/medium reactions and 134(43.2%) negative or unfavorable reaction towards abortion practice. Most of the FGD participants from youths also put their views as follows:

> *Abortion is the common practice in our community including the married ones. We youths mostly support the legalization of abortion but the elders are against abortion practice. There are negative reactions such as 'sew yemiferaw sewn naw' [you are labeled as a deviant if you are practicing abortion] even talking about it despite some changes in abortion sigma and reaction.*

One of my elderly key informants further strengthened the above idea as follows:

> *Based on our culture and religion bearing a child before marriage and abortion is strictly forbidden; If you violate such norms and societal values you are labeled as 'gagna, meren yelekekech' in local language [one who violates the cherished values of the society]. Many years ago, when someone practicing abortion, people called them' embededi' in local language [socially excluded, neglected, separated]. But, now a day there is no discrimination from various social services like Idir[3] and religious programs but gossips and reactions* (Male, age 88).

During an in-depth interview, a 34 year-old woman having induced abortion also strengthened the negative reaction of the community as follows: "I have faced negative reactions from my neighbors. They labeled me as 'shermuta' [a promiscuous and immoral woman] and they do not respect me as the previous one and now I got divorced/have been divorced".

In addition, respondents were asked whether they were willing to give social support if a woman asked them after experiencing induced abortion for various reasons. Accordingly, 219(70.6%)

[3] An informal institution created by Ethiopians and an association established among neighbors or workers to raise funds that will be used during emergencies, such as death within these groups and their families (Ayele 2003).

responded that they would be voluntary while the remaining 91(29.4%) would not be willing to support. Thus, majority of the respondents would be voluntary in helping a woman having induced abortion. The open ended questionnaire results indicated that helping and supporting each other is a human nature and they also believed that everybody will face unwanted pregnancy in one's life time. The puzzle of why all this happens was addressed by one of my key informants working in women and children office:

> *Though there were stringent cultural values and beliefs that stigmatized women practicing abortion especially induced abortion, currently there are changes/improvements where people do not totally stigmatize and discriminate women having induced abortion without reasons; rather various considerations were taken into account such as rape, incest, poverty, and related factors. They try to understand the living situations of women/adolescents. However, there is still gossips and rumor in various situations* (female key informant, 45).

From this quote, it can be understood that despite scandals and gossips are evident, the society understands internal and external factors forcing women to abortion. They try to understand the living situations of women/adolescents. However, the FGD and IDI results contradict the above quote as the community's response is more of negative towards abortion and women having induced abortion.

Respondents were also asked why they did not support a woman practicing induced abortion. In doing so, out of 91 respondents, 15(16.5%) claimed that she is adulteress, 54(59.3%) she is murderer, 14(15.4%) she violates cultural values, 37(40.7%) she may encourage other women and the remaining 1(1.1%) identified other reasons.

Besides survey results, FGD discussants added that since abortion is believed to be the act of killing a baby and encourages other women, majority of the respondents were not willing to support abortion practice in their community.

As table 4.7 depicts, respondents were asked what could be done if unwanted pregnancy occurred in their family members. Accordingly, majority of the respondents 155 (50%) would decide to raise, 114 (36.8%) terminate safely, 39(12.6 %) did not know what to do and 2(0.6%) expel from the family the one who experienced abortion. As the FGD result indicated, most people terminated unwanted pregnancy through medical procedures as compared to the past. One of the FGD participants reason out why people use safe abortion practice as follows:

> *Now a day we are aware of family planning and safe abortion practices. Health extension workers always told us about the advantage of 'beteseb mitane' [family planning] and unwanted pregnancy. Health workers taught us how to terminate unwanted pregnancy through medical procedure accordingly. And also we have been discussing about the advantage of family planning and how to handle unwanted pregnancy through 1:5 organization and 1:30 'yelimatbudin' [developmental force].*(FGD, Female).

Respondents were asked a straight forward question whether they would share the problem of unwanted pregnancy and abortion experience to someone else. As a result, 219(70.6%) would share if they experienced the case and the remaining 91(29.4%) did not want to share the case they faced. Moreover, the respondents were asked to whom they would share the problem they would face. Accordingly, 123(58.3%) would share to their family members, 98(46.4. %) to their peers /closest friends, 61(28.7%) to their religious leaders and 3(1.4%) to others. However, the remaining 7(3.3%) were uncertain as to whom they would share. Hence, majority of the respondents would share to their family members followed by their closest friends. One of my

FGD participants reflected the experience of community why they would share to family members and closest friends as follows:

> *Abortion by nature is secret; it would be difficult if you share the story to someone else. If you do not share the case to family members, you will experience burdens, stress and difficulties. If you share to some else [not closest ones], the societal reaction is very high. Therefore, you have to keep secret or tell to your bests such as your family members* (FGD, female).

According to table 4.7, respondents were asked to pinpoint the main reasons why they would not share to someone else if they experience/encounter/ unwanted pregnancy or abortion. In this regard, 42(46%) responded that due to fear of societal stigma/reaction/, 36(39%) fear of expose to others, and 14(15%) fear family reaction. Thus, societal stigma and reaction was the leading factor identified by respondents. In this regard, in-depth interview results confirm the above finding. For instance, one of the interviewee during the in-depth interview having induced abortion narrated the experience of telling to others as follows:

> *I am working as a house maid; I was raped by someone and became pregnant. I did not have any information how and where to terminate. I do not want to tell the case to owners (someone else). [How did you do finally?] I went to my parents, then, my mother told the case to someone else to get money. Then, we went to clinic [private] and paid 1500 birr. The pregnancy was 5 months. It was very painful. Now everybody insults me, no one gives me any respect. If I was not poor and did not tell to others, I would not be ashamed of and stigmatized* (uneducated, unmarried, age 24).

Finally, respondents were asked if they experienced induced abortion in their life times in their family or not. Consequently, 246(79.4%) did not have any experience regarding induced abortion; but, only 64(20.6%) of the household heads said that they faced/experienced induced abortion in one of their family members because of various factors such as economic

reasons/problems/,sociocultural beliefs and health related issues as open ended responses indicated. One of the healthcare providers working for NGO explained the situations as follows from the lived experience of women having induced abortion.

> *As to my experience, a lot of clients terminate their pregnancy due to economic reasons and some due to fear of societal reactions, gossip and stereotypes. Some clients cried if the service they need is not available in our clinic, that is, if the gestation period is more than 12 weeks. If this happens, they told us they could not afford the private clinics. And most are coming alone because they fear the societal reactions and disclosure* (female, age 58).

The FGD results conducted with household level confirmed that the main reasons to terminate pregnancy in their community were societal reactions and economic reasons. Moreover, one of youth FGD participant also strengthened the above justifications in one way or another as follows:

> *In our context, there are many factors that compel women to terminate pregnancy. This includes fear of societal reactions because giving birth before marriage [wedlock] and economic and financial reasons to raise the child. Women /adolescents also think that giving birth before marriage will be difficult to get husband since men do not want them if they have given birth from a prior relationship. However, discussants mainly raise that societal reactions and economic problems were the leading factors* (FGD, male age 29).

There are also reasons that enforce women to experience induced abortion; for instance, the divorce. Here is a narration during in-depth interview about the overall situation why a woman would want to terminate pregnancy:

> *I have three children and I got divorce but unfortunately I started relation with someone else. Then, when I checked up the pregnancy test, it was positive. I was very shocked*

and frustrated because I have no financial capacity to raise my children because I have no job; even he does not help me. Therefore, I was worried and stressed and depressed; but my best friends told me that I can terminate my pregnancy safely at either private clinic or NGO health centers. Then, I did it! I finally got a relief (Zewde, unmarried, age 27).

Table 4.7: Experience of the Community towards Abortion Practice

Variables	**Responses**		**F**	**%**
How do you evaluate the response of the community towards pregnancy termination/induced abortion?	positive reaction(favorable)		56	18.1
	moderate reaction/medium /		120	38.7
	negative stereotype and discrimination		134	43.2
	Total		310	100.0
Will you voluntary if a woman asks you any support after experiencing abortion?	Yes		219	70.6
	No		91	29.4
	Total		310	100.0
What would be your reason/s/ not to support?(Multiple response is possible)	Responses	F (N=91)	% responses	% of cases
	I consider her as adulteress	15	12.4%	16.5%
	she is a murder	54	44.6%	59.3%
	she violates cultural values	14	11.6%	15.4%
	she may encourage other women	37	30.6%	40.7%
	other reasons not to support	1	0.8%	1.1%
	Total	121	100.0%	133.0%
What if one of your family members experiences unwanted /unplanned pregnancy?	Responses		F	%
	she should terminate safely		114	36.8
	she has to raise it		155	50.0
	I just go out her from home		2	.6
	I don't know how could she do		39	12.6
	Total		310	100.0
Will you share the problem to someone else if unwanted pregnancy occurred in your family?	Yes		219	70.6
	No		91	29.4
	Total		310	100.0
To whom you may share the problem you face?	Responses	F(N=219)	% of responses	% of cases
	Family members	123	42.1%	58.3%
	my friends	98	33.6%	46.4%
	for religious leader	61	20.9%	28.9%
	I am uncertain	7	2.4%	3.3%
	Others	3	1.0%	1.4%
	Total	292	100.0%	138.4%
What is the main reason behind not to share your problems to others?	Responses		F	%
	Fear of social stigma		42	46
	It may be disclosed to others		36	39
	family reaction		14	15
	Total		91	100
Have you ever experienced an induced abortion in your family?	Yes		64	20.6
	No		246	79.4
	Total		310	100.0

4.3 The Influence of Socio-Cultural Discourses on Community Attitude towards Abortion practice

Abortion practice is predominantly influenced by various factors such as moral, religious, legal and medical values discourses. These contextual variables that shape the attitude of people towards abortion practice and on one hand and women's choice and autonomy on pregnancy termination and lived experience, which is being implicated within the larger social structure on the other. As a result, in this sub-section, an attempt was made to examine a relation between socio-cultural discourses and community attitude towards abortion practice. The variables measured at interval scales/Likert scales/ such as stigmatizing attitude, beliefs and actions, moral and religious discourses, legal and medical discourses as independent variables were examined with community attitude towards abortion practice as the dependent variable. To this end, Pearson's Product Moment Correlation coefficient and regression coefficient was computed and interpreted accordingly in the following tables.

4.3.1 The Relationship between stigmatizing attitudes, beliefs and actions and Community Attitudes towards Abortion Practice

Table 4.8:- The correlation between stigmatizing attitudes, beliefs and actions and community attitudes towards abortion

Correlations			
		stigmatizing attitudes, beliefs and actions	community attitude towards abortion practice
stigmatizing attitudes, beliefs and actions	Pearson Correlation	1	.341**
	Sig. (2-tailed)		.000
	N	310	310
community attitude towards abortion practice	Pearson Correlation	.341**	1
	Sig. (2-tailed)	.000	
	N	310	310
**. Correlation is significant at the 0.01 level (2-tailed).			

As far as empirical evidences are concerned, most women feared disclosing their abortion practice by fearing the responses of community level stigma including labeling, stereotyping, separating, and discrimination (Cockrill and Nack 2013). Hence, the finding of this study confirms in the table 4.8 above, one can see that there is a statistically significant positive correlation between stigmatizing attitudes, beliefs and actions and community attitude towards abortion practice ($r=0.341$ at $p<0.01$).

The findings of this study supports the hypothesis which states that the more stigmatizing attitudes, beliefs and actions, the more unfavorable attitude people have towards abortion practice. But there is weak positive correlation between the two variables as the value of correlation coefficient lies between 0.1 and 0.5 based on Cohen's (1988) classification of correlation coefficient. When we looked at its coefficient of determination, it is about 12% [obtained by squaring the **r** and multiplied by 100] effect upon the dependent variable-community attitude towards abortion practice.

In addition to correlation analysis presented above, a regression analysis was run in order to check for spuriousness of the associations found out by the tests used in the foregoing section.

Table (4.9): The Impact of Stigmatizing Attitudes, Beliefs and Actions on Community Attitude towards Abortion Practice

ANOVA[a]

Model		Sum of Squares	Df	Mean Square	F	Sig.
1	Regression	1583.519	1	1583.519	40.409	.000[b]
	Residual	12069.578	308	39.187		
	Total	13653.097	309			

a. Dependent Variable: community attitude towards abortion practice
b. Predictors: (Constant), stigmatizing attitudes, beliefs and actions

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	T	Sig.
		B	Std. Error	Beta		
1	(Constant)	22.662	1.834		12.358	.000
	stigmatizing attitudes, beliefs and actions	.415	.065	.341	6.357	.000

a. Dependent Variable: community attitude towards abortion practice

As the above table (4.9) reveals, the linear regression analysis was run to predict the respondents' attitude towards abortion practice from stigmatizing attitudes, beliefs and actions. As F ratio in ANOVA table above shows, the independent variable statistically significantly predict the dependent variable, $F (1,308) = 40.409$, $p < 0.05$, $R^2 = .116$. Therefore, stigmatizing attitudes, beliefs and actions was found to be important variable that influence the attitude of the respondents' attitude towards the abortion practice. The independent variable(X) has 12 % influence upon the dependent variable (Y).The relation between the independent variable and dependent variable was not by chance rather it was causal connection between the two variables.

4.3.2 The Relationship between Socio cultural Discourses and Community Attitude towards Abortion Practice

Before examining the influence of the independent variables (stigmatizing, attitudes beliefs and actions; moral and religious discourses, legal and medical discourses) on the attitude of the community towards abortion practice, it was very important to know the correlation between independent and dependent variables through Pearson's product moment correlation coefficient(r).

