Assessment of Healthcare Providers' Attitudes, and Associated Factors on Abortion Service Provision in Public Health Facilities of Amhara, Oromia, SNNP and SWEP

Impacts for Development (I4D)

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Executive summary

Introduction: Unsafe abortion is a major public health problem globally contributing to significant proportion of maternal mortality in developing countries. Each year an estimated 36 million to 53 million abortions are performed worldwide. Of this, around 20 million are considered unsafe. In Ethiopia 382,000 induced abortions occurred in 2008 and abortion rate was 23 per 1,000 women in reproductive age. The unfavorable attitude of health care providers is one of the challenges to making the services accessible and available to women and girls. The study provides inputs on issues that need to be addressed with regard to the unfavorable attitude of health care providers rendering the safe abortion services and helps to inform the magnitude of unfavorable attitudes towards abortion among health care providers, associated factors, resistance of providers and the stigma associated with providing the services.

Objectives: The study aims to assess healthcare providers' attitude towards providing Comprehensive Abortion Care (CAC) services in health facilities. The specific objectives include exploring providers' attitudes towards Safe Abortion services, identifying reasons for resistance to providing CAC services, assessing the effects of provider attitude on CAC services, identifying contributing factors to stigma and resistance, and determining the key roles of program experts and service providers in destigmatizing CAC services.

Study Design, Data Collection, and Analysis: This study employed a cross-sectional mixed-method approach, utilizing both quantitative and qualitative methods to assess the attitude of healthcare providers towards providing safe abortion care services in selected Ipas-supported health facilities across four regions in Ethiopia. The study population included healthcare providers, facility managers, and team leaders related to maternal, newborn, and child health in selected health facilities, while selected experts from Regional Health Bureau (RHB), Zonal Health Departments (ZHD), and WoHOs were the study population for the Focus Group discussion (FGDs). The sample size for the study was determined using a single population proportion formula, and a total of 442 providers were selected using systematic random sampling techniques of which 374 were interviewed. In addition, we conducted three FGDs and 27 In-depth interviews. Attitude of healthcare providers towards providing safe abortion care services is the dependent variable and individual and socio-demographic factors, training, practice of health providers, and health facility related factors are the independent variables. Bivariate and multivariate logistic regression were used to select predictor variables and measure associations to the outcome variable using IBM® SPSS® Statistics 29.

Results and discussion: A total of 442 health providers were approached and 374 were consented to be interviewed with 85% response rate. The majority of health providers who responded to the survey were from health centers, making up 88% of the total. A total of 374 health providers completed the survey. Most health providers (89.6%) reported a favorable attitude towards the provision of safe abortion services, while 10.4% reported an unfavorable attitude. The mean

attitude score for the respondents was 3.9 (SD=0.7). Based on the multivariate analysis, Muslims were 65% less likely to have a favorable attitude towards safe abortion services compared to Orthodox individuals (AOR=0.35, 95%CI: 0.13-0.95, p=0.04). Similarly, participants who stayed at the health facility for 3-5 years were 65% less likely to have a favorable attitude compared to those who stayed less than 3 years (AOR=0.35, 95%CI: 0.13-0.99, p=0.047). Participants who were not aware of the national abortion law were 63% less likely to have a favorable attitude compared to those who were aware (AOR=0.37, 95%CI: 0.14-0.98, p=0.045). Participants who felt uncomfortable performing safe abortion services were 68% less likely to have a favorable attitude compared to those who felt comfortable (AOR=0.32, 95%CI: 0.13-0.75, p=0.009). The majority of the respondents from the in-depth interviews and focus groups reported that the attitude of the health providers towards safe abortion service provision has been improving due to the continuous trainings that have been provided by Ipas.

Conclusion and Recommendation: Having favorable attitude towards safe abortion service among health care providers is crucial for accessibility and quality of safe abortion care. The study revealed that some healthcare providers (10.4%) of the surveyed participants still exhibit unfavorable attitudes, influenced by factors such as religious beliefs, lack of awareness of national laws and length of stay at the health facilities. Addressing these attitude issues, as well as barriers such as stigma and resistance of health care providers, requires a multi-faceted approach. Efforts also need to be made to address cultural and social norms affecting the attitude of health care providers in providing the services. Ongoing education and training for providers, such as that provided by Ipas Ethiopia, is essential for improving the attitude of health care providers towards provision of safe abortion services.

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Acronyms

CAC	Comprehensive Abortion Care
EFMOH	Ethiopia Federal Ministry of Health
EPHA	Ethiopian Public Health Association
FGD	Focus group discussions
HC	Health Center
HF	Health Facility
I4D	Impacts For Development
KII	Key Informant Interviews
MOH	Ministry of Health
ODK	Open Data Kit
PI	Principal Investigator
PII	Personally Identifiable Information
RHB	Regional Health Bureaus
SNNP	Southern Nations, Nationalities, and Peoples
SWEP	South-West Ethiopia Peoples
USAID	United States Agency for International Development
VCAT	Value Clarification and Attitude transformation
WHO	World Health Organization
WoHO	Woreda Health Offices
ZHB	Zonal Health Bureaus

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1. Background

1.1 Statement of the Problem

Globally, over 42 million abortions are performed annually and 10–15% of the cases take place in the second trimester period, over half of which are considered unsafe and contribute to maternal death [1]. Death due to unsafe abortion accounts for a significant proportion (13%) of global maternal mortality. Each year an estimated 36 million to 53 million abortions are performed worldwide. Of this figure, around 20 million are considered unsafe [2]. World Health Organization (WHO) estimates show that the proportion of maternal mortality due to abortion complications ranges from 8% in Western Asia to 26% in South America, with a worldwide average of 13%. In developing countries complications of unsafe abortion cause between 50,000- and 100,000-women's deaths annually [2–4].

Unsafe abortions are a major public health problem. Half of abortions globally are unsafe or estimated to be between 21 million and 22 million, therefore around one in ten pregnancies ends in an unsafe abortion. Almost all of them occur in developing countries, with the higher number of deaths concentrated in Africa, especially Sub-Saharan Africa, and South Asia [5]. Ethiopia Federal Ministry of Health (EFMOH) in 2006 estimated that abortion-related deaths accounted for more than 30% of maternal deaths in Ethiopia. Besides this, access to second trimester abortions is severely limited. Only 9–10% of all facilities have a provider who can perform this service [6]. Unsafe abortion is still common and demands a heavy toll on women in Ethiopia and 382,000 induced abortions occurred in 2008 and abortion rate is 23 per 1,000 women in reproductive age; 11–15 abortions occurred per 100 live births [7]. According to the 2010 report of EFMOH, 32% of all maternal deaths in Ethiopia were related to unsafe abortion [8, 9]. Therefore, there is a consensus among various bodies that legalization of abortion is central in preventing the suffering and death of women [5]. To address the large number of maternal deaths caused by unsafely performed abortions, as part of law reform in Ethiopia in 2005, the penal code was revised to broaden the indications under which abortion is permitted [8]. Since then, maternal death due to unsafe abortion decreased from 32% in 2006 to 4% in 2018 [24].

1.2 Justification of the study

A shortage of abortion providers in health facilities has a significant challenge to making abortion services accessible and available to women and girls at different levels. There is not enough research to assess the level of providers' attitudes and perceptions toward safe abortion in Ethiopia. Different studies which are conducted in different countries have found that healthcare providers are resistant to providing abortion services and have unfavorable attitudes to the clients who seek abortion services. The experience from Ipas Ethiopia in the past indicated that some providers are not willing to attend the CAC training and some of them resisted providing safe induced abortion services after they had already taken the CAC training.

In many low-resource countries, the stigma associated with abortions means that the providers offering these services suffer discrimination in and outside the workplace [10,11]. The discrimination causes many providers to cease providing abortion services [10,11]. Furthermore, abortion providers' attitudes may conflict with the national abortion law [12,13]. These conflicts may cause moral distress and hamper the professional–patient relationship. The lack of willingness and commitment among health care providers to deliver timely, thoughtful, and supportive abortion care may directly or indirectly contribute to maternal mortality due to unsafe abortions. Therefore, it is important to understand healthcare providers' perceptions of and attitudes towards induced abortions, as they have a substantial effect on the accessibility to abortion services and the quality of these services.

1.3 Significance of the Study

The assessment intended to explore the level of providers' perceptions and attitudes towards abortion and identify the causes of resistance to providing abortion services. The study helps to identify key challenges/problems to providing comprehensive abortion care services as other healthcare services and provides recommendations to normalizing and destigmatizing abortion service provision in public health facilities. The assessment provides invaluable information for designing suitable strategies and interventions to improve provider perception and attitude towards abortion and mitigate resistance to service provision. Additionally, the findings of this assessment sheds light on the accessibility and availability of abortion services in public health facilities in Ethiopia.

1.4 Scope

The assessment is conducted in Amhara, Oromia, Southern Nations, Nationalities, and Peoples (SNNP), and South-West Ethiopia Peoples (SWEP). We conducted desk-based research on relevant literature including relevant documents, reports, and data from Ipas such as Value Clarification and Attitude transformation (VCAT) training manuals, and VCAT training reports. We employed a mixed-method study consisting of quantitative and qualitative research methods. Quantitatively, we conducted surveys of 187 facilities and 374 providers[1] to assess abortion service provision and the level of attitude and perception towards abortion at the health facility level. Qualitatively, we conducted 27[2] in-depth interviews with health workers and facility managers to investigate concerns about providing Comprehensive Abortion Care (CAC) services, reasons for not providing CAC services, and getting suggestions to destigmatize CAC services in health facilities. The key respondents were identified during the desk review process. Additionally, we conducted three Focus Group Discussions (FGD) with program experts selected from the four regions including Regional Health Bureaus (RHB), Zonal Health Bureaus (ZHB), and Woreda Health Offices (WoHO) to assess government's effort in supporting CAC service and reducing

[1] The sample size determined including anticipated non-response was 442 health providers from 221 health facilities.

[2] 30 in-depth interviews were planned of which 27 were conducted.

provider resistance/objection to providing abortion service. Program experts discussed what it takes to normalize and destigmatize CAC services in health facilities. Each FGD was conducted with five to eight participants and lasted about an hour and half.

We conducted the interviews and FGDs in the local language using an audio recorder. We carried out transcriptions and translations of the verbatim into English. We developed the data collection tools/guides, trained, and deployed data collectors.

2. Objectives of the Assessment

The main objective of the study is to assess the providers' attitude towards providing CAC services and identify the challenges and recommendations to normalizing and destigmatizing CAC service provision in public health facilities.

Specific Objectives

- To explore the level of providers' attitudes towards Safe Abortion services
- To identify determinant factors of provider's attitude towards providing safe abortion services in public health facilities
- To assess the effects of provider's attitude on CAC services in public health facilities.
- To identify contributing factors towards abortion provision stigma and resistance in public health facilities.
- To identify the key roles of program experts and service providers in normalizing and destigmatizing the CAC services in the facilities.

3. Methodology

3.1 Study Setting and Period

The study was conducted in four regions namely Amhara, Oromia, SWEP, and SNNP from September 2022 to January 2023. According to the 2014 Ethiopian Fiscal Year Health and Health Related Indicators Report of the Ministry of Health (MOH), there are 90 functional hospitals (8 specialized, 15 general and 67 primary) and 885 Health Centers (HC) in Amhara. Of these Ipas intervention Health Facilities (HF) include 15 hospitals and 144 HCs. In Oromia, there are 116 hospitals (4 specialized, 36 general and 76 primary) and 1414 HCs among which Ipas supported HFs are 31 hospitals and 310 HCs. In SNNP, among 46 hospitals (3 specialized, 9 general and 34 primary) and 501 HCs found in the region, 11 hospitals and 136 HCs are Ipas supported. The report also shows, in Amhara, among 770,986 expected number of pregnancies, 5.4% have received comprehensive abortion care services. In Oromia, among the 1,387,335, 8.3% and in SNNP of the 475,49 expected pregnancies, 5.2% of them were provided with CAC services.

3.2 Study Design

The assessment employed a cross-sectional study design using a mixed-method approach including quantitative and qualitative research methods.

Secondary data: Available literature from Ipas Ethiopia including VCAT training report, Annual reports and other national level reports such as MOH's Annual performance report.

Primary data: Quantitative primary data from healthcare providers was collected using a structured self-administered survey whereas qualitative data was collected through key informant interviews with providers, health facility managers/team leads and FGDs with selected experts from RHB, ZHD and WoHOs to drive firsthand information across the four regions.

3.3 Target Population

The study population included healthcare providers, facility managers or team leaders (related to maternal, newborn, and child health) in selected Ipas-supported health facilities. These population groups were engaged in surveys and in-depth interviews. Selected experts from RHB, ZHD and WoHOs were the study population for the FGDs.

3.4 Inclusion and exclusion criteria

Inclusion criteria: All Ipas supported hospitals and health centers and respective health service providers.

Exclusion criteria: hospitals and health centers that are difficult to reach due to security challenges.

3.5 Sample Size and Sampling Technique

3.5.1 sample size for first objective

The list of Hospitals and HCs providing CAC services in which Ipas intervenes are taken as a sampling frame. In addition, the lists of providers in these facilities are taken from the IPAS database for sampling purposes. Among the CAC-trained and non-CAC-trained providers, CAC-trained abortion providers and a non-CAC-trained healthcare provider were selected randomly from the selected health facilities using systematic random sampling. According to evidence from studies conducted in Ethiopia, the level of favorable attitude on provision of abortion care ranges from 48% to 54% [16, 17]. In this study 50% is taken as the anticipated proportion of providers with the attribute of interest The sample size determined for the health providers in the selected facilities is based on the total number of Ipas-supported facilities in the sampling frame.

The total sample size to select providers was determined using the following single population proportion formula and taking providers attitude as an outcome variable:

$$n = \frac{(Z_{\alpha/2})^2 P(1-P)}{d^2}$$

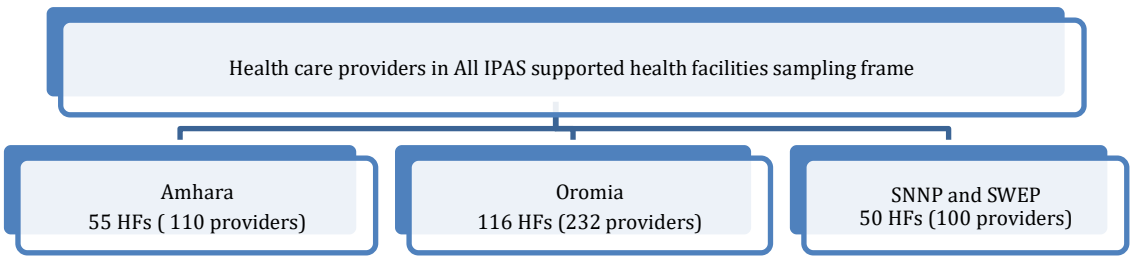
Where, n=required sample size, Zα/2 = confidence interval at 95% (1.96) and P is the proportion of provider's favorable attitude. Finally, d is marginal error which refers to the degree of making error in estimates from random sampling surveys. Since the average proportion for the outcome variable in different studies is 50%, the proportion is taken to be 0.5 to determine sample size. Thus, at 5% (0.05) margin-of-error, the total sample size is determined to be 384.

$$n = \frac{(1.96)^2 0.50(1-0.50)}{(0.05)^2} = 384$$

Considering 15% non-response rate, the required sample size would be 384*1.5= 442.

Based on these parameter values, the total estimated number of health facilities is 221. Data collectors selected two providers (one CAC trained & one non-trained provider) from each selected health facility using random lottery techniques. Thus, the total number of participating healthcare providers was 442 providers.

Figure 1 Schematic diagram of sampled health facilities distribution



3.5.2 Sample Size for Second Objective

Sample size for the second objective (factors associated with providers' resistance in providing safe abortion services/negative attitude towards service provision is calculated using factors that showed association in other similar studies by taking 1:1 ratio, 95% CI and 80% power to detect an effect size. We used a study conducted in the Oromia region, North Shoa Zone as a reference to compute sample size using the odds ratio for the factors showing association and their corresponding p1 (percent outcome in unexposed group). Accordingly, we proved that the sample size estimated for the first objective is higher than the sample size for the second objective. Hence 442 is taken as the final sample size for the study. The following table shows the distribution of the samples in the four regions.

Table 1 Distribution of HFs and sampled healthcare providers per the sampling frame of Ipas database.

Region	Proposed Number of HFs per region and woreda				Proposed # of participants for in-depth interview	Proposed # of FGDs
	Hospitals (all types)	HCs	Total	Total number of providers		
Amhara	6	49	55	110	9	2
Oromia	12	105	116	232	12	2
SNNP & SWEP	4	46	50	100	9	2
Total	**22**	**200**	**221**	**442**	**30**	**6**

3.6 Study Variables

Dependent variables: The dependent variable of this assessment is the attitudes of health care providers.

Independent variables: Independent variables include: individuals and socio demographic factors: age, sex, marital status, religion, profession, years of professional experience, years of work in the health facility; training and practice of health providers factors: training status on CAC, training status on VCAT; abortion law and health facility related factors: awareness on national abortion law; availability of functional equipment and supplies, type of health facility, level of activity, availability of guidelines, availability of trained provider; providers perception related factors: willingness to provide CAC services.

3.7 Data Collection Tools

3.7.1 Provider assessment

Structured questionnaire was developed to collect data related to provider perception and attitude towards CAC service provision. A total of 374 healthcare providers were interviewed of the estimated sample of 442 providers to assess their perceptions and attitudes toward providing CAC services in selected health facilities. In a facility, we interviewed one CAC-trained provider and one non-trained provider to check their perception and attitude toward CAC service provision

between the two groups. We used a hybrid data collection using in-person and virtual methods. We developed a Google form for the virtual data collection and coordinated the filling of the data virtually by the selected providers.

3.7.2 In-depth-interview

The assessment used an in-depth interview guide to gather qualitative data on 20 purposively selected providers to explore concerns about providing CAC services, reasons for not providing CAC services, and getting suggestions to destigmatize CAC services in health facilities. Additionally, we conducted 10 in-depth interviews with knowledgeable and experienced facility managers or team leaders who have served in the facility for at least one year to provide information related to provider availability and turnover status and identify challenges and recommendations in providing CAC services.

