VIEWS OF WOMEN ABOUT ACCESSIBILITY OF SAFE ABORTION CARE SERVICES IN ADDIS ABABA, ETHIOPIA

by

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DECLARATION

I declare that the dissertation **VIEWS OF WOMEN ABOUT ACCESSIBILITY OF SAFE ABORTION CARE SERVICES IN ADDIS ABABA, ETHIOPIA** is my own work, that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references, and that this work has not been submitted before for any other degree at any other institution.

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10 February 2013 — **Date**

VIEWS OF WOMEN ABOUT ACCESSIBILITY OF SAFE ABORTION CARE SERVICES IN ADDIS ABABA, ETHIOPIA

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ABSTRACT

Background: In many developing countries, maternal deaths occur mainly as a result of unsafe abortions, a situation reflecting the inaccessibility of safe abortion services in such countries. In Ethiopia, unsafe abortion accounts for 32% of maternal deaths and almost 60% of gynaecological admissions, and is one of the top ten causes of general hospital admissions.

Purpose: The purpose of this study was to assess the views of women about the accessibility of safe abortion services in governmental health centres.

Methods: A quantitative cross-sectional descriptive and non-experimental study using structured questionnaires was conducted. 342 women who had received abortion care services in governmental health centres participated.

Findings: 46.8% of the participants do not know about the penal code regarding safe abortion care. 52.9% of the participants viewed safe abortion care as inaccessible because there are various and competing factors which make abortion service to be viewed as accessible or inaccessible and these include distance to nearest health centre, the time it takes to receive the service, the cost of the service, and the lack of appropriate skills in the service providers.

Conclusion: An improvement in the accessibility of abortion services will prevent deaths resulting from unsafe abortions.

KEY CONCEPTS
Safe abortion care, accessibility, the views of women, the distance travelled, abortion, health centres, governmental health centres, time spent waiting, the cost of the service, and the skill of the providers.

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Dedication

To my father and my mom who believed in me.

Your prayers and love have counted, and will continue to count. Long live both!

Wube, Mintye and Nani, you are always my delight, and when I think of you I feel thankful to the Lord for blessing me with such kind siblings!

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BCC	Behavior change and communication
SPSS	Statistical Package for Social Science
STI	Sexually Transmitted Infections
USAID	United States Agency for international development
WHO	World Health Organization

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CHAPTER 1

ORIENTATION TO THE STUDY

1.1 INTRODUCTION

According to the World Health Organization (2008:1), unsafe abortion is one of the major causes of maternal death. Each year 21.6 million unsafe abortions are estimated to occur globally, of which 21.2 million occur in developing countries. Although unsafe abortions are preventable through sexuality education, family planning and the provision of safe and legal abortion care services, they still continue to endanger the lives of many women. In 2008 13% of the maternal deaths In Africa were due to unsafe abortion. In Ethiopia this figure is disproportionately higher. Studies performed in Ethiopia have shown that unsafe abortion accounts for 32% of maternal deaths. It is also one of the top ten causes of hospital admissions, accounting for nearly 60% of gynaecologic admissions and almost 30% of all obstetric and gynaecologic admissions (Federal Ministry of Health 2006:4).

Among the barriers that hinder women from receiving safe abortion care in Ethiopia, women's inability to access comprehensive abortion care services is the major one (Goodman, Sackett & Vasilver 2008:3).

1.2 BACKGROUND TO THE STUDY

Globally more than 500,000 women die from pregnancy and childbirth-related complications each year, and 99% of these occur in developing countries, the major causes being haemorrhage, infection, obstructed labour, hypertensive disorders in pregnancy, and complications arising from unsafe abortion (USAID 2010:2).

As in most developing countries, the most common causes of maternal mortality in Ethiopia include unsafe abortion, obstructed labour, haemorrhage (antepartum or postpartum), puerperal sepsis i.e. infection, hypertension, and pelvic inflammatory diseases. Co-morbidity with anaemia, diabetes, malaria, and STI increases the chance

of death during pregnancy and labour, and these are therefore are indirect causes of maternal mortality (World Health Organization 2011:20).

Unsafe abortions, and other associated morbidity, mortality and socioeconomic impacts are not inevitable. Unsafe abortion is likely to occur in settings where there are strong legal bans or where more liberal laws have not translated into access to safe and comprehensive services. Studies also suggest that children born under abortion prohibitions experience substantial socio-economic adversity such as lower rates of education or poor labour market outcomes (Benson, Andersen & Samandari 2011:2).

According to the Federal Democratic Republic of Ethiopia, Ministry of Health (2005:6), unsafe abortion is the most common cause of maternal mortality, accounting for 32% of maternal deaths in the country.

It is evident that the accessibility of health care services can be greatly influenced by structural factors (such as the distance from the village of the health institution providing safe abortion care), procedural and administrative factors (the waiting time and the monetary factors), moral factors (the provider's attitude towards clients), medical factors (special extra-legal qualifications for accessing the service), service-related factors (the perceived or known unsatisfactory quality of the provision of care), the objections raised by a life partner, and other socio-cultural, legal, managerial and personal factors. Accessibility is also related to the level of client satisfaction. Surely essential health care services should be accessible to all individuals and communities without any discrimination (International Planned Parenthood Federation 2008:7).

The 1957 penal code of Ethiopia permitted abortion only to save the life or health of the mother. However, in 2005 Ethiopia revised the criminal code on abortion allowing abortion to be carried out only under the following conditions:

1 When the pregnancy has resulted from rape or incest.
2 When the continuation of the pregnancy endangers the health and life of the mother or the foetus.
3 If the foetus has abnormalities.
4 If the woman has physical or mental disabilities.

5 If the pregnant woman is a minor who is physically or psychologically unprepared to raise a child.

The law also notes that poverty may be a ground for reducing the criminal penalty for abortion. Although the law allows abortion under the above conditions, illegal abortion may be still punishable by up to three years of imprisonment (Goodman et al 2008:7).

In many countries mortality and morbidity resulting from abortion are declining due to the legalisation of abortion and the provision of accessible and affordable safe services (Alemu 2010:30). In Ethiopia, despite the formulation of a more liberal abortion law and the efforts made to expand the number of trained health care providers and health facilities as part of the health sector development plan, the inadequate state of the health system continues to limit access to safe abortion services (Goodman et al 2008:8).

1.3 RESEARCH PROBLEM

A significant number of maternal deaths in developing countries occur due to unsafe abortion. This often reflects women's inability to access safe abortion services. Unsafe abortion is often the result of the existence of legal and other barriers to accessing safe abortion. In 2005 the Ethiopian government liberalised the then restrictive abortion law and passed a new abortion law which makes women eligible to get safe abortion care services under certain conditions. The ministry of health acknowledged that the revision of legal policies alone might not in itself ensure the accessibility of the service if other factors were not addressed as well (Federal Ministry of Health 2006:6).

Although most measures of health care quality and accessibility focus on medical outcomes rather than clients' assessment of access, these do not reveal a full picture of the problem, because clients' perceptions of their access to the service is important, for instance in that it determines their decision on whether or not to return or recommend the service to other potential users (Gebresilase, Fetters, Singh, Abdella, Gebrehiwot, Tesfay, Geresu & Kumbi 2008:10).

There is a very limited body of literature dealing with clients' views on the accessibility of safe abortion service in Addis Ababa, Ethiopia. This study was therefore aimed at

assessing the views of women about the accessibility of safe abortion care services in Ethiopia and will help to fill the gap, which is a contributory factor influencing the women's health seeking behaviour.

1.4 RESEARCH PURPOSE

The purpose of the study was to assess the views of women about the accessibility of safe abortion care in the governmental health centres in Addis Ababa City Administration.

1.4.1 Research objectives

The objectives of the study were to

- determine women's views about safe abortion care services
- examine women's views about the distance of the health institution providing safe abortion care from their village
- determine women's views about the cost of the abortion care service
- determine women's views about the time they had to wait to get the service
- examine the extent of women's confidence in the skills of the providers of the health care and other factors that affect service accessibility

1.5 SIGNIFICANCE OF THE STUDY

Most measures of health care accessibility focus on medical outcomes than on clients' assessment of access. But clients' perceptions of access to the service are also important, as they determine their decision as to whether or not to return or recommend the service to other potential users (Gebresilase et al 2008:10).

The results of this study will primarily be used to provide information on women's views regarding the accessibility of safe abortion care services in Addis Ababa. It will also help providers, health care authorities and policy makers to prioritise problems, design client centred and tailored services, and allocate resources to make safe abortion services accessible in health institutions.

1.6 DEFINITION OF TERMS

Brief descriptions of the terms used in the study are as follows:

1.6.2 The dependent variable

Accessibility to health services refers to the continued and organised supply of equitable health care services within easy-to-reach distance, at the right health facility, by a skilled provider at an affordable price, provided to all individuals and communities.

1.6.2 Independent variables

Geographic factors refer to the distance from the individual's or community's residence, the time it takes to reach a particular health facility, and the availability of a means of transport.

Financial factors refer to the availability of the service at an affordable price to all individuals.

Health services factors refer to the availability of appropriate care in terms of staffing, operational hours and equipment.

Cultural factors refer to the acceptability of the services provided within the cultural norms and values of Ethiopian women.

1.7 RESEARCH DESIGN AND METHOD

1.7.1 Research design

A quantitative, cross-sectional, descriptive and non-experimental study was used to assess the views of women regarding the accessibility of safe abortion care. The assessment was performed numerically, without any manipulation of their views, to provide a clear picture of how they think.

1.7.2 Research method

Population and sample selection

Population: The population for this study consisted of all women between the ages of 18-49 years living in Ethiopia who attend government health centres for reproductive health care.

Target population: The target population for the study consisted of all women between the ages of 18-49 years who attend health centres providing safe abortion care for reproductive health services in Addis Ababa.

Sample frame: The sample frame for the study consisted of the list of the 24 governmental health centres found in Addis Ababa which provide safe abortion care.

Accessible population: Women between the ages of 18-49 years who in the study period received safe abortion care at the 10 health centres selected from the available 24 were the accessible population for this study.

Sampling: The sampling approach used was probability sampling - specifically simple random sampling. Participants were selected at random from those attending 10 health centres selected from among the 24 which provide safe abortion care in Addis Ababa. 342 women between the ages of 18-49 years who came to the selected health centres for safe abortion care during the data collection period were interviewed.

1.8 SCOPE OF THE STUDY

The study encompasses the area of reproductive health, specifically abortion care, in that it assesses the view of women who between the ages of 18 and 49 years towards the accessibility of the safe abortion care service. The respondents were women who went to the selected governmental health centres to receive safe abortion care in Addis Ababa.

1.9 ORGANISATION OF THE DISSERTATION

The dissertation is divided into the following four chapters. Chapter 1 introduces the study and gives a brief background to the study. Chapter 2 provides a review of related theoretical and empirical literature. Chapter 3 describes the research methodology pursued. Chapter 4 presents the results derived from the data collected and illustrates the findings using figures and tables. The final chapter, chapter 5, summarises the findings of the research work, points out the limitations of the study, concludes the presentation of the results, and finally makes recommendations based on the findings of the study.

1.10 CONCLUSION

This chapter has provided a brief overview of the study by introducing background information relating to the situation of unsafe abortion in the global scenario, in Africa, and in the Ethiopian context. It further clearly indicated the research problem, the purpose of the research, the research objectives, significance of the study, research methodology, the scope and definition of terms. The next chapter deals with the literature reviewed to obtain information regarding the accessibility of safe abortion care both theoretically and empirically.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

The purpose of this chapter is to provide an overview of the theoretical and empirical literature relevant to the study of the views of women on the accessibility of safe abortion care services in Ethiopia. The chapter reviews the global situation of abortion and factors influencing the accessibility of safe abortion care, and finally gives a summary of the empirical research performed in similar areas of study, as well as major findings arising from the existing research.

2.2 THE GLOBAL SITUATION OF ACCESS TO ABORTION SERVICES

Unsafe abortion remains one of the major causes of injury and death among women worldwide. A review of the literature shows that an estimated half of all abortions worldwide are unsafe and nearly all unsafe abortions (98%) occur in developing countries (Iqbal & Ahman 2008:169).

In many developing countries, especially in sub-Saharan Africa, Latin America and South and Southeast Asia, where abortion laws are relatively restrictive, the unmet need for contraception is high and the status of women in society is low. The prevalence of unsafe abortion could be reduced through interventions such as providing universal access to family planning services, comprehensive sex education, improved access to safe abortion and high-quality post-abortion care, integrated with post abortion contraceptive counselling and on-site services. The most important factor determining the implementation of such intervention is the commitment of governments to prevent unsafe abortion and reduce its prevalence and consequences (Faundes 2010:477).

2.3 THE SITUATION IN ETHIOPIA

Even though Ethiopia has recently increased its efforts to broaden the number of trained health care providers and build more health facilities, the inadequate state of the health system continues to limit access to safe abortion services. It is estimated that only one physician is available for every 35,000 people, and one midwife for every 3,756 expected deliveries. Access to health care services is restricted due to insufficient distribution of medical supplies and a great disparity between the provision of health care in urban and rural areas (Goodman et al 2008:18).

Many factors can prevent women from getting medical advice or treatment for themselves when they are sick. Information on such factors is particularly important in understanding and addressing the barriers women may face in seeking care during pregnancy and at the time of delivery. Even where health services exist, social, cultural, and economic factors may cause women not to use the services, particularly when their concern is related to sexual or reproductive matters (Central Statistical Agency and ICF International 2012:131-132).