Table 4.10: The correlation between socio-cultural discourses and peoples attitude towards abortion practice

Correlations

		community attitude towards abortion practice	stigmatizing attitudes, beliefs and actions	moral and religious discourses	legal and medical discourses
community attitude towards abortion practice	Pearson Correlation	1	.341**	.549**	.254**
	Sig. (2-tailed)		.000	.000	.000
	N	310	310	310	310
stigmatizing attitudes, beliefs and actions	Pearson Correlation	.341**	1	.316**	.299**
	Sig. (2-tailed)	.000		.000	.000
	N	310	310	310	310
moral and religious discourses	Pearson Correlation	.549**	.316**	1	.216**
	Sig. (2-tailed)	.000	.000		.000
	N	310	310	310	310
legal and medical discourses	Pearson Correlation	.254**	.299**	.216**	1
	Sig. (2-tailed)	.000	.000	.000	
	N	310	310	310	310
**. Correlation is significant at the 0.01 level (2-tailed).					

As it can be seen from the table 4.10 above, there is statistically significant correlation between stigmatizing attitudes, beliefs and actions, moral and religious discourses and legal and medical discourses and community attitude towards abortion practice (r= 0.341, .549,.254 respectively at

p<0.01). When we see the strength of the association between independent variables and dependent variable, there is weak positive relation between stigma(r=0.341) and legal and medical discourses(r=.254). However, there is moderately positive relation between moral and religious discourses and community attitude towards abortion practice. Generally, people had unfavorable attitude towards abortion practice due to the more negative sociocultural discourses regarding abortion within the normative structure of the study community.

Having this in mind, multiple regression analysis was run to ascertain whether the correlation between the above mentioned independent variables and dependent variable is spurious/by chance/ or not. As a result, the table 4.11 depicts as follows:

Table 4.11: The Impacts of socio-cultural discourses on the attitude of community towards abortion practice

ANOVA[a]

Model		Sum of Squares	Df	Mean Square	F	Sig.
1	Regression	4671.317	3	1557.106	53.049	.000[b]
	Residual	8981.780	306	29.352		
	Total	13653.097	309			

a. Dependent Variable: community attitude towards abortion practice

b. Predictors: (Constant), legal and medical discourses, moral and religious discourses, stigmatizing attitudes, beliefs and actions

Coefficients [a]

Model		Unstandardized Coefficients		Standardized Coefficients	T	Sig.	95.0% Confidence Interval for B	
		B	Std. Error	Beta			Lower Bound	Upper Bound
1	(Constant)	5.231	2.427		2.155	.032*	.455	10.007
	stigmatizing attitudes, beliefs and actions	.194	.062	.159	3.145	.002*	.072	.315
	moral and religious discourses	.607	.063	.477	9.662	.000*	.484	.731
	legal and medical discourses	.123	.058	.104	2.119	.035*	.009	.238

a. Dependent Variable: community attitude towards abortion practice

b. Predictors: (Constant), stigmatizing attitudes, beliefs and actions, moral and religious discourses, and legal and medical discourses

As the table 4.11 above reveals, multiple regression analysis was run to predict the respondents' attitude towards abortion practice from stigmatizing attitudes, beliefs and actions, moral and religious discourses, and legal and medical discourses. As F ratio in ANOVA table above shows that the independent variables statistically significantly predict the dependent variable, $F(3, 306) = 53.049$, $p < 0.05$, $R^2 = .342$). Therefore, stigmatizing attitudes, beliefs and actions, moral and religious discourses, and legal and medical discourses were found to be important variables that influence the attitude of the respondents' attitude towards the abortion practice. Moreover, the independent variables(X_1, X_2 and X_3) had 34.2 % influences upon the dependent variable(Y).

To this end, the relationship between independent variables and dependent variable was not spurious. They are significantly predicting the respondents' attitude towards abortion practice. This perhaps is consistent with Komut (2009) where he argued that religion still has a powerful influence in shaping people's attitude towards abortion.

Similarly, key informant interviews and FGD results also strengthened that the socio cultural discourses such as religion, moral, legal and medical and societal stigma had a profound effect upon the women's abortion practice and community attitudes towards abortion. One of the key informants working for women and children office explained the impacts of socio-cultural structures and discourses upon the lives of women and the community attitude towards abortion as follows:

> *Pregnancy may occur in one way or another; the same is true for pregnancy termination. This is due to the fact that the existing socio-cultural structures and community values, discourses and expressions have their own impact on women's*

> *reproductive rights and community attitude towards abortion and pregnancy. Among other things, in religion, abortion is intolerable, immoral and a sinful act or against the law of God and condemnation of spiritual fathers on their followers. In fact, gender norms (male dominancy), societal stigma, social exclusion and bad words and the like determined people's attitude towards abortion practice. Besides, the willingness and lack of confidentiality of doctors are also great problems in practicing abortion* (male key informant, 38).

One of my elderly key informant remarks upon the socio-cultural values as follows:

> *The stringent values and norms of the society prohibit abortion practice. If someone practices abortion, the community negatively reacts since s/he violates such desirable values such as marriage is the respected practice, giving birth out of wedlock is forbidden and abortion violates the law of God and so on. Besides, religious teachings, for instance one who experience abortion has no place in Heaven and one who abort the given child will not have another child again and the like have frustrations and psychological impact on people* (female, age 60).

Another key informant put his claims concerning the legal discourses upon the practice of abortion and its impacts on community attitude towards abortion as follows:

> *The previous penal /criminal/codes of FetehaNegest, 1923 and 1949 were highly influenced by Christianity [Orthodox religion]. As a result, they prohibited abortion practice. This was implicated within the larger society [Ethiopia] for a long period of time. Even the 2005 revised criminal law disregards the autonomy of a woman to end pregnancy at regardless of any reason. It only permits on specific circumstances and narrow interpretation; which is not allowed in principle* (male key informant, age 29).

Table 4.12: Respondents' Attitude towards Abortion Practice

	Cutoff point	Frequency	Percent
Valid	10-29	227	73.2
	30	11	3.5
	31-50	72	23.2
	Total	310	100.0

According to a cutoff point by Kothari (2004), as mentioned in methodology part, table 4.12 above depicted that 227(73.2%) of the respondents scored 10-29, which is below 30 showed unfavorable attitude towards abortion practice, 11(3.5%) had neutral attitude and 72(23.2%) of the respondents scored 31-50 had favorable attitude towards abortion practice. Thus, from this information, one can understand that majority of the respondents had negative attitude towards induced abortion practice. See also appendix 3.5 for further analysis.

4.3.3 Sex Differences on the Attitude of Head of Households towards Abortion

Finally, T-test was computed whether there is attitudinal difference between sex of respondents or not. To this end, table 4.13 below depicts that there is statistically significant attitudinal difference between male and female towards abortion practice ($p=.000$). This finding contradicts with Narendra (2010) where sex was found to have no significant effect on abortion attitudes.

Table 4.13 sex difference of respondents and attitude towards abortion practice

One-Sample Test

	Test Value = 0					
	T	Df	Sig. (2-tailed)	Mean Difference	95% Confidence Interval of the Difference	
					Lower	Upper
sex of respondents	55.150	309	.000	1.558	1.50	1.61
Attitude towards abortion practice	50.096	298	.000	1.241	1.19	1.29

Table 4.14 Sex of Respondents and Attitude Towards Abortion Practice

Count		Attitude towards abortion practice			
					Total
		10-29	30	31-50	
sex of respondents	Male	96(70%)	4(3%)	37(27%)	137(100%)
	Female	131(75%)	7(4%)	35(21%)	173(100%)
Total		227	11	72	310

Where, 10-29 unfavorable, 30 neutral and 31-50 favorable attitude, Kothari (2004) cutoff point

Moreover, the cross tab in table 4.14 above clearly depicts attitudinal difference between male and female towards abortion practice. In this regard, out of 137 male respondents, 96(70%) had unfavorable attitude, 4(3%) neutral and 37(27%) favorable attitude whereas out of 173 females, 131(75%) negative, 7(4%) neutral and 35(21%) favorable attitude towards abortion practice. Hence, male respondents had slightly favorable attitude than females. This is due to the fact that women are more responsible in abortion decision than males as FGD evidences showed.

4.3.4 Attitude of Community towards Abortion

As table 4.12 above indicated, more than half of the respondents, 227(73%) had the most unfavorable attitude towards abortion practice and individual statements especially “condemnation of abortion practice”, “abortion is a murder and a sinful act” and “abortion exposes societal stigma” most respondents had negative attitude(see appendix 3.6) . Moreover,

most informant interviews with elders of the community and religious leaders (Orthodox Christianity, Islam and Protestant) and in-depth interview with women having induced abortion results showed that abortion practice was negatively attributed/perceived/. On the contrary, most FGD discussants, lawyers, health care providers had moderate attitude towards abortion practice.

Furthermore, as the in-depth interview and case studies with women indicated, out of 12 interviewees 7 of them had negative attitude towards induced abortion while 2 moderate and 3 had positive outlook. Here, from the above results, one can understand that most women who experienced induced abortion had negative attitude towards abortion due to the health risks and the associated social stigma.

A quote from one of my elderly key informant interview showed his negative attitude towards abortion practice as follows:

> *I condemn abortion practice as it is strictly forbidden in our religion and culture. God ordered us to be multiplied on earth. So, it violates the rule of God. Even, in our culture bearing a child without marriage , marriage without formal procedure [wulna masreja yelelew gabcha] and abortion are culturally and socially undesirable* (male key informant, age 88).

4.4 Abortion Experience and Negotiating Strategies of Women: Agency and Structure in Focus

In this section, women's subjective and unique experiences of abortion, negotiating strategies and resilience mechanisms of women having induced abortion were separately analyzed so as to see how they tried to manage structural and individual factors on their abortion experience.

4.4.1 Women's Negotiating Strategies Having Induced Abortion within Multiple and Competing Discourses

Participants of this study (Women experienced induced abortion) identified various negotiating strategies in abortion decision and practice within the existing discourses. Most of the interviewees identified strategies such as social strategies (sharing the problem to others such as family members, peers and others), confessing to the spiritual fathers but rarely, silence (performing abortion in secret), perceived risks and benefits (cost-benefit analysis) of pregnancy termination, world view (openly discuss the issue, considered abortion as normal) and prioritizing health than the future health problem to mothers. Thus, 9 out of 12 interviewees employed social strategies and cost benefit analysis of pregnancy termination (future considerations of the problem). Thus, it can be understood that most of the participants negotiated various competing factors through sharing problems to their social networks and giving priorities to their problems. A 19 year-old woman, who participated in the in-depth interview, supports this as follows:

> *One day I went to hospital for pregnancy test. When the result was positive, I was very nervous. At that time, I was worried because I was a student. I was in dilemma to decide to end my pregnancy because I feared my families, my religion, and societal stigma. Besides, I felt like God will punish me by forbidding me another child. However, finally I decided to terminate. I told to my mother how I could do. I thought that I should confess to my religious father and finally I just compare and contrast the problem that I faced. If I give birth, my life will be complicated and I want to finish my education. Besides, giving birth without wedlock in our community exposes to psychological and moral crisis and societal stigma.*

As the above quote shows religion, family pressure, social stigma or reaction and abortion myths and legal issues played a decisive role in impacting women's lived experience and abortion decision. As a result, social strategies, confessing to spiritual fathers and cost benefit analysis of pregnancy termination were used as the negotiating strategies within various conflicting ideas. Moreover, in the sense of structuration theory the existing social structure can be of constraining and enabling to actors (Giddens 1984). This is practically true that religion, for example, played a dual function as constraining for decision making and at the same time a window for releasing strain brought by practicing abortion.

According to the above narration, it can be understood that women having induced abortion experience various obstacles in deciding abortion practice. Accordingly, there are factors such as fear of dying, gestational period (greater than three months) and economic problems or abortion fees were the central factors in abortion decision and performing abortion. To this end, women experiencing induced abortion used strategies such as silence (keeping secret) and giving much weight to the existential problems.

Unlike social factors which are external to an individual, personal factors also played a greater role in abortion decision. Some women experience relief in performing abortion. In other words, women have their own intentions, rationales and motives to take actions especially in pregnancy termination. To this end, a 22 year -old, married woman, who participated in an in-depth interview, narrated her experience in abortion decision as follows:

> *Though to some extent my religion influenced my decision and performing abortion, as to me it was easy to decide for pregnancy termination because I know that the problem I would face otherwise was difficult. I am a high school student; and I married when I was at the age of 19 and I have one child. I got pregnant immediately after my first*

baby. My husband is working in private organization but his salary is not enough to raise our children so it was me who should decide on the future life and living condition. But after performing abortion I got depressed and feel guilty.

Another woman seconded the above situation as follows:

> *I personally believe that abortion is not a good practice which is condemned by religion. But, unfortunately I missed family planning effectively then I got pregnancy after 4 months of giving birth. Therefore, I was in dilemma whether continuing or terminating it. However, after discussing about the issue with my husband, I decided to end my pregnancy because continuing pregnancy affects both our living condition and our children* (married, age 25).

As it can be understood from the above quotes, abortion decision is positively influenced by personal factors or women's right to decide on matters of their future life despite external factors such as religion, societal reactions and the like. This clearly indicates the role of agents as active decision makers by challenging the existing normative order behavior of the society (Giddens 1984).