3.7.3 Focus Group Discussion (FGD)

The FGDs were conducted with selected RHB, ZHB, and WHO officers to understand the status of CAC service provision, challenges to providing CAC services, and recommendations for normalizing and destigmatizing the CAC services in the health facilities. A total of three FGDs were conducted with healthcare managers, team leaders, and different level cadres in Amhara, Oromia and SNNP and SWEP.

4. Data Collection and Analysis Plan

4.1 Data Collection, Management and Processing

We identified and trained fieldworkers and supervisors to serve as data collectors for the main fieldwork. To ensure quality, we involved experienced data collectors and supervisors who completed at least a first degree in public health or relevant discipline. To cover the sampled hospitals and health centers in the four regions, nine data collectors and seven supervisors were recruited in the four regions. All data collectors were provided with one-day training on how to use data collection instruments including questionnaires, key informant interview guides, and FGD guides. The training also included instruction on data collection techniques and field procedures, a detailed review of data collection instruments, field pretest of the data collection tools, and practice data collection with actual respondents in areas outside the sampled sites. Team leaders/supervisors received additional instructions on performing supervisory activities, including assigning respondents and receiving completed data from data collectors; identifying, and dealing with data quality; and transferring data to the Principal Investigator (PI) via a secure file transfer mechanism. In addition to their role in supervision, field supervisors were trained to conduct interviews and FGDs.

The team used Google forms for entering and sharing data. Data collection tools were printed for use ahead of field work. All paper-based data collection tools used in the field were kept securely by data collection supervisors. Consent forms were also printed and made available for data collectors. Supervisors checked the completeness and consistency of completed surveys daily. During the data collection process, close follow up and support was provided by the principal invigilator throughout the data collection process. Ipas regional Advisors and coordinators provided support in the coordination of logistics for the field work.

Data collection teams were organized for field data collection in the selected health facilities in the four regions. Data collection began in December 2022, and it was completed in February 2023. A total of 16 data collectors (9 enumerators for the quantitative data collection, and 7 supervisors serving as qualitative data collectors) were engaged in the data collection.

4.2 Data Quality Assurance

The PI and supervisors conducted daily data checks for inconsistencies, incompleteness, and outliers. Data quality validation mechanisms were embedded in the Google form to identify errors during data entry. The data was cleaned and checked for consistency to ensure completeness of work in the field. The data cleaning and processing happened concurrently with data collection to allow for regular monitoring of team performance and data quality. The study team also conducted secondary editing, which requires resolution of computer-identified inconsistencies. Rigorous follow-ups were made during data collection by the field supervisors to check the progress and quality of data, ensure that all protocols are followed, and resolve any challenges that the data

collectors were encountering. The supervisors regularly communicate with the PI to provide status updates on how data collection processes are developing, any challenges encountered (including recruitment, logistics, or content), and any new themes that have emerged that the assessment team should consider including in the interview or focus group guide.

4.3 Data Entry and Analysis

The survey data was entered into the Google form and the completed data was exported into excel and then to SPSS for analysis. As for the qualitative data, the audio records were transcribed first and then translated into English. The qualitative data was organized in a way that can be more easily sorted for review and analysis. This involves coding and identifying themes to analyze the data and substantiate the findings obtained through the quantitative method.

A data analysis working group led by the PI conducted the data analysis. Analysis was done using IBM® SPSS® Statistics 29. The group created composite variables and scores using the data collection tools annexed in this report that provide overall proxy indicators for the mean outcomes. For instance, the dependent/outcome variable (attitude of healthcare providers) was measured in Likert-scale (1-5) where 1 refers to 'Strongly disagree' and 5 refers to 'Strongly agree'. The Likert-type measurements used multiple statements to define the content and meaning of the level of attitude quantitatively. We calculated the mean based on responses to questions to dichotomize the attitude of respondents into "favorable attitude" and "unfavorable attitude.

The responses from each respondent were labeled as "favorable attitude" or "unfavorable attitude" based on the mean scores of the responses. The mean score >3 for favorable statements was taken as "favorable attitude" while the rest are labeled as "unfavorable attitude". For negative statements, the score is reversed to the opposite direction prior to computing the mean.

Crude associations between dependent and independent variables were assessed using bivariate analysis and a chi-square test was performed for each independent variable against the dependent variable. Those variables below p-value of 0.2 were put on multivariate logistic regression to control for confounding factors. Strength of association is presented using adjusted odds ratios and 95% confidence intervals. Hosmer and Leme show model was used to check the goodness of fit.

Qualitative data collected through in-depth interviews and FGDs were transcribed and analyzed using thematic analysis that presents the key themes and issues that emerge from the interviews and discussions. These themes are used to guide the description of providers' perception and attitude on CAC services, determinant factors associated with provider resistance in providing CAC services, and the key roles of program experts and service providers in normalizing and destigmatizing the CAC services in public health facilities.

5. Ethical Considerations

The study protocol was submitted to the Ethical Review Committee of Ethiopian Public Health Association (EPHA) for Scientific Ethical review and approval was received. The study participants were asked for their informed verbal consent for participating in the study and only those who provided consent for participating in the study were interviewed. The risks and benefits of participation in the assessment were explained to respondents. Each participant was given the opportunity to review the consent form. For the study participants who completed the response via Google form, the consent form was integrated in the front page of the questionnaire requiring participants to read and consent. The informed consent process was carried out in the local language.

Direct human interaction in this assessment occurred with the in-depth interviews of healthcare staff in selected health facilities. The human subjects included in the assessments were males and females over the age of 18. Through the providers' survey, direct identifiers related to individual and socio-demographic information were collected. The lists of identifiers collected were names, age, sex, marital status, religion, location description (region, zone, woreda), profession, and years of professional experience***. There is no sensitive information collected in this assessment. Thus, there is no harm or injury (physical, psychological, social, or economic) occurring as a result of participation in this assessment.*** All data and other information were maintained confidentially to the greatest extent possible during and after data collection and reporting.

6. Results

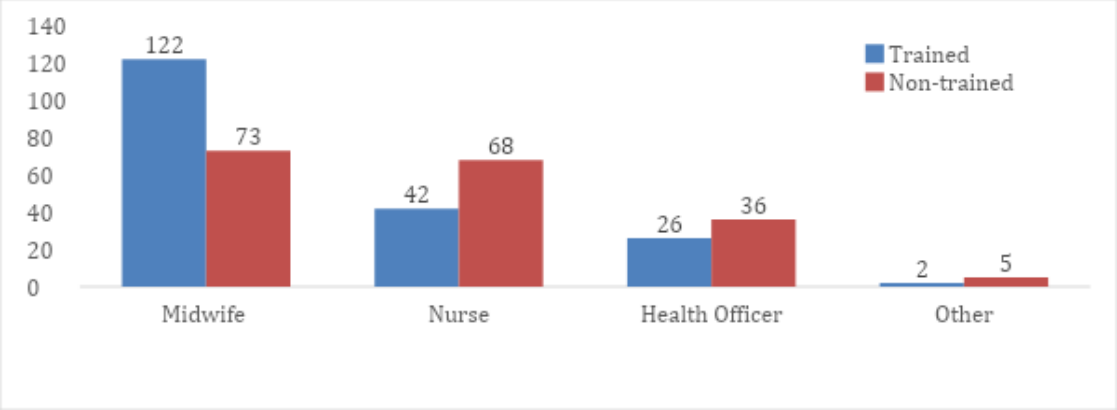
6.1 Socio-demographic Characteristics

The data collection for this study utilized both virtual and in-person methods. Virtual data collection was chosen as an additional method to collect primary quantitative data for some reasons, including its convenience and ability to reach wider study participants at sampled health facilities that are located at places with security concerns. In addition, this approach was utilized since the in-person data collection from all sampled facilities was found to be budget intensive. To ensure data quality, different measures were employed, such as using standardized questions, building validation rules on the instruments, checking the real time data entry process, and intervening as needed whenever there was a concern on accuracy. The study team also adhered to ethical and privacy procedures during communicating study participants over the phone and sharing google forms by ensuring their consent is received. Similarly, the study team undertook the appropriate procedures for the in-person data collection as stipulated in the methodology section.

A total of 442 healthcare providers were approached and 374 were consented to be interviewed with 85% response rate. The majority of healthcare providers who responded to the survey were from health centers, making up 88% of the total. Among the interviewed providers, 248 (66%) provided their responses through an in-person data collection while the remaining responded virtually. In both cases, a self-administered structured data collection tool was used. Of the healthcare providers interviewed, men and women accounted for 214 (57%) and 160 (43%) respectively. The mean age for the study participants was 30 years (5.13±SD) in which 20 years of age being the least and 55 the maximum. About two thirds of the healthcare providers, 239 (63.9%) were married/cohabiting while 129 (34.5%) were never married and the remaining 6 (1.6%) responded as divorced, widowed, or separated. (Table 2)

Looking at the professional composition, midwives constitute the largest group at 52%, followed by clinical nurses at 29%. The remaining respondents were mostly health officers, with only a few from other professions. Among the interviewed providers, midwives scored the highest percentage in terms of receiving training on CAC (63%) while training rates among health officers and nurses showed a lower percentage being 42% and 38% respectively. (see figure 2).

Figure 2 Number of CAC trained, and non-trained health care providers interviewed disaggregated by profession, December 2022



More than half of the providers (57%) stated that they were employed at MCH centers during the data collection period. The second-largest group of providers, comprising 23% of the total respondents, worked at Outpatient Departments (OPDs). Providers working in delivery wards accounted for 10%, while those in gynecology wards made up 3% of the respondents. Other respondents included health facility heads and professionals working in the emergency ward. Among the 212 providers working at MCH centers, 60% had received training on safe abortion. In contrast, among those working at OPDs, 36% had received such training. Out of the providers in the delivery ward, 62% (23 individuals) had undergone Comprehensive Abortion Care (CAC) training, while 70% (7 individuals) of those working in gynecology wards had received CAC training (Table 2).

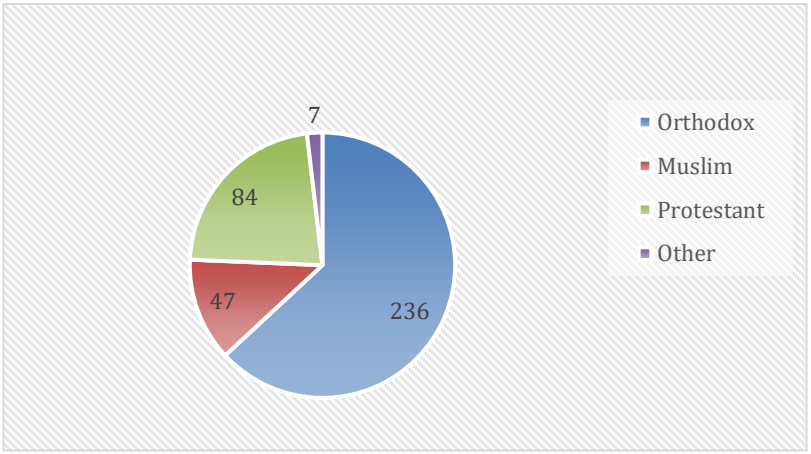
Table 2 shows the distribution of participants based on their years of professional experience in two groups: trained and non-trained on Comprehensive Abortion Care (CAC). The findings indicate that 288 (77%) of the respondents have more than three years of experience while the remaining 19% and 4% have one to three and less than one year of experience respectively. It showed that the trained group had a lower proportion of participants in the “less than one year” and “one to three years' of experience category constituting 31% and 39% respectively. On the other hand, the trained group had a higher percentage in the “more than three years' ' category, specifically (56%) in the "five-ten years" category and 54% in the “more than ten years” category.

In terms of length of stay at their current health facility, 40% had worked for less than three years, and 31% had worked for three to five years. Among those who had worked for three to five years or more, 57% had received training and from those who worked less than three years, 38% received training.

About two-third, 236 (63%) of them were Orthodox, followed by protestant, 47 (22.5%) and Muslim 47 (12.6%). The remaining 2% accounted for other religions such as Catholicism and

Wakefata. The following figure illustrates the proportion of health providers according to their religious affiliation per the interview.

Figure 3 Number of respondents disaggregated by religions followed (n=374), December 2022



The regional distribution of respondents showed 193 (51.6%) were from Oromia, 103 (27.5%) Amhara, 47 (12.6%) SNNP, and 31 (8.3%) SWEP.

Figure 4 . Regional distribution of respondents (n=374) December 2022

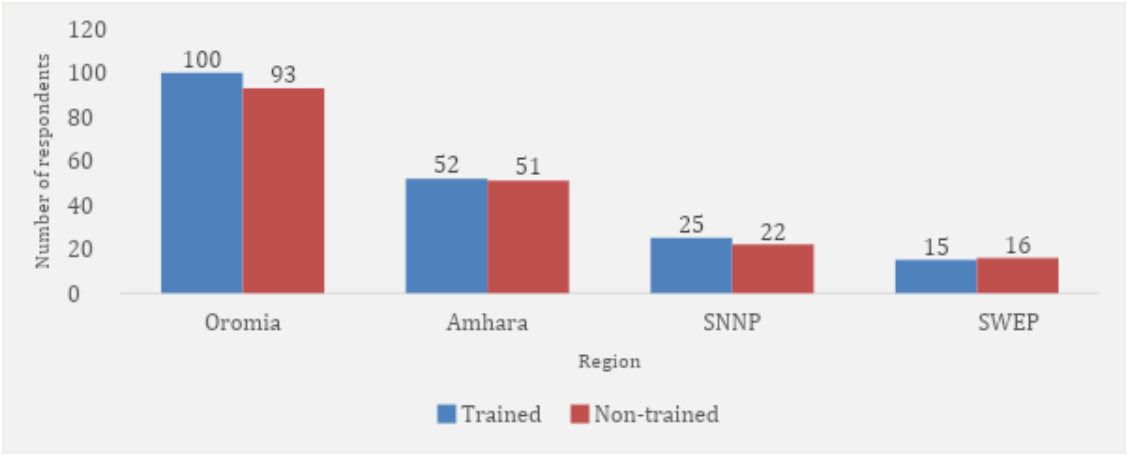


Table 2 . Socio-demographic characteristics of healthcare providers on in HFs of Amhara, Oromia, SNNP, and SWEP regions, Ethiopia, December 2022

Characteristics	CAC Trained (n=192)	Non-CAC trained (n=182)	Total
	n(%)	n(%)	n
Sex			
Female	83 (52)	77 (48)	160
Male	109 (51)	105 (49)	214
Age (years)			
20-25	38 (50)	38 (50)	76
26-30	89 (51)	86 (49)	175
31-35	45 (49)	47 (51)	92
36-40	12 (67)	6 (33)	18
41-45	6 (86)	1 (14)	7
46-50	1 (25)	3 (75)	4
>50	1 (50)	1 (50)	2
Religion			
Orthodox	121 (51)	115 (49)	236
Muslim	21 (45)	26 (55)	47
Protestant	46 (55)	38 (45)	84
Other	4 (57)	3 (43)	7
Marital Status			
Married/cohabiting	135 (57)	103 (43)	238
Never married	55 (42)	75 (58)	130
Widowed/Divorced/separate	2 (33)	4 (67)	6
Region			
Amhara	52 (50)	51 (50)	103
Oromia	100 (52)	93 (48)	193
SNNP	25 (53)	22 (47)	47
SWEP	15 (48)	16 (52)	31
Profession			
Nurse	42 (38)	68 (62)	110
Midwife	122 (63)	73 (37)	195
Health Officer	26 (42)	36 (58)	62
Other	2 (29)	5 (71)	7
Unit of work			
MCH	127 (60)	85 (40)	212
Gynecology ward	7 (70)	3 (30)	10
Delivery ward	23 (62)	14 (38)	37
OPD	27 (31)	59 (69)	86
Other	8 (28)	21 (72)	29
Years of professional experience			
Less than one year	5 (31)	11 (69)	16
One-three years	27 (39)	43 (61)	70
Three-five years	39 (57)	30 (43)	69
Five-ten years	77 (56)	60 (44)	137
More than ten years	44 (54)	38 (46)	82
Facility type			

Health Center	169 (52)	159 (48)	328
Hospital	23 (50)	23 (50)	46
Length of stay at Health Facility			
less than 3 yrs	44 (38)	71 (62)	115
3-5 yrs	86 (57)	65 (43)	151
>5 yrs	62 (57)	46 (43)	108

6.2 Competency, Awareness and Health Facility Environment Characteristics

Among the providers, 192 (51%) reported that they had received training on CAC. The proportion of trained versus non-trained respondent providers on CAC in the four regions is depicted in figure 5. A little over half (51%) of the trained providers got their training within the last three years, followed by 25% who received their training between three and five years ago. Few of them (8%) received training five years ago (see figure 5).

Figure 5 5 Proportion of trained respondents by year of training (n=192), December 2022

We also included a question to gauge providers' familiarity with the revised national abortion law, which permits abortion services under certain conditions. 97% of the non-trained providers reported that they were not aware of the law.

We inquired of healthcare providers whether they possessed adequate supplies and equipment necessary to perform safe abortion procedures in their health facilities. 75% of the respondents reported that they did, while the remaining indicated a lack of supplies comprising 17% and those who don't have information about the availability constitute 8%. Ninety-three percent of the trained providers confirmed that they are equipped with the necessary guidelines related to safe abortion services.