A study which was conducted by using indirect estimation techniques to calculate the incidence of induced abortion found that in 2008 alone, an estimated 382,000 induced abortions were performed in Ethiopia, and 52,600 women were treated for complications arising from abortions. There were an estimated 103,000 legal procedures in health facilities nationwide, which comprised 27% of all abortions. Nationally, the annual abortion rate was 23 per 1,000 women aged 15–44, and the abortion ratio was 13 per 100 live births. The abortion rate in Addis Ababa (49 per 1,000 women) was twice the national level. Overall, about 42% of pregnancies in Ethiopia were unintended, and the unintended pregnancy rate was 101 per 1,000 women (Gebresilase et al 2008:16).

2.4 FACTORS INFLUENCING THE ACCESSIBILITY OF SAFE ABORTION CARE

2.4.1 Legalisation of abortion

Since 1997, 19 countries or administrative areas have liberalised their abortion laws. A few countries, however, have moved to further restrict access to safe pregnancy termination. Studies show that the worldwide trend in abortion law towards liberalisation has benefited many women. For example, in South Africa after the abortion law was changed in 1996, infection resulting from abortion was reduced by 52%. However, there are still millions of women (40% of all women of childbearing age) living in countries with highly restrictive laws, especially in sub-Saharan Africa. Furthermore, the legalisation of abortion does not always guarantee women's safety, because factors such as economic, social, cultural and other barriers continue to impede women's access to safe abortion in many developing countries (Tripney, Schucan, Kwan & Karanagh 2011:15).

2.4.2 Providers' attitude towards abortion

A study in Ethiopia on the perception of health providers on safe abortion care showed that, even though the great majority of the providers believed that unsafe abortion was a serious health problem, only a quarter of the health providers were actually willing to participate in pregnancy termination (Abdi 2008:78).

The same study by Abdi (2008:79) showed that there is limited knowledge among providers on Ethiopian abortion law. It also found that less than half of the respondent providers were pro-legalisation, and these respondents justified their position by suggesting that legalisation reduces mortality and morbidity attributable to unsafe abortion. The study also showed that only a few facilities have well-trained personnel and functional, adequate equipment.

2.4.3 The accessibility of abortion care services

A study conducted in India concluded that despite the availability of strong and flexible abortion policies, perceived access to safe abortion services can remain low unless information is communicated through different interventions such as behaviour change communication (BCC) and the provision of a supportive environment that addresses

negative perceptions by improving community knowledge about abortion and the local availability of safe abortion services (Banerjee, Andersen, Buchanan & Warvadekar 2012:10).

The accessibility of health services has been shown to be an important determinant of the utilisation of health services in developing countries. In most areas in Africa, one in three women lives more than five kilometres from the nearest health facility. The scarcity of vehicles especially in remote areas, the cost of transport, poor road conditions and the difficulty of walking for hours to the nearest health facility pose threats to these women. The high cost of the fees for health services also reduces women's use of maternal health care services and keep millions of women from seeking care even when complications arise (Wube 2006:29).

In many settings, user fees for health care service are usually charged at the time of service delivery, which can be an important barrier to services for poor women and adolescents. In addition, women seeking abortion may be expected to pay substantial fees which, when combined with travel expenses and opportunity costs such as time lost from paid employment, pose a barrier for many women. The barrier of high costs to women is likely to generate higher costs for the health system by increasing the number of women who attempt to self-induce abortion or go to unsafe providers and as a result require hospitalisation for serious complications (World Health Organization 2012:90).

The quality of care in health service delivery and the perceptions of the quality of care are key factors in the choice and use of health services. These are important considerations in the decision to seek care. The role that the quality of care plays in the decision to seek care is related to people's personal assessment of the quality of service delivery, which largely depends on their own experiences with the health system and those of people they know. Studies conducted in developing countries suggest that women seeking care at hospitals for complications resulting from induced abortions are often viewed as criminals and verbally abused. In some cases they are denied anaesthesia and made to wait longer than other patients thought to be suffering from spontaneous abortion (Wube 2006:30).

2.5 EMPIRICAL STUDIES ON SAFE ABORTION CARE SERVICES IN ETHIOPIA

This part of the literature review provides a brief summary of empirical literature that investigates the various aspects of safe abortion care service in different parts of Ethiopia.

Buruh (2011:44) studied an assessment of determinants of induced abortion among women of child-bearing age attending maternal and child health clinics. The results showed that the main determinants of induced abortion were health problems, which accounted for 21.5% of the respondents, and child spacing, which accounted for 15% of the respondents. Contraceptive failure, rape, and incest were also substantial determinants among the respondents.

Wube (2006:48) used a cross-sectional study design to assess the factors influencing the utilisation of post-abortion care in public facilities. The participants were women of child-bearing age (15-49 years). Abortion was reported by 17% of the respondents. This study also found that education and marital status were significantly associated with post-abortion care service utilisation in public facilities. Women with induced abortion were less likely to utilise post-abortion care in a public facility than those who had experienced spontaneous abortion. The study also showed that women's attitudes towards general and post-abortion care in public health facilities differed significantly between women who utilised post-abortion care in public facilities and those who did not (Wube 2006:48).

On the other hand, Abdi (2008:10) conducted a study on the assessment of health providers' perceptions and preparedness of health facilities to provide safe abortion at selected health facilities in Addis Ababa. The results of the study indicated that the great majority of the providers believed that unsafe abortion was a serious health problem, but only 37.0% of health providers were actually willing to participate in pregnancy termination. Only 41.8% of the health providers were pro-legalisation. Actual practice and knowledge about the law governing abortion were found to be significantly associated with the practitioner's attitude towards safe abortion.

A qualitative study done by Alemu (2010:4) on minors' awareness of the new abortion law and perception of their access to safe abortion services revealed that most girls and

women are not aware of the new liberalised abortion law. Their access to safe abortion services is also very limited due to lack of awareness on legal status of abortion and on where to go for the service. The major reasons for the limited use of contraceptives among minors are socio-cultural and religious. According to Alemu's study, a minor who uses contraceptives may be considered as promiscuous, but when she gets pregnant she is in contravention of the social norm and if she terminates the pregnancy, the society stigmatises her. The study also pointed out that most of the minors among the participants used self-induced abortion mechanisms before visiting abortion service providers. They also went to illegal and unsafe abortion service providers because of their lack of information about the legality of abortion, their inability to afford the fee charged by legal practitioners, the lengthy process involved, and the lack of confidentiality.

Lastly, Yirga (2009:35) conducted a descriptive, cross-sectional, facility-based study among safe abortion service providers with the objective of assessing the status of safe abortion service utilisation and the levels of satisfaction with the public health facilities in the southern region of Ethiopia. The study found that 40% of women travelled more than ten kilometres to receive an abortion service and the time taken to reach the health facilities was one hour or more for 25% of the service users. 46% of the users of the service travelled the distance on foot, and only 32.8% of them easily accessed transportation. More than 49% of the women waited one hour or more to be served. About 25% of the women paid more than 100 Birr and according to 22.9% of respondent women, the service payment was costly. Of all the safe abortion service users, 44.3% had knowledge of the current abortion law. Only 62% of the women used any method of contraception after undergoing a safe abortion.

2.6 CONCLUSION

This chapter has focused on the relevant theoretical and empirical literature to give a clear picture of the global-, continental- and country-specific situations of unsafe abortion, the factors which influence access to safe abortion care such as the legalisation of safe abortion care and the providers' views about safe abortion care. The chapter also reviewed empirical studies performed in areas of Ethiopia, and presented the results and conclusions of such research. Chapter 3 will discuss the study design, study population, sampling method and the data collection instrument used in this study.

CHAPTER 3

RESEARCH DESIGN AND METHOD

3.1 INTRODUCTION

This chapter discusses the study design and method, the method of sampling and data collection instrument used. It also describes the method of data analysis, discusses ethical considerations, and the internal and external validity of the study.

3.2 RESEARCH DESIGN

The research design chosen for the study was a cross-sectional descriptive non-experimental design.

Descriptive: Descriptive studies are concerned with gathering information from a representative sample of a population. The collection of data in descriptive studies focuses on structured observation, questionnaires, interviews, or surveys. The purpose of a descriptive research design is to observe, describe and document aspects of a situation as they occur naturally (Polit & Beck 2008:274; Brink 2006:102). In this study information about the views of women is described numerically in frequencies and percentages.

Cross-sectional: A cross-sectional study design is an observational study design in which measurements are made on a single occasion (Brink 2006:105). In this study all of the women who visited the health facility for abortion care service on any of the days from June 1 to 30, 2012 were included.

Non-experimental: A non-experimental study is a type of study in which individuals are observed or certain outcomes are measured as naturally occurring events (Wilhelm 2008:993). In this study there was no manipulation of the dependent variable (access to safe abortion) or the independent variables (Brink 2006:102-105).

The study complies with the characteristics of cross-sectional descriptive and non-experimental study in such a way that it assessed what women feel regarding the accessibility of safe abortion care. The study participants were clients who went to the health centres during the data collection period to receive safe abortion care. The study therefore assessed the variables numerically using a structured questionnaire without any manipulation of the variables.

Study setting: The study was conducted in Addis Ababa, the capital city of Ethiopia, which hosts an estimated total population of 3,650,889 (Federal Ministry of Finance and Economy 2007). There are 27 government owned health centres in the city and out of these, 24 health centres provide safe abortion care service.

3.3 RESEARCH METHODS

3.3.1 Sampling

Sampling is the process of selecting a portion of the population to represent the entire population so that inferences about the population can be made (Polit & Beck 2008:339).

The sampling approach in this study was probability sampling, specifically simple random sampling.

Simple random sampling is a type of probability sampling where samples are drawn randomly by ensuring all the elements in the sampling will have an equal chance of being included in the study (Brink 2006:126).

The characteristics of probability sampling are as follows: it allows estimation of sampling error, reduces sampling bias, findings can be generalised to the population, and it involves a one-stage selection process (Brink 2006:126-127).

In this study, respondents were selected using simple random sampling by selecting a random sample of 10 health centres from the 24 health centres which provide safe abortion care in Addis Ababa. A sample of 342 women between the ages of 18 and 49 years who received safe abortion care at the selected 10 health centres during the data

collection period were then interviewed. The simple random sampling method was chosen to allow generalisation of the findings to the study population.

3.3.1.1 Population

A study population is all individuals or objects with common defining characteristics under study (Polit & Beck 2008:67). It is an aggregate or totality of the elements sharing some common set of specifications or criteria (Burns & Grove 2005:366).

Site population: The site population in the study was all of the 24 governmental health centres found in Addis Ababa

Respondent/participant population: The participant population in the study were all women between the ages of 18 and 49 years of age living in Addis Ababa.

3.3.1.2 Sampling

Site sampling technique: 10 health centres were selected at random from the 24 health centres that provide safe abortion care, the number of respondents from each site being in proportion to the number of clients served at each site.

3.3.1.3 Sample size and sampling procedure

The student researcher consulted a statistician and the sample size of the study was determined to be 352 respondents who went to the selected 10 health centres. In order to estimate the sample size for this study, the researcher used a single proportion formula which is described hereunder:

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

Where

- n=the required minimum sample size
- $Z_{\alpha/2}$=1.96 for 95% confidence interval, which gives the percentile of normal distribution

- P=is the estimated prevalence, which in this study of the prevalence of abortion in Ethiopia is equal to 32%
- d=(the margin of error) = 0.05 (Sample size determination 2011)

Therefore the sample size $n=0.32*(1-0.32)*(1.96^2)/ (0.05)^2$

n=335+5% contingency

n=352

3.3.1.4 Sampling procedure

In this study 10 out of the 24 health centres were randomly selected by a lottery method. A total of 352 respondents were expected to be interviewed during the data collection period, which was from June 19 to July 20, 2012, but 342 respondents were actually interviewed, making the response rate 97%.

3.3.2 Data collection

3.3.2.1 Data collection approach and method

Data was collected from the participants using a questionnaire administered by trained data collectors. The questionnaires were collected at a particular point in time, since the study was a cross-sectional design.

The research instrument for the study was a structured questionnaire. The questionnaire was divided into four sections: the first section was about the socio-demographic background of the respondents, the second section enquired about the respondents' reproductive history, the third attempted to establish the respondents' perceptions relating to abortion, and the fourth asked about the respondents' perceptions regarding the accessibility of safe abortion care.

3.3.2.2 Development and testing of the data collection instrument

The questionnaire was carefully developed after reviewing the relevant literature. In order to ensure that it addressed all of the objectives of the study, it was reviewed by colleagues who work in the area of reproductive health. Then it was pretested using the

same procedure and with a similar target group. The respondents who were involved in pre-testing did not participate in the main study.

The pre-tested findings showed that the questions asked were generally appropriate, except that a few changes had to be made in some of the questions where the wording was unclear. In addition, some questions were deleted from the questionnaire, and some questions which specifically asked about the accessibility of safe abortion were added.

3.3.2.3 Characteristics of the data collection instrument

Content validity is an assessment of how well the instrument represents all of the components of the variable to be measured. The researcher developed the instrument based on a review conducted with the aim of establishing precisely what aspects of the variables should be included in the study. The researcher sent the questionnaire to reproductive health experts for their review, and their comments were incorporated (Brink 2006:160).

Face validity refers to whether or not the instrument used appears to measure what it is supposed to measure, based on the intuitive judgement of experts in the field (Brink 2006:160). The questionnaire was reviewed by reproductive health experts and pretested in the field, and was found to be valid.