4.4.2 Lived experience of Women in abortion practice: before, during and after

Regret, fear of dying and health threat, relief, fear of punishment from God, psychological and emotional impacts and fear of being blamed by others were the common problems repeatedly narrated for most of the women during the in-depth interview. Out of 12 interviewees, 6 of them experience regret after performing induced abortion whereas 3 of them experience good feeling about abortion. They also claimed that they got relief by performing induced abortion due to the constraining factors in which otherwise they did not have exit. Hence, the following quote from a 19 year-old woman who had induced abortion illustrates the challenges and negative feelings as follows:

> *After pregnancy test, I was getting confusion and dilemma because my religion prohibits such undesirable practice. Besides, I was very stressed if my families heard. Above all, there are bad words from the neighbors; they would insult me as 'shermuta' [a promiscuous]. Finally, it was mandatory to terminate pregnancy because of being a student and economic problems to raise the child. For me, abortion is the worst practice that brings moral crisis, psychological stress and a sinful act. When I faced unwanted pregnancy, I accepted to end the pregnancy but later on I was really depressed, regretted for doing such a bad and hated practice by God. Since I performed abortion, I always regret especially when I thought the baby being terminated. After abortion, I faced not only mental unrest and psychological distress but also physical pain such as continuous bleeding and irregularity of menstruation.*

Conversely, a 27 year- old woman during the in-depth interview narrated her feelings about abortion as follows:

> *In my opinion, abortion is a good practice and important especially for unwanted pregnancy. Of course, I know abortion is strictly forbidden in my religion and threat to health and life. However, for people like me living in severe poverty, it is good. A year ago I have got divorced but unfortunately I got pregnant with someone else so it was a must to end pregnancy because I have three children who are little boys and girls. I was happy to get this service in this clinic with cheap price. If I had continued the pregnancy, my life would have been getting worse and worse.*

The above case and quotes showed that abortion practice would result emotional impact upon women' lived experience and lives. Consequently, for some, abortion makes women's life vulnerable to mental, physical, psychological, spiritual and moral crisis while for others make them plan their life in a proper manner. The later one agrees with a study conducted by Pacillo (1997); Kimport *et al*. (2011) some women experience relief following abortion in which, abortion is "a window of relief''. As a result, the meaning each individual gives is different.

A. The Experience of Women before Abortion

During the in-depth interviews, most women (5 out of 12) experience positive feelings before they performed abortion. However, results of pregnancy test, fear of dying and health threat, fear of being seen by others (gossips and stigma, shame), source of information, service availability, cost and quality, preference of health institution, social networking (to whom shall I share or being secret), feeling of depression and legality issue were the factors that makes women in trouble and dilemma to decision and perform abortion. The most common factors repeatedly expressed by most participants were societal stigma (fear of being seen/blamed/ by others and shame, service availability (quality and cost) and to whom they may share. Hence, social stigma of abortion is still pervasive in the study area. To this end, an 18 year-old woman narrated her experience before she decided to terminate as follows:

> *I was tensioned because of my pregnancy because if my parents knew the case, it would be difficult. I was also in dilemma since abortion is '**haram'** [religiously forbidden]; and it is an act of killing an innocent person. My thought of how and to whom I may share my case was another headache to me. I felt also I would die if I carry out abortion since the fetus was more than five months old. In the end, I decided to terminate the pregnancy by consulting the doctor and my friend.*

B. The Experience of Women during Abortion

Change of decision due to pre-abortion counseling, legal procedures/requirements and the type of abortion procedure-medical or surgical determined the level of stress of women during abortion. However, all of them did not change their decision due to pre-abortion counseling services provided by health workers. Only 2 out of 12 experience surgical abortion due to service unavailability in FGAE. Besides, in both FGAE and private clinics they did not face any legal

procedures and requirements for service they needed. During in-depth interview, most women experience good felling during abortion as it was medical abortion that simply taking misoprostol to end pregnancy. However, the following case study indicates the situation of a woman during induced abortion having surgical abortion. Jemila (case 3) who experienced surgical abortion best describe the situation as follows:

> *The procedure was very dreadful/shocking/. I condemned the day in which I was born. After the procedure, I was asked to think about it again if I have changed my mind. I have faced difficult health complications such as high body temperature, huge bleeding, abdominal pain and others.*

The gynecologist working in the private clinic reaffirms the condition of women during induced abortion as follows:

> *Women are more stressed in surgical abortion than medical abortion; this might be talks from the society. Of course, it is more severe than the medical one. Anyways, women are double victims, that is, on one hand they are worried about the health conditions; fear of dying during abortion procedure and societal reactions as if they are criminal and socially neglected persons on the other.*

A female healthcare provider working in one of the NGOs further seconded in one way or another as follows:

> *Though most women are eager to be okay for the service, there is yet stress during abortion. Some are worried about their religion, while some on their health and still others about the societal reactions, privacy/confidentiality. The degree of stress is more severe in those who came alone and keeping the abortion secret than those who came by discussing with their spouses and with someone else (*key informant age 58).

C. The Experience of Women after Abortion

As the in-depth interview results revealed, regarding stress and feeling of women, there is a significant (quite) difference between pre-abortion and post abortion procedures; that is, in pre-abortion abortion procedure, 5 out of 12 had positive feeling towards abortion; nevertheless, after abortion only 2 women experience good feeling towards abortion practice whereas the remaining 10 experience a feeling of regret, distress, simple to severe health complications such as nausea, bleeding (hemorrhage) , abdominal pain and the like. Besides, societal reactions such as stereotype and gossip even bad words such as '*newregna'*(deviant from the normal) and '*nefsegeday'* (killer or murderer) were frequently narrated by the interviewees during the interview. Besides, the key informant interview results from healthcare providers consolidated that women experience negative feelings such as regret to terminate the pregnancy, punishment from God, severe societal stigma, rumor and gossip and fear of future fertility as compared to the first encounter.

Concerning the post abortion counseling, almost all of the participants had got counseling services about the family planning, HIV/AIDS, STDS/STIS/ and the impacts of repeated abortion and its associated risks such as infertility and ectopic pregnancy. As a result, majority of the participants were satisfied with the service provision in the institution and approaches of the healthcare providers. Only few of them were dissatisfied especially those who served in private clinics due to exaggerated abortion fee.

D. Women's Abortion Experience and Resilience Mechanism

After experiencing induced abortion, women used various resilience mechanisms (ability to bounce back to normal life situation) such as planning the future such as effective family

planning, social connections such as sharing the problem to others, consulting health professionals which is related to health risks, confessing to the spiritual fathers , praying and developing self-confidence[I can principle] and problem solver rather than victims of the problem were the main strategies that women used after they experience abortion during the in-depth interview. Thus, most of the interviewees applied future planning and social connection strategies respectively. As the above result reveals, women employed the following resilience mechanisms such as ignoring the past miserable life and planning the future and developing social connection which were frequently quoted by the participants. In this regard, the following three cases illustrated the overall life situations and resilience mechanisms of women experiencing induced abortion. In other words, each case study with individuals would reveal a unique perspective of the dynamic and complex ontological reality of the women as agents, and some of the most important relationships between structure and agency that the women experienced and which both enabled, and constrained, their pregnancy termination.

Case1: Abebech

Abebech was born in 1990 and lives with her parents in Woldia Town. She is the follower of Orthodox Christianity. She started sexual relation when she was in grade nine with someone whom she gave the virginity. Still she loves him. But once upon a time, she got pregnant; but decided to terminate since it was not formal relation and unknown by the parents. Currently, she is married to the same man and she is attending college education at Woldia Town. Abebech experienced induced abortion when she was grade ten. Regarding her abortion experience, she narrated as follows:

Initially, I feared of dying, severe health problems and fear of disclosing the secret. However, after taking the medicine [misoprostol] there was a big disturbance in my health such as nausea, severe bleeding, and delay of menstruation but thanks to God things were not as such expected. Moreover, I just developed a feeling of inferiority because though the neighbors and community members were not that much aware about it, there was a rumor/ gossip that made me hopeless, aggressive and also touched my moral. Everybody would insult me as 'shermuta' (promiscuous), immoral since I had no formal partner or husband if the people knew the case. Certainly, Hakimu [doctor] told me that I should comeback for checkup and told me told me about the pregnancy was totally terminated and asked me the health condition after the abortion procedure. Besides, they also added that about the effective family planning and the consequence of repeated abortion. I found the post abortion counseling as fantastic and important because I did not have any information about the consequence of repeated abortion which causes 'mekaninet' [infertility]. Of course, informally some people talk about it. But I was not quite sure. There are societal stigma, gossip and other things in our community; it is terrible and difficult if everybody heard it. You are labeled as 'sid' [abnormal] and other bad words. I always felt stress because abortion is very difficult procedure from the beginning to the end. It is full of problematic and stressful event especially if the case is disclosed to someone since they labeled you so. However, despite touching and unforgettable mistake I made [killing the baby], but later on, I confessed the case to 'nisiha abate' [spiritual father] and I convinced myself to forget the past and should continue my education. And now I am living with my friend [former husband] by legitimating with my parents.

Case2: Beletech

Beletech was born in 1979 and currently lives in Ethiopia. She is an Arab returnee. She got divorce and had two children and currently living with someone after she returned to Ethiopia. As she narrated about her spirituality, she is the follower of orthodox Christianity. She is

illiterate. Unfortunately she got pregnant with an informal sexual partner. Then, she experienced induced abortion since she wanted to go abroad again. The case below indicates her overall situation from the beginning to the end. Concerning the reason behind pregnancy termination she elaborated as follows:

Immediately coming from abroad, I got pregnant. It was not planned and programmed so that I got tension because I want to go back there. I did not have any information about the pregnancy termination but my friends told me how it is so. I got some relief. Then, I went to [FGAE].

After she experienced induced abortion Beletech added the following statements:

I was very depressed after the abortion procedure; as it disturbs my health condition such as fatigue/tiredness/, nausea, loss of food appetite. Concerning the societal reaction, I was keeping it secret no one knows expect my partner and best friend because I know how the people how they backbites, stigmatize and gossip especially abortion without marriage. Of course, there are two types of reaction in our community that is, some claimed that abortion and giving birth without wedlock are condemned and makes you to be excommunicated, while, others consider that human being is to err so it is normal. As a result, I was always in frustration but thanks to God no one knows about it.

Regarding the resilience mechanism she explained the situation as:

The unplanned and unwanted pregnancy especially without formal marriage disturbed my life. I was thinking my future life after I got pregnancy. I was really disappointed because if I give birth I will not go abroad with due time and even I have no parents to raise my children. Therefore, ending my pregnancy was the best solution. It is me who is responsible to adjust and plan my life. Now I just consider it as a normal *activity. And here after, I believe that I should be careful and I got good lessons from my mistake.*

Case 3: Jemila

Jemila was born in 1975 in Habru Woreda, North Wolo Zone. She is married and had two children. Currently, she is living with her children. Her husband is living in another country. As to her spiritual life, she is the follower of Islam. She has completed primary education and now she is unemployed. Concerning her abortion experience she speaks:

It is shameful to speak about my abortion experience. I have a husband and two children. I got marriage at the age of 20. I love my husband. Now he is living abroad and working as chauffeur. Unfortunately, I started sexual relation with somebody and got pregnant. Then, I was in dilemma whether to continue or terminate the pregnancy. After many thoughtful processes, I decided to end. I tried to keep it secret because I was ashamed of doing this. After decision, one of the headaches was financial problem. I was stressed again. Everything became complicated; and the pregnancy was above 5 months that was a threat for my life. Even the doctor advised me to continue pregnancy but I would rather die than continuing the pregnancy. Then, I paid 4000 birr. Then, the procedure was very dreadful/shocking/. I insulted the day in which I was born. After the procedure, I was asked to visit again if something is new. I have faced difficult health complications such as high body temperature, huge bleeding, abdominal pain and others. When I visited the clinic for checkup, I was also asked to pay again which makes me nervous. After abortion, not only health problem but also gossips, rumors and 'ashimur' [veiled, scandal] disturbed my overall life. Even they told to my husband and now I got divorce and am living alone.

Regarding the resilience mechanism Jemila speaks as follows:

I have no words to speak. I passed miserable life. I lost many things including my home (marriage). I did a sinful act condemned by Allah [God]. It was ***haram****. I had no futurity; it was dark. However, now I always pray. I hope Allah will forgive me. I tried to make things secret but not as expected. Now I have convinced myself to ask my husband's excuse to live together and raise our children.*

From the above three cases, one can understand that unwanted pregnancy caused by various reasons enforced women to experience induced abortion. Consequently, women and their families suffer both temporarily and lifelong consequences due to abortion experience. To this end, particularly after induced abortion, health complications and stringent societal reactions were the pervasive effects upon the lives of women. Resilience is the ability to bounce back to the normal life situation. Hence, according to Giddens (1984) structuration theory certainly recognizes that there are constraints on actors, but this does not mean that actors have no choices and make no difference. In doing so, the coping mechanism and the lived experience of each women was greatly differed from one person to another. For some, avoiding the pathology and focusing the strength was easy whereas for others it was difficult to forget the past and start a new life. Generally speaking, every woman relays her experience in her own voice and it cannot be compared or made similar to another woman's experience. Every woman's subjective experience of any traumatic event or any event at all is unique. As a result, their experiences are also colored by their cultural differences, religious beliefs, society's influences, personality traits (Davies 1991).

CHAPTER FIVE: DISCUSSION, IMPLICATION AND CONCLUSION

5.1 Discussion

In this study, I have argued that abortion practice is the interface between structural and individual level constraining and enabling factors. Hence, the role of agency- personal motives, intentions and power could influence the normative order of the community and be influenced by the existing socio-cultural discourses or structural or contextual factors. In this regard, agency structure theory was employed to combine the influence of structural factors with the individual (micro level) factors in abortion practice and community response and vice versa.

5.1.1 The Practice of Abortion: Knowledge, Experience of the Community and Context of Abortion

The present study revealed that more than half of the respondents, (58.4%), had the information about induced abortion or medical termination of pregnancy (MTP) followed by unsafe abortion practice-performed clandestinely. Moreover, the FGD and key informant interview results revealed that unsafe abortion is still a tenacious problem which agrees with Senbeto and Yeneneh (2005) unsafe abortion and illegal abortion are still the leading causes of death especially for young women in Ethiopia. However, regarding knowledge of safe abortion the present finding contradicts with Mekuriaw *et al*. (2015) showed that majority of the respondents 382 (90.52%) reported they had never heard about safe abortion.