During the interviews and FGDs several providers indicated that there is a shortage of supplies in their health facilities. Informants also reported that there is a serious shortage of separate rooms dedicated to perform quality abortion care services and keep the privacy and confidentiality of the

clients. For these reasons, comprehensive abortion care services could not be made available in some health facilities. A key informant healthcare provider from Oromia region said,

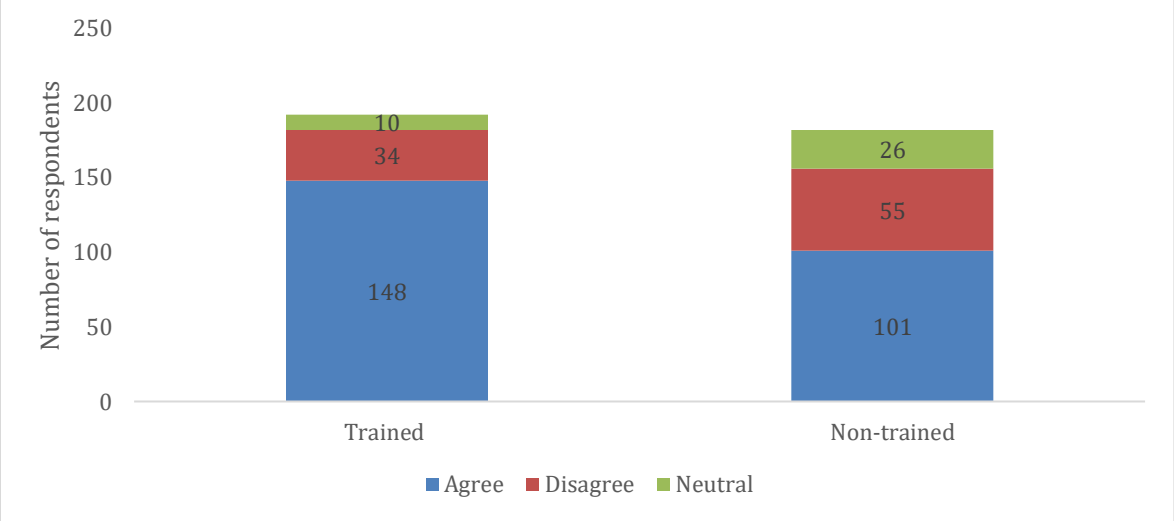
> *"We have a shortage of supplies and equipment in our facilities. Besides, our health facility compromises clients' privacy while providing abortion and family planning and counseling services. The service is provided in the corridor or delivery room. When clients come to seek abortion service, they are sent to the maternity ward where they are not comfortable as many other women can be around for maternity service. Absence of dedicated rooms for* comprehensive abortion care service *is one of the barriers to seeking abortion service in public health facilities. There should be a separate and independent room for abortion and family planning services."*

Some of the informants reported that there are electric power interruptions and shortage of drugs to provide uninterrupted abortion care service. A provider in Amhara region indicated,

> *"Most of abortion cases come during nighttime but often there is an electric power outage to provide abortion services. We don't have an adequate budget to buy back up generators. We need support and attention from the government or aid organization to make sure that we have uninterrupted electric supply. On the other hand, there is a serious shortage of abortion drugs which affects the provision of the services."*

In order to understand the perception of health providers, on provision of elective abortion services, we asked them about their opinion whether they agree or not in terms of providing elective abortion services. The result showed that the majority (67%) agree while 24% of them disagree with the remaining 9% responding as neutral. When the finding is viewed from the training status perspective, 148 (77%) of the trained providers responded as agreed (see figure 6).

Figure 6 Elective abortion should be legal and accessible under all circumstance (n=374), December 2022



In a subsequent query that allowed for multiple response options, we discovered that out of the 89 providers who disagreed with legalizing elective abortion services under all circumstances, a little over half of the respondents (52%) cited religion as one of the reasons. Other commonly mentioned

reasons included cultural unacceptability, concerns that it would encourage women to have unwanted pregnancies, and the belief that it could increase women's susceptibility to sexually transmitted diseases as a result of engaging in unsafe sex.

Table 3 Training, profession and health facility characteristics of respondents Amhara, Oromia, SNNP, and SWEP regions, Ethiopia, December 2022

Characteristics	Trained (n =192)	Non-trained (n=182)	Total (n=374)
Training on VCAT			
Yes	114 (91)	12 (9)	126
No	78 (32)	170 (68)	248
Awareness on national abortion law			
Yes	191 (63)	111 (37)	302
No	1 (1)	71 (97)	72
Agree on the provisions of current legislation on safe abortion			
Yes	174 (67)	85 (33)	259
No	10 (31)	22 (69)	32
Don't know	7 (64)	4 (36)	11
Availability of supplies and equipment			
Yes	159 (57)	122 (43)	281
No	32 (50)	32 (50)	64
Don't know	1 (3)	28 (97)	29
Availability of guidelines on safe abortion services			
Yes	178 (59)	124 (41)	302
No	12 (32)	24 (68)	36
Don't know	2 (6)	34 (94)	36
Feeling comfortable performing safe abortion services			
Yes	153 (61)	97 (59)	250
No	39 (32)	85 (68)	124
Willingness to provide services			
Yes	168 (63)	100 (37)	268
No	24 (23)	82 (77)	106

Among the 192 trained providers, those who responded that they actively offer safe abortion services constitute 89% while the remaining providers were not offering such services at the time of this assessment. In a related matter, among the 126 providers who received training on VCAT, 91% of them reported that the training had a positive impact on their provision of safe abortion services.

Based on the findings from the FGD and IDIs, most have confirmed that the in-service training enhanced their competencies and strengthened their confidence to undertake safe abortion care service appropriately. One of the study participants from Amhara region mentioned that:

"The in-service trainings were great and well-structured which were conducted by Ipas, and as a result we are providing the services more efficiently."

Another provider from Oromia region indicated that:

"I was trained on how to provide safe abortion care and how to perform abortion procedures and manage complications through the in-service training"

The findings of the FGDs highlighted the positive impact of the training on the quality of safe abortion services provided by the health providers. A Health Officer from a Zonal Health Office in Oromia Region said,

"In my area, there are four health centers. Safe abortion service is provided by all these health centers. Ipas has provided training to all healthcare providers working in these four health centers which increased their knowledge and skills and improved the quality of the services they provide"

Regional and Woreda Health Officers who participated in the FGDs recognize the skills gaps that exist in different health facilities related to safe abortion care. They reported that Ipas supported the assessment and mapping of existing skills and health facility burden and identified the health facilities that needed capacity strengthening. One of the Health Officers from Amhara Regional Health Bureau said:

"Ipas identified the health centers that have skill gaps and conducted a series of training to healthcare providers on value clarification and attitude transformation. The training not only provided the healthcare providers with the skills and competencies necessary to provide safe abortion care services, but also educated the providers to support women on how and where to access contraception to prevent unwanted pregnancy."

Despite the comments received on the provision of training by Ipas, there were also gaps in lack of training in some health facilities per the findings from the survey. The results of the FGDs indicated that there are several healthcare providers who have not been trained in safe abortion care resulting in an increase in waiting times for service and burnouts of existing providers which consequently affect the quality and safety of services. A health official from Oromia region said,

"Training on safe abortion services was not provided for all health centers in our woreda. Four health centers haven't received the training. The service is provided by health officers in these health centers, and they mainly focus on post-abortion service due to lack of training. In addition, abortion is not included in the job description of each health provider. There is also no feeling of ownership by the providers which is essential to delivering high-quality health care; safe abortion service appears to be neglected.

A provider from Amhara region added,

"Sometimes there is a delay in service provision because we have only one or two trained providers in the facility who may be engaged in laboring a mother and or being engaged in other sexual and reproductive health services. There is a long waiting time for clients to receive abortion care services. As a result, the healthcare providers work long hours to provide care and are vulnerable to burnout which affects their performance and quality of care provision."

On a related issue, respondents explained that absence of requirements for abortion training and non-existent of trained providers tracking mechanism makes it challenging for health facilities to confirm whether newly assigned providers need to be trained on abortion or not.

"There is no strong mechanism to track the trained healthcare providers. For example, Ipas provides training on safe abortion services, but the list of trained healthcare providers is not submitted to the government institutes. When we say there is high staff turnover, all healthcare providers do not move to non-governmental organizations. They may rotate in the same woreda or zone. So, if there is a strong mechanism that helps us track the trained healthcare providers, turnover won't be a challenge in the provision of abortion services. The system may make them provide the service wherever they move."

We also inquired providers who are aware of the national abortion law about their opinions on provisions included in the law. Out of the 302 respondents, the majority (86%) agreed with the provisions while 11% disagreed, and 3% didn't know. Among the trained providers, 91% of them responded that they agree on the provisions in the law. On the other hand, 77% of the non-trained providers responded that they agree with the law.

Findings from the interviews and FGDs confirm that the majority of the providers are aware about the abortion law and agree with its provisions. The providers made substantial efforts to follow the abortion law and it not only legitimized their services but also provided justifications to their moral and ethical questions. A health provider from Amhara region explained as:

"I know about the abortion law and agree with the provisions stipulated in the law. I also followed the abortion laws without any hesitation because it has given me a legal background."

Participants of the FGDs in all the four regions agreed that there are challenges in the implementation of the abortion law and technical guidelines and the penalty associated with violating the law and guidelines. One of the FGD participants reported that,

"Everyone has a copy of the abortion law. The problem is with implementing the law. There are still healthcare providers who are not comfortable in providing abortion services. Providers refuse to provide the service indirectly by denying women from getting the service."

Some providers feel uncomfortable when women provide incorrect information about the cause of seeking safe induced abortion and their age to obtain safe abortion services. Some providers acknowledged that one of the sources of frustration is when a woman denied having an abortion service and told lies about what had happened, increasing the assessment time, and complicating the service provision. This could lead to mistreatment and disrespect by the providers.

"Women cheat to get abortion services," said a provider in the Amhara region. She continued, "And some women cheat to get their pregnancy terminated because they know there is a room for playing with the abortion law criteria, and as a result some providers feel cheated and refuse to provide abortion services."

On the other hand, some providers reported that there are still several cases of women going through unsafe abortion services due to the restrictions of abortion care service to eligible clients as indicated in the abortion law. A provider in Oromia region indicated,

"Trained health professionals depend on the criteria set forward in abortion law to provide abortion care services to eligible clients only. Those clients who are ineligible had to go through unsafe and harmful practices which could risk their health and life."

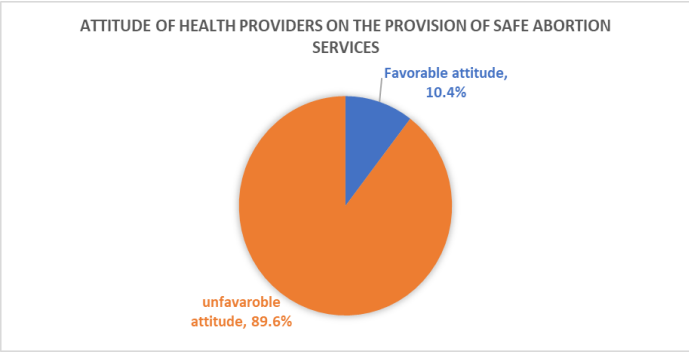
This shows that the eligibility of women to access safe abortion care services is dependent on the provider's assessment of a woman's reasons as 'justifiable' or not and judgments of the adequacy of women's reason for abortion.

6.3 Attitude of Providers on Provision of Safe Abortion Services

We utilized a group of 10 inquiries using a Likert scale with 5 levels where 1 refers to 'Strongly disagree' and 5 refers to 'Strongly agree' to assess the attitude of the providers. We then calculated the average score for each respondent and categorized their responses as either "favorable" or "unfavorable". Mean scores of the responses were used to label as "favorable attitude" or "unfavorable attitude". The mean score >3 for positive statements was taken as "favorable attitude" while the rest are labeled as "unfavorable attitude". For negative statements, the score is reversed to the opposite direction prior to computing the mean. Annex 1 displays the percentage of providers who responded in each level of the scale.

A total of 374 healthcare providers completed the survey. Most healthcare providers (89.6%) reported a favorable attitude towards the provision of safe abortion services, while 10.4% reported unfavorable attitude. The mean attitude score for the respondents was 3.9 (SD=0.7) (see Figure 7).

Figure 7 Attitude of Healthcare Providers on safe abortion service provision, December 2022 (n=374)

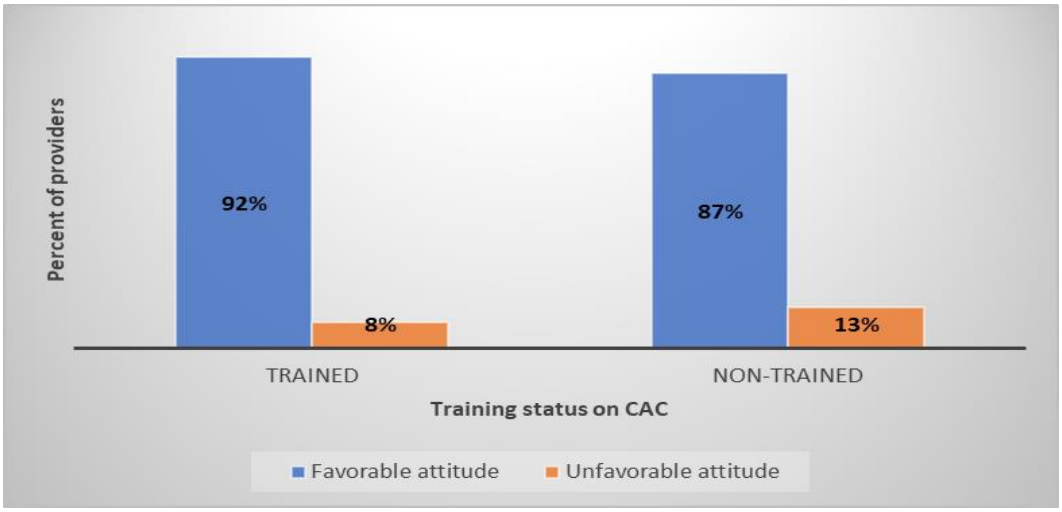


We compared the findings of this study regarding the level of health care providers' attitude towards provision of safe abortion services with another study conducted in Mekele and Adama of Ethiopia. The results show that 5% and 48% of the respondents in Mekele and Adama respectively have had a negative attitude as compared with 10% in our study. This shows that there

could be variations in the levels of attitude among health care providers working in different parts of the country which calls for further investigations.

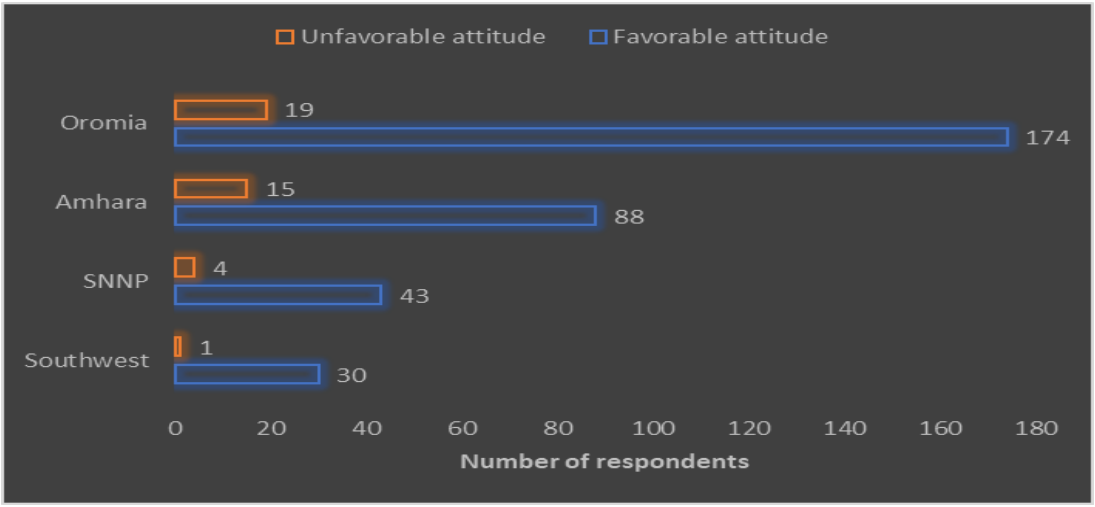
When we looked at the level of attitude between trained and non-trained providers, 177 (92%) of the trained providers had a favorable attitude while the remaining 15 (8%) showed a negative attitude. On the other hand, among non-trained healthcare providers, 158 (87%) revealed a favorable attitude and the other 24 (13%) didn't have a favorable attitude (see Figure 8).

Figure 8 Level of attitude among trained and non-trained providers on CAC services, December 2022 (n=374)



We conducted an analysis of the data to investigate the findings and differences in attitudes among healthcare providers in the provision of CAC services by regions. Figure 9 below displays the distribution of respondents with favorable and unfavorable attitudes across the four regions. The Southwest region had the highest percentage of respondents with a favorable attitude at 96.7% and mean attitude score of 4.3 followed by SNNP and Oromia with favorable attitude levels of 91.5% (mean score of 4.0) and 90% (3.9 mean score), respectively. Amhara had the lowest percentage of respondents with a favorable attitude at 85.4% and a mean score of 3.4. However, it is important to exercise caution when interpreting these findings as the sample size for each region is insufficient to allow for valid comparisons.

Figure 9 Level of attitude disaggregated by region (n=374)



6.4 Factors Associated with Healthcare Providers' Attitude on Provision of Safe Abortion Services

In this study, we aimed to identify factors associated with healthcare providers' attitudes towards the provision of safe abortion services. In the bivariate analysis, we used chi-square and explored the relationship between the dependent variable (providers' attitude) and the different independent variables (sex, age, marital status, health facility type, length of stay at health facility, profession, unit of work, years of professional experience, training on CAC, training on VCAT, awareness on national abortion law, feeling comfort in providing safe abortion services and willingness to provide services). Accordingly, variables that were statistically significant with a p-value of <0.05 include training on VCAT (p=0.01), awareness on national abortion law (p<0.0001, availability of supplies and equipment (p=0.002), feeling comfortable performing services (p<0.001) and willingness to provide services (p=0.004). On the other hand, factors that were not statistically significant independently were sex, age, region religion, marital status, health facility type, profession, unit of work, years of professional experience and length of stay at health facility (see Table 4).

6.4.1 Sex, Marital Status, Age and Religion versus Attitude of Providers

The proportion of favorable and unfavorable attitudes among females and males is compared. The analysis indicated that there is no significant association between sex and attitude (p-value = 0.26). Among females, 88% have a favorable attitude, while 12% have an unfavorable attitude. For males, 91% have a favorable attitude, and 9% have an unfavorable attitude.

The analysis across different age groups (20-25, 26-30, 31-35, and >35) indicates no significant association between age and attitude (p-value > 0.9). In the age group 20-25, 89% have a favorable attitude, and 11% have an unfavorable attitude. For the age group 26-30, 90% have a favorable

attitude, and 10% have an unfavorable attitude. Similarly, for the age groups 31-35 and >35, the proportions of favorable and unfavorable attitudes are 89%/11% and 90%/10%, respectively.

The comparison among different marital status categories (Never married, Married/cohabiting, and Widowed/Divorced/separated) suggests no significant association between marital status and attitude (p-value = 0.77). Among never married individuals, 91% have a favorable attitude, and 9% have an unfavorable attitude. For married/cohabiting individuals, the proportions are 89% and 11%, respectively. Among widowed/divorced/separated individuals, 83% have a favorable attitude, and 17% have an unfavorable attitude.