3.3.2.4 The process of data collection

Before commencing with data collection the researcher obtained ethical clearance from the Department of Health Studies at the University of South Africa (annexure A). Then letter requesting permission to perform the study was sent to the Addis Ababa Health Bureau (annexure B), which consented to the study. Then the researcher contacted each health centre head and explained the purpose of the study by means of presenting the letter of support from the Health Bureau (annexure C)

The data collectors were given a three day orientation course on the data collection instrument and the overall data collection process. Each data collector was given a chance to perform a role play using the questionnaire as a basis for the activity. Then

the research instrument was tested at a health centre which had not been included in the study.

During the actual process of data collection client exit interviews using the questionnaire (annexures D and E) were conducted at points where the clients were ready to be discharged. The respondents were given full information regarding the study, consent was obtained from each respondent (annexure F), and privacy and confidentiality were guaranteed. The researcher supervised the overall data collection procedure and collected and checked each questionnaire received from the data collectors on a daily basis.

3.3.2.5 Ethical considerations related to the data collection

The data collection instruments were designed in such a way as to generate actual facts. Each relevant provider in attendance at the time of the data collection approved the physical and psychological readiness of each of the patients before the interview commenced.

The willingness of the respondents to participate was ascertained in each instance before the data was collected. The data collection instrument was designed carefully in order to generate valid and reliable data and the questions were designed in such a way as not to cause any discomfort to the respondents. The study was therefore conducted in accordance with universally acknowledged rights-based ethical principles as endorsed by the Department of Health Studies of the University of South Africa. The elements of the University's guidelines are as follows

3.3.2.5.1 Informed consent

Informed consent was obtained from each participant (annexure F). The data collectors would read to participants a description of the nature of the study and of the objectives and potential benefits or risks to the participants, in order that they might fully understand what they were agreeing to and make a reasonable decision to participate or not to participate in the study. The respondents who were willing to participate were asked to sign the consent form before they were interviewed (Brink 2006:35).

3.3.2.5.2 Privacy and anonymity

The respondents were assured that their names and any information which might be used to identify them would not be given in the study, and that such information would not be divulged to anybody. They were assured that the information they provided will be used for purpose of the research only, and that the completed questionnaires would be kept in a secure place. In fact the researcher kept all of the questionnaires in a secure place where no one could get access to them (Brink 2006:35).

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3.3.2.5.3 Permission to perform the study

After gaining permission from the ethical committee at the Addis Ababa Health Bureau (annexure C), the researcher contacted the heads of the ten health centres, explained the objectives and the purpose of the study, and got their permission to conduct the study.

3.3.2.5.4 Ethical clearance

Ethical clearance was obtained from the Research and Ethics Committee of the Department of Health Studies of the University of South Africa (annexure A).

3.3.3 Data analysis

After every day of data collection, each questionnaire was manually checked for completeness. The data was coded and entered into the Statistical Package for Social Sciences (SPSS) for Windows Version 16.0. The results were depicted using tables and graphs.

3.4 INTERNAL AND EXTERNAL VALIDITY

3.4.1 Internal validity

Internal validity refers to the extent to which it is possible to draw an inference that the independent variable is truly causing or influencing the dependent variable and that the

relationship between the two is not the spurious effect of an extraneous variable (Polit & Beck 2008:213). To enhance the reliability of the study, information obtained by using a structured data collection instrument was statistically analysed, and the findings were interpreted by accounting for all available evidence.

3.4.2 External validity

External validity concerns inferences about the extent to which relationships observed in the study hold true over the variation of people, conditions and settings. It refers to the generalisability of a research finding to other settings or samples. It is the extent to which the results of a particular study could be generalised beyond the samples (Polit & Beck 2008:301; Burns & Grove 2005:234). The generalisability of this particular study may be low since those who came to the selected health centres may not be representative of all women in reproductive age groups living in Addis Ababa. But to allow for generalisability a random sample of 10 health centres was selected from the 24 health facilities in Addis Ababa, and the number of participants selected from each health centre was proportionate to the total number of clients served by each centre.

3.5 CONCLUSION

Chapter 3 has outlined the research methods used to answer the research question. The population sampling, data collection, instrument, ethical considerations, and data analysis were also discussed. Chapter 4 will present the results of the study.

CHAPTER 4

RESULTS, ANALYSIS, PRESENTATION AND DESCRIPTION OF THE RESEARCH FINDINGS

4.1 INTRODUCTION

This chapter presents the findings of the dissertation arrived at after processing the data collected from participants. The discussion is presented in accordance with the sections in the questionnaire as follows: background information, reproductive history, views related to abortion, and views related to the accessibility of safe abortion care.

4.2 DATA MANAGEMENT AND ANALYSIS

The student researcher consulted a statistician during the data collection and analysis phases of the study. The study was conducted from June 19 to July 20, 2012 at 10 selected governmental Health Centres in Addis Ababa. A total of 352 women were eligible to participate in the study, but only 342 women were accessible and gave their informed consent to take part in the research, a fact which resulted in a response rate of 97%.

The data was collected by means of a questionnaire and was compiled by the researcher on daily basis. Then it was cleaned and entered into SPSS version 16.0 to be analysed and interpreted. Descriptive statistical methods such as percentages and means were used to describe the findings of the study. The data obtained from the completed questionnaires was analysed, and where applicable was presented in tables and illustrated by means of graphs or charts.

4.3 RESEARCH RESULTS

4.3.1 Sample characteristics

4.3.1.1 Background information about the respondents

4.3.1.1.1 Age of the respondents

A total of 342 respondents between 18 and 46 years of age were included. Table 4.1 illustrates the age distribution of the subjects.

Table 4.1 Age of respondents (N=342)

	Range	Minimum	Maximum	Mean	Std. Deviation	Variance
Age of the respondent	28.00	18.00	46.00	26.0322	6.66031	44.360

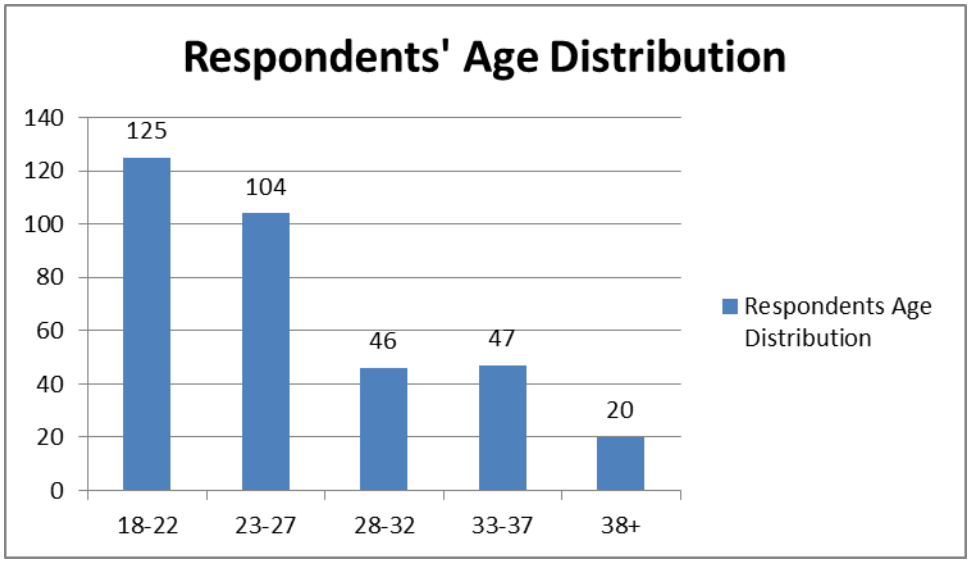

Figure 4.1 Age distribution of respondents (n=342)

As illustrated in Figure 4.1, the majority of the respondent women (36.6%; n=125) were in the age category between 18 and 22 years, 30.4% (n=104) of them fell into the age category of 23-27, and 13.5% (n=46) of the respondents were found in the age category 28-32. Similarly, 13.7% (n=47) of the respondents belonged to the age category of 33-37 and finally 5,8% (n=20) respondents were over 38 years old.

4.3.1.1.2 Religious background of the respondents

As depicted in table 4.2 and figure 4.2, of the total number of respondents 39.2% (n=134) were orthodox Christians, 35.5% (n=121) were Muslims, 24.6% (n=84) were Protestants, and 0.9% (n=3) were Roman Catholics.

Table 4.2 Religious background (N=342)

Religion	Frequency	Percent
Orthodox	134	39.1
Muslim	121	35.4
Protestant	84	24.6
Catholic	3	0.9
Total	**342**	**100.0**

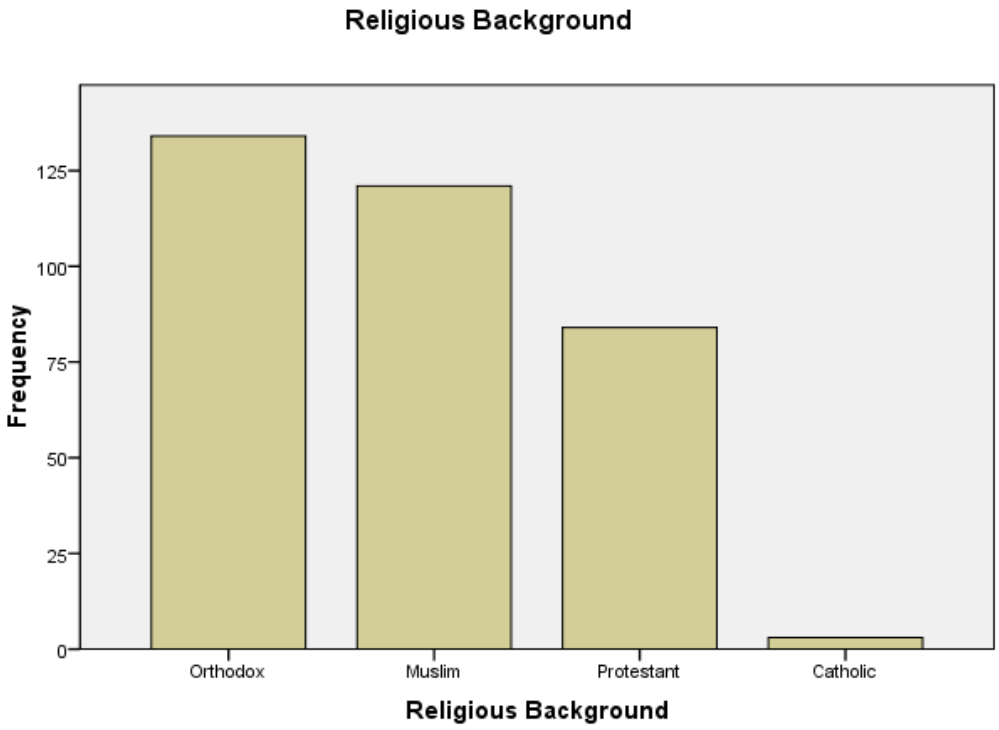

Figure 4.2 Religious background of respondents (N=342)

4.3.1.1.3 Place of residence

Table 4.3 and figure 4.3 below depict the residential situations of the respondents classified as either rural or urban. It can be observed that most of the respondents (74%; n=253) came from urban areas, while the remaining 26% (n=89) were from rural areas.

Table 4.3 Place of residence (N=342)

Place of residence	Frequency	Percent	Cumulative percent
Urban	253	74.0	74.0
Rural	89	26.0	100.0
Total	**342**	**100.0**	

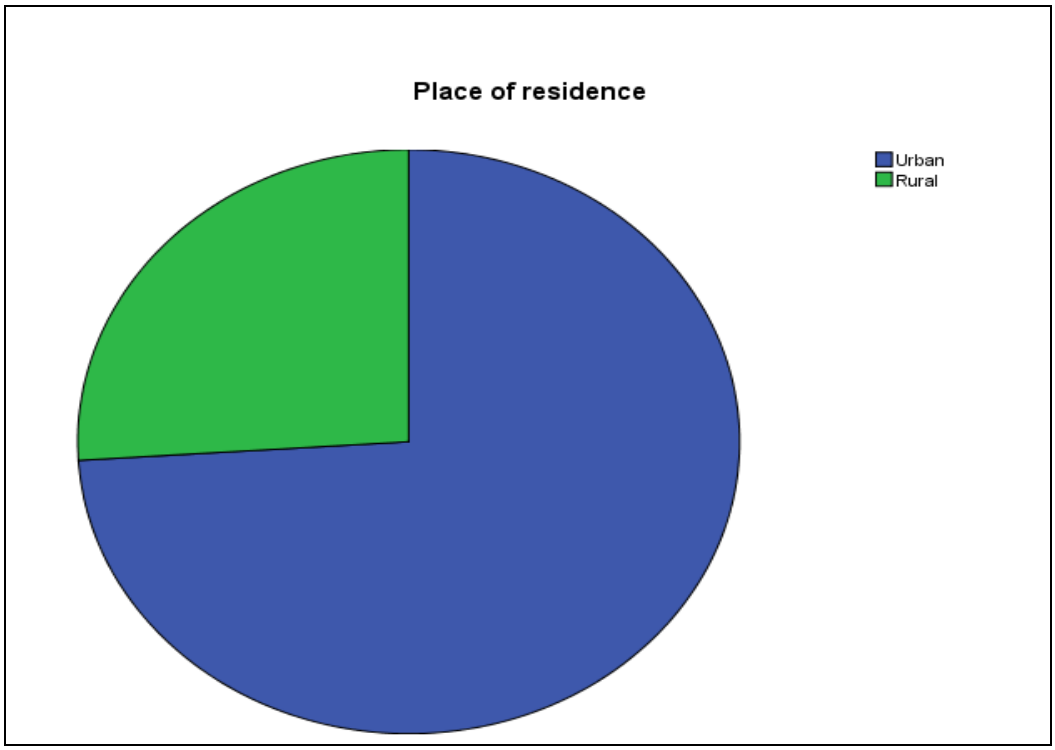

Figure 4.3 Place of residence (N=342)

4.3.1.1.4 Educational level of the respondents

As depicted in table 4.4 and figure 4.4, the majority of the respondents have an educational background of college level and above (33%, n=113), and the next group

has secondary school as its level of education (31.9%). Of the respondents 20.5% (n=70) have only primary education. Participants with an educational background below the primary level of education are 14.6% (n=50) of the total sample.