Regarding the recently revised abortion law, 54.5 % of the respondents did not have any awareness. Moreover, most of the FGD discussants in the present study did not know whether Ethiopia had abortion law. This finding is consistent with a study by (Mihret 2010) done in

Addis Ababa which revealed that only 44% of the respondents had information about the Ethiopian abortion law and its circumstances.

Concerning the legalization of abortion (opinion of respondents), the present study revealed that less than half (48%) believed that the existing law endorsed by the government is enough; otherwise, it will violate the fundamental societal values and norms that bind the society. This study result is consistent with Gizaw (2014) where nearly half of the respondents, 100 (46.9%), believe abortion is legally allowed in Ethiopia under the condition of pregnancy as the result of rape or incest and when the woman's or the fetus life is threatened, while 60 (28.2%) believe abortion should not be legally allowed in Ethiopia. But still, 141(36%) of respondents, who believed in abortion legalization, and FGD results disconfirmed the aforementioned realities as the law disregards various social and economic justifications of a woman within the existing social scenario. This finding agrees with Tsehai (2008) where the revised abortion law disregards the social dynamism and the segments of the population who are vulnerable. Moreover, CRR (2008) world abortion policy report revealed that Ethiopia did not accept abortion conditions under the perverse mental health, socioeconomic grounds or upon request without any reason. However, regarding the legalization of abortion, more than half of the respondents, (59%), believed that abortion should be legalized mainly under the conditions of minor age and rape through recognized officials and legally reported. Thus, the survey result of this study disagrees with Denbow (2005) where autonomy of a woman to end pregnancy within her life circumstances and conditions because the nature of abortion is not only moral, religious and medical issue but also human rights since it involves the right of the women.

On the contrary, informant interview results showed that prohibition of abortion law aggravates maternal mortality, unsafe abortion practice and harsh life conditions of women. Thus, this

finding completely agrees with legal restrictions on abortion often causes high levels of illegal and unsafe abortion that leads to maternal mortality (WHO 2011; CRR 2014).

As the present finding indicated, majority of the respondents i.e. 53% and 49% thought that societal reactions as it is believed to be violating the desired societal/community norms and economic reasons respectively were the major reasons for pregnancy termination. Hence, this study finding is consistent with Grimes *et al*. (2006) which says that all over the world women choose to terminate unwanted pregnancy through abortion due to various socioeconomic reasons and socio-cultural beliefs.

As far as consequence of abortion is concerned, more than half of the respondents, 66.1% and 54.5% and interview results showed that induced abortion brought health complications such as nausea, infertility, and hemorrhage to death on women. This is perhaps due to repeated abortion and the practice of unsafe abortion performed clandestinely and lack of proper equipment, unskilled personnel and unclean environment. The finding of the present study is consistent with (Singh *et al*. 2010) where abortion brings not only social but also health consequences on women, their families and society at large because of stigma from their families and communities and associated health risks such as depression, mortality. Moreover, medically, abortion procedure needs safety equipment or clean environment and skilled personnel otherwise it is usually brings health complications during medical or surgical procedures that is mostly associated with infections to health risks to death (Gale 2014).

The practice of induced abortion is influenced within the existing contextual factors which impede abortion decision of women including religion and morality. In this regard, 38.7% and 31.3%, 22.3% respondents said that religion and morality, social stigma and gender roles

played the decisive role in abortion decision process of women in particular and the larger community in general. The present study is congruent with (Atkins 1994; McCulloch 1996; Komut 2009) where contextual factors such as societal attitudes, religious beliefs and morality, cultural beliefs and interpretations predominantly influence abortion decision. In addition, personal desires of a women and contextual factors such as medical, moral, ethical, gender and other socio-cultural issues and related contextual variables influenced women's decision making process (Plous 1993; Ahmed and Ray 2013).

According to the present study at hand, there are several factors which impede the practice of safe abortion. To this end, 20.5% of respondents said that conscious objection of doctors, 32.5 % unsafe abortion practice in the study area, 42.9% stringent values and norms of the society, 18.5% lack of confidentiality healthcare providers and 26% cost of abortion fee mentioned as barriers of safe abortion. Thus, this study is congruent with Lamina (2013) which states that personal and contextual factors such as moral agency, religious beliefs and societal stigma played a central role not only abortion but also performing safe abortion. Besides, the given reproductive health policies, legal barriers, conscientious objections of doctors, social and cultural beliefs against abortion(reprisals and social condemnation), the adequacy of hospital facilities and the others determines the practice of safe abortion(WHO 2008;WHO 2012).

As the finding of the present study indicate that over half of the respondents, 68.1 % believed that gender roles are also the major factors on abortion decision. In other words, women are denied to the right of decision making regarding abortion in one way or another due to the fact that abortion is believed to be a sign of illicit sexuality (pregnancy outside of marriage) and the male dominancy system (men's power to decision). As a result, it is consistent with Evens (2003) in which men are placed at the center of the universe and women are marginal and have

meaning when they are fulfilling roles that are significant for men, as mother, as partner, as daughter and agrees with Ndlovu (2006) where in the patriarchal setting where men arguably dominate social and economic relations, gender relations are expected to play an important role in influencing reproductive behaviors and decisions.

Regarding the community's experience towards, the present study revealed that 43% of the respondents thought that the community had unfavorable response towards abortion. Yet, some of the respondents did not want to provide any sort of social support for women since they believed that abortion practice is against the community norms. In this regard, this study agrees with Kumar *et al.* (2009) why people had negative reactions towards abortion due to their conservative opinions and societal responses. Besides, the finding of this study consistent with Abay (2002), Worku and Binyam (2014) in Ethiopia revealed that most had negative attitudes and reactions towards abortion practice in general and abortion laws in particular.

Owing to severe societal reactions towards women practicing induced abortion and abortion attitude, the present study showed that 91(310) respondents and most women experienced induced abortion wanted to keep silent since they feared the social stigma and labeling in the community. Due to this reason, more than half (71%) of the respondents would share to their intimates if they experience and abortion. Hence, this study agrees with Norris *et al.* (2011) abortion exposes social stigma in any culture and society though the degree is varied. In doing so, silence is an important mechanism for individuals coping with abortion stigma; people hope that if no one knows about their relationship to abortion, they cannot be stigmatized.

5.1.2 The Influence of Sociocultural Discourses on Community's Attitude towards Abortion

Abortion stigma and stigmatizing discourses embrace a woman or a community decrease in providing social support to those who experience abortion. In other words, the more women experienced stigma, the more likely they were to have adverse emotional outcomes (Major & Gramzow 1999 in Kumar *et al*. 2009). According to Parker (2003) stigma decays the ability to hold on to what matters for most ordinary people in a local world such as life chances and relationships with others. As the correlation tests in the present study showed that there was a statistically significant positive correlation between stigmatizing attitudes and beliefs and people's attitude towards abortion; where the independent variable had 12 % influence upon the dependent variable. Furthermore, as the regression tests indicated stigma, religious and moral discourses, legal and medical discourses had impacts upon the community attitude towards abortion. In doing so, the independent variables had 34% influences on the dependent variable. This finding agrees with perhaps with Cockrill *et al*. (2013) as there is a relationship between community-level stigma and the norms, prejudicial attitudes and negative behaviors toward abortion that exist in communities.

Religious discourses are powerful factors in predicting attitudes towards abortion; in shaping people's attitude towards abortion as it emphasizes the sanctity of life. Moreover, religion and morality are inextricably linked concepts that influence abortion debate and attitude (Komut 2009). Some scholars believed that legalization has the social costs including the erosion of essential moral values such as sanctity of human life and decline of traditional sexual morality, increasing infanticide, murder and the like (Schwartz 1972). As the regression analysis indicated, stigmatizing attitudes, beliefs and actions, moral and religious discourses, and legal and medical discourses were found to be important variables that influence the attitude of the respondents'

attitude towards the abortion practice. The FGD results also strengthened that the socio-cultural discourses such as religious, moral, legal and medical and societal stigma had a profound effect upon the women's abortion practice and community attitudes towards abortion. The in-depth interviews with women also consolidated the above findings as stringent societal values and rhetoric discourses were the pervasive effects not only women's abortion decision making process but also upon the lives of women in general. This agrees with Gilbert and Sewpaul (2014) where women are constrained by structural factors such as poverty and socio cultural influences of stigma, and shame in view of familial, religious, and cultural sanctions against pregnancy and abortion.

Public opinions regarding abortion are not easy as such expected because the decision to end pregnancy and access to legal and safe abortion requires multiple and contextual circumstances such as personal beliefs, socio-cultural factors like gender ,which influence people's attitudes and opinions towards abortion (Butler 2015). The issue of abortion attitude is complicated almost in all African countries; the community stigmatized and ostracized women as murderers and they also have strong beliefs regarding the immorality of abortion (Marlow *et al*. 2014; Creswell *et al*. 2015). In Ethiopia, most people have negative attitude towards abortion. For example, an empirical study conducted by Abay (2002); Mihret (2010); Worku and Binyam (2014) in university students showed that most had negative attitudes and reactions towards abortion practice in general and abortion laws in particular. The present study revealed that more than half of the respondents, 73% had unfavorable attitude towards abortion practice and 23% had favorable attitude towards abortion practice. Besides, case study and in-depth interview results showed that women after having induced abortion had negative attitudes towards abortion due to the pervasive stigma and reactions in the society. Thus, the study agrees with previous findings;

but; it disagrees with empirical studies found in Australia revealed that over 80 % of the population accepts the women's right to abort (Durey 2010).

5.1.3 Women's Abortion Experience and Negotiating Strategies: Agency-Structure in Focus

As the qualitative results showed, most women having induced abortion experience negative feelings regret, fear of punishment from God, severe societal stigma, gossip, and even sometimes discrimination. This finding more or less is consistent with Madeira (2014) because of disrespecting the traditional values and roles of womanhood would ultimately cause a woman feeling of regret, guilt and remorse.

Regarding with resilience mechanisms, the present study showed that though women suffer in abortion practice and unfavorable attitude -from the inception to the end together with community attitude towards abortion, they employed their own resilience mechanisms such as social connections (sharing the problem to others), consulting health professionals, confessing to the spiritual fathers and praying to get back to the normal life situation. This finding agrees with the study done by Liljas Stalhandske *et al*. (2011) in Sweden in which women use common strategies such as cognitive, social and symbolic strategies as a rational actors try to resolve the complexity of decision making process to end pregnancy. Hence, the present study confirms that agents are not necessarily passive entities that are always constrained by discourses and structural forces; rather they use their own capacities and resources (Eyles *et al*. 2015).

5.2 Implications of the Study for Policy, Theory and Research

The ultimate goal of any research is to refute, modify or validate a certain theory and vice versa. The practical application of research, therefore, is to enable the researcher to indicate policy gaps, further research areas and synthesis of theory. Thus, the major findings of this study would certainly enable the researcher to indicate policy implications, theoretical underpinnings and further research areas. So, the researcher suggests the following implications in light of the major findings of the study.

5.2.1 Implications for Policy

Ethiopia experienced successive health policies in different times; for instance, the 1993 health policy is one of the dominant policies which followed formulation of a comprehensive Health Sector Development Program (HSDP) in 1998, and the recent Health Extension Program (HEP) and currently it is GTP/HSIP, which gives priority to RH/FP. Consequently, the National RH Strategy builds on a number of notable initiatives undertaken to serve the health needs of all Ethiopians. Hence, the goal of the national RH strategy is built *on the thrust occasioned by the MDGs to garner the multicultural support needed to meet the reproductive and sexual health needs of our culturally diverse population - one characterized by its youthfulness, geographic dispersion, conjugality(husband-wife relationship), and persisting gender inequalities (*MoH 2006).

Despite the fact that the health policy and national RH of Ethiopia considers the unwanted pregnancy and legal framework protects women's reproductive health rights and promote gender equality and maternal health in theory, in practice it is questionable as the evidences collected from surveys and informants, that is, 54.5 % of the respondents and most FGD discussants did

not have any awareness of abortion law. The finding implies that the abortion law should consider the social dynamism- social and economic factors which will be emerged and the associated needs. Moreover, in the study area, government health centers refuse to provide abortion services for women who are in need of it. As a result, incentives, trainings and supervision activities should be targeted for health professionals. Besides, community based interventions should be designed so as to improve women's and community members' knowledge about the legality of abortion, safe abortion methods available in their communities, to address some of the misconceptions about abortion and to reduce the stigma associated with abortion through raising community level awareness.

Moreover, in the present study there were two important but contradictory ideas concerning induced abortion. On one hand, societal norms about abortion as immoral, inhumane and a widespread beliefs and community myths about the health risks and complications of abortion and women's rationale to terminate pregnancy within the existing moral world on the other would be the best entry point for legal and health policies around abortion and improvements of the existing legal document and the implementation of national RH strategy and healthcare providers about the conscious objections. This is because competing discourses and moral concerns might continue to impede girls' and women's sexual and reproductive rights in practice. As the present finding reveals, medical and social dimensions of abortion needs a concerted effort both locally and nationally so as to improve the wellbeing of women and the practice of safe abortion within the constraining contextual factors such as moral, religious, gender roles as abortion is not the mere medical issue rather it is also a human rights issue (MoH 2006).

As the finding of this study revealed, community level stigma played a decisive role in abortion decision and abortion practice. Hence, due to stringent societal values and reactions, a significant number of women are facing stressful life conditions. As a result, this phenomenon is one of the prevalent and impeding factors for safe abortion practice. To this end, I recommend a multi-stakeholder approaches such as the integration of religious, gender, health and legal institutions so as to curve the problems identified by the present study. Hence, the national health policy should revisit the current reproductive health strategies by giving larger emphasis for the existing normative structures and women's reproductive right and maternal health through empowering women's capacity and skills. In a nut shell, to curb unsafe abortion or improve safe abortion practice and to understand the associated social and medical consequences of abortion, structural and personal level factors would be an entry point for policy implications and its practical implementations.