When the proportions of favorable and unfavorable attitudes are compared among different religious groups (Orthodox, Muslim, Protestant, and Other), the analysis shows no significant association between religion and attitude (p-value = 0.34). Among individuals of the Orthodox religion, 92% have a favorable attitude, and 8% have an unfavorable attitude. For Muslims, the proportions are 83% and 17%, respectively. Among Protestants, 88% have a favorable attitude, and 12% have an unfavorable attitude. For individuals of other religions, the proportions are 86% and 14%.

On the other hand, the findings of the FGDs and IDIs show that religion has a major impact influencing the perceptions and attitudes of some of the providers towards abortion. For these providers abortion is seen as sinful which makes the providers not to fully accept the provision in abortion law and this has significantly affected abortion service provision in some health facilities. A provider from a health center in Oromia region said:

"Almost half of the trained healthcare providers in my facility are not comfortable working in the site where safe abortion is done due to religious factors. They believe that terminating a fetus is a sin. There is still such a challenge in our area. The service is not given properly."

These findings of the qualitative survey are consistent with other studies conducted in Zambia, and Tanzania and in Addis Ababa Ethiopia which found out that cultural and religious beliefs took a leading cause for unfavorable attitude of healthcare providers [16, 17, 18, 19, 20].

Health facility staff with religious beliefs tried to influence others' attitude about their provision of abortion services which has a direct impact on the women who seek the service. A provider from Amhara region mentioned that,

"These attitude and value changes can directly affect the service quality. For example, we had clients who were counseled by trained staff and decided for safe abortion care service at the facility, however they were influenced by other health professionals within the facility who discouraged health workers not to provide abortion services because of religious beliefs. So, this has a negative impact on the service, and the morals of the providers. This is mainly the inability of these professionals to differentiate personal belief and professional responsibility which are indicated under the abortion law."

6.4.2 Profession, Unit of Work, Professional Experience and Length of Stay at Health Facility versus Providers' Attitude

The analysis comparing attitudes among different professions (Nurse, Midwife, Health Officer, and Other) indicates no significant association between profession and attitude (p-value = 0.98). 90% of the nurses have a favorable attitude, and 10% have an unfavorable attitude. For midwives, the proportions are 89% and 11%, respectively. Among health officers, 90% have a favorable attitude, and 10% have an unfavorable attitude. For individuals in other professions, the proportions are 86% and 14%.

Comparing attitude across different units of work (Maternal and Child Health (MCH), Gynecology Ward, Delivery Ward, OPD, and Other), the analysis reveals no significant association between units of work and attitude (p-value = 0.47). Among those working in the MCH unit, 92% have a favorable attitude, and 8% have an unfavorable attitude. For individuals in the Gynecology Ward, the proportions are 90% and 10%, respectively. In the Delivery Ward, the proportions are 87% and 13%. Among those working in the Outpatient Department (OPD), the proportions are 85% and 15%. For individuals in other units, the proportions are 93% and 7%.

Attitudes are compared across different ranges of professional experience. The analysis shows no significant association between years of professional experience and attitude (p-value > 0.97). Across different ranges of professional experience, the proportions of favorable and unfavorable attitudes are as follows: less than one year (94%/6%), one to three years (87%/13%), three to five years (88%/12%), five to ten years (90%/10%), and more than ten years ((90%/10%). There is no significant difference in attitudes based on years of professional experience (p-value > 0.97).

Attitudes are compared based on the length of stay at the health facility (less than 3 years, three to five years, and greater than 5 years). The analysis suggests a significant association between length of stay and attitude (p-value = 0.12), with those staying less than three years exhibiting a higher proportion of favorable attitudes. Among those with a length of stay at the health facility less than three years, 94% have a favorable attitude, and 6% have an unfavorable attitude. For individuals with a length of stay between three to five years, the proportions are 86% and 14%, respectively. Among those with a length of stay greater than five years, 90% have a favorable attitude, and 10% have an unfavorable attitude.

6.4.3 Training on CAC, VCAT and awareness on abortion law versus Provider's Attitude

We compared attitude between those who received training on Comprehensive Abortion Care (CAC) and those who did not. The analysis shows no significant association between CAC training and attitude (p-value = 0.09). Among those who received training on Comprehensive Abortion Care (CAC), 92% have a favorable attitude, and 8% have an unfavorable attitude. Among those who did not receive CAC training, 87% have a favorable attitude, and 13% have an unfavorable attitude.

Attitudes are compared between those who received training on VCAT and those who did not. The analysis indicates a significant association between VCAT training and attitude (p-value = 0.01), with a higher proportion of favorable attitudes among those who received VCAT training. Among those who received training on VCAT, 95% have a favorable attitude, and 5% have an unfavorable attitude. Among those who did not receive training on VCAT, 87% have a favorable attitude, and 13% have an unfavorable attitude.

Among those who are aware of the national abortion law, 92% have a favorable attitude, and 8% have an unfavorable attitude. For individuals who are not aware of the law, 78% have a favorable attitude, and 22% have an unfavorable attitude. There is a significant difference in attitudes between those who are aware and those who are not aware of the national abortion law (p-value < 0.0001).

The majority of the respondents from the IDIs reported that the attitude of the healthcare providers towards safe abortion service provision has been improving due to the continuous training that have been provided by Ipas. A Woreda health official from Amhara region explained,

"The attitude of providers towards safe abortion care services in our health facilities have significantly improved following the training that Ipas conducted and this has a positive impact on the services that they provide."

Participants of the FGDs and IDIs confirmed that the training enhanced providers' competencies and confidence by overcoming fear to deliver safe abortion care information and services, and eventually transformed their attitudes in relation to safe abortion care. A FGD participant from Amhara region mentioned:

"Ipas has provided training on valid value clarification and attitude transformation. Now, the attitude and confidence of the healthcare providers in providing abortion services has improved. The healthcare providers serve 24/7 with clear communications among themselves, exchange information on how they manage safe abortion cases and challenges they faced and the way they manage the cases related to safe abortion services during the procedure. They have a favorable attitude towards safe abortion care and providing the services without any problem. They exhibit a friendly relationship with their clients to obtain client's trust and help clients receive appropriate abortion care information and services."

Another FGD participant from Oromia region added:

"As I observe as a health expert, the attitude of the healthcare providers has improved due to the training provided by Ipas. Prior to the training, health workers had a wrong perception of abortion care services; providing safe abortion services was considered as killing a human-being. After the training, providers at least in my facility have changed their perception towards safe abortion care into the belief that they are saving mothers' lives."

In contrast, lack of training on value clarification and attitude transformation among the healthcare providers and non-health professionals in health facilities was identified as one of the factors that

affect the confidence and willingness of providers to provide safe abortion services. One of the FGD participants in Amhara region said:

There is a lack of training on abortion among the health workers and non-health professionals or supportive staff in our health facility. All staff of the health facility are not getting the training which has created a skill gap and misunderstanding about safe abortion care. If healthcare providers and supportive staff have wrong attitudes towards abortion, they may refuse to provide or support abortion care."

All the interview and FGD participants highlighted that abortion law and technical guidelines provided a positive legal environment for the healthcare providers that contributed to facilitating the provision of CAC services. Respondents confirmed that the healthcare providers are performing safe abortion services according to the guideline. The majority also believe that the guideline has not only improved their attitude towards safe abortion care, but also boosted their confidence in delivering safe abortion care services. This was confirmed by a provider who participated in the interview as,

"We use abortion guidelines with no objections. It has made professional decisions easy and no conflict with the guideline. The guideline brought improvement in provider attitude and confidence to perform safe abortion procedures. We are confident and making evidence-based decisions."

On the contrary, we found that healthcare providers also face difficulties in making decisions when women seek safe abortion services but do not meet the eligibility criteria outlined in the national abortion law. They also believe that the women would seek for the services elsewhere mainly at private facilities or traditional places when denied and eventually return with complications for post abortion services in many cases.

6.4.4 Health Facility Type, Supplies and Equipment versus Provider's Attitude

In terms of health facility type, attitude is compared between health center and hospital settings. The analysis finds no significant association between health facility type and attitude (p-value = 0.68). Among those working in health centers, 89% have a favorable attitude, and 11% have an unfavorable attitude. For individuals working in hospitals, the proportions are 91% and 9%, respectively.

Among those who report the availability of supplies and equipment at their health facilities, 93% have a favorable attitude, and 7% have an unfavorable attitude. For individuals who report the unavailability of supplies and equipment, 84% have a favorable attitude, and16% have an unfavorable attitude. Among those who are unsure, 72% have a favorable attitude, and 28% have an unfavorable attitude. There are significant differences in attitudes based on the availability of supplies and equipment (p-value = 0.002), with higher proportions of favorable attitude when supplies and equipment are available.

Among those who feel comfortable performing safe abortion services, 94% have a favorable attitude, and 6% have an unfavorable attitude. For individuals who do not feel comfortable, 80% have a favorable attitude, and 20% have an unfavorable attitude. There is a significant difference in attitude between those who feel comfortable and those who do not feel comfortable performing safe abortion services (p-value < 0.001).

Among those who are willing to provide services, 93% have a favorable attitude, and 7% have an unfavorable attitude. For individuals who are not willing to provide services, 82% have a favorable attitude, and 18% have an unfavorable attitude. There is a significant difference in attitudes between those who are willing and those who are not willing to provide services (p-value = 0.004).

Table 4 Result from bivariate analysis; Attitude with demographic, facility characteristics, training status, December 2022

Characteristics	Attitude		COR (95%CI)	p value
	Favorable n (%)	Unfavorable n (%)		
Sex				0.26
Female	140 (88%)	20 (12%)	1	
Male	195 (91%)	19 (9%)	1.47(0.75, 2.84)	0.26
Age (years)				0.9
20-25	68 (89%)	8 (11%)	1	
26-30	157 (90%)	18 (10%)	1.03(0.43, 2.47)	0.95
31-35	82 (89%)	10 (11%)	0.97(0.36, 2.58)	0.94
>35	28 (90%)	3 (10%)	1.09(0.27, 4.44)	0.89
Religion				0.34
Orthodox	216 (92%)	20 (8%)	1	
Muslim	39 (83%)	8 (17%)	0.45 (0.19, 1.09)	0.08
Protestant	74 (88%)	10 (12%)	0.69 (0.31, 1.53)	0.36
Other	6 (86%)	1 (14%)	0.56 (0.06, 4.85)	0.59
Marital Status				0.77
Never married	118 (91%)	12 (9%)	1	
Married/cohabiting	212 (89%)	26 (11%)	0.83 (0.4, 1.7)	0.61
Widowed/Divorced/separated	5 (83%)	1 (17%)	0.51 (0.06, 4.72)	0.55
Health facility type				0.68
Health center	293 (89%)	35 (11%)	1	
hospital	42 (91%)	4 (9%)	1.25 (0.42, 3.71)	0.68
Profession				0.98
Nurse	99 (90)	11 (10)	1	
Midwife	174 (89)	21 (11)	0.92 (0.43, 1.99)	0.83
Health Officer	56 (90)	6 (10)	1.04 (0.36, 2.96)	0.95
Other	6 (86)	1 (14)	0.67 (0.07, 6.06)	0.72
Unit of work				0.47
MCH	194 (92)	18 (8)	1	
Gynecology ward	9 (90)	1 (10)	0.84 (0.1, 6.97)	0.87
Delivery ward	32 (87)	5 (13)	0.59 (0.21, 1.71)	0.34
OPD	73 (85)	13 (15)	0.52 (0.24, 1.12)	0.1
Other	27 (93)	2 (7)	1.25 (0.28, 5.7)	0.77
Years of professional experience				0.97
Less than one year	15 (94)	1 (6)	1	
One-three years	62 (87)	8 (11)	0.52 (0.06, 4.45)	0.55
Three-five years	61 (88)	8 (12)	0.51 (0.06, 4.38)	0.54
Five-ten years	123 (90)	14 (10)	0.59 (0.07, 4.77)	0.62
More than ten years	74 (90)	8 (10)	0.62 (0.07, 5.3)	0.66
Region				0.32
Amhara	88 (85)	15 (15)	1	
Oromia	174 (90)	19 (10)	1.56 (0.76, 3.22)	0.23
SNNP	43 (92)	4 (8)	1.83 (0.57, 5.86)	0.31
SWEP	30 (97)	1 (3)	5.11 (0.65, 40.4)	0.12

Length of stay at Health Facility				0.12
less than 3 yrs	108 (94%)	7 (6%)	1	
3-5 yrs	130 (86%)	21 (14%)	0.4 (0.16, 0.98)	0.05
>5 yrs	97 (90%)	11 (10%)	0.57 (0.21, 1.53)	0.27
Training on CAC				0.09
Yes	177 (92%)	15 (8%)	1	
No	158 (87%)	24 (13%)	0.56 (0.28, 1.1)	0.09
Training on VCAT**				0.01*
Yes	120 (95%)	6 (5%)	1	
No	215 (87%)	33 (13%)	0.33 (0.13, 0.8)	0.01
Awareness on national abortion law**				<0.0001*
Yes	279 (92%)	23 (8%)	1	
No	56 (78%)	16 (22%)	0.29 (0.14, 0.58)	<0.0001
Availability of supplies and equipment**				0.002*
Yes	260 (93%)	21 (7%)	1	
No	54 (84%)	10 (16%)	0.44 (0.19, 0.98)	0.044
Don't know	21 (72%)	8 (28%)	0.21 (0.08, 0.54)	0.001
Feeling comfortable performing safe abortion services**				<0.001*
Yes	236 (94%)	14 (6%)	1	
No	99 (80%)	25 (20%)	0.24 (0.12, 0.47)	<0.001
Willingness to provide services**				0.004
Yes	248 (93%)	20 (7%)	1	
No	87 (82%)	19 (18%)	0..37 (0.19, 0.72)	0.004*

**Factors that have statistical significance, *Characteristics within categories with statistical significance.

To control confounding variables and determine predictors of the healthcare providers' attitude towards safe abortion service provision, we selected variables with p-value of less than 0.2 for inclusion in the multivariate analysis. In addition, based on the literature and findings from the qualitative data analysis in this survey, we determined religion (p=0.34) to be included in the multivariate analysis model (see Table 4).

Table 5 below shows the results of a multivariate analysis investigating the association between various factors and healthcare providers' attitudes towards the provision of safe abortion services. The outcome variable in this analysis is attitude (favorable or unfavorable). The table shows the adjusted odds ratio (AOR) with a 95% confidence interval (CI) and p-values for each predictor variable, after controlling for other variables in the model. The adjusted odds ratio (AOR) represents the change in the odds of having a favorable attitude towards safe abortion services for each level of the independent variable, holding all other variables constant.

After controlling for other variables, religion, length of stay at health facility, awareness of national abortion law, and feeling comfortable performing safe abortion services are found to be

significantly associated with healthcare providers' attitudes towards the provision of safe abortion services (indicated by the p-values marked with **).

The results show that Muslims were 65% less likely to have a favorable attitude towards safe abortion services compared to Orthodox Christians (AOR=0.35, 95%CI: 0.13-0.95, p=0.04). Similarly, participants who stayed at the health facility for 3-5 years were 65% less likely to have a favorable attitude compared to those who stayed less than 3 years (AOR=0.35, 95%CI: 0.13-0.99, p=0.047). Participants who were not aware of the national abortion law were 63% less likely to have a favorable attitude compared to those who were aware (AOR=0.37, 95%CI: 0.14-0.98, p=0.045).

Participants who felt uncomfortable performing safe abortion services were 68% less likely to have a favorable attitude compared to those who felt comfortable (AOR=0.32, 95%CI: 0.13-0.75, p=0.009).

Other variables such as training on CAC and VCAT, availability of supplies and equipment, and willingness to provide services were not found to be significantly associated with attitudes towards safe abortion services. (Table 5).

Table 5 Result from multivariate analysis; December 2022

Characteristics	Attitude		COR (95%CI)	AOR (95%CI)	p value
	Favorable n (%)	Unfavorable n (%)			
Religion					0.14
Orthodox	216 (92%)	20 (8%)	1	1	
Muslim	39 (83%)	8 (17%)	0.45 (0.19, 1.09)	0.35 (0.13, 0.95)	0.04**
Protestant	74 (88%)	10 (12%)	0.69 (0.31, 1.53)	0.66 (0.28, 1.56)	0.34
Other	6 (86%)	1 (14%)	0.56 (0.06, 4.85)	0.21 (0.02, 2.08)	0.18
Length of stay at Health Facility					0.13
less than 3 yrs	108 (94%)	7 (6%)	1	1	
3-5 yrs	130 (86%)	21 (14%)	0.4 (0.16, 0.98)	0.35 (0.13, 0.99)	0.047**
>5 yrs	97 (90%)	11 (10%)	0.57 (0.21, 1.53)	0.41 (0.14, 1.25)	0.12
Training on CAC					0.15
Yes	177 (92%)	15 (8%)	1	1	
No	158 (87%)	24 (13%)	0.56 (0.28, 1.1)	2.14 (0.75, 6.06)	0.15
Training on VCAT					0.1
Yes	120 (95%)	6 (5%)	1	1	
No	215 (87%)	33 (13%)	0.33 (0.13, 0.8)	0.41 (0.14, 1.2)	0.1
Awareness on national abortion law*					0.045
Yes	279 (92%)	23 (8%)	1	1	
No	56 (78%)	16 (22%)	0.29 (0.14, 0.58)	0.37 (0.14, 0.98)	0.045**
Availability of supplies and equipment					0.16
Yes	260 (93%)	21 (7%)	1	1	
No	54 (84%)	10 (16%)	0.44 (0.19, 0.98)	0.53 (0.22, 1.27)	0.16
Don't know	21 (72%)	8 (28%)	0.21 (0.08, 0.54)	0.42 (0.14, 1.25)	0.12
Feeling comfortable performing safe abortion services*					0.009
Yes	236 (94%)	14 (6%)	1	1	
No	99 (80%)	25 (20%)	0.24 (0.12, 0.47)	0.32 (0.13, 0.75)	0.009**
Willingness to provide services					0.5
Yes	248 (93%)	20 (7%)	1	1	
No	87 (82%)	19 (18%)	0..37 (0.19, 0.72)	0.75 (0.32, 1.78)	0.5

***Categories that have association with attitude of healthcare providers on safe abortion provision independently,*

** Factors that have association with the attitude of healthcare providers on the multivariate analysis.*

The model was fit with a score of 0.1 on the Hosmer-lemeshow goodness-of-fit test.