Table 4.4 Level of education (N=342)

Level of education	Frequency	Percent	Cumulative percent
Cannot read or write	25	7.3	7.3
Can read and write	25	7.3	14.6
Primary education	70	20.5	35.1
Secondary education	109	31.9	67.0
College/university education	113	33.0	100.0
Total	**342**	**100.0**	

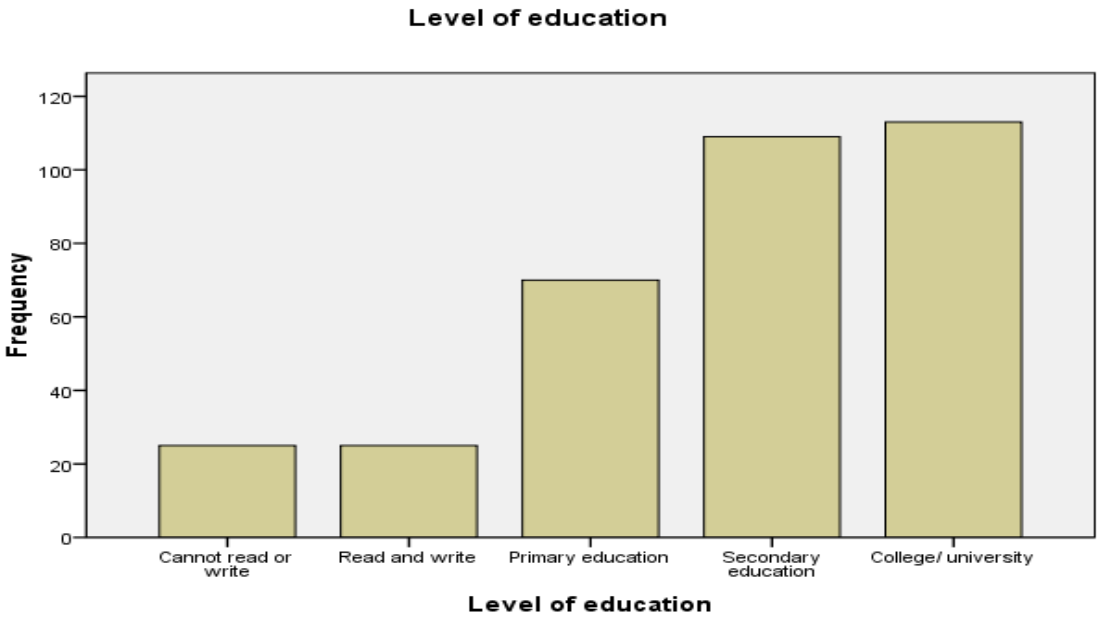

Figure 4.4 Level of education (N=342)

4.3.1.1.5 Ethnicity of respondents

When ranked in terms of their frequency, as in table 4.5, the Oromo, Amhara, Gurage, Tigre, and Wolayita ethnic groups rank from 1st to 5th place and collectively constitute more than 99% of the sample size.

Table 4.5 Ethnic background of participants (N=342)

Ethnic groups	Frequency	Percent
Oromo	100	29.2
Amhara	87	25.4
Tigre	51	14.9
Gurage	60	17.5
Wolayta	43	12.7
Other	1	0.3
Total	**342**	**100.0**

4.3.1.1.6 Occupation of respondents

Table 4.6 displays the occupation of the respondents. Most of them (30.6%; n=105) were employees in government institutions. The next greatest number were employees of privately owned Institutions, which accounted for 27.8% (n=95) of the participants. Student participants took third place with a proportion of 15.5% and women who were housewives and housemaids constituted nearly 12.9% and 12% of the sample size respectively. Women entrepreneurs accounted for less than 1% of the sample size.

Table 4.6 Occupation of respondents (N=342)

Occupation	Frequency	Percent	Cumulative percent
Student	53	15.4	15.4
Housewife	44	12.9	28.3
Government employee	105	30.7	59.1
Privately employed	95	27.8	86.8
Entrepreneur	3	0.9	87.7
Housemaid	42	12.3	100.0
Total	**342**	**100.0**	

4.3.1.1.7 Marital status of respondents

Table 4.7 and figure 4.5 show that unmarried single women participants accounted for 72.8% (n=249) of the respondents, married women participants constituted 24.6%

(n=84) of the respondents, and the remaining 2.6% (n=9) were women who are divorced or widowed.

Table 4.7 Marital status of respondents (N=342)

	Frequency	Percent	Cumulative percent
Single	249	72.8	72.8
Married	84	24.6	97.4
Divorced	8	2.3	99.7
Widowed	1	0.3	100.0
Total	**342**	**100.0**	

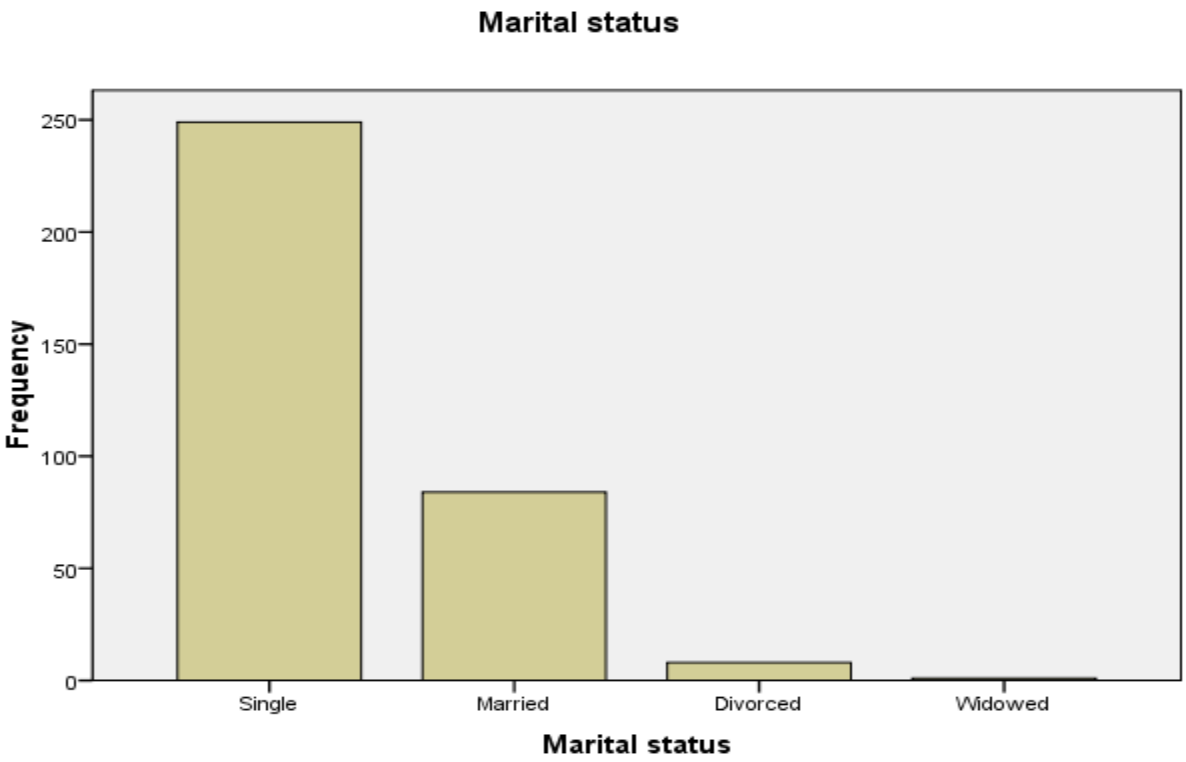

Figure 4.5 Marital status of the respondents (N=342)

4.3.1.2 The reproductive history of the respondents

4.3.1.2.1 The number of pregnancies

Panel A of table 4.8 indicates that the average number of pregnancies experienced by the respondents was 3. The maximum number of pregnancies was 6 and the minimum was 1. The number of live births, however, ranged from 0 to 6 with a mean value of

approximately 2 children. Panel-B of table 4.8 shows that (61.1%) of the respondent women had been pregnant at least twice. The remaining 38.9% of the participants had been pregnant only once

Table 4.8 Number of pregnancies (N=342)

Panel A: Descriptive statistics of pregnancy experience of respondents					
	N	**Minimum**	**Maximum**	**Mean**	**Std. Deviation**
Number of pregnancies	342	1.00	6.00	2.1404	1.17059
Number of live births	342	0.00	6.00	1.2135	1.31026
Panel B: Frequency of number of pregnancies					
Number of pregnancies	**Frequency**	**Percent**	**Cumulative percent**		
1	133	38.9	38.9		
2	94	27.5	66.4		
3	60	17.5	83.9		
4	47	13.7	97.7		
5	5	1.5	99.1		
6	3	0.9	100.0		
Total	**342**	**100.0**			

4.3.1.2.2 Previous experience of abortion

Table 4.9 shows respondents who had had previous experience of abortion before the current experience. About half (50.3%) of the women had come in for abortion for at least the second time, and 49.7% (n=170) of the women said the current abortion was their first experience of abortion.

Table 4.9 Previous experience of abortion (N=342)

Responses	**Frequency**	**Percent**	**Cumulative percent**
Yes	172	50.3	50.3
No	170	49.7	100.0
Total	**342**	**100.0**	

4.3.1.2.3 Cause of previous abortion

Table 4.10 shows that of the 172 women who had a previous history of abortion 72.1% (n=124) of the women had undergone an induced abortion and the remaining 27.9% (n=48) had had a spontaneous abortion.

Of those 172 women with a previous history of abortion, 76.2% (n=131) had sought the service from government health service institutions, 23.2% (n=40) of the respondents had gone to private health institutions, and one woman (0.6%) (n=1) had sought the service from a traditional healer in her own locality.

Table 4.10 Cause of previous abortions (N=342)

Responses	Frequency	Percent	Valid percent	Cumulative percent
Spontaneous	48	14.0	27.9	14.0
Induced	124	36.3	72.1	100.0
Sub Total	**172**	**50.3**	**100.0**	
Missing System	170	49.7		
Total	**342**	**100.0**		

4.3.1.3 Perceptions related to abortion

4.3.1.3.1 Reasons for seeking abortion care and the institutions consulted

Respondents were also asked about their views regarding why women undergo abortion. The results show that the main reasons for seeking abortion (listed below in the order of their importance) were given as:

- Due to premarital pregnancy (46.4%; n=218)
- Because they want to limit the number of children they have (20.9%; n=98)
- To space their pregnancies (11.7%; n=55)
- Because the mother had encountered health problems (6.6%; n=31)
-

Other reasons which were cited by respondents as reasons for seeking abortion (accounting for 2.3%; n=11 included:

A. When pregnancy results from rape
B. When pregnancy results from incest
C. When the boyfriend denies the that the conceived child as his
D. When there are economic problems in raising a child
E. To process an immigration case and get out of country
F. When there is dependence on the woman's family

Note that in table 4.11 the total number of responses (n=470) is greater than the sample size (n=342). This arises because the specific question allows respondents to give multiple responses.

Table 4.11 Reasons for seeking abortion care and institutions consulted

Panel-A: Why do women seek abortion care services?			
Responses	**Frequency**	**Percent**	**Cumulative percent**
Don't want any more children	98	20.9	20.9
To space pregnancies	55	11.7	32.6
Premarital pregnancy	218	46.4	78.9
Health problems	31	6.6	85.5
I don't know	57	12.1	97.7
Other	11	2.3	100.0
Total	**470***	**100.0**	
Panel-B: Institutions from which help was obtained			
Responses	**Frequency**	**Valid Percent**	**Cumulative percent**
Traditional healer	1	0.6	0.6
Private institution (clinic, hospital)	40	23.3	23.8
Governmental health institution (health centre, hospital)	131	76.2	100.0
Total	172	**100.0**	
Missing system	170		
Total	**342**		

4.3.1.3.2 When do you think that women should seek abortion care?

The women were also asked about when they thought it was appropriate for a woman to seek abortion care. 34.7% (n=175) said it was appropriate to undergo abortion when a woman encountered a health problem, 29.4% (n=148) said when a woman encountered a premarital pregnancy, and 23.4% (n=118) said if a woman did not want to have additional children (see table 4.12)

Table 4.12 When do you think that women should seek abortion care?

Responses	Frequency	Percent	Valid per cent	Cumulative percent
Don't want any more children	118	23.4	23.4	23.4
To space pregnancies	54	10.7	10.7	34.1
Premarital pregnancy	148	29.4	29.4	63.5
Health problems	175	34.7	15.1	78.6
Contraceptive failure	4	0.8	0.8	79.4
I don't know	5	1.0	1.0	100.0
Total	**504**	**100.0**	**100.0**	

4.3.1.3.3 Knowledge of the Ethiopian penal code regarding safe abortion care

As table 4.13 reveals, nearly half (46.8%; n=160) of the respondents had no knowledge of the existence of a law regarding abortion in the penal code of Ethiopia, .whereas the respondents having some knowledge of the existence of a penal code in Ethiopia regarding safe abortion care accounted for 53.2% (n=182) of the total number of respondents

Table 4.13 Participants' knowledge of the existence of a penal code of regarding safe abortion care in Ethiopia (N=342)

Responses	Frequency	Percent	Cumulative percent
Yes	182	53.2	53.2
I don't know	160	46.8	100.0
Total	**342**	**100.0**	

4.3.1.3.4 Knowledge of the legal conditions in which abortion is permitted by the law

Respondents who said they knew about the existence of a penal code in Ethiopia regarding safe abortion care were further asked to list the legal conditions in which abortion is permitted. The results depicted in table 4.14 revealed the following facts: of the 182 respondents who stated that they knew about the relevant penal code, 69.2% (n=126) were able to mention at least one legal condition to permit abortion, whereas the remaining 30.8% (n=56) did not know the specific conditions in which the law permits abortion.