5.2.2 Implications for Theory

In theoretical aspect, the present study employed structuration theory to understand abortion within a larger sociocultural context with a particular emphasis on the interface of structural variables/contextual factors and agency roles in practicing abortion. The basic assumption of this theory is that actors are not seen independently from the structure of society, where actors are affected and at the same time transgressing the normative structures of the society and the moral order. The finding suggests that the contemporary feminist theories and public debates such as pro-life and pro-choice would address future social dynamism of abortion in the context of our society. The qualitative findings and results of in-depth interview with women indicate psychological theories would address the strain managements of women having regret, guilt and other stressful life situations. Finally, the finding of the study revealed that some women

consciously act to distance themselves from the existing normative order and therefore they decide by their own. This, in fact, needs a theoretical critic of structuration theory since the relationship between any individual and the rules and resources of a context is variable and therefore it is not possible to offer duality of structure as Giddens stated (Mozelis 2000).

5.2.3 Implications for Research

Future research should be conducted concerning the long term effects of induced abortion, the association between abortion and mental illness by using longitudinal research design and robust regression analysis and multinomial logistic regression to understand the problem holistically as the in-depth interview and case study results indicated. Moreover, the role of religious institutions in curving abortion prevalence and associated sigma should be given due emphasis for the forthcoming researchers as religion serve as a dual purpose (as a constraining in abortion practice and a relief for women experiencing abortion).

5.3 Conclusion

The main objective of the study was to examine the interface between abortion practice and community response within the existing socio-cultural discourses in Woldia Town. Considering the empirical knowledge generated from the study, conclusion has been drawn in light of findings and implications of the study. The finding of this study mainly spins around medical, legal and social dimensions of abortion.

The findings of this study pronounced that induced abortion is evidently practiced in the study area in spite of negative attitudes of community towards abortion. Surprisingly, unsafe abortion practice is still one of the burning issues which are done clandestinely. Conversely, most

participants reported that safe abortion practice is mainly performed in private and NGO health centers. Hence, as per the preference of health institutions, the survey and key informant interview results indicated that the aforementioned institutions were the first choices of the community to terminate pregnancy. The findings also indicated that study community had information about the associated health impact and risks in either legal or illegal abortion procedures. Regarding knowledge on abortion law, more than half of the respondents, 169(54.5%), did not have any sort of knowhow about the abortion law of Ethiopia and its constituent implications. Less than 50 % of the participants had information about the recently revised abortion law and most of them believed that the law should be revisited as it does not consider all segments of the population who are at risk such as women under poverty and vulnerable such as commercial sex workers.

Both quantitative and qualitative results concomitantly showed that medical/health, socio-economic and socio-cultural factors determine a woman whether to end or continue pregnancy. In this regard, women's narratives notified that societal reactions and labeling largely incite women for pregnancy termination since abortion and birth out of wedlock is believed to be against societal norms.

The finding of this study indicated that there are numerous structural and personal factors which hinder the practice of safe abortion. Socio-cultural discourses and strict community values and norms found to have a predominant influence upon the decision making process and abortion practice as well. Religion, which is one of the strong predictor of abortion attitude, largely determined the lived experience of women having induced abortion and the attitude of the larger community towards abortion.

Structure is not to be equated with constraint but is always both constraining and enabling. As opposed to Durkheim, structure is an external to an individual, in structuration theory, it is in a certain sense it is more of internal to agents' activities (Giddens 1984). In this regard, the present study indicated religion is both the burden and the relief for abortion practice. The in-depth and key informant interview with women and healthcare providers showed that religion is an obstacle for abortion decision and simultaneously the window for stressful life-strain management strategy. In the present study, gender role and patriarchal system played a detrimental effect on women's reproductive right and decision power. Individuals are not passive agents, where simply dominated by the existing normative patterns (Giddens 1984). However, the finding asserted that majority of respondents reported that women are denied the right of decision making regarding abortion in one way or another due to the fact that abortion is believed to be a sign of illicit sexuality (pregnancy outside of marriage) and the male dominancy system (men's power to decision) and many more contextual factors upon women's lives.

Community experience towards abortion practice and social support was pertinent to the societal values and norms regarding marriage and womanhood. The result of the study indicated that the community response towards abortion was largely unfavorable reactions so that some of the respondents did not want to provide any sort of social support for women since they believed that abortion practice was against the community norms.

Stigma, religious and medico-legal discourses were found to be important factors impacting abortion practice and people's attitude towards abortion. As the correlation and regression tests and results affirmed that such discourses are the predicting variables of community attitude towards abortion practice. In doing so, as key informant and in-depth interview results as well as

survey results i,e. 227(73 %), augmented the community had unfavorable attitude towards abortion.

In this respect, particularly women experiencing induced abortion faced complicated life challenges. As the case studies and in-depth interview results indicated, women are double sufferers where they are responsible for their living situation and managing the societal reactions/stigma.

To sum up, the study examined structural and personal factors regarding women's abortion experience and community response. In this regard, structuration theory was found to be sounding in addressing macro and micro level analysis (Giddens 1984). The structural factors such as religion, moral, and cultural beliefs which are against abortion practice influenced both the community attitude and women's abortion decision lived experience. Consequently, social stigma and the social construction of abortion as killing an innocent person and as a sinful act constrain the practice of safe abortion. In contrast, legal and medical discourses at national level despite in paper and the existence of SRH clinics would enable both women and the society in practicing abortion to some extent. According to Giddens (1984), individuals as actors develop their own rational justifications to their actions and forming their life world and in turn created the social structure. Hence, women who experience abortion influence the existing normative structure through various mechanisms such as social networking. In other words, some women obtained information about abortion from their peers and intimates. Besides, the reasons, intentions and practical consciousness of women shape the society's basic values and norms of womanhood. As a result, abortion practice is the interface between the normative structure and response of the community and the woman's justification.

Generally speaking, the present study concluded that the normative structure and the agents are interfaced each other. Hence, women as agents reasoned out justifications in practicing induced

abortion despite the impeding normative structures and vice versa. The constraining nature of the existing contextual factors is more evident than its enabling upon the lives of women. This implies that the scope of the control of an agent is limited to the immediate contexts of actions and interactions (Giddens 1984). Then, this study proposed policy implications both at structural and personal levels in addressing societal stigma and reactions with the associated abortion practice of women.

References

Abiy Zegeye, Alemayehu Worku, Daniel Tefera, Melese Getu ,Yilma Sileshi .2009. Introduction to Research Methods. Addis Ababa university graduate research office, Addis Ababa.

Adamczyk, A. 2009. Understanding the effects of personal and school religiosity on the decision to abort a premarital pregnancy. *Journal of Health and Social Behavior, 2009, 50(5): 180-195.*

Adler.N.E, Henry P. David, Brenda N. Major, Susan H. Roth, Nancy F. Russo, and Gall E.Wyatt. 2007.*Psychological response after abortion. Science series, vol 248 no 4951 pp 41-44*.

Agrawal, S .2008. *Determinants of Induced Abortion and Its Consequences on Women's Reproductive Health:* Findings from India's National Family Health Surveys. Macro International Inc.

Agyekum, A .2014. Abortions in Ghana: experiences of university students.

Ahmed. S and Ray, R. 2013. Determinants of Pregnancy, Induced and Spontaneous Abortion in a Jointly

Alan Gutmacher Institute .1999.Sharing Responsibility: Women, Society and Abortion Worldwide

Alan Guttmacher Institute. 2006. Abortion in women's lives. New York.

Alan Guttmacher Institute.2010. Protecting women's health: advancing women's reproductive rights. New York.

Alan Guttmacher Institute.2015.Advancing sexual and reproductive health worldwide through research, policy analysis and public education. New York.

Alex, L and Hammarstrom, A., 2003, Women's experiences in connection with induced abortion –a feminist perspective: University, Umea˚, and Sweden.

Anderstoep, Scott W, Deirdre D. V. Johnston.2009.Research Methods for Everyday Life: Blending Qualitative and Quantitative Approaches: Jossey-Bass.

Anghel R.E. 2015. Coping Mechanisms that Predict Resilience among At-Risk Romania n Youth. *Journal of Experiential Psychotherapy, vol. 18, no1 (69).*

Aniteye, Patience and Susannah Mayhew. 2011. Attitudes and Experiences of Women Admitted to Hospital with Abortion Complications in Ghana. *Afr J Reprod Health 2011; 15[1]: 47-55.*

Atkins, Rachel .1994. The abortion Discussion: Abortion and Ethical Considerations.

Ayele Bekele.2003.Idir and Iqub: socio economic traditions of Ethiopians. *African studies and research center, Cornel University.*

Balkin, Jack M.2007.Abortion and Original Meaning Faculty Scholarship Series. Paper 228. *Constitutional commentary [vol. 24:291*

Berman, Cathy. 2008. Women and Abortion: A Review of Assessment and Treatment Strategies for Therapists.

Bhattacherjee, Anol.2012.*Social Science Research: Principles, Methods, and Practices*. University of South Florida. Biola University.

Bogdan, R.C. & Biklen, S.K. 2003. *Qualitative research for education: An introduction to theories and methods (4th ed.)*. New York: Pearson Education group.

Bryman, Alan. 1998. *Social Research Methods*. 2nd ed. Oxford, UK: Oxford University Press.

Butler, Lindsey.2015. Complexity of People's Attitudes towards Abortion: Health, Human Performance and Recreation Undergraduate Honors Theses, University of Arkansas.

Callahan, S .1986.Abortion and the sexual agenda.

Carr, Deborah and Debra Umberson.2013. *The Social Psychology of Stress, Health, and Coping*. USA.

Casey ,Katie.2014. *Religion and the Public Domain:* University of Groningen.

Center for Demography and Ecology (CDE).1995.Abortion and Public Opinion: Demographic and Measurement Contexts. University of Wisconsin-Madison.

Center for Reproductive Rights. 2008. World's Abortion Laws.

Center for Reproductive Rights.2005. Religious Voices Worldwide Support Choice: Pro-choice Perspectives in Five World Religions.

Chavez , L. R. 2004.A Glass Half Empty: Latina Reproduction and Public Discourse. Human Organization, Vol. 63, No. 2

Chavkin ,Wendy, Liddy Leitman and Kate Polin.2013.Conscientious objection and refusal to provide reproductive healthcare: A white paper examining prevalence, health consequences, and policy responses. Global Doctors for Choice.

Chung Ho, Pak.2006.Women's perceptions on medical abortion. Department of Obstetrics and Gynecology, University of Hong Kong, Hong Kong Special Administrative Region, China.

Chung Ho, Pak.2006.Women's perceptions on medical abortion. Department of Obstetrics and Gynecology, University of Hong Kong.

Cockrill, Kate, Steph Herold, Ushma Upadhyay.2013.Addressing Abortion Stigma through Service Delivery. Routledge.

Cook R.J and Bernard M. Dickens .2003.Human Rights Dynamics of Abortion Law Reform.

Corberta, Piergiorgio.2003. Social Research: theory, methods and techniques .sage publications Ltd.

Crane, Barbara B. and Charlotte E. Hord Smith.2006.Access to Safe Abortion: An Essential Strategy for Achieving the Millennium Development Goals to Improve Maternal Health, Promote Gender Equality, and Reduce Poverty.

Crano ,W. D. and Marilynn B. Brewer.2002. *Principles and Methods of Social Research*: Lawrence Erlbaum Associates, Inc. Publishers, London.

Cresswell JA, Schroeder R, Dennis M,. Owolabi O, V,walika B, Musheke M, Campbell, O, Filippi V.2016.Women's knowledge and attitudes surrounding abortion in Zambia: a cross- sectional survey across three provinces. *BMJ Open 2016;6:e 010076. doi:10.1136/bmjopen-2015-010076.*

Creswell, John W. 2014.Research design: *A qualitative, quantitative, and mixed method approaches.* SAGE Publications India Pvt. Ltd.

Creswell, John. 2009. *Research design: A qualitative, quantitative, and mixed method approaches*. United States of America: SAGE Publications, Inc. Delhi, India: Pearson Education, Inc.

Crock J. Rosemary.2007. Abortion Decision-Making Attitudes of Adolescents Attending Roman Catholic Schools. Kansas State University Manhattan, Kansas.

CSA (Central Statistical Authority). 2013. Population Projection of Ethiopia for All Regions at Wereda Level from 2014 – 2017. Federal Democratic Republic of Ethiopia Central Statistical Agency, Addis Ababa.

CSA (Central Statistical Authority).2007. National Population and Housing Census of Ethiopia.

CSA (Central Statistical Authority).2012.the 2010/2011 Ethiopian household consumption and expenditure survey: "results for county level" Statistical report. Addis Ababa, Ethiopia: EPDRF CSA.

Curley, Maureen.2010. Psychological Distress after Abortion among University Students: Developing an Intervention. A Thesis submitted to McGill University in partial fulfillment of the requirements of the degree of Doctor of Philosophy.

Davies, V. 1991. *Abortion and afterwards.* Bath: Ashgrove Press.

Davis, A. R., & Beasley, A. D. 2009. Abortion in adolescents: epidemiology, confidentiality, and methods. Adolescent and pediatric gynecology.

Demirel, Serdar .2011. Abortion from an Islamic Ethical Point of View: International Journal of Business and Social Science Vol. 2 No. 1.

Denbow, Jennifer.2013. Abortion: When Choice and Autonomy Conflict. ***Berkeley Journal of Gender, Law & Justice.*** Volume 20 (13) issue no 1.

Desjarlais, R. and Jason Throop.2011. Phenomenological Approaches in Anthropology: The Annual Review of Anthropology. Determined Framework: Evidence from a Country wide District Level Household Survey in India.

Dimoula Y,Iordani .M, Konstantinou M, Kamenidou D, Zirilios K, Katsaouni M. And Galiatsato s G(n.d). Attitudes towards Abortion. Journal of health science.