6.5 Providers' Resistance on Safe Abortion Services and Stigma at health facilities

As one of the objectives of the study, we conducted FGDs and IDIs to identify the contributing factors towards abortion provision stigma and resistance in public health facilities. The findings

show that most of the health service providers don't experience any sort of stigma for undertaking safe abortion services, however some get stigmatized by health facility staff and communities for providing the service. One of the respondents from SWEP witnessed,

" Some health workers criticize us for providing safe abortion services as if we are killing babies."

A health provider in Amhara region mentioned,

"I know this practically; at health centers I observed that some providers stop providing the service as they are insulted and considered as a killer by their colleagues, and they are stigmatized."

Additionally, some providers refrain from providing the services to avoid stigma and discrimination from colleagues within the health facility and the community at large. A FGD participant in Amhara region explained,

"Providers may not be comfortable providing safe abortion service due to fear of negative comments from the community and their colleagues. For this reason they refuse to provide the service and most women are obliged to seek unsafe abortion service."

In contrast, the findings of the FGDs indicate that there is a significant reduction of stigma associated with abortion service provision. Almost all the FGD participants reported that in recent times abortion related stigma has declined as a result of various training provided to health professionals and community awareness activities. One of the FGD participants in Amhara region stated,

"Nowadays the stigma associated with abortion service provision has been decreasing. In the past many providers have stopped providing any abortion service, and there was frequent turnover of abortion providers. Through awareness raising and health education programs people start developing positive perceptions towards abortion."

6.6 Roles of experts to improve safe abortion services

To identify the key roles of program experts and service providers in normalizing and destigmatizing the CAC services in the facilities, we conducted FGDs and IDIs. Almost all respondents have clearly outlined the key roles and responsibilities of providers and program experts in availing and providing safe abortion care services in health facilities. They highlighted that program experts and leaders should plan, manage, monitor, and evaluate safe abortion care services and the performance of the healthcare workforce. One of the providers interviewed in Oromia region stated,

"Program experts should plan, evaluate, and monitor the safe abortion services provided in different facilities and adjust the resources according to the need. It is their responsibility to ensure availability of adequate supplies and commodities to provide safe abortion care."

Providers were also clear in their explanation of their roles in providing safe abortion care services in health facilities. They emphasized how important it is to be responsive to service users' needs to make sure that clients have access to safe options. One of the providers participated in the FGDs in Amhara region explained,

"Since we have taken the training on CAC, we are abortion service providers and should provide the service. It is our responsibility to provide the service. And if we didn't provide the service to those who seek it, we didn't carry out our responsibility which could lead clients to seek unsafe options. According to our oath, we are responsible to provide health care services that improve the health outcomes of individuals and the community as a whole including SRH services."

The informants also discussed the responsibility of the providers to respect the rights of clients.

"The professionals should respect the rights of service users; keep their responsibility through preparations of procedure rooms, materials, and should undergo proper communications with colleagues as well as clients; and serve the patients according to their need. the attending professional might provide proper counseling about the procedures and danger signs to the client, and the provider can make his/her phone no available so that if complications happen, she can call and consult with the provider for next action."

Some providers went further to indicate the roles of stakeholders in the training, orientation, and mentoring of providers.

"For me we should work with stakeholders. They can help us train and orient new health workers. They can also mentor and evaluate the programs and help providers to carry out what is expected of them, being responsible, accountable and stand for what they are assigned."

One provider emphasized the roles to be played by stakeholders to train private sectors to standardize the quality and safety of abortion care services.

"Providers need continuous follow ups and feedback. Stakeholders should train private sectors for the proper provision of abortion services. This is because we are receiving an increasing number of postabortion cases whose procedure is already initiated at private sectors and when we examine, we get the medications administered improperly. Their services should be evaluated and at a minimum they need to have abortion trained health professionals."

Consistent to the findings from our qualitative survey, other studies conducted in Ethiopia, Kenya and India found that women who had abortions experienced stigma and judgment from healthcare providers, which affected their expectations of care and ability to access services [21, 22]

7 Limitations

- Social Desirability Bias: Health providers may be reluctant to express their true attitudes towards abortion due to social desirability bias, as they may be concerned about being

judged or stigmatized by the researchers. In order to minimize this, we used a self-administered questionnaire.

- Limited number of literatures in Ethiopia on the subject matter: We have searched for the available literatures conducted in the country and we found that there is limitation in adequacies to help substantiating and making comparisons of our findings within the context of similar socio-demographic characteristics.

8 Conclusion

Healthcare providers' attitude towards safe abortion services is crucial in ensuring women have access to safe and legal abortions. It is important to acknowledge that while the vast majority of healthcare providers demonstrate favorable attitudes towards providing safe abortion services, the presence of a considerable number of providers with unfavorable attitudes towards abortion care requires attention. It's important to address this issue because even a small number of healthcare providers with unfavorable attitudes can have a significant impact on the safe abortion service provision. Therefore, it is imperative that there is a need to continue to work towards improving the attitudes of all healthcare providers to alleviate provider resistance and ensure that women receive comprehensive safe abortion services free from stigma and discrimination.

Overall, the findings from the study showed that attitudes of healthcare providers towards providing safe abortion services are complex and are shaped by a variety of factors. The findings suggest that providers' attitudes are influenced by various factors of which religious beliefs, length of stay at the facility, and awareness of national abortion laws were those that showed statistical significance after confounding variables are controlled.

The findings from the qualitative survey showed that the CAC training has significantly contributed to improving the attitudes of providers. Hence, ongoing education and training for providers, such as that provided by Ipas Ethiopia, is essential for improving the attitude of health care providers towards provision of safe abortion services.

We found out that religious beliefs impact healthcare providers' willingness to offer safe abortion services. According to findings from a qualitative survey, some providers perceive abortion as sinful, which affects service provision in some facilities. Providers may also refrain from offering abortion care to avoid stigma and discrimination within the facility and outside or prioritize personal bias over professional ethics.

The existence of the abortion law and guidelines legitimized the abortion care service provision and provided justification to providers' moral and ethical questions. We found that healthcare providers are performing safe abortion services according to the guideline. The majority also believe that the guidelines have improved their attitude towards safe abortion care and also boosted their confidence in delivering safe abortion care services. On the other hand, we found that healthcare providers also face challenges in making decisions when women seek safe abortion services but do not meet the eligibility criteria outlined in the national abortion law. They also believe that the women would seek for the services elsewhere mainly at private facilities or traditional places when denied.

Addressing unfavorable attitudes as well as related matters such as provider resistance towards safe abortion provision requires a multi-faceted approach, including health workers and non-

workers training, community education and efforts in addressing cultural and social norms that affect the attitude of health care providers in providing safe abortion services.

Our findings also showed that there are still gaps in health facilities that hinder the provision of quality abortion care, such as shortages of supplies and trained providers, and a lack of separate rooms to perform services while ensuring privacy and confidentiality.

9 Recommendation

Policy makers:

- Facilitate the allocation of adequate resources for VCAT training and whole staff education that would help to improve health workers attitude towards delivering safe abortion service in a sustainable manner.

Health facility managers:

- Ensure that healthcare providers are working in a supportive and non-judgmental environment by fostering a supportive work environment. This will help to improve their attitudes, reduce stigma, and increase their comfort level in providing safe abortion services.
- There are many instances where service providers show resistance against abortion service which has a serious effect on the health of the women. Study participants have suggested various points to improve service providers' resistance. One of the points raised by most is that facility management gives special attention and support to service providers to consider safe abortion service as part of essential SRH care. and enabling women to access the service.

Healthcare leaders and providers:

- Address misunderstandings about safe abortion services among health care providers in particular and health workforce at large. Health care providers and health officials can work jointly to reduce safe abortion misconceptions and misunderstandings affected by religious beliefs, personal bias and community norms/stigma by implementing appropriate interventions and disseminating accurate information .
- To reduce site level abortion stigma and improve providers' attitude, trained providers should Collaborate with other health workers and facility management to create awareness about abortion law and the benefits of safe abortion services among facility staff including non-trained health workers and supportive staff f.
- Provide health education at health facilities and in the community using appropriate messaging techniques to improve social norms and attitude on safe abortion which could in turn influence providers' attitude.
- Facilitate knowledge and skill transfers among healthcare providers rendering safe abortion services at health facilities to improve their feelings and confidences when providing safe abortion service.
- Ensure the inclusion of safe abortion service provisions in annual work plans and monitor the implementations.

Researchers:

- Further investigate the reasons on how length of stay of health care providers at health facilities affects their attitude and propose possible solutions that can help address this specific condition.

Supporting stakeholder and advocacy groups:

- Increase coverage of values clarification and attitude transformation training to non-trained healthcare providers and whole staff in public health facilities. This could help improve the health facility settings and create a conducive environment for safe abortion service.
- Advocate for the establishment of sustainable capacity building interventions on safe abortion services that would help improve health workers attitudes on safe abortion.
- Further refine/investigate for any gaps on the CAC and VCAT training approaches and content in terms of significance in making a difference on providers attitude as these were not found to be significantly associated with provider's attitude although both trainings were important in raising awareness and improving attitude per the qualitative finding.
- Promote and contribute for evidence generations to help understand the extent and direction of the different factors affecting providers 'attitude and resistance.

10 References

1. Lalitkumar S, Bygdeman M, Gemzell-Danielsson K. Mid-trimester induced abortion: A review. Human Reproduction Update 2007; 13: 37–52.
2. Fourth Edition of the Alarm International Program Chap. 23. Risk Manag 2002; 1–7.
3. Faúndes A, Miranda L. Unsafe Abortion. Int Encycl Public Heal 2016; 18: 301–310.
4. Warriner IK, Shah IH. Preventing Unsafe Abortion and its Consequences. Guttmacher Institute, 2006.
5. International Planned Parenthood Federation. Youth and Abortion: Key strategies and promising practices for increasing young women's access to abortion services. 2014.
6. Pregnancy U. Facts on Unintended Pregnancy and Abortion in Ethiopia.
7. Gebreselassie H, Fetters T, Singh S, et al. Caring for Women with Abortion Complications in Ethiopia: National Estimates and Future Implications. Int Perspect Sex Reprod Health 2010; 36: 006–015.
8. Family Health Department. Technical and Procedural Guidelines for Safe Abortion Services in Ethiopia. 2006.
9. Plan T. Federal Democratic Republic of Ethiopia Growth and Transformation Plan Annual Progress Report for F. Y. 2012 / 13.
10. Botes A. Critical thinking by nurses on ethical issues like the termination of pregnancies. Curationis. 2000;23(3):26–31.
11. Harris J, Cooper D, Stebel A, Colvin CJ. Conscientious objection and its impact on abortion service provision in South Africa: a qualitative study. BMC Reprod Health. 2014;11(1):16.
12. Hill A, Spittlehouse C. What is critical appraisal? Evidence Based Med. 2003;3(2):1–8.
13. World Health Organization. Social Science Methods for Research on Reproductive Health. Geneva, Switzerland: World Health Organization; 1999.
14. Yitagesu S. Health Care Providers' Perception and Associated Factors towards Safe Abortion in Selected Health Facilities in Adama, Ethiopia: 2018
15. Zaid T., Alemayehu B. Assessment of Health Care Providers' Attitude and Associated Factors to Wards Safe Abortion at Public Hospitals, in Mekelle City, Tigray, Ethiopia; A Cross Sectional Study
16. Terefe T. Assessment of health service providers' perception on safe abortion care in Kimbibit District, North Shoa Zone, Oromia Regional State, Ethiopia: 2021
17. Dr. Chibesa W. Chishimba. Health Providers' Attitudes Towards Termination of Pregnancy: A Qualitative Study in Zambia" by et al. (2017).
18. Dr. Gisella Kaganda. Healthcare Providers' Attitudes and Practices Regarding Abortion: A Cross-Sectional Study in Western Tanzania", et al. (2021).
19. Dr. Dawit Desalegn. Healthcare Providers' Attitudes Towards Safe Abortion Services in Addis Ababa, Ethiopia", et al. (2019).
20. Dr. Jennifer McCleary. Sills Exploring the Attitudes and Practices of Healthcare Providers Towards Abortion in Zimbabwe: A Mixed Methods Study, et al. (2019).
21. Dr. Alice N. Kiwanuka Healthcare Providers' Attitudes Towards Safe Abortion Services in Ugand, et al. (2018).

22. Shelly M., Rebecca W. Exploring stigma and social norms in women's abortion experiences and their expectations of care PubMed central 2019.
23. Kathryn.K, Addisalem T. Signs of a turning tide in social norms and attitudes toward abortion in Ethiopia: Findings from a qualitative study in four regions Reproductive health, 2022
24. Federal Democratic Republic of Ethiopia, Ministry of Health, Health Sector Transformation Plan II

Annex 1. Percent of responses for questions used to measure attitude[3]

No	Variables	1-Strongly disagree (n (%)	2-Dis Agree (n (%)	3-Undecided (n (%)	4-Agree (n (%)	5-Strongly agree (n (%)
501	Provision of safe and voluntary abortion should be made legal and accessible	44 (12)	35 (9)	22 (6)	177 (47)	96 (26)
502	A woman should have the right to decide for herself whether or not to have an abortion	37 (10)	34 (9)	21 (6)	169 (45)	113 (30)
503[4]	Abortion should not be provided for any reason	115 (31)	129 (3)4	20 (5)	23	25 (7)
504	Abortion provision should be legal if the woman's physical health is endangered by the pregnancy	26 (7)	23 (6)	14 (4)	144 (38)	167 (45)
505	Abortion should be legal if the woman's mental health is endangered by the pregnancy	24 (6)	18 (5)	21 (6)	156 (42)	155 (41)
507	Abortion provision should be legal if the family (or woman) cannot afford to raise the child	46 (12)	94 (25)	44 (12)	141 (38)	49 (13)
508	Abortion provision should be legal if the fetus shows signs of serious congenital defect or malformation	21 (6)	8 (2)	11 (3)	121 (32)	213 (57)
509	Abortion provision should be legal if the pregnancy was a result of incest or rape	24 (6)	16 (4)	24 (6)	115 (31)	195 (52)
510	Abortion provision should be legal if the pregnancy was unplanned and unwanted	41 (11)	95 (25)	47 (13)	123 (33)	68 (18)
511	Safe abortion should be accessible under any circumstances	42 (11)	77 (21)	35 (9)	139 (37)	81 (22)
512	If woman requested an abortion, I will provide her the service or refer the woman to the facility where she obtains the service	23 (6)	47 (13)	30 (8)	182 (49)	92 (24)
513	I would try to convince other health care providers to perform abortions	31 (8)	80 (21)	55 (15)	155 (41)	53 (14)
514	All healthcare providers should be able to provide medical abortion for first-trimester pregnancy	53 (14)	102 (27)	29 (8)	123 (33)	67 (18)
515	All healthcare providers should be able to provide medical abortion for first-trimester pregnancy	91 (24)	126 (34)	41 (11)	82 (22)	34 (9)
516	Referral arrangements for social support and care should be an integral part of overall abortion care.	22 (6)	23 (6)	36 (10)	179 (48)	114 (31)

[3] *Question number 507, 510, 511, 514, and 55 were excluded when computing the mean score and determining the attitude status of the health providers as we believe these are questions with ambiguities given the research objectives and the national abortion law of Ethiopia. The remaining questions are instead.*

[4] *The responses for the question number 503 were reversed and re-coded as the nature of the question is negative unlike the other questions.*

Annex 2: Data collection questionnaire for health providers Survey

CONSENT FORM

Introduction and Consent Script/Form for Providers
(To be read by the data collector participant)

Hello, my name is <Data collector's name>. I am a data collector recruited by Impacts for Development (I4D) which is a private consultancy firm registered in Ethiopia to provide health and development consultancy services. I4D is providing consultancy services for Ipas Ethiopia in conducting an Assessment on Attitudes and perceptions of healthcare providers towards providing Abortion service in public health facilities. The purpose of the assessment is to explore the level of providers' perceptions and attitudes towards abortion and identify the causes of resistance to providing abortion services. The study will therefore provide invaluable information for designing suitable strategies and interventions related to safe abortion services.

If you decide to participate in the study, you will be asked to respond to questions related to your perception on provision of safe abortion services. Completing the responses to the questions is estimated to take on average one hour.

Your participation is voluntary, and you are not obligated to answer any question which you do not wish to answer. If you feel discomfort to respond to any of the question, please feel free to choose "decline to answer" and move on to the next question. Your decision on whether to participate will not affect your current job, any services you get and your relationship with any of the stakeholders working in the provision of safe abortion services. The study has procedures to protect your confidentiality. The information you provide will be kept confidential. Your name will not appear in any internal or published reports from the study.

There is no compensation for participating in this interview. This study is primarily intended to generate information, and thus offers no immediate benefit to you, but by participating in the study you may help to strengthen and improve the provision of Comprehensive Abortion Care services in the country.

Who to contact if you have any concerns: If you have any questions or concerns about this study, you may contact:

Dawit Getachew, Principal Investigator, I4D Plc. by email at dawitgt2005@gmail.com + (251) 911563531

Bekalu Mossie, by email at bekalumossie@gmail.com + (251) 911713902

I have read all the process and the objective of the study, and I have understood the same as written. I understood that the research imposes no risk to me.
Could I have your permission to continue?