Since the researcher allowed multiple responses to this particular question, the total responses (611) are greater than the number of participants (182). The most commonly cited conditions, according to table 4.14, are presented as follow:

1. When pregnancy results from rape (29.6%; n=181)
2. If a minor is physically or psychologically unprepared to raise a child (20%: n=122)
3. When pregnancy results from incest (15.1%; n=92)
4. When the continuation of the pregnancy endangers the life of the mother or the foetus (12.4%; n=76)
5. When the foetus has abnormalities (7.5%; n=46)
6. When the mother is physically and mentally unprepared to raise the new-born (6.2%, n=38)

Table 4.14 Frequency of opinions about the legal conditions in which abortion is permitted

	Frequency	Percent	Valid percent
When pregnancy results from rape	181	23.5	29.6
If a minor is physically or psychologically unprepared to raise a child	122	15.8	20.0
When pregnancy results from incest	92	11.9	15.1
When the continuation of the pregnancy endangers the life of the mother or the child	76	9.9	12.4
When the foetus has abnormalities	46	6.0	7.5
When the mother is physically and mentally unprepared to raise the child	38	4.9	6.2
I don't know	56	7.3	9.2
Sub Total	**611**	**79.2**	**100.0**
Missing system	160	20.8	
Total	**771**	**100.0**	

4.3.1.3.5 Opinions regarding the intensity of the abortion law

The same women who knew about the existence of relevant law were asked to rate the intensity of the law. Table 4.15 shows that 53.8% (n=98) of them consider the law to be restrictive, 14.3% (n=26) feel that the law is liberal, and the others 31.9% (n=58) couldn't rate the intensity of the law.

Table 4.15 How do you rate the intensity of the law? (N=182)

	Frequency	Percent
Restrictive	98	53.8
Liberal	26	14.3
Don't know	58	31.9
Total	**182**	**100.0**

4.3.1.3.6 Opinion about the number of abortions a woman should be allowed to undergo

Table 4.16 indicates that only 14.9% (n=51) of the respondents said that preferably a woman should never undergo abortion in her lifetime. 16.7% (n=74) of the respondents, on the other hand, said that a woman should be allowed to abort more than once in her lifetime. Most of the respondents (217 - 63.4%) couldn't comment in this regard.

Table 4.16 Opinions about the number of times a woman should be allowed to have an abortion (n=342)

Responses	Frequency	Percent	Cumulative percent
0 times	51	14.9	14.9
Once	57	16.7	31.6
Twice	17	5.0	36.5
I don't know	217	63.4	100.0
Total	**342**	**100.0**	

4.3.1.3.7 Opinion about the complications arising from having an abortion

Table 4.17 summarises the opinion of participants' opinion with regard to the physical complications arising from having an abortion. According to the table, bleeding (37.4%; n=189), developing an infection (29.8%; n=151), the possibility of death (19.8%; n=100), and the possibility of not conceiving again were the most salient adverse effects to in the minds of the participants. Other complications of abortion mentioned by the respondents include uterine rupture and the risk of cancer.

Table 4.17 Opinions about the complications arising from having an abortion

Responses	Frequency	Percent
She may bleed	189	37.4
She may develop infection	100	19.8
She may die	151	29.8
She may not conceive again	53	10.5
I don't know	12	2.3
Other	1	0.2
Total	**506**	**100.0**

4.3.1.3.8 Previous experience of abortion by other women/adolescent girls

The participants were also asked if they know a woman in their locality who had undergone an abortion. The summarised survey results are presented in Panel A, and Panel C of table 4.18.

Table 4.18 Previous experiences of abortion

Panel A: Do you know a woman/adolescent girl in your family or neighbourhood who had an abortion in the past year?

Responses	Frequency	Percent
Yes	134	39.2
No I do not	196	57.3
I do not remember	12	3.5
Total	**342**	**100.0**

Panel B: What was the reason for the abortion?

Responses	Frequency	Percent	Valid percent	Cumulative percent
Don't want any more children	23	6.7	17.2	17.2
To space pregnancies	1	0.3	0.7	17.9
Premarital pregnancy	106	31.0	79.1	97.0
Health problems	3	0.9	2.2	99.3
Contraceptive failure	1	0.3	0.7	100.0
Sub Total	**134**	**39.2**	**100.0**	
Missing system	208	60.8		
Total	**342**	**100.0**		

Panel C: Institutions from which help was obtained

	Frequency	Percent	Valid percent	Cumulative percent
Traditional Healer	1	0.3	0.7	0.7
Private institution	33	9.6	24.6	25.4
Governmental Institution	100	29.2	74.6	100.0
Sub Total	**134**	**39.2**	**100.0**	
Missing system	208	60.8		
Total	**342**	**100.0**		

The majority of the respondents, 60.8% (n=208), did not know a woman who had experience of abortion, nor did they remember if they had ever had contact with such a woman. As confirmed in panel B of table 4.18, when asked about the reason for the abortion, those respondents who knew a woman who had experienced an abortion thought that the predominant reason to undertake an abortion was premarital pregnancy (79.1%; n=106) and the other major reason was not wanting an additional child (17.2%; n=23). Other reasons given (by very few respondents) were health problems (2.2%), the

desire to space successive pregnancies (0.7%; n=1), and contraceptive failure (0.7%; n=1).

The respondents also expressed the opinion (see Panel C of table 4.18) that the health institutions of first choice are government health institutions (29.2%; n=100). The next preferred institutions are private health institutions, and only one respondent had consulted a traditional healer.

4.3.1.4 Perceptions of the accessibility of safe abortion care services

This section of the data analysis presents the interpretation of questions which are included in part four of the questionnaire, which are designed to assess the views of the research participants about the accessibility of a safe abortion care service in Addis Ababa.

The following table summarises all of the dimensions of the accessibility of safe abortion, based on the data collected from the questionnaire.

Table 4.19 Perceptions of the accessibility of safe abortion care services (N=342)

Panel A: How many kilometres did you have to travel to reach this health centre?			
Responses	**Frequency**	**Percent**	**Valid pecent**
5-10 kms	207	60.5	60.5
10-20 kms	64	18.7	18.7
20-30 kms	24	7.0	7.0
Above 30 kms	47	13.8	13.8
Total	**342**	**100.0**	**100.0**

Panel B: How do you rate the distance travelled to get the health facility?			
Responses	**Frequency**	**Percent**	**Valid percent**
Very long	53	15.5	15.5
Moderate	68	19.9	19.9
Appropriate/fair	221	64.6	64.6
Total	**342**	**100.0**	**100.0**

Panel C: How did you identify the service delivery unit after you got to the health facility?

Responses	Frequency	Percent	Valid percent
I saw a signboard	141	41.2	41.2
I was told by a member of staff in the registration room	163	47.7	47.7
I found the unit with difficulty	38	11.1	11.1
Total	**342**	**100.0**	**100.0**

Panel D: How long did you have to wait to receive the service after you reached the health centre?			
Responses	**Frequency**	**Percent**	**Valid percent**
I waited more than an hour	37	10.8	10.8
I waited less than an hour	305	89.2	89.2
Total	**342**	**100.0**	**100.0**

Panel E: How do you rate the waiting time to get service?			
Responses	**Frequency**	**Percent**	**Valid percent**
Very long	31	9.1	9.1
Moderate	68	19.8	19.8
Fair	243	71.1	71.1
Total	**342**	**100.0**	**100.0**

Panel F: How do you rate the cost of abortion care?			
Responses	**Frequency**	**Percent**	**Valid percent**
Appropriate/fair	251	73.4	73.4
Moderate	91	26.6	26.6
Expensive	0	0	0
Total	**342**	**100.0**	**100.0**

Panel G: How do you rate the treatment you got from and the skill of the providers?			
Responses	**Frequency**	**Percent**	**Valid percent**
They are highly skilled	298	87.1	87.1
They are moderately skilled	39	11.4	11.4
They are poorly skilled	5	1.5	1.5
Total	**342**	**100.0**	**100.0**

4.3.1.4.1 Perceptions regarding the distance travelled to reach the health centre

Panel A of table 4.19 shows the number of kilometres travelled by the respondents to reach the health centre. The majority of the respondents (60.5%; n=207) travelled 5-10 kilometres to reach the particular health care centre which provides safe abortion. Of the respondents, 18.7% (n=64) had to travel 10-20 kilometres to arrive at the specific health care centre. Those who travelled more than 30 kilometres constituted 13.8%

(n=47) of the entire sample size and 7% of the respondents travelled 20-30 kilometres to visit and receive the service from a nearby health centre.

Panel B of table 4.19 also reveals that 64.6% (n=221) of the respondents said the travelling distance to the health institution providing a safe abortion care service was fair, while 19.9% (n=68) of the respondents said it was moderate and the remaining 15.5% (n=53) said it was very far.

4.3.1.4.2 The ease of Identifying the service delivery unit in the health centre

Panel C of table 4.19 also shows how easy it was to find the service delivery unit after entering the compound of the health centre. Of the total number of respondents, 11.1% (n=38) found it hard to identify the service delivery unit. Of the respondents, 41.2% (n=141) of the respondents stated that they found the service delivery unit without difficulty by simply referring to the signboard posted at the entrance of the health centre. On the other hand, 47.7% (n=163) of the women found the service delivery unit with the aid of an employee working in the health centre.

4.3.1.4.3 The waiting time after reaching the abortion care unit and respondents' perceptions of the amount of time they had to wait

Panel D of table 4.19 shows how long clients waited to get the abortion service after they reached the unit. As can be seen in the table, only 10.8% (n=37) of them waited for more than an hour to receive the service, while the remaining 89.2% (n=305) waited less than an hour to get the safe abortion. Panel E shows the respondents perceptions regarding the waiting time, and the majority of the respondents (71.1%; n=243) considered that the length of time that they had to wait to receive the service was fair. The remaining respondents rated the waiting time as very long (9.1%; n=31) or moderate (19.8%; (n=68).

4.3.1.4.4 Perceptions regarding the cost incurred by clients to get the service

In order to capture the participants' responses to the cost of the service they were asked to rate the cost from their own points of view. The results of this inquiry are illustrated in Panel F of table 4.19. The majority of the participants (73.4%; n=251) considered the cost of the abortion care to be appropriate or fair. Considerable numbers of these respondents even said that they had accessed the service for free. On the other hand, 26.6% (n=91) of them rated the cost of the safe abortion care service as moderately costly. However, none of the respondents thought the cost was expensive.

4.3.1.4.5 The confidence of the clients in the skills of the service providers at the safe abortion care units

Substantial numbers of respondents (87.1%; n=298) are highly satisfied with the skills of the service providers and rated them as highly skilled. Of the research participants, 11.4% (n=39) rated the skills of the service providers as moderate, and 1.5% (n=5) of the participants rated the providers as poorly skilled (see Panel G of table 4.19).

In this study, the operational definition of access to health services is as follows: "*accessibility is the continued and organised supply to all individuals and communities of equitable health care services within easy-to-reach distance at the right health facility by a skilled provider at an affordable price*." In the context of this operational definition, the questions asking for respondents' views regarding the distance travelled, the waiting time, the cost of the services, and their confidence in the skills of the providers were used as measures of the accessibility of safe abortion care services in Addis Ababa. Those participants who responded positively to all of these questions, i.e. those who believed that they had easily accessed the health services, who considered the distance they had travelled to reach the respective health centres and the time they had had to wait to receive the services as fair, who rated the treatment they received from the providers as satisfactory, and rated the cost they expended on getting safe abortion care services as fair, were therefore taken as having a positive perception of the accessibility of safe abortion care.

Table 4.20 elucidates the results obtained after the analysis and the subsequent paragraphs give details of the interpretation.

Table 4.20 The accessibility of safe abortion care (N=342)

	Frequency	Percent	Cumulative percent
Not Accessible (0)	181	52.9	52.9
Accessible (1)	161	47.1	100.0
Total	**342**	**100.0**	

It can be concluded from table 4.20 that 47.1% (n=161) of the total participants perceived safe abortion care services as being accessible in terms of the distance they travelled to reach the health centre, the time they waited at the abortion care unit, the cost they paid for the service, and the service provided. On the other hand, a little more than half of the respondents (52.9%; n=181) perceived safe abortion care services as being inaccessible for one or more of the following (perceived) reasons:

1. The great distance between their places of residence and the government health centres providing safe abortion care services.
2. The difficulty in identifying the service delivery unit and/or the long hours they had to wait to receive the service at the unit.
3. The high cost of the safe abortion care service.
4. The low level of skills of the providers of safe abortion care at the service delivery units.

4.4 OVERVIEW OF RESEARCH FINDINGS

4.4.1 Perceptions of women regarding safe abortion care

In this study women were asked for their opinion on when they think women should seek abortion. 34.7% of them said it is appropriate to undergo abortion when a woman encounters a health problem, 29.4% said this should occur when a woman encounters a premarital pregnancy, 23.4% (n=118) said this should occur if a woman does not want to have additional children, and 10% thought that the procedure would be appropriate when a woman wanted to space her pregnancies. A study by Buruh (2011:44) also showed that the most common reported determinants of induced abortion were health

problems and child spacing. Contraceptive failure, rape and incest also contributed substantially as reasons for having an induced abortion.