Doherty, Cara.2013. Current discourses to Abortion in Ireland.

Dollar, D.1979.The Experience of Abortion: A Bibliographic Essay. *Journal of Psychology in society (PINS), pp47-59 Rhodes University*.

Durey, Rose .2010. Women and Abortion: women' health issue paper no 6, Australia.

Edmeades, Jeffrey, Laura Nyblade , Anju Malhotra , Kerry MacQuarrie , Sulabha Parasuraman , and Sunayana Walia.2010. Methodological Innovation in Studying Abortion in Developing Countries: A ''Narrative'' Quantitative Survey in Madhya Pradesh, India. *Journal of Mixed Methods Research 4(3) 176–198.*

Evens, M. 2003. *Gender and Social Theory.* UK: Open University Press.

Eyles, John, Bronwyn Harris, Jana Fried, Veloshnee Govender and Pascalia Munyewende.2015. Endurance, resistance and resilience in the South African health care system: case

studies to demonstrate mechanisms of coping within a constrained system. *BMC Health Services Research vol (15)432.*

FDRE , Ministry of Health Ethiopia .2006. Technical and procedural Guidelines for safe abortion services in Ethiopia Addis Ababa.

Finlay, L. 2011. Interpretative Phenomenological Analysis, in Phenomenology for Therapists: Researching the Lived World. John Wiley & Sons, Ltd:

Fowler, Erin .2013.Advancing Reproductive Rights in a Religious World: A Comparative Survey of Reproductive Rights in Poland, Indonesia and Israel. University of Toronto.

Gale. 2014. Opposing Viewpoints Online Collection, Opposing Viewpoints in Context.

Giddens, Anthony.1984. *The constitution of society: outline of the theory of structuration.* University of California press, Berkeley and Los Angeles.

Gilbert ,Indira and Vishanthie Sewpaul.2014.Challenging Dominant Discourses on Abortion From a Radical Feminist Standpoint. *Journal of Women and Social Work 30(1), 83-95.*

Gilbert, Indira .2013."Narratives on Abortion: Psychosocial, Ethical and Religious Considerations." PhD dissertation submitted to department of social work, University of KwaZulu-Natal Durban. Retrieved from Proquest dissertation.

Gizaw Thomas.2014. Assessment of Knowledge, Attitude and Practices Regarding Medication Abortion among Regular Undergraduate Female Students in College Of Social Sciences, Addis Ababa University.

Goenee Maaike, G. A. 2014. Decision-making concerning unwanted pregnancy in general practice . Family Practice Advance Access published.

Grimes, D. A., Benson, J., Singh, S., Romero, M., Ganatra, B., Okonofua, F. E., & Shah, I. H. 2006. Unsafe Abortion: the preventable pandemic.

Grisanti , Michael, A.2000. The Abortion Dilemma.

Hassan.H.B.205. Women's Long-Term Life Experience after Pregnancy Termination for Fetal Abnormality: Interpretive Phenomenological Study. The University of Western Ontario.

Henn, Matt, Mark Weinstein and Nick Foard.2006.A Short Introduction to Social Research. Sage publications.

Henshaw, Stanley .2006. "The Impact of Religion on Abortion Practice." presented at FIAPAC Conference, Rome.

Hilton, A. 2007.The different religions' views on abortion in religion & spirituality.

Hinman, Lawrence M .2014.Abortion: An Overview of the Ethical Issues, University of San Diego.

Hng, N.M, Jørgen Kurtzhals, Th Thu Thy and Vibeke Rasch.2009. Reproductive tract infections in women seeking abortion in Vietnam . *BMC women's health*.

Human Rights Watch .2005. Human rights and abortion: International Human Rights Law and Abortion in Latin America.

Hunte, G. S, Robert L.W, and Christiane C.S. (undated). Structure, Agency, and Resilience. Retrieved from www.resilience engineering-association.

IPAS (International Products and Services). 2016. Abortion Stigma Around the World: A synthesis of the qualitative literature. International Network for the Reduction of Abortion Discrimination and Stigma (inroads). Chapel Hill, NC: inroads.

Jackson, Caroline .2014. The Lived Experience of the Popular Music Festival-Goer. Bournemouth University.

Jones, R.P, Daniel Cox and Rachel laser.2011.Committed to availability, conflicted about morality: what the millennial generation tells us about the future of abortion debate and the culture wars. Public religion research institute, Inc.

Kidist Degifie. 2015. Exploring Women's Socio-Emotional Experiences of Induced Abortion in Marie Stopes Ethiopia. MA Thesis Report Submitted to the School of Psychology, Addis Ababa University.

Kimport,K, Kira Foster and Tracyweitz .2011.Social Sources of Women's Emotional Difficulty After Abortion: Lessons from Women's Abortion Narratives: Perspectives on Sexual and Reproductive Health, 2011, 43(2):pp. 103–109,

Kitzinger, Jenny.1994. The methodology of Focus Groups: the importance of interaction between research participants: *Journal of Sociology of Health & Illness Vol. 16 No.1.*

Klusendorf, Scott.2010. Advanced Pro-Life Apologetics

Komut, S.2009. Discourse Analysis of the Abortion Debate in Turkey and the United States. MA Thesis T.C. Kadir Has University, Istambul.

Konney, T.2009. Attitude of women with abortion-related complications toward provision of safe abortion services in Ghana. *Journal of Women's Health*.

Kothari, C.R. (2004). Research Methodology: Methods and Techniques. New Delhi: New Age International (P) Limited, Publishers.

Kumar, A., Hessini, L., & Mitchell, E. M. (2009). Conceptualizing abortion stigma. *Culture, Health & Sexuality, 11, 625–639.*

Kumar, Ranjit.2011. *Research Methodology: a step-by-step guide for beginners*: SAGE Publication.

Lamina M.A. 2013. Health care providers' attitudes towards termination of pregnancy: A qualitative study in Western Nigeria. *Open Journal of Obstetrics and Gynecology, 2013, 3, 400-410.*

Larsson, Sofia, Miriam Eliasson, Marie Klingberg Allvin, Elisabeth Faxelid, Lynn Atuyambe and Sara Fritzell.2015.The discourses on induced abortion in Ugandan daily newspapers: a discourse analysis. *Journal of Reproductive Health.*

lauro, Don.2011. Abortion and Contraceptive Use in Sub-Saharan Africa: How Women Plan Their Families: *African Journal of Reproductive Health 15 (1).*

Lawrence B. Finer, Lori F. Frohwirth, Lindsay A. Dauphinee, Susheela Singh and Ann M. Moore.2005. Reasons U.S. Women Have Abortions: Quantitative and Qualitative Perspectives. *Perspectives on Sexual and Reproductive Health, 2005, 37(3):110–118.*

Lazdane, Gunta.2005. Abortion in Europe: Ten Years after Cairo.

Lee1, T.Y, Cheng-Chen Chou, Chin-Mi Chen, Liljas Stålhandske. M, Ekstrand. M, and Tydén. T .2011. Existential Experiences and Strategies in Relation to Induced Abortion: An Interview Study with 24 Swedish Women, Uppsala Universitet, Sweden.

Lopez, R. 2012. Perspectives on Abortion: Pro-Choice, Pro-Life, and What Lies in between. *European Journal of Social Sciences, vol 27 (4).*

Machado CL, Osis MJD, Makuch MY, Azevedo RCS and Fernandes A. 2016. Experiences of Brazilian Women Who Got Pregnant after Sexual Violence and Underwent Legal Abortion. Crit Care Obst &Gyne. 2016, 2:11.

Madeira ,Jody L. 2014. Aborted Emotions: Regret, Relationality, and Regulation: *Michigan Journal of Gender & Law.*

Malhotra, Anju, Laura Nyblade, Sulabha Parasuraman, Kerry Mac Quarrie, Namita Kashyap, Sunayana Walia.2003. Realizing Reproductive Choice and Rights Abortion and Contraception in India.

Mappes, Thomas A., Jane S. Zembaty. 2002. Social Ethics: Morality and Social Policy. New York: McGraw Hill.

Marvasti, Amir, B. 2004. *Qualitative Research in Sociology:* An Introduction. Sage publications.

McCulloch, U. R.1996.Women's Experiences of Abortion in South Africa: An Exploratory Study: MA thesis submitted for clinical psychology, university of Cape Town.

Mihret Habte.2010.Determinants of Abortion Practice In Addis Ababa.MA thesis submitted to Population studies, Addis Ababa university.

Mikkelesen, B.2005. Methods for Development Work and Research: A New Guide for Participation. (2nd. ed). New Delhi: Sage Publication.

Moore, A. M, Gabriel Jagwe-Wadda, and Akinrinola Bankole.2010.Men's Attitudes about Abortion in Uganda. *Journal of Biosocial Science (2011), 43, pp 31-45.*

Mozelis,N. 2000. The subjectivist-objectivist Divide. Against Transcendence. *Sociology 34(4).*

Nalenga ,G.Z.2012. Causes of unintended pregnancy among adolescents in Addis Abeba, Ethiopia. Norwegian University of Life sciences (UMB).

Narendra, Anna.2010. Implications of Sex and Education on Abortion Attitudes: A Cross-Sectional Analysis

Ndlovu, Vezumuzi.2006. Gender and Reproductive Decision-Making among Couples with HIV/AIDS In

Ngubane, S.J.2010.Gender Roles In The African Culture: Implications For The Spread Of HIV/AIDS.

Oduwole, E.2010. Personhood and Abortion: An African Perspective.

Pacillo, E.L. 1997. Expanding the Feminist Imagination: An Analysis of Reproductive Rights: *Journal Of Gender And Law Vol 6(113).*

Parker.2003. HIV and AIDS-related stigma and discrimination: a conceptual framework and implications for action.

Patil, A.B ,Pranil Dode and Amruta Ahirrao.2014.Medical Ethics in Abortion. *Indian Journal of Clinical Practice, Vol. 25, No. 6.India.*

Payne, Geoff and Judy Payne .2004. *Key Concepts in Social Research*. SAGE Publications.

Pickless, C.2012. Termination-of-Pregnancy Rights and Fetal Interests in Continued Existence in South Africa: The Choice on Termination of Pregnancy Act 92 of 1996.

Plous, S. 1993. The psychology of judgment and decision-making. New York, McGraw-Hill.

Pollitt, K. 2005. Feminists for (Fetal) Life. In The Nation.

Population Reference Bureau (PRB) .2006.Unsafe abortion, facts and figures.

Pregnancy Advisory Centre (PAC).2016.Emotional responses after abortion qualitative and quantitative approaches. San Francisco: Jossey Bass.

Ramos,Silvina, Mariana Romero,and Lila Aizenberg.2014. Women's experiences with the use of medical abortion in a legally restricted context: the case of Argentina. Journal of *Reproductive Health Matters 2014; Supplement (43):1–12.*

Reardon, D.C. 2003. Abortion Decisions and the Duty to Screen: Clinical, Ethical, and Legal Implications of Predictive Risk Factors Of Post-Abortion Maladjustment. *Journal of Contemporary Health Law and Policy Vol. 20(33).*

Ritzer, George.2011. *sociological theory*. MacGraw Hill.

Rossier, C.2007. Attitudes towards abortion and contraception in rural and urban Burkinafaso. *Demographic Research vol 17(2), 23-58.*

Royal College of Obstetricians and Gynaecologists.2011. The Care of Women Requesting Induced Abortion The Care of Women Requesting Induced Abortion Evidence-based Clinical Guideline Number 7. RCOG Press, London.

Saleebey, D. 1996. The strengths perspective in social work practice: Extensions and cautions. Social Work, 41(3), 296-305.

Sarrah, Shahawy. 2016. Perspectives on Elective Abortion among Palestinian Women: Religion, Culture and Access in the Occupied Palestinian Territories. Doctoral dissertation, Harvard Medical School.

Schuster, S. 2005. Abortion in the moral world of the Cameroon grass fields. *Reproductive Health Science, 19(3), 1-13.*

Schwartz, R.A .1972. The Social Effects of Legal Abortion.

Selamawit Adnew.2013. Views of Women about Accessibility of Safe Abortion Care Services in Addis Ababa, Ethiopia. MA thesis submitted to Department of public health, University of South Africa.

Sell1,S. E, Evanguelia Kotzias Atherino dos Santos, Manuela Beatriz Velho, Alacoque Lorenzini Erdmann, Maria de Jesus Hernandes Rodriguez.2013. Reasons and meanings attributed by women who experienced induced abortion: an integrative review: *journal of school of nursing*.

Shah I, Åhman E .2009.Unsafe Abortion: Global and Regional Incidence, Trends, Consequences, and Challenges. *J Obstet Gynaecol Can; 31(12):1149–1158.*

Siegel, R.B .2012. Abortion and the "Woman Question": Forty Years of Debate. Social Work Research & Development ,Pretoria, South Africa.

Simon, Marilyn.2011.Analysis of qualitative data.

Singh Y.K.2006. *Fundamentals of research methodology and statistics.* New Age International (P) Ltd., Publishers, New Delhi.

Singh, S., Sedgh, G., & Hussain, R. 2010. Unintended Pregnancy: Worldwide Levels, Trends, and Outcomes. Studies in Family Planning, 41(4), 241–250.

Sintayehu Mekuriaw, Robel Mesay, Adissalem Dereje, Abera Kumalo, Mulugeta Feyissa and Andualem Henok.2015.Knowledge, Attitude and Practice towards Safe Abortion among Female Students of Mizan-Tepi University, South West Ethiopia. Women's Health Care.

Smoller, S.W, Raymond C. Lerner, Charles B. Arnold, and Susan L. Heimrath.1973. *New York State Physicians and the Social Context of Abortion.*

Stålhandske, Liljas, M., Ekstrand, M. & Tydén, T. 2011. Existential Experiences and Strategies in Relation to Induced Abortion: An Interview Study With 24 Swedish Women. Uppsala universete, Sweden.