1. Yes ☐
2. No ☐

Section – one: Individual and Socio-Demographic information

Serial No.	Questions	Response	Code	Skip
001	Region	1. Amhara 2. Oromia 3. SNNP 4. Southwest		
002	Facility name or identifying ID	_____		
003	Assigned participant ID	Starts with 10 if Amhara region provider, 20 if Oromia, 30 if SNNP, 40 if Southwest (e.g. 1001, 2001)		
101	Your age in completed years (enter number)	_____ years		
102	Sex	1. Female 2. Male	/____ /	
103	Marital status	1. Never married 2. Married 3. Divorced 4. Cohabiting 5. Separated 6. Widowed	/ ____ /	
104	Religion	1. Orthodox 2. Muslim 3. Protestant 4. Catholic 5. Other (Specify) _____	/ _____ /	
105	Profession	1. Physician 2. Nurse (diploma) 3. B.Sc. nurse 4. Midwife (diploma) 5. Midwife (BSc) 6. Health Officer 7. Others (specify) _____	/_____ /	
106	Current unit of work	1. MCH 2. Gynecology ward 3. Delivery ward 4. OPD 5. Medical ward 6. Surgical ward 7. Other specify_____	/_____ /	

107	Years of professional experience	1. Less than one year 2. one-three years 3. three -five years 4. five-ten years 5. More than 10 years	/ _____ /	
108	Type of public health facilities you are working in	1. Health center 2. Primary hospital 3. General hospital 4. Referral hospital 5. Specialized hospital	/ _____ /	
109	For how long have you been working in this health facility?	_____ year/s		

Section two: Training and practice of service providers on safe abortion

Serial No.	Questions	Response	Code	Skip
201	Have you ever been trained on safe abortion services?	1. Yes 2. No	/____ /	
202	If you were trained, are you practicing the safe abortion services?	1. Yes 2. No	/____ /	
203	If yes to Q 201, How long has it been since you received the training	1. 1-3 years before 2. 3-5 years before 3. Before 5 years 4. Don't remember	/____ /	
204	Have you ever been trained on Value Clarification and Attitude transformation (VCAT)?	1. Yes 2. No	/ ____ /	
205	If yes to Q 204, do you think the VCAT training influences your willingness to provide safe abortion services	1. Yes 2. No	/_____ /	

Section three: Abortion law and facility related questions

Serial No.	Questions	Response	Code	Skip
301	Are you aware of the National abortion law?	1. Yes 2. No	/____ /	
302	If Yes to Q301, Do you agree on the current legislation and institutional regulation of termination of pregnancy?	1. Yes 2. No 3. Don't know	/____ /	
303	Does your facility have adequate and functional equipment	1. Yes 2. No 3. Don't know	/____ /	
304	Is your facility equipped with guidelines related to safe abortion services	1. Yes 2. No 3. Don't know	/ _____ /	
305	If you do disagree, what is your reason? (Multiple answers is possible)	1. My religion doesn't allow 2. Culturally not accepted 3. It is homicide on the fetus 4. Encourages to have unwanted Pregnancies 5. Encourages pre/extra- marital sex 6. Encourages unsafe sex which will predispose to STDs including HIV AIDS 7. I don't know 8. others(specify)_____	/ _____ /	
306	Mid-level health providers should be able to provide medical abortion for first trimester pregnancy?	1. Strongly agree 2. Agree 3. Disagree 4. Strongly disagree 5. Neutral	/_____ /	
307	Mid-level health providers should be able to provide medical abortion for first trimester pregnancy?	6. Agree 7. Disagree 8. Neutral	/_____ /	
308	Mid-level health providers should be able to provide surgical abortion for first trimester pregnancy	1. Strongly agree 2. Agree 3. Disagree 4. Strongly disagree 5. Neutral	/_____ /	

Section 4: Perception and knowledge of service providers on safe abortion

Serial No.	Questions	Response	Code	Skip

401	Why do you think women seek abortion?	1. Inadequate Knowledge 2. Economical constraint 3. Used as a Contraceptive 4. To avoid unwanted pregnancy 5. Health reasons 6. Partner pressure 7. Too many and too close pregnancies 8. To complete their education 9. Not being married 10. Underage (less than 18 years) 11. Other(specify)_____ 12. I Don't know	/____ /	
402	Do you feel comfortable working in a site where safe abortion is being performed?	1. Yes 2. No	/____ /	
403	Are you willing to provide safe abortion services at all	1. Yes 2. No	/____ /	
404	If your answer is No, What is/are your reason/s? (more than one answer is possible)	1. Outside of the scope of my practice 2. Against my religious practice 3. Against my Personal value 4. I didn't have the opportunity to be trained in abortion technique 5. Discrimination and stigma if provided the service 6. I don't know 7. 8. Other(specify)_____	/ ____ /	
405	Elective abortion should be legal and accessible under all circumstance	1. Agree 2. Neutral 3. Disagree 4. Other Specify_____	/_____ /	
406	For whom do you think you will give safe abortion? (more than one answer possible)	1. pregnancy following rape 2. pregnancy following incest 3. when continuation of the pregnancy endangers the health or life of the woman or the fetus 4. for women with physical or mental disabilities 5. if she is under 18 years or minor who is physically or psychologically unprepared to raise a child 6. in cases of fetal congenital anomaly incompatible for life	/_____ /	
407	Legal abortion is used as a form of contraception.	1. Strongly agree 2. Agree 3. Disagree 4. Strongly disagree 5. Neutral	/ _____ /	

408	Which abortion method are you comfortable with?	1. Medical abortion 2. Surgical abortion 3. Both 4. Neither of the two	/____ /	

Section 5: Attitude of health service providers on safe abortion

Instruction: Read each question and respond by mentioning your level of agreement or disagreement by ticking on only one of the options indicated as:**1-Strongly Disagree, 2-Disagree, 3-Neutral or Undecided, 4-Agree, and 5-Strongly agree**

No	Variables	Strongly disagree	Dis agree	Undecided	Agree	Strongly agree
501	Provision of safe and voluntary abortion should be made legal and accessible	1 ☐	2☐	3☐	4☐	5☐
502	A woman should have the right to decide for herself whether or not to have an abortion	1☐	2☐	3☐	4☐	5☐
503	Abortion should not be provided for any reason	1☐	2☐	3☐	4☐	5☐
504	Abortion provision should be legal if the woman's physical health is endangered by the pregnancy	1☐	2☐	3☐	4☐	5☐
505	Abortion should be legal if the woman's mental health is endangered by the pregnancy	1☐	2☐	3☐	4☐	5☐
506	Abortion should be legal if the woman is not married and want to terminate her pregnancy	1☐	2☐	3☐	4☐	5☐
507	Abortion provision should be legal if the family (or woman) cannot afford to raise the child	1☐	2☐	3☐	4☐	5☐
508	Abortion provision should be legal if the fetus shows signs of serious congenital defect or malformation	1☐	2☐	3☐	4☐	5☐
509	Abortion provision should be legal if the pregnancy was a result of incest or rape	1☐	2☐	3☐	4☐	5☐
510	Abortion provision should be legal if the pregnancy was unplanned and unwanted	1☐	2☐	3☐	4☐	5☐
511	Safe abortion should be accessible under any circumstances	1☐	2☐	3☐	4☐	5☐
512	If woman requested an abortion, I will provide her the service or refer the woman to the facility where she obtains the service	1☐	2☐	3☐	4☐	5☐
513	I would try to convince other health care providers to perform abortions	1☐	2☐	3☐	4☐	5☐
514	All health providers should be able to provide medical abortion for first-trimester pregnancy?	1☐	2☐	3☐	4☐	5☐
515	All health providers should be able to provide surgical abortion for first-trimester pregnancy	1☐	2☐	3☐	4☐	5☐
516	Referral arrangements for social support and care should be an integral part of overall abortion care.	1☐	2☐	3☐	4☐	5☐

አባሪ 2፡ ለአገልግሎት ሰጪ የጤና ባለሙያዎች የተዘጋጁ የቃለ መጠይቅ ጥያቄዎች

የስምምነት ፎርም

መግቢያና የስምምነት ጽሑፍ (በመረጃ ሰብሳቢው የሚነበብ)

ሠላም፤ ስሜ----------ይባላል::(የመረጃ ሰብሳቢው ስም ማለት ነው):: "ኢምፓክትስ ፎር ደቨሎፕመንት" (I4D) በሚባል ድርጅት ተቀጥሬ የምሠራ መረጃ ሰብሳቢ ነኝ:: አይፎርዲ (I4D) በኢትዮጵያ የየተs sመና በጤናና በልማት ጉዳዮች ላይ የማማከር አገልግሎት የሚሠጥ የግል ድርጅት ነው:: በአሁኑ ጊዜም አይፓስ ኢትዮጵያ ለተባለ ድርጅት የጤና ባለሙያዎች በጽንስ Ts[Ø አገልግሎት ላይ ባላቸው አመለካከትና እይታ ላይ ለሚያካሄደው ጥናት የማማከር አገልግሎት በመስጠት ላይ ይገኛል:: የጥናቱ ዓላማም አገልግሎት ሰጪ የሆኑ የጤና ባለሙያዎች በፅንስ Ts[Ø ላይ ያላቸውን የአመለካከትና እይታ ደረጃ በማወቅ አገለግሎቱን እንዳይሰጡ የሚከለክሉ ምክንያቶችን ለመለየት ነው:: በመሆኑም ጥናቱ አመቺ እስትራቴጂዎችንና የመፍትሔ አቅጣጫዎችን ለመቅረጽ የሚረዱ ጠቃሚ መረጃዎችን በማስገኘት አገልግሎት ሰጪ የጤና ባለሙያዎች በፅንስ Ts[Ø አገልግሎት አሰጣጥ ላይ ያላቸውን አሉታዊ አመለካከትና እይታ ለማሻሻልና እንቅፋትነታቸውን ለመቀነስ ያስችላል ተብሎ የታሰበ ነው::በዚህ መሰረት በጥናቱ ላይ ለመሳተፍ ከወሰኑ ከፅንስ Ts[Ø አገልግሎት ጋር በተያያዘ ያሎትን አመለካከትና እይታን ለማወቅ የሚያስችሉ ጥያቄዎች ይቀርቡሎታል:: ጥያቄዎቹን ለመጨረስ በአማካይ አንድ ሰዓት ይፈጃል ተብሎ ይገመታል::

ተሳትፎዎ በፈቃደኝነት ላይ የተመሰረተ ነው፤ ለመመለስ የማይፈልጉትን ማንኛውንም ጥያቄ ለመመለስ አይገደዱም:: የትኛውንም ጥያቄ ለመመለስ ምቾት ካልተሰማዎት ቃለ-ምልልሱን በማንኛውም ሰዓት Ts[Ø ይችላሉ:: ለመሳተፍም ሆነ ላለመሰተፍ የሚወስኑት ውሳኔ አሁን በሚሠሩት ሥራ፣ በሚያገኙት አገልግሎት፣ ከእርሰዎ ጋር ግንኙነት ካላቸውና የፅንስ Ts[Ø አገልግሎት በሚሠጡ አካላት ላይ ምንም ተፅዕኖ አያሳድርም::

ጥናቱ ምስጢርዎን የሚጠብቅባቸው ዘዴዎች አሉት:: የሚሠጡት መረጃ ሁሉ ምስጢራዊነቱ የተጠበቀ ነው::ስምዎ በውስጣዊውም በሚታተሙ ሪፖርቶች ላይ አይጠቀስም::

በዚህ ቃለ ምልልስ ላይ በመሳተፍዎ የሚያገኙት ክፍያ የለም:: ይህ ጥናት ከመነሻውም የታቀደው ጠቃሚ መረጃዎችን እንዲያስገኝ በመሆኑ ለጊዜው የሚያስተርፉት ጥቅም የለም:: ይሁን እንጂ በዚህ ጥናት ላይ መሳተፍዎ በአገሪቱ የተ J ላ የፅንስ አገልግሎት አሠጣጥን ለማሻሻልና ለማጠናከር ሊያግዝ ይችላል::

ከዚህ ጥናት ጋር በተያያዘ ጥያቄና የሚያሳስቦት ጉዳይ ካለ ስማቸው ከዚህ በታች የተመለከተውን ማናገር ይችላሉ::

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እንድቀጥል መልካም ፈቃድዎ ነው?
1. አዎ ☐
2. አይደለም

ክፍል አንድ: የግልና ማህበረ-ዲሞግራፊያዊ (Socio-Demographic) መረጃዎች

ተ ቁ	ጥያቄዎች	መልስ	ኮድ	እለፍ
001	ክልል	1. አማራ 2. ኦሮሚያ 3. የደቡብ ብሔር ብሔረሰቦችና ህዝቦች ተወካዮች 4. የደቡብ ምዕራብ ህዝቦች		
002	የጤና ትቋም ስም/ የመለያ ቁጥር	_____		

003	የተሳታፊ የመለያ ቁጥር	ለአማራ በ 10 ፤ ኦሮሚያ በ 20፤ ደቡብ በ 30፤ ደቡብ ብ 40 ቁጥር አስቅድም		
101	ዕድሜ (ሙሉ ዓመት ብቻ)	_____ ዓመት		
102	ፆታ	1. ሴት 2. ወንድ	/_____ /	
103	የጋብቻ ሁኔታ	1. ያላገባ 2. ያገባ 3. የፈታ 4. አብሮ የሚኖር (ለጋብቻ) 5. የተለያዩ 6. የሞተባት/የሞተችበት	/ _____ /	
104	ሃይማኖት	1. አርቶዶክስ 2. ሙስሊም 3. ፕሮቴስታንት 4. ካቶሊክ 5. ሌላ (ግለጽ) _____	/ _____ /	
105	ሙያ	1. ጠቅላላ ሃኪም 2. ነርስ (ዲፖሎማ) 3. ቢ ኤስ ሲ ነርስ 4. አዋላጅ ነርስ (ዲፕሎማ) 5. አዋላጅ ነርስ (ቢኤስሲ) 6. የጤና መኮንን 7. ሌላ (ግለጽ) _____	/_____ /	
106	አሁን ያሉበት የሥራ ክፍል	1. የእናቶችና ሕፃናት ሕክምና 2. የማህፀንና ፅንስ 3. ማዋለጃ 4. ምርመራ (OPD) 5. ሜዲካል ዋርድ 6. ሰርጂካል ዋርድ 7. ሌላ (ግለጽ)_____	/_____ /	
107	በሙያው ያገለገሉበት ዓመታት	1. ከአንድ ዓመት ያነሰ 2. ከ1-3 ዓመት 3. ከ3-5 አመት 4. ከ5-10 ዓመት 5. ከ10 ዓመት በላይ	/ _____ /	
108	የሚሠሩበት የመንግስት የጤና ተSም ዓይነት	1. ጤና ጣቢያ 2. የመጀመሪያ ደረጃ ሆስፒታል 3. አጠቃላይ ሆስፒታል 4. ሪፈራል ሆስፒታል 5. ስፔሻላይዝድ ሆስፒታል	/ _____ /	
109	አሁን ባሉበት የጤና ተSም ለምን ያህል ጊዜ ሠሩ?	_____ ዓመት		

ክፍል ሁለት: ጥንቃቄ የተሞላበት የፅንስ Ts[Ø የአገልግሎት ሠጪው ሥልጠናና ልምድ

ተ ቁ	ጥያቄዎች	መልስ	ኮድ	እለፍ
201	ደህንነቱ በተጠበቀና የተJላ የፅንስ Ts[Ø አገልግሎት ሥልጠና ወስደው ያውቃሉ?	1. አዎ 2. አይደለም	/_____ /	
202	ሥልጥነው ከሆነ ሠርተውበታል?	1. አዎ 2. አይደለም	/_____ /	
203	ለጥያቄ 201 የሠጡት መልስ አዎ ከሆነ ሥልጠናውን ከወሰዱ ምን ያህል ጊዜ ይሆናል?	1. 1-3 ዓመት በፊት 2. 3-5 ዓመት በፊት 3. ከ 5 ዓመት በፊት 4. አላስታውስም	/_____ /	
204	የእይታ ማጥራትና አመለካከት መቀየሪያ (Value Clarification and Attitude transformation -VCAT) ሥልጠና ወስደው ያውቃሉ?	1. አዎ 2. አይደለም	/ _____ /	
205	ለጥያቄ 204 የሠጡት መልስ አዎ ከሆነ ሥል ጠናው ደህንነቱ የጠበቀ የፅንስ Ts[Ø እንዲሠጡ አመለካከትዎን የቀየረ ይመስልዎታል?	1. አዎ 2. አይደለም	/_____ /	

ክፍል ሶስት: ከፅንስ Ts[Ø ሕግና ጤና ተsማት ጋር የተያያዙ ጥያቄዎች

ተ.ቁ	ጥያቄዎች	መልስ	ኮድ	እለፍ
301	ስለአገሪቱ የፅንስ Ts[Ø ሕጎች የሚያውቁት ነገር አለ?	1. አዎ 2. አይደለም	/_____ /	
302	ለጥያቄ 301 የሠጡት መልስ አዎ ከሆነ በፅንስ ማቃረጥ ባሉት የአገሪቱ ሕጎችና መመሪያዎች ይስማማሉ ?	1. አዎ 2. አይደለም 3. አላውቅም	/_____ /	
303	የሚሠሩበት የጤና ተቋም በቂ አገልግሎት የሚሠጡ መሣሪያዎች አሉት?	1. አዎ 2. አይደለም 3. አላውቅም	/_____ /	
304	እርስዎ የሚሠሩበት የጤና ተቋም ደህንነቱ የተጠበቀ የፅንስ Ts[Ø አገልግሎት የሚሰጥበት መመሪያዎች አሉት?	1. አዎ 2. አይደለም 3. አላውቅም	/ _____ /	
305	ሕጋዊ የሆነ የፅንስ Ts[Ø አገልግሎት በማንኛውም ሁኔታ መሠጠት አለበት	1. እስማማለሁ 2. አልስማማም 3. አይመለከተኝም	/ _____ /	
306	የማይስማሙ ከሆነ ምክንያትዎ ምንድ ነው?	1. ሃይማኖቴ አይፈቅድልኝም 2. በባህላችን ተቀባይነት የለውም 3. የፅንሱን ነፍስ ማጥፋት ስለሆነ 4. ያልተፈለገ እርግዝናን ማበረታታት ስለሆነ 5. ከጋብቻ በፊት ወሲብን/እርግዝናን ማበረታታት ስለሆነ 6. ጥንቃቄ የጎደለውና ኤችአይ ቪን ጨምሮ የአባለዘር በሽታዎችን የሚያስከትል ወሲብን ማበረታታት ስለሆነ 7. አላውቅም 8. ሌላ (ግለጽ)_____	/ _____ /	
307	በመካከለኛ ደረጃ ላይ የሚገኙ የጤና ባለሙያዎች ከ 9 ሳምንታት በታች የሆነ ፅንስን በእንክብል የTs[Ø አገልግሎት መስጠት አለባቸው	1. እስማመለሁ 2. አልስማማም 3. ገለልተኛ ነኝ (አይመለከተኝም)	/_____ /	
308	በመካከለኛ ደረጃ ላይ የሚገኙ የጤና ባለሙያዎች ከ 9 ሳምንታት በታች የሆነ ፅንስን በመሣሪያ የታገዘ የTs[Ø አገልግሎት መስጠት አለባቸው	1. እስማመለሁ 2. አልስማማም 3. ገለልተኛ ነኝ (አይመለከተኝም)	/_____ /	