A study done in Zambia on attitudes towards abortion found that 41% of the respondents believed that abortion should be legalised in certain situations, including where the pregnancy occurred because of rape, incest, threat to the life of the mother, the mother's not wanting another child, the woman's not being able to afford to raise the child, her wanting to continue her studies, the possible of a birth defect, a health risk to the child, a health risk to the mother, or even when no specific reason can be given by the woman. 32% of the respondents believed it was legal to have an abortion for at least one named indication. Risks to the health or life of the mother or the child garnered the most support for legalisation, but support was still weak for all indications (Geary, Gebreselassie, Awah & Pearson 2012:148-151).

Even though the penal code on abortion in Ethiopia was revised in 2005 to allow abortion in certain conditions, this study has revealed that nearly half (46.8%) of the respondents who visited the selected health facilities to seek safe abortion care did not even know about the existence of a legal code regarding abortion. A study performed in Addis Ababa on minors' awareness of the law showed that awareness of the law was almost non-existent among the participants, and that access to safe abortion was also very limited. Even knowledge of where to go for the service was too low (Alemu 2010:70). Knowledge of the legality of abortion in other countries where abortion is legal ranges from 45% in Mexico to 57% in Latvia and 78% in the Gauteng province of South Africa. In a qualitative study done among South African women who had had abortions outside of the legal abortion services, 54% reported having done so because they did not know about the law (Yirga 2009:35).

Of those respondents in this study who said that they knew of the existence of a legal code regarding abortion, more than half (53.8%) felt that the law is restrictive and only 14.3% of them thought that the law is liberal. Of these, 67% could give at least four conditions where the current Ethiopian penal code allows safe abortion. In a study by Yirga (2009:35), 44.3% of the women knew that abortion is legal in certain conditions. This shows that in Addis Ababa knowledge regarding the legality of abortion is relatively higher than in the regional towns. This may be so because Addis Ababa is more urban

and women can easily get information from various sources, unlike their counterparts in the regional towns.

4.4.2 Perceptions regarding the distance travelled to reach the health centre

The distance travelled to the health facility, access to transport, the waiting time and the cost of the service are usually believed to affect positively or negatively the decision of women either to use a safe abortion service or not.

Regarding the distance they travelled to reach to the health centre which provides safe abortion care, 60.5% of the respondents travelled between 5 to 10 kilometres and 39.5% of them travelled more than 10 kilometres. The majority of the respondents (64.6%) felt that the tdistance travelled form where they lived was appropriate. In this study the distance travelled to the health centre was shorter than in some other studies in Ethiopia. For example, the findings derived from the national demographic and health survey performed in 2011 were that 66% of Ethiopian women were not able to access a health facility because they lived too far away from the health facility, and also showed that 71% of the women couldn't access a health facility due to their lack of access to a means of transportation (Central Statistical Agency and ICF International 2012:132). The findings on the distance travelled in a similar study performed in the southern region of Ethiopia showed that 40% of women travel more than 10 kilometres to access a health service. In another study performed in public health facilities in the Amhara and Oromiya regions, 56.3% of the respondents said that they travelled less than two hours to reach the facility providing the service (Kumbi, Melkamu & Yeneneh 2008:28). This could be attributed to the expansion of safe abortion services at the health centres in the capital city.

4.4.3 The ease of identifying the service delivery unit in the health centre

In this study 11.1% of the respondents claimed to have identified the unit where safe abortion care is provided only with difficulty, 47.7% of the respondents identified the unit by asking the staff for information and 41.2% the respondents were able to get to the unit by reading a signboard posted which indicated where to find various services. When compared with other studies, this study showed a relatively low result with respect to clients being able to locate the service unit. For example, in another study

79.6% of the women had no difficulty in locating the particular services they required after reaching the health facilities (Kumbi et al 2008:28).

4.4.4 Perceptions regarding waiting time

Another factor which is supposed to affect perceptions of the accessibility of health services is the length of time that clients have to wait before they receive a service. In this study 89.2% of the women received the service within less than an hour, and for 71.1% of them the waiting time was appropriate. In the study by Wube (2006:25) 70.3% of the respondents received the service within less than 40 minutes. The findings in the current research improve on those in the study by Yirga (2009:35), where 49% of the women waited an hour or more to receive abortion care service.

4.4.5 Perceptions regarding the cost incurred by clients to receive the service

Most of the respondents (73.4%) rated the amount of money they paid to get the service as appropriate, a finding which is almost similar to that in the study done by Yirga (2009:35) in which 61% of the women said the payment was fair. However, the Central Statistical Agency (2012:131) states that 68% of the respondents in their study reported that they lacked the money to pay for health services, which prevented them from seeking health care services for their reproductive health issues.

4.4.6 The confidence of clients in the skills of service providers

Clients' satisfaction with the safe abortion service is a key factor in the continuing utilisation of the service by the community. This study has found that 87.1% of the respondents felt that the safe abortion care providers were highly skilled, and were satisfied with the service provided. This finding is lower than that in the study by Yirga (2009:36), where more than 98% of the clients were satisfied with the skills of the providers and the services they received.

4.4.7 Cumulative measures of accessibility

Of the respondents in this study, 47.1% perceived safe the abortion care service as being accessible in terms of the distance they travelled to reach the health centre, the

time they waited at the abortion care unit, the cost they paid for the service and their satisfaction with the service providers. On the other hand, 52.9% of the respondents perceived that safe abortion care services as inaccessible because they were dissatisfied on the same counts. A study done by Yirga (2009:39) showed that the prospective clients thought the safe abortion service to be inaccessible due to the inaccessibility of transport, the longer time they had to wait for service, and the cost of the service.

4.5 CONCLUSION

The results of this study indicate that a little more than half of the women generally perceive that safe abortion care is not accessible for them in terms of the combined effects of the distance travelled to reach particular health centres, the time they spend waiting to receive the service, the cost of their consultation, and their dissatisfaction with the skills of the providers.

CHAPTER 5

SUMMARY, CONCLUSIONS, RECOMMENDATIONS AND LIMITATIONS OF THE STUDY

5.1 INTRODUCTION

This chapter briefly summarises the overall research undertaking and the major findings of the study. It also makes recommendations to the concerned stakeholders in order to improve the accessibility of safe abortion care in Ethiopia and elucidates the contributions of this study and the limitations in its scope. Finally, it draws conclusions from the research findings.

5.2 SUMMARY

The purpose of this study was to assess the views of women about the accessibility of safe abortion care in the governmental health centres found in Addis Ababa and the objectives were to

- determine women's views about the safe abortion care services provided
- examine women's views about the distance from their villages of the health institution providing safe abortion care
- determine women's views about the cost of the abortion care service
- determine women's views about the length of time they had to wait to receive the service
- examine women's confidence in the skills of the providers

A quantitative cross-sectional descriptive and non-experimental study was performed to assess what women feel regarding the accessibility of safe abortion care. The research participants were women between the ages of 18 and 49 who had gone to selected health centres to seek a safe abortion care service.

Simple random sampling was used to select 10 governmental health centres from the total of 24 governmental health centres providing safe abortion care. Then a sample of 342 women between the ages of 18 and 49 years, who had received safe abortion care at the selected health centres during the data collection period, were interviewed

The data collection tool was a structured questionnaire which was administered by trained data collectors. The questionnaire comprised of closed-ended questions. Some of these had an open-ended portion. The questionnaire was developed by reviewing the relevant literature, and it was pre-tested.

The questionnaire was divided into four sections and was intended to elicit the following information:

Part I: Socio demographic information about the respondents.
Part II: The reproductive history of the respondents.
Part III: Their perceptions regarding safe abortion care.
Part IV: Their perceptions regarding the accessibility of safe abortion care.

Data was analysed quantitatively using SPSS for Windows Version 16.0.

5.3 SUMMARY OF FINDINGS

The following findings are drawn after the analysis, interpretation and discussion of the study

5.3.1 Views of women regarding safe abortion care

This study revealed that a substantial number of participant women think that women can use safe abortion care services in cases of contraceptive failure, to space their pregnancies, and to limit the number of their children. This clearly indicates that the women have limited knowledge of contraceptive options and family planning methods.

Even though the penal code on abortion in Ethiopia was revised in 2005 to allow abortion in certain conditions, this study also revealed that nearly half of the respondent women who visited the selected health facilities to seek safe abortion care did not know

that it existed. In this study, of those who said they knew of the existence of a legal code regarding abortion, more than half felt that the law is restrictive. The study therefore identified a need to provide information to the general public about the purpose and use of abortion services.

5.3.2 Views regarding the distance travelled to reach a health centre

Regarding the distance they travelled to reach to the health centre which provides safe abortion care, a large proportion of the respondents travelled between 5 to 10 kilometres. Most of the respondents felt that the distance was appropriate. The distance travelled to get to the service centre is less in this study than in some studies in Ethiopia, but, the impact of the distance travelled needs to be borne in mind in the planning of other health centres.

5.3.3 Views regarding the waiting time and the ease of identifying the location of the service delivery unit in the health centre

Fewer than half of the respondents were able easily to locate the unit where safe abortion care is provided. As against other studies, this study showed that it was difficult for clients to locate the service units in the health centres, thus indicating the difficulty of location as a possible barrier to the use of such services.

Another factor which is often thought to affect the accessibility of health services is clients' waiting time to receive a service. In this study the majority of the women received the service in less than an hour and thought that the waiting time was unproblematic

5.3.4 Views regarding the cost incurred by clients to receive the service

Most of the respondents rated the amount of money they paid to receive the service as appropriate, a finding which is similar to those in other studies conducted in other parts of Ethiopia.

5.3.5 Confidence of the clients in the skills of the service providers

This study found a lower level of satisfaction with the skills of providers than was found by other studies performed in Ethiopia.

5.3.6 A cumulative measure of the perception of accessibility

When the four variables of accessibility were analysed for each respondents, the combined effect of the measures of accessibility indicated that the majority of the respondents do not think that they had appropriate access to safe abortion care services.

5.4 RECOMMENDATIONS

The following recommendations are made, based on the findings of the study:

5.4.1 Recommendations for improving access to safe abortion care services in Ethiopia

- The study found that most women in the study didn't have knowledge of current abortion law; awareness creation activities should therefore be devised so that unsafe abortions can be minimised.
- Safe abortion services should be expanded at all health facilities in places where the community can access the services.
- The provision of safe abortion services should be strengthened at an affordable cost.
- Providers should be trained in their skills in accordance with acceptable standards; and post training follow-up should be done in order to ensure that the standards are maintained.
- Adequate supplies and equipment and an adequate number of trained providers should be made available at all health facilities so that clients can be served without inappropriate delay.

5.4.2 Recommendations for further studies

- Further research needs to be conducted at a community level to further explore the views of women who have not used health facilities for safe abortion care services. This will give a more comprehensive view of the opinions of women in general, rather than only those of women who use these services
- Furthermore, a more detailed study designed to assess the perceptions of women about the accessibility of safe abortion care may assist in determining the relationship between the independent and dependent variables.

5.5 THE CONTRIBUTIONS OF THE STUDY TO PUBLIC HEALTH

This study has generated up-to-date findings about the views of women relating to the accessibility of safe abortion care in Addis Ababa, Ethiopia. Stakeholders who have concerns in the area of the accessibility of safe abortion care may devise more meaningful policy aimed at improving the service offered if they take these findings into account. Finally, the current study could be a stepping stone towards the performance of further studies by other scholars interested in assessing the various aspects of safe abortion care service.

5.6 LIMITATIONS OF THE STUDY

In the process of conducting the dissertation, the following limitations were encountered:

- The study was conducted at the selected 10 government-owned health centres in Addis Ababa city, and this might limit the generalisability of the study findings to all types of health facilities providing safe abortion care services (government-owned or privately owned hospitals, health centres, and clinics) found in the capital, and the results may not be representative of the situation in other parts of the country.
- The exclusion of the minors who came to the selected health care centres for the safe abortion care service may have resulted in presenting a picture different from what it would have been if the minors had been included. This is so because the needs and views of minors may be different from those of adults. The study

excluded minors to avoid the legal complexity of dealing with minors in such a sensitive area of health services.

- This study was a descriptive study designed to reach the identified research objectives; hence it did not estimate epidemiological measures of effect such as the odds ratio to test the association between variables.

5.7 CONCLUSION

The findings of the study clearly indicate that women view safe abortion care as inaccessible because of one or more factors, including the distance they travel to the health centre, the time they wait to receive the service, the cost of the service, or the lack of skills of the providers who serve them. The study has also revealed that most women do not know about the penal code dealing with abortion. This indicates that making safe abortion care and contraception available to women needs greater consideration by governmental, non-governmental and private stakeholders, in order to reduce the rate of unsafe abortion and its consequences in the country. This study could be used to improve the quality and the accessibility of safe abortion care in Ethiopia through different interventions.