Strickler, Jennifer and Nicholas L. Danigelis.2002.Changing Frameworks in Attitudes Toward Abortion. *Sociological Forum, Vol. 17, No. 2.*

Svanemyr, J and Sundby, J.2007. The social context of induced abortions among young couples in Côte d'Ivoire. *African Journal of Reproductive Health.*

Swartz, L. 1998. Fertility Transition in South Africa and its Implications. Pretoria.

Tesfaye Zeleke.2015. Interaction, Institutions and Impacts of Tourism on the Bishoftu-Modjo-Hawassa Route, Central Ethiopia. A Dissertation submitted to the department of sociology Addis Ababa University.

Thorseng, A. A.2008. Managing complexity through flexible scaling: A case study of the expansion of a health information system in Botswana.MA thesis submitted to UNIVERSITY OF OSLO Department of informatics Technology, Organisation and Learning.

Tracy, S. 2010. Abortion, the Marginalized, and the Vulnerable a Social Justice Perspective Reducing Abortion . *A Journal for Theology of Culture, Vol 6 No 2.*

Tsehai Wada.2008. Abortion Law in Ethiopia: A Comparative Perspective. Addis Ababa University

UNFPA.2014. Reproductive Rights Are Human Rights: A Handbook For National Human Rights Institutions.

Van Breda A. D.2001. Resilience Theory: A Literature Review. South African Military Health Service, Military Psychological Institute.

Vanderstroep, S, and Johnston, Dreidre. 2009. *Research methods for everyday life*: blending

Walliman, N. 2006. *Social Research Methods.* SAGE Publications.

Warriner, I.K and Shah I.H .2006.Preventing Unsafe Abortion and its Consequences: Priorities for Research and Action, New York: Guttmacher Institute.

Welter, L.B. 2015. Mexican-American women and abortion : experiences and reflections .

WHO .1999. Abortion in Developing World.

WHO. 1999. Abortion in Viet Nam: an Assessment of Policy, Program and research Issues. World Health Organization.

WHO. 2011. Unsafe abortion: global and regional estimates of incidence of unsafe abortion and associated mortality in 2008, WHO.

WHO.1970. Spontaneous and Induced Abortion. WHO technical report series no 461.

WHO.2007.Unsafe abortion. Global and regional estimates of the incidence of unsafe abortion and associated mortality in 2003.Fifth edition. Geneva, WHO.

WHO.2008. Unsafe abortion Global and regional estimates of the incidence of unsafe abortion and associated mortality in 2008 sixth edition.

WHO.2012. Safe Abortion: Technical and Policy Guidance for Health Systems Second Edition.

Williams, M.E.2002.Abortion : opposing viewpoints , Green haven Press, Inc., San Diego, California

Winikoff, B, Irving sivin, kurusj.coyaji,evelio cabezas,and Xiao Bilian.1997.The acceptability of medical abortion in china, Cuba and India. *Internatoional Familyplanning Perspectives Vol 23 Pp 73-78.*

Worku Animaw and Binyam Bogale.2014.Awareness and attitude to liberalized safe abortion services among female students in University and Colleges of Arba Minch Town, Ethiopia. Science Journal of Public Health.

Yeasmin, Sabina and Khan Ferdousour Rahman.2012.Triangulation' Research Method as the Tool of Social Science Research. *Bup Journal, Volume 1, Issue 1.*

Yin, R. 1994.*Case Study research: Design and Methods*. 2nd edition. Thousand Oaks, CA: Sag

Ymane, Taro.1967. *Statistics: an Introductory Analysis.* New York, Harper and Row publications.

Appendix 1: Instruments

Addis Ababa University

College of Social Sciences

Department of Sociology

I. Household Head Survey Questionnaire

Introduction

Dear respondent! My name is Antehunegn Birhanu. I am carrying out a study entitled as **"***The Interface between the Lived Experience of Women Practicing Abortion and Attitude of the Community towards Abortion in a Sociocultural Context: The Case of Woldia Town, North Wollo Zone, Amhara National Regional State*. The study is the part of the requirements for degree of Masters of Arts in Sociology at Addis Ababa University. The main aim of this study is to examine the lived experience of women experiencing abortion and community attitudes within the existing moral, religious, legal and medical discourses in Woldia Town.

Trust that the information you will provide is strictly confidential and serve only for academic purpose. The information you provide is indispensible about the practice of abortion and community response in the study area. To this end, your participation and genuine response to the questions is invaluable to the success of the study. No need of writing your name or any personal identification. Thus, I kindly ask your cooperation in filling this questionnaire truthfully.

Thank you for your cooperation!!

Section 1: Identification and Certification

Section 1: General Information

Interviewer's Name: ______________________________ Signature: __________________

Date (western, DD/MM/YYYY): ____________ ___________ _____________________

Supervisor's Name _______________________________Signature __________________

Date (western DD/MM/YYYY): ________ _____________ ________________________

Respondent's ***Kebele*** Name: _________________________________

Questionnaire ID Number: ____

General Instruction: In giving your answer please write the number of your choice in the corresponding box provided. But, if you have different answer other than the given options, use the space provided **(YOU ARE NOT RESTRICTED TO THE SPACE PROVIDED FOR OPEN ENDED QUESTIONS).**

Part I: Socio-demographic Characteristics of the Respondent

No	Items	Code category	Response	Skip to
1	Sex	(Male=1, Female=2)		
2	Age of the respondent (in complete year)			
3	Marital Status	(never married=1, married=2, divorced=3,widowed=4, separated=5)		
4	Religious Affiliation	(Orthodox=1, Muslim=2, Catholic=3, Protestant=4, Other=5:specify____________________________)		
5	Total family size:	(1-2=1, 3-4=2, 5-6=3, 7 and above=4)		
6	Educational Level of Household Head	(unable to Read and Write=1,Can Read and Write=2, Primary School Complete=3, Secondary School Complete=4; Certificate or Diploma=5 , Degree and above=6)		
7	What is your main source of income	(commercial activity=1, daily labor=2,government employee=3,remittance=4, self-employed/NGO=6 if other specify______________________________		

Part II: The practice of abortion: knowledge, contexts/settings/ and experience of community about abortion

No.	Items	Coding category	Response	Skip to
8	What kind of pregnancy termination **mainly** do you know?	(Safe=1, unsafe=2,spontaneous =3, other=4 specify__________)		
9	In which places women terminate unwanted pregnancy?**(Multiple response is possible)**	(government hospital=1,government health center=2, non-government health clinics=3, private clinic=4,traditional practitioner=5, other=6: specify_______________		
10	What do you think that the reasons why women terminate pregnancy? **(multiple response is allowed)**	Financial reasons=1, health threat to mother=2, fetal abnormality=3, fear of societal stigma/reaction=4, other: specify_________________		
11	What problems do you think that women face after terminating pregnancy? **(Multiple response is possible)**	Health problems=1, death=2,social stigma=3, I don't know=4,other=5: specify_______________		
12	Do you know Ethiopian 2005 revised abortion law?	(Yes =1 No =2)		**Q14** if no
13	What is your opinion about the revised abortion law?	I believe it is sufficient=1, I oppose as it violates norm of the society=2, I think it is insufficient=3, other=4 specify___________________		
14	Do you believe that abortion should be liberalized?	Yes =1,No=2		Q 16& 17 if no
15	Under what **conditions** do you think that abortion should be justified? **Multiple response is possible**	In case of rape that is legally approved and reported=1, to prevent maternal death=2, if a pregnant is a minor approved by recognized officials =3,up on the desire and request of a woman=4, I am not quite sure=5,		

		other=6: specify___________________		
16	Which factor **mainly** influence abortion decision in your community?	Religion=1,morality=2,gender role=3, legality=4,stigma=5, other=6: specify________________________________		
17	What are the **barriers** of safe abortion? (**multiple response is possible**)	Conscientious objection of doctors=1, availability of TBAs=2, confidentiality of healthcare providers=3, values and norms of the society=4,cost of abortion fee=5, other=6 specify_________________		
18	Who do you think that responsible for reproductive decision making in family? Multiple response is possible	husband=1,wife=2,children=3, other =4 specify__________________		
19	Do you think that females have the right to terminate pregnancy by their own?	(Yes =1, No=2)		**Q20 if no**
20	What would be the possible reasons why women do not influence men in reproductive decisions? (**Multiple response is possible)**	Male dominance system=1, women are perceived as not leaders=2, abortion is a sign of illicit sexuality=3, if other specify______ 4		
21	What do you think the response of the community towards pregnancy termination?	Positive reaction=1, negative stereotype=2, discrimination from community participation and services, =3 other specify_____________		
22	Will you voluntary if a woman asks you any support after experiencing abortion?	(Yes =1, No=2)		**Q 23 & 24 if no**
23	If the response to **Q 22 is No**, what is your reason not to support? (**Multiple response is possible)**	I consider her as adulteress=1, she is murder=2, she violates cultural values=3, she may encourage other women other: specify______________________		
24	What if one of your family members experiences unwanted /unplanned pregnancy?	she should terminate safely=1, she has to raise it=2,I just go out her from home=3, she will go to TBAs=4, I don't know how could she do, other specify____________________________5		
25	Would you share the problem to someone else if unwanted pregnancy occurred in your family?	(Yes =1, No=2)		Q 26 if no
25.1	If **yes to Q no 25**, to whom you may share the case you face?(**More than one response is possible)**	Family members =1, my friends=2, I am uncertain=4, other specify__________		
26	What is the **main** reason behind not telling your problems to others?	Fear of social stigma=1, I believe that the secret will be disclosed=2,family reaction=3, other specify______________		
27	Have you ever experienced an induced abortion in your family?	(Yes =1, No=2)		
27.1	If yes to Q 27, What was your reason/s/ to terminate your pregnancy? ____			

28. Generally speaking, what are your views about termination of pregnancy?____

____

29. Under what conditions you would agree or disagree if **someone else** experience unwanted pregnancy and wants to terminate (please put your preferences from greatest to least) **[questions taken from GSS (General Social Survey) employed by Crock (2007) having reliability score (Cronbach's alpha of 0.7).**

No	Items	Order
1	The family is very poor	
2	The pregnancy is the result of rape	
3	The pregnant women want to control her body and terminate pregnancy for any reason, at any time in pregnancy	
4	The father of the baby does not want a baby	
5	There are no conditions under which abortion is acceptable	
6	When the pregnancy affects physical, emotional and psychological aspects of a woman and her family	

Part III. The influence of socio-cultural discourses on community attitudes towards abortion practice

30. Stigmatizing attitudes, beliefs and actions scale (SABAS) (taken from Shellenberg *et al.* (2013)						
Negative stereotyping, discrimination and contagion towards Induced abortion		**Level of agreement**				
No	**Items**	SA	A	N	D	SD
1	A woman having an abortion is committing a sin	1	2	3	4	5
2	Once a woman has an abortion, she will make it a habit	1	2	3	4	5
3	A woman who has an abortion cannot be trusted by the community	1	2	3	4	5
4	A woman who has had abortion encourages other women to get abortion	1	2	3	4	5
5	A woman having induced abortion should be prohibited to religious services	1	2	3	4	5
6	A man should not marry a woman who practiced induced abortion	1	2	3	4	5
7	I would stop being friends if my friend/someone having induced abortion	1	2	3	4	5
8	A woman having abortion should be treated equally as anyone of us	5	4	3	2	1
9	I would respect a woman having abortion regardless of the reason	5	4	3	2	1
10	Making sex with women having abortion infects men	1	2	3	4	5
	SUM TOTAL OF SCORES (For use by the researcher)					

(SA=strongly agree, A=agree, N=neutral, D=disagree and SD= strongly disagree)

31.Moral and Religious Discourses on Abortion Attitude		**Level of agreement**				
Items		**SA**	**A**	**N**	**D**	**SD**
1	Abortion is inhumane	1	2	3	4	5
2	Abortion is immoral	1	2	3	4	5
3	Abortion violates the right to unborn	1	2	3	4	5
4	Abortion is a sin against God	1	2	3	4	5
5	There is no situation in which abortion is justified	1	2	3	4	5
6	A woman has the right and autonomy to control her body despite moral and religious values	5	4	3	2	1
7	Every conceived child has the right to be born	5	4	3	2	1
8	Abortion should be allowed depending on the situation	5	4	3	2	1
9	My Religiosity negatively affects to abortion decision	1	2	3	4	5
10	My religion prohibit me to perform abortion	1	2	3	4	5
SUM TOTAL OF SCORES (For use by the researcher)						

32. Medico-legal Discourses on Abortion Attitude

1	I don’t have trust on the confidentiality of healthcare providers	1	2	3	4	5
2	Government should prohibit law that promote abortion	1	2	3	4	5
3	Legalization of abortion increases abortion rate	5	4	3	2	1
4	Abortion clinics should be expanded	5	4	3	2	1
5	Induced abortion gives a relief for a woman	5	4	3	2	1

6	a woman should get legal consent from her husband or families to terminate her pregnancy	5	4	3	2	1
7	Abortion should be legally permitted if a woman is living with HIV/AIDS and related diseases	5	4	3	2	1
8	Legal abortion encourages promiscuous behavior	1	2	3	4	5
9	abortion causes STDs and RTI	1	2	3	4	5
10	Healthcare providers couldn't satisfy the demand of women seeking abortion	1	2	3	4	5
	SUM TOTAL OF SCORES (For use by the researcher)					

(SA=strongly agree, A=agree, N=neutral, D=disagree and SD= strongly disagree)

33. Community Attitude towards Abortion Practice						
No	**Items**	**Level of agreements**				
		SA	A	N	D	SD
1	I condemn the practice of abortion	1	2	3	4	5
2	Abortion is a murder and a sinful act	1	2	3	4	5
3	I believe that induced abortion gives a relief for a woman					
4	Abortion decreases sexual desire	1	2	3	4	5
5	Abortion aggravates divorce among couples	1	2	3	4	5
6	I oppose abortion as it exposes for social stigma	1	2	3	4	5
7	I personally believe that abortion violates human right	1	2	3	4	5
8	I argue that abortion violates the societal values and norms	1	2	3	4	5
9	I do not support abortion as it produces health complications to women	1	2	3	4	5
10	Abortion affects psychological and emotional wellbeing of women	1	2	3	4	5
	SUM TOTAL OF SCORES (For use by the researcher)					

(SA=strongly agree, A=agree, N=neutral, D=disagree and SD= strongly disagree)

34. Please write down if you have extra ideas regarding abortion/pregnancy termination____

II. FGD Guide for Household Heads and Youths

What are the most pressing issues regarding induced abortion in your community?