ክፍል 4: ጥንቃቄ የተሞላበት የፅንስ Ts[Ø ላይ የአገልግሎት ሰጪዎች እይታና ዕውቀት

ተ.ቁ	ጥያቄዎች	መልስ	ኮድ	እለፍ
401	ሴቶች ፅንስ Ts[Øን ለምን የሚፈልጉ የመስልዎታል?	1. ዕውቀት ስለሚያንሳቸው 2. በኢኮኖሚ አቅም ውስንነት 3. እንደእርግዝና መከላከያ ስለሚጠቀሙ 4. ያልተፈለገ እርግዝናን ለማስወገድ 5. በጤና ችግር 6. በፍቅረኛ ተፅዕኖ 7. በጣም ብዙና በተጠጋጋ እርግዝና ምክንያት 8. ትምህርታቸውን ለማጠናቀቅ 9. ያላገቡ በመሆናቸው 10. ከ18 ዓመት በታች በመሆናቸው 11. ሌላ (ግለጽ)_____ 12. አላውቅም	/_____ /	
402	የፅንስ Ts[Ø አገልግሎት የሚሠጥበት የጤና ተቃም ውስጥ በመስራትዎ ደስተኛ ኖት?	1. አዎ 2. አይደለሁም	/_____ /	
403	በአጠቃላይ የፅንስ Ts[Ø ለመስጠት ፈቃደኛ ኖት?	1. አዎ 2. አይደለሁም	/_____ /	
404	መልስዎ አይደለሁም ምክንያትዎ ምንድን ነው?	1. ከሥራ ድርሻዬ ውጪ በመሆኑ 2. ከሃይማኖታዊ ልማዴ ስለሚጻረር 3. ከግል እምነቴ ስለሚጻረር 4. በፅንስ ማቃረጥ አሠጣጥ ዘዴ ለመሠለጠን ዕድል አላገኘሁም 5. አድልዎና መገለል እንዳይደርስብኝ 6. አላውቅም 7. ሌላ (ግለጽ)_____	/ _____ /	
405	በፍላጎት ላይ የተመሠረተ ፅንስ Ts[Ø በሕግ መፈቀድ እና በመንኖውም ሀኔታ ቢሆን መሠጠት አለበት	1. አስማማለሁ 2. ገለልተኛ ነኝ (አይመለከተኝም) 3. አልስማማም 4. ሌላ ካለ ግለጽ_____	/_____ /	
406	ጥንቃቄ የተሞላበት የፅንስ Ts[Ø አገልግሎት የሚሠጡ ቢሆን ለማነው የሚሠጡት? (ከአንድ በላይ መልስ ይቻላል)	1. ተደፍራ ላረገዘች ሴት 2. ከዘመድ ላረገዘች ሴት 3. የእርግዝናው መቀጠል በእናትቱ ወይም በፅንሱ ጤና ወይም ሕይወት ላይ አደጋ ለሚያስከትል ሴት 4. የአካል ወይም የጤና ጉድለት ላለባት ሴት 5. ዕድሜዋ ከ18 ዓመት በታች ለሆነና ልጅ ወልዳ ለማሳደግ የአካል ወይም የስነልቦና ዝግጅት ለሌላት ሴት 6. ፅንሱ ፈጽሞ ሊድን የማይችል ከባድ ጉድለት ያለበት ከሆነ	/_____ /	

407	ሕጋዊ የሆነ የፅንስ Ts[Ø አገልግሎት እንደእርግዝና መከላከያ ዘዴ ያገለግላል	1. እስማማለሁ 2. አልስማማም 3. አይመለከተኝም	/ _____ /	
408	ከፅንስ ማቃረጥ ዘዴዎች የቱ ይመችዎታል	1. በእንክብል ፅንስ Ts[Ø 2. በመሣሪያ የታገዘ ፅንስ Ts[Ø 3. አይመለከተኝም	/_____ /	

ክፍል 5: አገልግሎት ሰጪ የጤና ባለሙያዎች በፅንስ Ts[Ø ላይ ያላቸው አመለካከት

መመሪያ: እያንዳንዱን ዐረፍተ ነገር በማንበብና ከቀረቡት አማራጮች መካከል ማለትም **1.በእጅጉ አልስማማም፣ 2.አልስማማም፣ 3.ገለልተኛ ነኝ ወይም አልወሰንኩም፣ 4.እስማማለሁ፣ 5.በእጅጉ እስማማለሁ** ከሚሉት አንዱ ላይ ብቻ ቲክ በማድረግ የመስማማትዎን ወይም ያለመስማማትዎን ደረጃ ይግለጹ

ተ.ቁ	ዐ. ነገሮች (Variables)	በእጅጉ አልስማማም	አልስማማም	አልወሰንኩም	እስማማለሁ	በእጅጉ እስማማለሁ
501	ጥንቃቄ የተሞላበትና በፈቃደኝነት ላይ የተመሠረተ የፅንስ Ts[Ø አገልግሎት በሕግ የተፈቀደና ተደራሽ መሆን አለበት	1 ☐	2☐	3☐	4☐	5☐
502	ማንኛዋም ሴት ፅንስ ለTs[Ø ወይም ላለTs[Ø ለራስዋ የመወሰን ሙበት ሊኖራት ይገባል	1☐	2☐	3☐	4☐	5☐
503	በማንኛውም ሁኔታ ፅንስ የTs[Ø አገልግሎት መሠጠት የለበትም	1☐	2☐	3☐	4☐	5☐
504	እርግዝና በሴትዮዋ አካላዊ ጤንነት ላይ አደጋ የሚያስከትል ከሆነ ፅንስ Ts[Ø በሕግ መፈቀድ አለበት	1☐	2☐	3☐	4☐	5☐
505	እርግዝና በሴትዮዋ አዕምሮ ጤንነት ላይ አደጋ የሚያስከትል ከሆነ ፅንስ Ts[Ø በሕግ መፈቀድ አለበት	1☐	2☐	3☐	4☐	5☐
506	ሴትዮዋ ያላገባችና እርግዝናዋን Ts[Ø የምትፈልግ ከሆነ ፅንስ ማቃረጥ በሕግ መፈቀድ አለበት	1☐	2☐	3☐	4☐	5☐
507	ሴትዮዋ (በተሰቦችዋ) ልጅ ማሳደግ የማይችሉ ከሆነ ፅንስ Ts[Ø በሕግ መፈቀድ አለበት	1☐	2☐	3☐	4☐	5☐
508	ፅንሱ ፊጽሞ ሊድን የማይችል ጉድለት ያለበት ከሆነ ፅንስ Ts[Ø በሕግ መፈቀድ አለበት	1☐	2☐	3☐	4☐	5☐
509	ፅንሱ ከዘመድ ወይም ተገዶ ከመደፈር የተረገዘ ፅንስ Tsረጥ በሕግ መፈቀድ አለበት	1☐	2☐	3☐	4☐	5☐
510	ዕርግዝናው ያልታቀደ ወይም ያልተፈለገ ከሆነ ፅንስ Ts[Ø በሕግ መፈቀድ አለበት	1☐	2☐	3☐	4☐	5☐
511	ጥንቃቄ የተሞላበት ፅንስ Ts[Ø በማንኛውም ሁኔታ ቢሆን ተደራሽ መሆን አለበት	1☐	2☐	3☐	4☐	5☐
512	ሴትዋ ፅንስ እንዲቃረጠላት ከጠየቀች አገልግሎቱን እሠጣተለሁ ወይም አገልግሎቱን ወደምተገኝበት የጤና ተቃም ሪፈር አደርጋታለሁ	1☐	2☐	3☐	4☐	5☐
513	ሌሎች የጤና ባለሙያዎች ፅንስ የTs[Ø አገልግሎት እንዲሠጡ ላማሳመን እሞክራለሁ	1☐	2☐	3☐	4☐	5☐
514	ሁሉም የጤና ባለሙያዎች ከ 9 ሳምንታት በታች የሆነ ፅንስን በእንክብል የTs[Ø አገልግሎት መስጠት አለባቸው	1☐	2☐	3☐	4☐	5☐
515	ሁሉም የጤና ባለሙያዎች ከ 9 ሳምንታት በታች ለሆነ ፅንስ በመሣሪያ የታገዘ የTs[Ø አገልግሎት መስጠት አለባቸው	1☐	2☐	3☐	4☐	5☐
516	የማህበራዊ ድጋፍና ክብካቤ ሪፈራልን ማመቻቸት የፅንስ Ts[Ø ዋና አካል መሆን አለበት	1☐	2☐	3☐	4☐	5☐

Miiltoo/Hordoftuu 2: Gaaffii fi deebii walitti-qabiinsa odeefannoo Ogeesota fayyaa tajaajila kennaniif

Gucha waliigaltee

Seensaa fi yaada waliigaltee tajaajila fayyaa kennitootaaf
(Ogeessa ragaa walttiqabuun kandubbsamu)

Harkafuune, Maqaankoo (maqaa raga sassabaa/duu) _____ jedhama. Ani ragaa walittiqabaa dhaabbata dhuunfaa tajaajila gorsaa fayyaa fi misooma irratti kennuuf Itoophiyaa keessatti hudeefame fi galmaa'e, "Impacts for Development (I4D)" jedhamuun filatamedha/ramadamedha. I4Diin qo'annoo waa'ee ilaalchaa fi yaada ogeesoti fayyaa dhaabilee fayyaa motummaa keessa hojjetan tajaajila ulfa baasuu irratti qaban ilaalchisee dhaabbata "Ipas Ethiopia" jedhamuuf tajaajila gorsaa kennaa jira. Kayyoon qo'annoo kanaa ilaalchi fi yaadni ogeesotni fayyaa waa'ee ulfa baasuu irratti qaban sadarkaa isaa baruu fi sababa tajaajilicha akka hin kennine isaan dhorku addaan bafachuuf. Kanaafuu, qo'annoon kun odeefannoo/ragaa gahaa fi bu'aa qabeessa ta'e irratti hundaa'uun tarsiimoo fi hojiiwwan ilaalcha fi yaada ogeessotni fayyaa ulfa baasuu irratti qaban foyyeesuu fi mormii isaanii salphisuuf kan gargaarudha. Qo'annoo kanarrtti hirmaachuuf yoomurteesitan gaaffiiwwan tajaajila ulfa baasuu gutuu (CAC) waliin walqabtee ilaalchaa fi yaadakeessan agarsiisan isinii dhiyaatu. Deebiiwwan gaaffiilee kanaa xummuruuf tilmamaan saatii tokko fudhata.

Hirmaannaankeessan fedhii irratti kanhundaa'edha; gaaffii deebisuu hinfeene kamiinuu deebisuuf hindrqsiifamtan. Gaaffii kamiinuu deebisuuf fedhii hinqabdan tanaan, yeroo barbaaddanitti addaan kutuu nidandeessu. Qo'annoo kanarrtti hirmaachuu dhiisuunkeessanm hojiikeessan irratti, tajaajila argachuu qabdanrratti, akkasumas quunnamtiikeessan qaamolee tajajila ulfa baasuu guutuu (CAC)kennan waliin qabdan irratti dhiibbaan fidu hinjiru. Qo'annoon kun haala ittiin iciitii eegu niqabaata. Haaluma kanaan, odeefannoon isin kennitan hudi iciitiin isaa kaneegame ta'e. Maqaankeessan gabaasa keessaattis ta'e kan maxxanfamu keessatti hinibsamu.

Qo'annoo karratti hirmaachuukeessaniif beenyaan/kafaitiin argattan hinjiru. Qo'annoon kun jalqabarratti odeefannoo/ragaa bu'aaqabeessa ta'e argamsiisuudha. Bu'aan hatattamaan ykn ammatti iniif argamsiisu hin jiru. Haata'u malee qo'annoo kanarratti hirmaachuukeessan iin tajaajila ulfa baasuu biyya kanaa cimsuu fi foyeesuuf toftaa fi tarsiimoo baasuuf nigargaara.

Qo'annoo kana ilaachisee gaaffii ykn yaaddoo yooqabbaattan namoota armaan gadii quunnamuu nidandeessu:
Daawit Geetaachoo, Qo'ataa Ol'anaa, I4D Plc. email at dawitgt2005@gmail.com + (251) 911563531
Baqaaluu Moosee, email at bekalumossie@gmail.com + (251) 911713902
Adeemsaa fi kayyoo qo'annoo kanaa hunda dubbiseera, haaluma barreefameen naagaleera. Qo'anichis anrratis ta'e maatiikoo irratti balaa kanhinqabne ta'uusaa hubadheera.
Akkan ittifufu naaf eyyamta?

1. Eeyyee ☐
2. Lakki ☐

Kutaa – tokko: Odeefannoo Dhuunfaa fi Hawaasummaa (Socio-Demographic)

Lakk. seerii.	Gaafiiwwan	Deebii	Koodii	Darbi (Skip)
001	Naannoo	1. Amhara 2. Oromia 3. SNNP 4. Southwest		
002	maqaa dhaabbataa/ adda baasuu	_____		
003	adda baasuu hirmaattootaa	Starts with 10 if Amhara region provider, 20 if Oromia, 30 if SNNP, 40 if Southwest (e.g. 1001, 2001)		
101	Umurii (Waggaa guutuudhaan qofa)	_____ years		
102	Saala	1. Dubartii 2. Dhiira	/____ /	
103	Waa'ee Gaa'ila	1. Takkumaa hinfuune/heerumne 2. Kan fuudhe/heerumte 3. Kan walhiike/hiikte 4. Walfaana jiraachuu (Cohabiting) 5. Kanaddaan bahe/baate 6. Kanirraadu'e/jalaaduute	/ ____ /	
104	Religion	1. Ortoodooksii 2. Musiliima 3. Pirooteestantii 4. Katoolikii 5. Kanbiraa (Ibsi) _____	/ _____ /	
105	Ogummaa	1. ogeessa fayyaa 2. Narsii (diploomaa) 3. B.Sc. narsii (Narsii Digirii) 4. Deesistuu (diploomaa) 5. Deesistuu Digirii (BSc) 6. Qondaala Fayyaa (Health Officer) 7. Kan biraa (Ibsi) _____	/_____ /	
106	Kutaa hojii (kan ammaa)	1. Kutaa haadholii fi Daa'imanii 2. Kutaa dubartoota ulfaa 3. Kutaa da'umsaa 4. Kutaa yaalii (OPD) 5. Kutaa ciisaa dhukbsatootaa 6. Kutaa baqaqsaa fi suphaa 7. Kan biraa (Ibsi) _____	/_____ /	

107	Muuxannoo hojii ogummaadhaan	1. Waggaa tokkoo gadi 2. Waggaa 1 - 3 3. Waggaa 3-5 4. Waggaa 5- 10 5. Waggaa10 ol	/ _____ /	
108	Gosa dhaabbata fayyaa kessa hojjettu	1. Buufata Fayyaa 2. Hoospitaala Sadarkaa Jalqabaa 3. Hoospitaala Waliigalaa 4. Hoospitaala riifaraalaa 5. Hoospitaala Ispeeshaalayzid (Specialized hospital)	/ _____ /	
109	Dhaabbata Fayyaa kana keessa waggaa meeqa hojjete?	Waggaa _____		

Kutaa 2: Waa'ee Leenjii fi Shaakala (practice) ogeessoti fayyaa tajaajila ulfa baasuu ofeeggannoo qabuu

Serial No.	Questions	Response	Code	Skip
201	Ulfa baasuu of-eeggannoo qabu fi guutuu (comprehensive) leenjifamteettaa?	1. Eeyyee 2. Lakki	/____ /	
202	Leenjifmteetta yoota'e tajaajila kennaa jirtaa?	1. Eeyyee 2. Lakki	/____ /	
203	Deebiinkee gaaffii 201f eeyyee yoota'e , erga leenjii fudhatee waggaa meeqa?	1. Waggaa 1-3 dura 2. Waggaa 3-5 dura 3. Waggaa 5 dura 4. Hinyaadadhu	/____ /	
204	Ulfa baasuu waliin walqabatee ilaalcha ofii addaan baafachuu fi yaada jijjirachuu (VCAT) irratti leenjii fudhatteettaa?	1. Eeyyee 2. Lakki	/ ____ /	
205	Deebiinkee gaaffii 204f eeyyee yoota'e, leenjich ulfa baasuu ofeeggannoo fi guutuu ta'e (CAC) kennuuf eyyamaa akkan ta'u dhiibbaa sirratti godheeraa jettee yaaddaa ?	1. Eeyyee 2. Lakki	/_____ /	

Kutaa 3:Gaaffiiwwan seera ulfa baasuu fi dhaabbilee fayyaa waliin walqabatan

Lakk. Seerii	Gaaffiiwwan	Deebii	Koodii	Darbi (Skip)
301	Waa'ee seera Ulfa baasuu biyya kanaa hubannoo qabdaa?	1. Eeyyee 2. Lakki	/____ /	
302	Deebiikee 301f 'Eeyyee" yoota'e, ulfa baasuu ilaalchisee seerri biyyitii fi dhaabbileen Fayyaa hordofaa/ittifayyadamaa jiran sirridha jettee amantaa?	1. Eeyyee 2. Lakki 3. Hinbeeku	/____ /	
303	Dhaabatni fyyaa keessan meeshaalee gahaa fi hoiiirra jiran qabaa?	1. Eeyyee 2. Lakki 3. Hinbeeku	/____ /	
304	Dhaabatni fayyaa keessan qajeelfamoota tajaajila ulfabaasuu guutuu (CAC) kennuuf barbaachisaa ta'an qabaa?	1. Eeyyee 2. Lakki 3. Hinbeeku	/ _____ /	
305	Haala kamiinuu ta'us tajaajilli ulfa baasuu seera qabeessa ta'e kennamuu qaba	1. Nan fudha (nanamana) 2. Hinfudhu (hinamanu) 3. Nahingachu (Neutral)	/ ____ /	
306	Yoo hinfudhattu) itthinamantu ta'e, sababiinkee maali?	1. Amantiinkoo naaf hineyyamu 2. Aadaan fudhatamaa miti 3. Lubbuu baasuu waanta'eef 4. Ulfa baasuu waanjajabeesuuf 5. Saal-quunmamtii fuudhaan dura/alaa waanjajabeesuuf 6. Sal-quunamtii of-eeggannoo hinqabnee fi dhibeewwan dadarbaa quunnamtii salaa akka HIV AIDS tiif waan nama saaxilaniif 7. Hinbeeku 8. Sababoota biroo (ibsi)_____	/ _____ /	
307	Ogeessoni fayyaa judu-galeessa ta'an (Mid-level health providers) tajaajila qorichaan ulfa baasuu torban sagalii gadii kennuu qabu	1. Nan fudha (nanamana) 2. Hinfudhu (hinamanu) 3. Nahingachu (Neutral)	/_____ /	
308	Ogeessoni fayyaa judu-galeessa ta'an (Mid-level health providers) tajaajila ulfa baasuu meeshaan deeggarame "surgical abortion" ulfa baasuu torban sagalii gadii kennuu qabu	1. Nan fudha (nanamana) 2. Hinfudhu (hinamanu) 3. Nahingachu (Neutral)	/_____ /	