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ANNEXURE A

Ethical Clearance Certificate from the University of South Africa

UNISA university of south africa

UNIVERSITY OF SOUTH AFRICA
Health Studies Higher Degrees Committee
College of Human Sciences
ETHICAL CLEARANCE CERTIFICATE

HSHDC/41/2012

Date of meeting: 30 April 2012 Student No: 4633-150-6

Project Title: Views of women about accessibility of safe abortion care services in Addis Ababa, Ethiopia

Researcher: Somega Selamawit Adnew

Degree: Masters in Public Health Code: DLMPH95

Supervisor: Dr K Mokwena
Qualification: PhD
Joint Supervisor: -

DECISION OF COMMITTEE

Approved [√] **Conditionally Approved** [ ]

Prof E Potgieter
CHAIRPERSON: HEALTH STUDIES HIGHER DEGREES COMMITTEE

Dr MM Moleki
ACTING ACADEMIC CHAIRPERSON: DEPARTMENT OF HEALTH STUDIES

PLEASE QUOTE THE PROJECT NUMBER IN ALL ENQUIRES

Annexure B: Letter asking permission From Addis Ababa city council health Bureau

To Addis Ababa city council health Bureau

Addis Ababa

Subject: permission to conduct a study

My Name is Selamawit Adnew, who is studying for master's degree in public health at the University of South Africa, in the department of health studies. I am conducting the research entitled "**Views of Women about Accessibility of Safe Abortion Care Services in Addis Ababa, Ethiopia"** as a partial fulfilment of the master's degree in public health.

The purpose of this study is to assess the perceptions of women about accessibility of safe abortion care in the governmental health centres found in Addis Ababa city Administration.

The results of this study will be used to provide information on how to improve accessibility of safe abortion care services to women and to recommend on ways of improving the accessibility of safe abortion care thereby improve utilization of the service.

Information obtained from this study will be kept confidential and information obtained for the purpose of this study will not be directly linked to the name of the institution. Upon the completion of the research I promise that I will submit one copy of the final draft of the research report and the results of this study will not be disseminated or published without getting the permission of your bureau.

I have submitted the proposal to the Higher Degrees Committee of the Department of health studies at the University of South Africa and have got the Ethical clearance attached with this letter of permission.

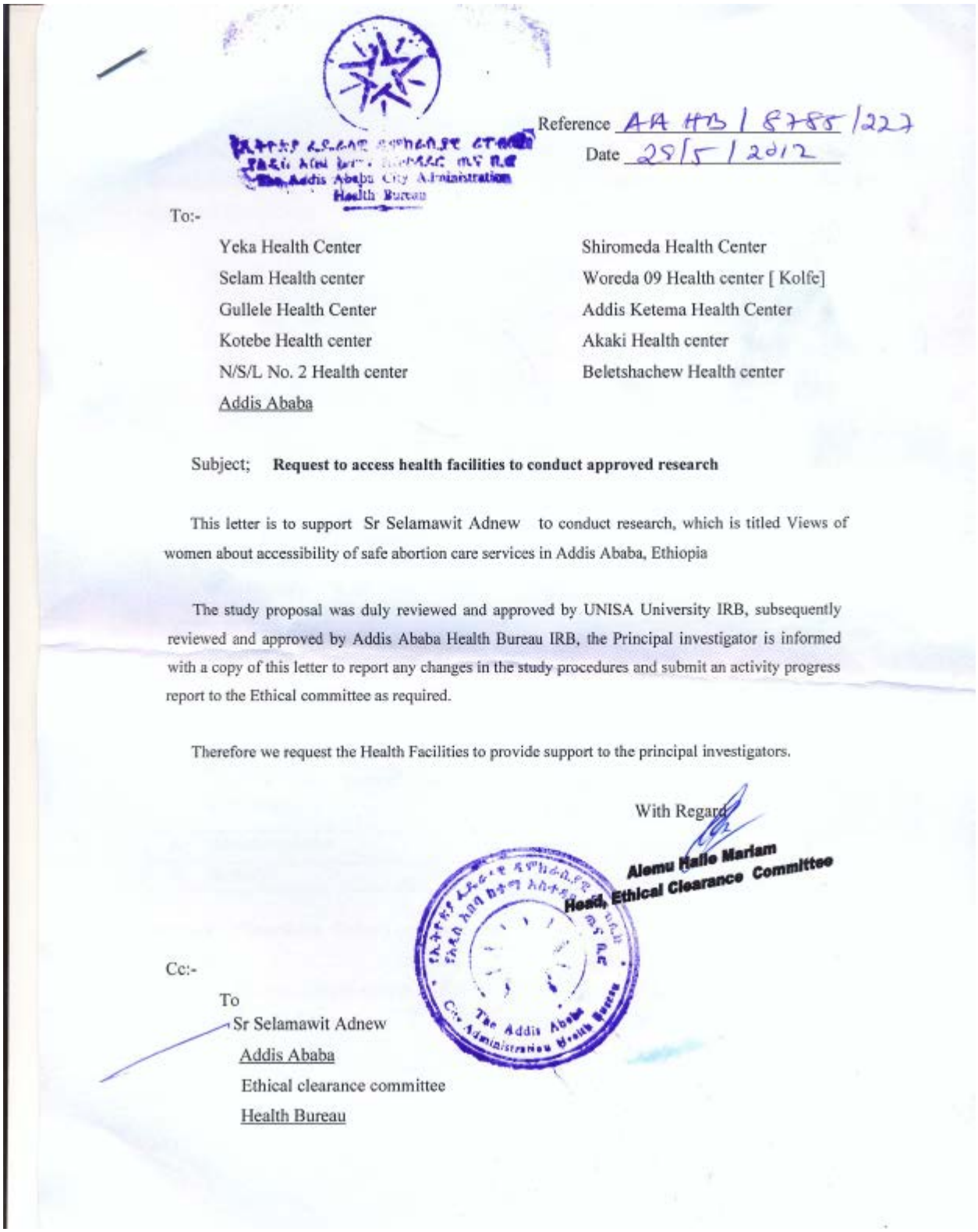
I would like to request the kind permission of your esteemed bureau to conduct this study. Thus I hereby request your respected office to write me a formal letter to the respective sub city, district health offices to facilitate and commence smooth conduct of the study. I assure you that I will communicate the progress of the study throughout the study process.

Thank you in advance for your cooperation!

SA SOMEGA

ANNEXURE C

Letter of permission from Addis Ababa Health Bureau



Reference AA HB/8785/227

Date 25/5/2012

The Addis Ababa City Administration Health Bureau

To:-

Yeka Health Center
Selam Health center
Gullele Health Center
Kotebe Health center
N/S/L No. 2 Health center
Addis Ababa

Shiromeda Health Center
Woreda 09 Health center [Kolfe]
Addis Ketema Health Center
Akaki Health center
Beletshachew Health center

Subject; **Request to access health facilities to conduct approved research**

This letter is to support Sr Selamawit Adnew to conduct research, which is titled Views of women about accessibility of safe abortion care services in Addis Ababa, Ethiopia

The study proposal was duly reviewed and approved by UNISA University IRB, subsequently reviewed and approved by Addis Ababa Health Bureau IRB, the Principal investigator is informed with a copy of this letter to report any changes in the study procedures and submit an activity progress report to the Ethical committee as required.

Therefore we request the Health Facilities to provide support to the principal investigators.

With Regard

Alemu Hailo Mariam
Head, Ethical Clearance Committee

The Addis Ababa City Administration Health Bureau

Cc:-

To
Sr Selamawit Adnew
Addis Ababa
Ethical clearance committee
Health Bureau

ANNEXURE D: QUESTIONNAIRE FOR WOMEN BETWEEN THE AGES OF 18-49 YEARS

INTRODUCTION

Hello, my Name is _____I am here to collect data on behalf of Miss Selamawit Adnew to conduct the research titled "**Views of Women about Accessibility of Safe Abortion Care Services in Addis Ababa, Ethiopia"**
The purpose of this study is to assess the perceptions of women about accessibility of safe abortion care in the governmental health centres found in Addis Ababa city Administration.

The results of this study will be used to provide information on how to improve accessibility of safe abortion care services to women and to recommend on ways of improving the accessibility of safe abortion care thereby improve existing situations.

There are no potential risks that are foreseen to occur as a result of participating in this study. Please note that all information obtained will be kept confidential and information obtained for the purpose of this study will not be directly linked to your name.

The questionnaire will take approximately 20-40 minutes and will take place in a private place convenient for you. Please note that your participation in this study will be voluntary and you will be free to withdraw from participation at any time.

If you have any question about the study or participating in the study, please feel free to call at +251-911-986520.

Thank you in advance for your cooperation!

Are you willing to participate in this study? (If the participant responds yes continue data collection, if responds no stop the questionnaire)

Yes---------
No----------
Signature of Participant: _____ Date: _____

Questionnaire Code number _____

Interviewer code number _____

Sub City_____ **District** _____ **Village** _____

#	Questions	Response category	Code
Section I Back ground information of respondents			
100	How old are you	Write in numbers_____	
101	Religion	1. Orthodox Christian 2. Muslim 3. Protestant 4. Catholic 5. Other (specify)_____	
102	Place of residence	1.Urban 2.Rural	
103	What is the highest education level you have attained	1. Cannot read or write 2. Read and write 3. Primary education 4. Secondary education 5. College/ University	
104	What is your ethnicity	1. Oromo 2. Amhara 3. Tigray 4. Guraghe 5. Wolayta 6 other (specify)_____	
105	Indicate your occupation	1. Student 2. House wife 3. Government employee 4. Private employee 5. Entrepreneur 6. Other (specify)_____	
106	Marital status	1. Single 2. Married 3. Divorced 4. Widowed 5. Separated 6. Unmarried but in a relation ship 7 Other (specify)_____	
Section II reproductive history			

200	How many times have you been pregnant including this pregnancy?	-------- times	
201	How many times have you given birth to baby?	--------times	
202	Did you ever have history of an still born?	1. Yes 2. No	
203	Did you ever have history of an abortion before the current episode?	1. Yes 2. No	
204	If the answer for Q 203 is yes, what was its reason?	1. Induced abortion 2. Spontaneous abortion	
205	If yes to Q 203, where did you go to seek help?	1. Traditional healer 2. Private institution(clinic, hospital) 3.Governmental health institution (health centre, hospital 00 other (specify)	
Section III perceptions related to Abortion			
300	In your community why do women seek abortion care?	1. Don't want any more children 2. To space between pregnancies 3. Premarital pregnancy 4. Health problems 5. Contraceptive failure 6. I don't know 7. Other (specify)	
301	In your opinion when do you think that women should seek abortion care?	1. when they don't want any more children 2. To space between pregnancies 3. Premarital pregnancy 4. Health problems 5. Contraceptive failure 6. I don't know 7. Other (specify)	
302	In Ethiopia, is there a law which is related with Safe abortion Care?	1.Yes 2. No 3. I don't know	
303	If you answer for Q 302 is yes, under what condition/s does/do the current Ethiopian penal code allow safe abortion?	1. When pregnancy results from rape 2. When pregnancy results from incest 3. When continuation of pregnancy endangers the health and life of the mother or foetus 4. If the foetus has abnormalities 5. If the woman has physical or mental disabilities 6. If a minor is physically or psychologically unprepared to raise a child 7 I don't know	

		8 Other (specify)	
304	How do you rate the current Ethiopian abortion law?	1. Very restrictive 2. Moderately restrictive 3. Liberal 4. I don't know the law	
305	How many times do you think should a woman be allowed to have an abortion?	1.------ times 2 I don't know	
306	What do you think are the harmful effects of having repeated abortion to the woman?	1. She may develop infection 2. She may bleed 3. She may die 4.She may not conceive again 5. She may become weak 6. I don't know 7. Other (specify)	
307	Do you know a woman/ adolescent girl who had an abortion in the past one year in your family or neighbourhood?	1. Yes 2. No If yes go to Q 308 if no skip to Q 400	
308	If yes to Q307 what was the reason for the abortion?	1. Don't want any more children 2. To space between pregnancies 3. Premarital pregnancy 4.Contraceptive failure 5. Extramarital pregnancy 6. Health problems 7. I don't know 8. Other (specify)	
309	If yes to Q 307, where did she go to seek help?	1. Traditional healer 2. Private institution(clinic, hospital) 3.Governmental health institution (health centre, hospital 4. Other (specify)	
Section IV perceptions related to accessibility of Safe abortion care			
400	How do you rate the accessibility of safe abortion care in your area?	1. Very easy 2. Fair 3. Very difficult 4. Impossible 5. Not accessible	
401	If you answer for Q 400 is very difficult or impossible to access, what is the reason?	1.Health facilities are not available 2.Health facilities are not near by 3. I cannot pay for the services 4.No transportation services	

		5.Cannot pay for transportation 6. Other (specify)	
402	How long did u travel to reach this health facility from where you are currently living?	1. With 5-10 kilometre 2. 10-20 kilometre 3. 20-30 kilometre 4. >30 kilometre	
403	How do you rate the traveling distance get the health facility?	1. Very long 2. Moderate 3. Appropriate	
404	How do you identify the service delivery unit after you got in to the health facility?	1. I saw a sign board 2. I was told by the staff at the registration room 3. I got the unit with difficulty	
405	For how long did you wait to receive the service after you reached the health centre?	----------(write minute in numbers)	
406	How do you rate the waiting time to get the service	1. Very long 2. Moderate 3. Appropriate	
406	If your answer for Q 406 is very long, what was the reason?	1. Providers were not in the room 2. There were many clients 3.Other (specify)----------	
408	How do you rate the cost for abortion care?	1. Fair 2. Moderate 3. Expensive	
409	How do you rate the skill of the providers?	1. Very skilful 2. Moderately skilful 3. Not skilful	