Theme 1: knowledge, experience and contexts of safe abortion (Awareness on the 2005 revised abortion law and its implication; Religious and moral views on abortion practice)

Theme 2: community response of stigma, attitude, social support towards abortion practice

Theme 3: abortion and the lived experience of women having abortion and decision making process, gender roles and dynamics of gender norms)

Theme 4: conflictual nature of women's reasons for pregnancy termination and community values (discourses) towards abortion

III. <u>In-depth Interview Guide for women having abortion in health centers</u>

1. **Factors influencing abortion decision and Negotiating Strategies of Women within Conflicting Ideas**

1.1 What factors mostly influence your decision making on termination of pregnancy?

1.2 How does your religion matter in practicing and decision making? Does it have an influence on your decision? What about the morality of the fetus?

1.3 How do you resolve conflicting ideas? With whom you have attempted to resolve (if any)?

1.4 What unique strategies you have used to decide practicing abortion?

1.5 Who was /were/helping you (if any)?

1.6 Did you share your case to others?

1.7 What was their response when you told them?

2. To examine the lived experience of women Practicing Abortion and Resilience Mechanisms

2.1 What are your general views on termination of pregnancy? Or perception towards abortion?

2.2 What is /are/your reason/s to terminate your pregnancy?

2.3 Did you have prior information about induced abortion? What about legality of practicing abortion?

2.4 What is/was /your feelings **before** experiencing medical/surgical abortion? Any dilemma in abortion decision? How was the family pressure if any?

2.5 Did you get pre-counseling service?

2.6 How do you explain the counseling service?

2.7 Have you changed your decision after pre-counseling?

2.8 How did you feel **during** abortion procedure if any? What type of abortion have you experienced; Medical or surgical? How was your expectation?

2.9 Was there any legal requirements /procedures/ while you are practicing abortion?

2.10 What did you felt **after** practicing induced abortion?

- What type of health problems did you face (if any)?
- Was there any post abortion counseling? How do you get it?
- What is your perception towards services being provided by healthcare providers?
- What reaction/s you faced from your partner, family, neighbors, and community? How did you get it compared to your previous expectation?
- What **resilience** mechanisms did you use to cope up your stress (if any)

2.11 Socio-Demographic Characteristics of Participants

Age_____Educational level _______________Occupation________________No of children_____

Key Informant Interview Guide

1. **Key Informant Interview Guide for Head of Health Institutions**

1.1 Clinic based abortion records (trend of safe abortion) based on before and after the 2005 revision of abortion law.
1.2 How is the change of abortion practice before and after revision?
1.3 Which age group is mostly performing induced abortion?
1.4 Which abortion practice is widely performed, Medical or surgical? Why?
1.5 How is the tendency of women in practicing first trimester abortion (<12 weeks)
1.6 What are the possible requirements for admission?
1.7 Is there any complications and mortality due to induced abortion?
1.8 Socio-demographic Characteristics of Key-informants
Sex________Age_____Religion_____________educational status ___________Profession/occupation/ ____________

2. **Interview guides for Healthcare Providers and Gynecologists**

2.1 How do you view the practice of induced abortion?
2.2 What factors and /or challenges most influence you in providing abortion service to your clients (if any)? (Moral agency, religion, social and culture values, others)
2.3 Is there any legal procedure which affects the provision of abortion?
- Does it have an effect in your activities?
- How do you describe response/s of women practicing abortion towards the legal procedure?

2.4 How do you describe the feeling of women practicing induced abortion?
2.5 How do you describe the myths about abortion? Do you agree with the ideas about it? Why?
2.6 Did you provide them pre and post abortion counseling (if any)? How do you describe its effectiveness?
2.7 Socio-demographic Characteristics of Key-informants:
Sex____Age_____Religion_____________educational status ___________Profession/occupation/ ____________

3. **Key Informant Interview Guide for Elderly of the Community**

3.1 How do you view the practice of terminating pregnancy?
3.2 Can you tell me reasons why women terminate pregnancy in your community?
3.3 What are the reasons that deter women to terminate pregnancy?
3.4 Do you think that termination of pregnancy should be justified in a certain cases? Why?
3.5 Socio-demographic Characteristics of Key-informants
Sex________Age_____Religion_____________educational status ___________Profession/occupation/ ____________

Key Informant Interview Guide for Religious leaders of the Community

3.6 How do you view abortion practice in your community?
3.7 Do you think that abortion should be prohibited by law?
3.8 What does your religion really say about terminating pregnancy?
3.9 When do you think that terminating pregnancy should be permitted?
3.10 What roles religious organizations should play in preventing social stigma towards women practicing abortion?
3.11 Socio-demographic Characteristics of Key-informants
Sex________Age_____Religion_____________educational status ___________Profession/occupation/ ____________

4. Key Informant Interview Guide for Women and Children Affair Office

- What is your view on induced abortion?
- How do explain the awareness of the community towards the safe abortion?
- How do you see women's reason to end pregnancy?
- How do you view the response of community on termination of pregnancy? What consequences did women face as a result of such community responses?
- Socio-demographic Characteristics of Key-informants

Sex________Age_____Religion_____________educational status ___________Profession/occupation/ ____________

5. **Key Informant Interview guide for Courts**

- ✓ How do you view termination of pregnancy?
- ✓ What is your view about the decriminalization of abortion? How to compromise women's right to terminate against sociocultural and moral values?
- ✓ How do you see the revised Ethiopian abortion law in addressing the social dynamism?
- ✓ How do rate the awareness of the community about the abortion law? Did you give any awareness?
- ✓ Socio-demographic Characteristics of Key-informants

Sex________Age_____Religion_____________educational status ___________Profession/occupation/

Appendix 2: Profile of Study Participants

A. Profile of Key Informants

No	Name	Sex	Age	Religion	Educational status	Occupation	Date of interview
1	H/Melaku Tegegne	M	88	Orthodox	Pension	Can read and write	05/07/09 E.C
2	Asnika Belay	F	60	Orthodox	Government employee	Diploma	05/07/09 E.C
3	Birhane Ayalew	F	56	Orthodox	Merchant	Primary completed	05/07/09 E.C
4	Halima Hussen	M	70	Islam	Merchant	Can read and write	05/07/09 E.C
5	Memhr Tsome lisan	M	50	Orthodox	Can read and write	Religious leader	10/07/09 E.C
6	Sheck Hussen Ali	M	72	Islam	Primary completed	Religious leader	14/07/09 E.C
7	Pastor Belay	M	58	Protestant	12th completed	Religious leader	18/07/09E.C
8	Desalegn Berhe	M	38	Orthodox	Government employee	Degree	19/07/09 E.C
9	Lemlem Alemneh	F	45	Orthodox	Government employee	Degree	19/07/09 E.C
10	Abera Hagos	M	35	Orthodox	LLB	Lawyer	20/07/09 E.C
11	Mesfin Alene	M	32	Orthodox	LLM	Lawyer	20/07/09 E.C
12	Ayalnesh assefa	F	58	Orthodox	HO	Healthcare provider	21/07/09 E.C
13	Ambaye tilahun	M	29	Orthodox	BSC Midwifery	Healthcare provider	21/07/09 E.C
14	Dr. Wassie Yimer	M	35	Orthodox	Private employee	MD	22/07/09E.C
15	Mahlet tesfaye	F	23	Orthodox	BSC nursing	HEW	22/07/09E.C
16	Haregewoin	F	26	Orthodox	BSC nursing	HEW	22/07/09E.C

Profile of in-depth interviewees

NO	Name	Age	Religion	Educational status	Occupation	Marital status
1	Zewde	27	Orthodox	Illiterate	Daily labor	Divorced
2	Selam	19	Muslim	Grade 8	Unemployed	Unmarried
3	Demeku	22	Orthodox	University student	Student	Unmarried
4	Kebebush	18	Muslim	Grade 9	Student	Unmarried
5	Lemlem	24	Orthodox	Illiterate	Housemaid	Unmarried
6	Emebet	24	Orthodox	10 grade	Daily laborer	Unmarried
7	Fenta	25	Orthodox	9 grade	House wife	married
8	Halima	20	Muslim	8 th		
9	Genet	22	Orthodox	10 grade	House wife	married
10	**Abebech**	**19**	**Orthodox**	**10+2**	**Student**	**married**
11	**Jemila**	**34**	**Muslim**	**Primary complete**	**Unemployed**	**married**
12	**Beletech**	**30**	**Orthodox**	**Illiterate**	**Unemployed**	**Unmarried**

Appendix 3: Additional Tabular Presentations of Data

3.1 Cross Tabulation: Socio-Demographic Background of Respondents and Reasons of Pregnancy Termination

	Responses	counts	So Socio-Demographic Background of Respondents Demographic					
			Age Category of Respondents					Total
			24-34	35-45	46-56	57-67	>=68	154
Reason of pregnancy Termination	Economic Reason	Count	33	77	36	6	2	154
	Health Threat To Mother	Count	26	57	28	2	3	116
	Fetal Abnormality	Count	26	62	26	4	4	122
	Fear Of Societal Reaction/Stigma	Count	42	74	35	9	3	163
	Total	Count	75	143	74	12	5	309
			Sex of Respondents					
	Responses	Counts	Male	Female	Total			
	Economic Reason	Count	73	81	154			
	Health Threat To Mother	Count	47	69	116			
	Fetal Abnormality	Count	52	70	122			
	Fear Of Societal Reaction/Stigma	Count	86	77	163			
Total	Total	Count	136	173	309			
Reason of pregnancy Termination	Responses	Counts	Marital Status					
		Counts	Married	Unmarried	Divorced	Widowed	Total	
	Economic Reason	Count	109	28	13	4	154	
	Health Threat To Mother	Count	85	21	8	2	116	
	Fetal Abnormality	Count	94	20	6	2	122	
	Fear Of Societal Reaction/Stigma	Count	101	43	13	6	163	
	Total		209	73	20	7	309	
	Responses	Counts	Religion of respondents					
			orthodox Christianity	Muslim	Catholic	Protestant	Total	
	Economic Reason	Count	112	33	2	7	154	
	Health Threat To Mother	Count	74	33	2	7	116	
	Fetal Abnormality	Count	83	31	1	7	122	

	Fear Of Societal Reaction/Stigma	Count	124	33	0	6	163
Total		Count	225	68	3	13	309

3.2 Cross Tabulation: Sex of Respondents and Knowledgeability on Abortion Law (Revised in 2005 G.C)

		sex of respondents		Total
		Male	Female	
Do you have information about Ethiopian 2005 revised abortion law which allows abortion (art 551)?	Yes	58	83	141
	No	79	90	169
Total		137	173	310

3.3 Cross tabulation: Sex of Respondents Vs. Legalization of Abortion Practice

		sex of respondents		Total
		Male	Female	
Do you believe that abortion should be legalized?	Yes	76	107	183
	No	61	66	127
Total		137	173	310

3.4 Cross Tabulation: Marital Status of Respondents and Main Factor Influencing Abortion Decision

Characteristics	Responses	Which factor mainly influence abortion decision in your community?				Total
		Religion And Morality	Gender Norms and Roles	Legality	societal stigma	
Marital status	Married	78	54	19	59	210
	Unmarried	25	14	3	31	73
	Divorced	12	1	2	5	20
	Widowed	5	0	0	2	7
Total		120	69	24	97	310

3.5 Cross Tabulation: Sex of Respondents and Right of Women to Terminate Pregnancy

Count				
Do you think that females have the right to terminate pregnancy by their own?	Responses	**Sex of Respondents**		Total
		Male	Female	
	Yes	48	51	99
	No	89	122	211
Total		137	173	310

3.6 Tabular Presentation of Respondents' Attitude towards Abortion Practice

Statements	Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
I condemn the practice of abortion	115(37.1 %)	53(17.1 %)	29(9.4%)	76(24.5 %)	37(11.9 %)
Abortion is a murder and a sinful act	121(39.0%)	93(30%)	40(12.9%)	41(13.2%)	15(4.8%)
I believe that induced abortion gives a relief for a woman	30(9.7%)	72(23.2%)	54(17.4%)	91(29.4%)	63(20.3 %)
Abortion decreases sexual desire	25(8.1%)	34(11%)	93(30%)	114(36.8%)	44(14.2%)
Abortion aggravates divorce among couples	46(14.8%)	118(38.1%)	63(20.3%)	57(18.4%)	26(8.4%)
Abortion exposes for social stigma	48(15.5%)	111(35.8%)	34(11%)	84(27.1%)	33(10.6%)
I personally believe that abortion violates human right	81(26.1%)	107(34.5%)	52(16.8%)	55(17.7%)	15(4.8%)
I argue that abortion violates the societal values and norms	56(18.1%)	115(37.1%)	40(12.9%)	76(24.5%)	23(7.4%)
I do not support abortion as it produces health complications to women	137(44.2%)	115(37.1%)	10(3.2%)	30(9.7%)	18(5.8%)
Abortion affects psychological and emotional wellbeing of women	119(38.4%)	124(40%)	23(7.4%)	32(10.3%)	12(3.9%)