ANNEXURE E

AMHARIC TRANSLATED QUESTIONNAIRE

እድሜያተው ከ 18-49 አመት ለሆነ ሴቶች የተዘጋጀ ቃለ መጠይቅ

እንደምን ዋሉ/አደሩ ስሜ ---------- ይባላል ። ንፅህናዉን የጠበቀ የውርጃ አገልግሎት ተደራሽነት ሁኔታ ለማወቅ የሚረዳ ጥናት ላይ እኔና እርሶ ከ 20-40 ደቂቃ ያህል እንወያያለን። የዚህ ጥናት ዓላማ በአዲስ በአበባ ውስጥ ንፅህናውን የጠበቀ የውርጃ አገልግሎት ተደራሽነት እንዲሻሻል ይረዳል። በቆይታችን ውስጥ የሚነግሩኝ መረጃ ሚስጥራዊነት እንደሚጠበቅ እያረጋገጥኩኝ እያንዳንዱ ተሳታፊ የራሱ የሆነ መለያ ቁጥር የሚሰጠው ሲሆን ስምዎት አይፃፍም። የሚሰጡት መልስም ለሌላ ሰው ተላልፎ አይሰጥም ። መጠይቁ በፈቃደኝነት ላይ የተመሰረተ ሲሆን እርሶ ለመሳተፍ ወይም ላለመሳተፍ እንዲሁም ጥያቄውን ላለመመለስ ፈቃደኛ አለመሆንና በማንኛዉም ሰዓት ቃለ መጠይቁን አቋርጠው መውጣት ይችላሉ።

በዚህ ጥናት በመሳተፍዎ በዚህ ጤና ድርጅት ውስጥ በሚያገኙት አገልግሎት ላይ ምንም አይነት ተፅእኖ አይኖርም። ማንኛውም ጥያቄ ቢኖሮዎት መጠየቅ ይችላሉ ።

ለትብብርዎ አመሰግናለሁ።

በጥናቱ ለመሳተፍ ፈቃደኛ ኖት

1. አዎ 2. አይደለሁም

(የጥናቱ ተሳታፊ በጥናቱ ለመሳተፍ ፈቃደኛ ከሆኑ ፊርማ ይፈርሙና ይቀጥሉ)

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ፊርማ ቀን

የመጠይቅ ኮድ ----------

የጠያቂው ኮድ ----------

ክፍለ ከተማ ---------- የጤና ጣቢያው ሥም ----------

ወረዳ ---------- ቀበሌ ----------

ተ/ቁ	ጥያቄ	መልስ	ኮድ
I አጠቃላይ መረጃ			
100	እድሜዎት	በቁጥር ----------	
101	ሃይማኖት	1. ኦርቶዶክስ ክርስቲያን 2. ሙስሊም 3. ፕሮቴስታንት 4. ካቶሊክ 5. ሌላ(ይገለጽ)	
102	የሚኖሩበት ቦታ	ነ. ከተማ 2. ገጠር	
103	የትምህርት ደረጃ	1.ማንበብና መፃፍ የማይችሉ 2. ማንበብና መፃፍ ብቻ 3.የመጀመሪያ ደረጃ ትምህርት 4. ሁለተኛ ደረጃ ትምህርት 5. ኮሌጅ ወይም ዩንቨርሲቲ 6. ሌላ (ይገለፅ) ----------	
104	ብሔር	1.ኦሮሞ 2. አማራ 3.ትግሬ 4. ወላይታ 5.ጉራጌ 6. ሌላ (ይገለጽ)	
105	የስራ ሁኔት		
106	የጋብቻ ሁኔታ	1. ያላገባች 2. ያገባች 3. የተፋታች 4. ባለቤቷ በሞት የተለየ 5. ሌላ/ይገለጽ/	
11 የስነተዋልዶ ሁኔታ			
200	በህይወት ዘመንዎ ምን ያህል ጊዜ አርግዘዉ ያውቃሉ ?	---------- ያህል ጊዜ	
201	በህይወት የተወለዱ ልጆች ብዛት	----------	
202	ከዚህ በፊት ሞቶ ተወለደ ልጅ	1. አዎ 2. የለም	
203	ከዚህ በፊት ውርጃ አጋጥሞት ያውቃል?	1.አዎ 2.የላም	

204	ለጥያቄ ቁጥር 203 መልሶ አዎ ከሆነ ምክንያቱ ምን ነበረ?	1.ድንገተኛ 2. ማስወረድ 3.ሌላ /ይገለጽ/	
205	ለጥያቄ ቁጥር 203 መልሶ አዎ ከሆነ አገልግሎት ለማግኘት ወዴት ሄዱ?	1.የባህል ሃኪም 2. የግል ሃኪም ቤት 3. የመንግስት የጤና ተቋም	
111 ውርጃን በተመለከተ የግል አስተያየት/አመለካከት/			
300	እርሶ በሚኖሩበት አካባቢ ሴቶች ውርጃ የሚያካሄዱ በምን ምክንያት ይመስሎታል?	1. ተጨማሪ ልጅ ስለማይፈልጉ 2. እርግዝናን ለማራራቅ 3. ከጋብቻ በፊት በሚያጋጥም እርግዝና 4. በጤና ችግር ምክንያት 5.የእርግዝና መከላከያ ዘዴ መከሸፍ	
301	በእርሶ አመለካከት ሴቶች በምን ምክንያት ውርጃ ቢያካሂዱ ትክክል ይመስሎዎታል?	1.ተጨማሪ ልጅ ስለማይፈልጉ 2.እርግዝናን ለማራራቅ 3. ከጋብቻ በፊት በሚያጋጥም እርግዝና 4. በጤና ችግር ምክንያት 5. የእርግዝና መከላከያ ዘዴ መክሸፍ 6.አላውቅም 7.ሌላ/ይገለጽ/	
302	በኢትዮጵያ ውስጥ ውርጃ በተመለከተ የተደነገገ ህግ አለ ?	ነ. አለ 2. የለም 3. አላውቅም	
303	ለጥያቄ ቁጥር 302 መልሶ አለ ከሆነ በምን ምክንያት ውርጃ ይፈቀዳል?	1.እርግዝናው በመደፈር ምክንያት የተከሰተ ከሆነ 2.እርግዝናው ከዘመድ የተከሰተ ከሆነ 3. እርግዝናወ ለእናትየውን ጤንነት አደገኛ ከሆነ 4. ጽንሱ አፈጣጠሩ ትክክለኛ ካልሆነ 5.የእናትየዋ እድሜ ከ 18 አመት በታች ከሆነ 6.የእናትየዋ አካላዊ ወይም አእምሮዋዊ ጤንነት ችግር ካለባት 7. አላውቅም 8.ሌላ/ይገለጽ/	
305	በእርሶ አመለካከት ህጉ እንዴት ይገልፁታል?	1. ጥብቅ ነው 2. የላላ ነው 3. አላውቅም	
306	በእርሶ አመለካከት አንዲት ሴት በህይወት ዘመኗ ምን ያህል ጊዜ ውርጃ ማካሄድ ትችላለች?	1.---------- 2 አላውቅም	
307	አንዲት ሴት በተደጋጋሚ ውርጃ ብታካሂድ ምን የጤና ችግር ሊያጋጥማት	1. የደም መፍሰስ	

	ይችላል?	2. ኢንፌክሽን 3. ሞት 4. መካንነት 5. አላውቅም 6. ሌላ/አላውቅም/	
308	በእርሶ አካባቢ ከአንድ አመት ወዲህ ወርጃ ያካሄደች ሴት ኢጋጥሞታል ወይ?	1.አዎ 2.አላጋጠመኝም 3. አላስታውስም	
309	በጥያቄ ቁጥር 308 መልሱ አዎ ከሆነ የውርጃው ምክንያት ምን ነበር?	1.ተጨማሪ ልጅ ስለማይፈልጉ 2.እርግዝናን ለማራራቅ 3.ከጋብቻ በፊት በሚያጋጥም እርግዝና 4. በጤና ችግር ምክንያት 5.የእርግዝና መከላከያ መክሸፍ 6.አላውቅም 7.ሌላ/ይገለጽ/	
310	በጥያቄ ቁጥር 308 መልሱ አዎ ከሆነ አገልግሎቱን ለማግኘት ወዴት ሄዱ?	1. የባህል ሃኪም 2. የግል ሃኪም ቤት 3. የመንግስት የጤና ተቋም 4. ሌላ/ይገለጽ/	
111 ንጽህናዉን የጠበቀ የውርጃ አገልግሎትን ተደራሽነት በተመለከተ			
400	እርሶ በሚኖሩበት አካባቢ ንፅህናውን የጠበቀ የውርጃ አገልግሎት ተደራሽነት ምን ይመስላል?	1. በቀላሉ ማግኘት ይቻላል 2. ለማግኘት አስቸጋሪ ነው 3. ተደራሽ አይደለም 4. ሌላ/ ይገለፅ/	
401	ለጥያቄ ዉጥር 400 መልሱ ተደራሽ አይደለም ካሉ ምክንያቱ ምን ይመስሎታል?	1. የጤና ድርጅት በጤና ድርጅት በአካባቢው ስለሌለ 2. የጤና ድርጅቶች ከአካባቢያችን ስለሚርቅ 3. ክፍያው ከአቅማችን በላይ ስለሆነ 4. ትራንስፖርት ስለማይገኝ 5. ለትራንስፖርት የምንከፍለው ክፍያ ውድ ስለሆነ 6. ሌላ/ይገልጽ/	
402	ወደ እዚህ ጤና ድርጅት ለመምጣት ምን ያህል ተጓዙ?	1. ከ 5-10 ኪሎ ሜትር 2. 10-20 ኪሎ ሜትር 3. ከ20-30 ኪሎ ሜትር 4. ከ30 ኪሎ ሜትር በላይ	
403	በእርስዎ አመለካከት ወደ እዚህ ጤና ድርጅት ለመምጣት ከመኖሪያዎ ያለውን	1. በጣም እሩቅ ነው	

	ርቀት እንዴት ይገልፀታል?	2. መካለኛ ነው 3. ቅርብ ነው	
404	ወደዚህ የጤና ድርጅት ከገቡ በኋላ የአገልግሎት መስጫ ክፍሉ ያለበትን ቦታ እንዴት አወቁ?	1. አቅጣጫ ጠቋሚ ምልክት አይቼ 2. የጤና ድርጅት ሰራተኞች ጠቁመውኝ 3. በብዙ ድካም ክፍሉ የሚገኝበትን ፈልጌ 4. ሌላ/ይገለጽ/	
405	አገልግሎቱን ለማግኘት ምን ያህል ደቂቃ ጠበቁ?	በቁጥር ይገለፅ ---------- ደቂቃ	
406	አገልግሎቱን ለማግኘት የጠበቁትን ጊዜ እንዴት |ይገልፁታል?	1. ለረጅም ጊዜ 2. መካከለኛ ነው 3. ተመጣጣኝ ነው	
407	ለጥያቄ 406 መልስዎ ረጅም ሰዓት ነው ካሉ ምክንያቱ ምን ነበር?	1. አገልግሎቱን የሚሰጡ ባለሙያዎች አልነበሩም 2. ብዙ ደንበኛ ስለነበር 3. ሌላ/ይገለጽ/	
408	አገልግሎቱን ለማግኘት የከፈሉትን ከፍያ እንዴት ይገልጹታል?	1. ተመጣጣኛ ነው 2. መካከለኛ ነው 3. ውድ ነው 4. በጣም ውድ ነው	
409	አገልግሎቱን የሚሰጡ ባለሙያዎች ችሎታ በእርስዎ አመለካከት እንዴት ይገልፁታል?	1. በጣም የተካኑ ናቸው 2. መካከለኛ ችሎታ ያላቸው 3. ችሎታ የላቸውም	

ANNEXURE F: Questionnaire for Women between the Ages of 18-49 Years

INTRODUCTION

Hello, my Name is _____I am here to collect data on behalf of Miss Selamawit Adnew to conduct the research titled "**Views of Women about Accessibility of Safe Abortion Care Services in Addis Ababa, Ethiopia".**

The purpose of this study is to assess the perceptions of women about accessibility of safe abortion care in the governmental health centres found in Addis Ababa city Administration.

The results of this study will be used to provide information on how to improve accessibility of safe abortion care services to women and to recommend on ways of improving the accessibility of safe abortion care thereby improve existing situations.

There are no potential risks that are foreseen to occur as a result of participating in this study. Please note that all information obtained will be kept confidential and information obtained for the purpose of this study will not be directly linked to your name.

The questionnaire will take approximately 20-40 minutes and will take place in a private place convenient for you. Please note that your participation in this study will be voluntary and you will be free to withdraw from participation at any time.

If you have any question about the study or participating in the study, please feel free to call at +251-911-986520

Thank you in advance for your cooperation!

Are you willing to participate in this study? (If the participant responds yes continue data collection, if responds no stop the questionnaire)

Yes---------

No----------

Signature of participant: _____ Date: _____

ANNEXURE G: LETTER FROM STATISTICIAN AND ENGLISH EDITOR

ጎንደር ዩኒቨርሲቲ
የሕብረተሰብ ጤና አጠባበቅ ተቋም
ጎንደር፣ ኢትዮጵያ

University of Gondar
Institute of Public Health
Gondar, Ethiopia

College of Medicine & Health Sciences

NO SPH/1443/02/2005

October 23, 2012

To: Dr. Kebogile Mokwena

Subject: Testifying my consultancy for your student

This is **Dr. Berihun Megabiaw**, director of the Institute of Public Health (formerly the School of Public Health) and assistant professor of Public Health at the department of Epidemiology and Biostatistics, University of Gondar, Ethiopia.

This is to let you know that I had consulted one of your advisees at UNISA (student ***Selamawit Adinew Somega***) on the statistical analysis of her thesis work entitled "**Views of women about accessibility of safe abortion care services in Addis Ababa, Ethiopia**".

Furthermore, I kindly testify that I have also copy edited the language as well.

With Kind regards!

Berihun Megabiaw (MD, MPH)
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University of Gondar
Gondar, Ethiopia