Kutaa 4:Ilaalchaa fi beekumsa ogeesoti fayyaa ulfa baasuu irratti qaban

Lakk. Seerii	Gaaffiiwwan	Deebii	Koodii	Darbi/Skip
401	Dubartootni ulfa baasuu maaliif barbaadu? (sababiin saanii maali jettee yaadda?)	1. Hanqina beekumsaatiin 2. Rakkina dinagdee 3. Akka toftaa ittisa ulfaatti fayyadamuuf 4. Ulfa hinbarbaadamne ittisuuf 5. Rakina fayyaatiif 6. Dhiibbaa hiriyaatiin 7. Ulfa baayee fi walitti dhiyaate ittisuuf 8. Barnoota xummuruuf 9. Waan hinheerumneef 10. Waan waggaa 18 gadi ta'aniif 11. Kanbiroo (ibsi)_____ 12. Hinbeeku	/____ /	
402	Dhaabbata fayyaa tajaajilli ulfa baasuu kennu keessa hojechuukeetti nigammaddaa?	1. Eeyyee 2. Lakki	/____ /	
403	Tajaajila ulfa baasuu kennuuf eyyamaadhaa?	1. Eeyyee 2. Lakki	/____ /	
404	Deebiinkee "Lakki " yoota'e sababiinkee maali?	1. Gahee hojiikootiin ala 2. Faallaa amantiikooti 3. Faallaa duudhaa dhuunfaa (p[ersonal value) kooti 4. Toftaa ulfa baasuu irratti lenjii hinarganne 5. Loogii fi addaan bahuuf (stigma) nasaaxila 6. Hinbeeku 7. Kanbiroo (Ibsi)_____	/ ____ /	
405	Ulfa baasuun fedhii irratti hudaa'e (elective abortion) seeraan eyyamamaa fi haala kamiinuu kennamuu qaba	1. Ittin amana 2. Nangalchul 3. Ittin amanu 4. Kanbiroo (Ibsi) _____	/_____ /	
406	Tajaajila ulfa baasuu of-eeggannoo qabu eenyuu kennuu feeta? (Deebii tokkoo ol ta'uu danda'a)	1. Ulfa gudeeddiirraa uumame 2. Ulfa fira irraa uumame 3. Ittifuufiinsi ulfichaalubbuu haadha ykn lubbuu mucaa (fetus} irra balaa kangeesisu yoota'e 4. Dubartii hirdhina qaamaa ykn sammuu qabduuf 5. Ijoolee durbaa umuriishee waggaa 18 gadi ta'ee fi qaamaanis ta'e xiinsammuun qophooftuu hintaneef	/_____ /	

		6. Ulfisun uumamaan hirdhina fayyuu hindadeenyee fi dhalatees nama ta'uu kan hindadeenye yoota'e		
407	Ulfa baasuun seera qabeesa ta'e (seeraan eyyamame) akka tofta ittisa ulfatti (contraception) nifayyada.	1. Ittin amana 2. Ittin amanu 3. Nangalchu	/ _____ /	
408	Toftaalee ulfa baasuu keessaa isakamtu sitti tola?	1. Qoricha (kiniiniin) baasuu 2. Baqsanii baasuu (Surgical abortion 3. Nangalchu	/____ /	

Kutaa 5: Ilaalcha tajaajila kennitoonni ulfa baasuu irratti qaban

Qajeelfama: Jechoota armaan gadii tokko tokkoon erga dubbitee booda sadarkaa ittiamanuukee ykn ittiamanuu dhisuukee filannoo dhiyaatan keessaa :1-Ciminaan Ittihinamanu, 2-Ittihinamanu, 3-nangalchu ykn hinmurteesine, 4-Ittinaman, fi 5-Ciminaan itti amana kan jedhan tiikii gochuun agarsiisi

Lak	Jechoota (Variables)	CiminaanItt tihinamanu	Ittihina manu	Hinm urtees ine	Ittin amana	Ciminaan ittin amana
501	Ulfa baasuun of-eeggannoo qabuu fi fedhirratti hundaa'e Seeraan eyyamamuu fi kennamuu qaba	1 □	2□	3□	4□	5□
502	Dubartiin tokko ulfa baasuufis ta'e dhisuu irratti mirga ofishee murteefachuiu qabaachuu qabdi	1□	2□	3□	4□	5□
503	Haala kamiinu tajaajilli ulfa baasuu kennamuu hinqabu	1□	2□	3□	4□	5□
504	Ulfi fayyaa qama dubrtii irratti balaa kan uumu yoota'e ulfa baasuun seeraan eyyamamuu qaba	1□	2□	3□	4□	5□
505	Ulfi fayyaa sammuu dubrtii irratti balaa kan uumu yoota'e ulfa baasuun seeraan eyyamamuu qaba	1□	2□	3□	4□	5□
506	Dubrtiin ulfoofte kan hinheerumne yoota'e fi ofirraa baasuu kan barbaaddu yoota'e ulfa baasuun seeraan eyyamamuu qaba	1□	2□	3□	4□	5□
507	Dubrtiin ulfoofte (maatiinshee) mucaa guddisuu kan hindandeenye yoota'e ulfa baasuun seeraan eyyamamuu qaba	1□	2□	3□	4□	5□
508	Ulfi gadameessa kissa jiru hirdhina fayyuu hindadeenyee fi dhalatees nama ta'uu kan hindadeenye yoota'e ulfa baasuun seeraan eyyamamuu qaba	1□	2□	3□	4□	5□
509	Ulfi fira irraa ykn gudeeddi irraa kan uumame yota'e ulfa baasuun seeraan eyyamamuu qaba	1□	2□	3□	4□	5□
510	Ulfi karooraan ala fi kanhinbarbadamne yoota'e ulfa baasuun seeraan eyyamamuu qaba	1□	2□	3□	4□	5□
511	Ulfa baasuun of-eeggannoo qabu haala kamiinuu taanaan kennamuu qaba	1□	2□	3□	4□	5□
512	Dubartiin tokko ulfa baasuuf yoo nagaafatte tajaajilicha nikeenaaf ykn gara dhaabbata fayyaa biraa tajaajila kennuufitti riifariin gotha	1□	2□	3□	4□	5□
513	Ogeessonni fayyaa biroon tajaajila ulfa baasuu akka kennan amansiisuu nanyaala,	1□	2□	3□	4□	5□
514	Ogeessonni fayyaa hundu tajaajila qorichaan/kiniiniin ulfabaasuu turban sagalii gadii kennuu danda'u qabu	1□	2□	3□	4□	5□
515	Ogeessonni fayyaa hundu tajaajila sarjikaaliin ulfabaasuu (surgical abortion) turban sagalii gadii kennuu danda'u qabu	1□	2□	3□	4□	5□

516	Riifaraliin waldhansaa fi gargaasi hawaasummaa akka qaama tajaajila ulfa baasuu tokkoo ta’ee qindeefamu qaba	1□	2□	3□	4□	5□

Annex 3: Data collection guide for key informant interview with providers and health facility managers

CONSENT FORM

Introduction and Consent Script/Form for Providers and health facility leaders

(To be read by the interviewer)

Hello, my name is <Data collector's name>. I am a data collector recruited by Impacts for Development (I4D) which is a private consultancy firm registered in Ethiopia to provide health and development consultancy services. I4D is providing consultancy services for Ipas Ethiopia in conducting an Assessment on Attitudes and perceptions of healthcare providers towards providing Abortion service in public health facilities. The purpose of the assessment is to explore the level of providers' perceptions and attitudes towards abortion and identify the causes of resistance to providing abortion services. The study will therefore provide invaluable information for designing suitable strategies and interventions related to safe abortion services.

If you decide to participate in the study, you will be asked to respond to questions related to your perception on provision of safe abortion services. Completing the responses to the questions is estimated to take on average one hour.

Your participation is voluntary, and you are not obligated to answer any question which you do not wish to answer. If you feel discomfort to respond to any of the question, please feel free to feel free to decline to answer and we can move on to the next question. Your decision on whether to participate will not affect your current job, any services you get and your relationship with any of the stakeholders working in the provision of Comprehensive Abortion Care (CAC) services. The study has procedures to protect your confidentiality. The information you provide will be kept confidential. Your name will not appear in any internal or published reports from the study.

There is no compensation for participating in this interview. This study is primarily intended to generate information, and thus offers no immediate benefit to you, but by participating in the study you may help to strengthen and improve the provision of Comprehensive Abortion Care services in the country.

Who to contact if you have any concerns: If you have any questions or concerns about this study, you may contact:

Dawit Getachew, Principal Investigator, I4D Plc. by email at dawitgt2005@gmail.com + (251) 911563531

Bekalu Mossie, by email at bekalumossie@gmail.com + (251) 911713902

I have read all the process and the objective of the study and I have understood the same as written. I understood that the research imposes no risk would be provided to me.

Could I have your permission to continue?

1. Yes ☐
2. No ☐

KII questions For Providers and health facility managers

1. What do you know about safe abortion care service provision in health facilities? (only for providers)

   Probing:
   - In what way have you learned/knew about the service provision
   - How do you see the overall performance of the safe abortion provision at your facility?

2. Can you tell me what you know about the revised national procedural and technical guideline on abortion service developed by MOH? (only for providers)

   Probing:
   - Are you comfortable with the legal provisions related to safe abortion care services
   - How do you perceive the effect of the guideline on your knowledge and practice of safe abortion services at your facility

3. What is your insight regarding provider's perception and attitudes to providing safe abortion services in health facilities?

4. What do you think are the effects of provider's perceptions and attitudes on abortion service provision in health facilities?

5. In your opinion, what are the reasons for provider's resistance in provision of safe abortion care service in health facilities?

6. What roles should health providers play in normalizing and destigmatizing the abortion care services in health facilities?

7. What are the contributing factors, challenges or barriers on provision of safe abortion services in health facilities?

8. What are the contributing factors to safe abortion provision stigma in health facilities?

9. What are the opportunities and enabling conditions at each level of the health system for the provision of abortion services in health facilities?

10. What do you think are the key roles and responsibilities of providers and program experts in availing and providing safe abortion care service in health facilities?

11. What do you recommend and suggest strategies to enhance the provision of safe abortion service in health facilities?
12. How do you assess staff turnover due to the stigma associated with safe abortion provision

አባሪ 3: ለቁልፍ የመረጃ ምንጮች የቃለ-መጠይቅ መመሪያ (ለአገልግሎት ሰጪ የጤና ባለሙያዎችና የጤና ተቋም ሃላፊዎች)

የስምምነት ቅጽ

መግቢያና የስምምነት ጽሑፍ/ለቁልፍ የመረጃ ምንጮች

(በቀለመጠይቅ አድራጊው የሚነበብ)

ሠላም፤ ስሜ----------ይባላል::(የመረጃ ሰብሳቢው ስም ማለት ነው):: "ኢምፓክትስ ፎር ደቨሎፕመንት" (I4D) በሚባል ድርጅት ተቀጥሬ የሚሠራ መረጃ ሰብሳቢ ነኝ:: አይፎርዲ (I4D) በኢትዮጵያ የየተs sመና በጤናና በልማት ጉዳዮች ላይ የማማከር አገልግሎት የሚሠጥ የግል ድርጅት ነው:: በአሁኑ ጊዜም አይፓስ ኢትዮጵያ ለተባለ ድርጅት የጤና ባለሙያዎች በጽንስ Ts[Ø አገልግሎት ላይ ባላቸው አመለካከትና እይታ ላይ ለሚያካሄደው ጥናት የማማከር አገልግሎት በመስጠት ላይ ይገኛል:: የጥናቱ ዓላማም አገልግሎት ሰጪ የሆኑ የጤና ባለሙያዎች በፅንስ Ts[Ø ላይ ያላቸውን የአመለካከትና እይታ ደረጃ በማወቅ አገለግሎቱን እንዳይሰጡ የሚከለክሉ ምክንያቶችን ለመለየት ነው:: በመሆኑም ጥናቱ አመቺ እስትራቴጂዎችንና የመፍትሔ አቅጣጫዎችን ለመቅረጽ የሚረዱ ጠቃሚ መረጃዎችን በማስገኘት አገልግሎት ሰጪ የጤና ባለሙያዎች በፅንስ Ts[Ø አገልግሎት አሰጣጥ ላይ ያላቸውን አሉታዊ አመለካከትና እይታ ለማሻሻልና እንቅፋትነታቸውን ለመቀነስ ያስችላል ተብሎ የታሰበ ነው::በዚህ መሰረት በጥናቱ ላይ ለመሳተፍ ከወሰኑ ከፅንስ Ts[Ø አገልግሎት ጋር በተያያዘ ያሎትን አመለካከትና እይታን ለማወቅ የሚያስችሉ ጥያቄዎች ይቀርቡሎታል:: ጥያቄዎቹን ለመጨረስ በአማካይ አንድ ሰዓት ይፈጃል ተብሎ ይገመታል::

ተሳትፎዎ በፈቃደኝነት ላይ የተመሰረተ ነው፤ ለመመለስ የማይፈልጉትን ማንኛውንም ጥያቄ ለመመለስ አይገደዱም:: የትኛውንም ጥያቄ ለመመለስ ምኞት ካልተሰማዎት ቃለ-ምልልሱን በማንኛውም ሰዓት Ts[Ø ይችላሉ:: ለመሳተፍም ሆነ ላለመሰተፍ የሚወስኑት ውሳኔ አሁን በሚሠሩት ሥራ፣ በሚያገኙት አገልግሎት፣ ከእርሰዎ ጋር ግንኙነት ካላቸውና የፅንስ Ts[Ø አገልግሎት በሚሠጡ አካላት ላይ ምንም ተፅዕኖ አያሳድርም::

ጥናቱ ምስጢርዎን የሚጠብቅባቸው ዘዴዎች አሉት:: የሚሠጡት መረጃ ሁሉ ምስጢራዊነቱ የተጠበቀ ነው::ስምዎ በውስጣዊውም በሚታተሙ ሪፖርቶች ላይ አይጠቀስም::

በዚህ ቃለ ምልልስ ላይ በመሳተፍዎ የሚያገኙት ክፍያ የለም:: ይህ ጥናት ከመነሻውም የታቀደው ጠቃሚ መረጃዎችን እንዲያስገኝ በመሆኑ ለጊዜው የሚያስተርፉት ጥቅም የለም:: ይሁን እንጂ በዚህ ጥናት ላይ መሳተፍዎ በአገሪቱ የተ J ላ የፅንስ አገልግሎት አሠጣጥን ለማሻሻልና ለማጠናከር ሊያግዝ ይችላል::

ከዚህ ጥናት ጋር በተያያዘ ጥያቄና የሚያሳስቦት ጉዳይ ካለ ስማቸው ከዚህ በታች የተመለከተውን ማናገር ይችላሉ::

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የጥናቱን ዓላማና ሂደት ሁሉ በተጻፈው መሠረት አንብቤ ተረድቻለሁ፤ ጥናቱ በኔም፣ በቤተሰቦቼም ላይ ምንም አደጋ እንደማያስከትል ተረድቻለሁ::
እንድቀጥል መልካም ፈቃድዎ ነው?
1. አዎ ☐
2. አይደለም ☐

ለቁልፍ የመረጃ ምንጮች ቃለ-ምልልስ የተዘጋጁ ጥያቄዎች

1. በጤና ተsማት ውስጥ ስለሚሠጠው የተማላ የፅንስ Ts[Ø አገልግሎት ምን ያውቃሉ?

ቀስቃሽ ጥያቄዎች :

- ስለሚሠጠው አገልግሎት በምን መንገድ (እንዴት) ሊያውቁ ቻሉ?
- በጤና ተቋምዎ ውስጥ የሚሠጠውን የተሟላ የፅንስ Ts[Ø አገልግሎት እንዴት ያዩታል?

2. ደህንነቱ የተጠበቀ የፅንስ Ts[Ø አገልግሎት ለመስጠት የጤና ጥበቃ ሚኒስቴር ስላዘጋጀውና ስለተሻሻለው የአፈፃፀም መመሪያ (Technical and Procedural Guideline) የሚያውቁትን ሊነግሩኝ ይችላሉ?

   ቀስቃሽ ጥያቄዎች:
   - ከፅንስ Ts[Ø አገልግሎት ጋር ተያይዘው ባሉት ሕጎችና መመሪያዎች ይስማማሉ?
   - በጤና ተቋማችሁ የፅንስ Ts[Ø አገልግሎት ለመስጠት መመሪያው ያመጣውን የዕውቀና የተግባር ለውጥ እንዴት ያዩታል?
3. አገልግሎት ሰጪ የጤና ባለሙያዎች በሚሠጡት የፅንስ Ts[Ø አገልግሎት ላይ ስላላቸው እይታና አመለካከት የእርስዎ ግንዛቤ ምንድነው?
4. አገልግሎት ሰጪ የጤና ባለሙያዎች በፅንስ Ts[Ø አገልግሎት ላይ ያላቸው እይታና አመለካከት በአልግሎት አሠጣጡ ላይ የሚኖረው ተፅዕኖ ምን ይመስልዎታል?
5. በእርስዎ አስተያየት አገልግሎት ሰጪ የጤና ባለሙያዎች የፅንስ Ts[Ø አገልግሎት ለመስጠት የማይፈልጉበት (እንቅፋት የሚሆኑበት) ምክንያት ምን ይመስልዎታል?
6. የፅንስ Ts[Ø አገልግሎት በጤና ተቋማት ውስጥ መደበኛ ሆኖ እንዲሠጥና ከሌላ አገልግሎት ተለይቶ እንዳይታይ አገልግሎት ሰጪ የጤና ባለሙያዎች ምን ሚና መጫወት አለባቸው?
7. የፅንስ Ts[Ø አገልግሎት በጤና ተቋማት ውስጥ እንዳይሠጥ የሚያደርጉ ችግሮች፣ እንቅፋቶችና አባባሽ ምክንያቶች ምንድን ናቸው?
8. የፅንስ Ts[Ø አገልግሎት በጤና ተቃማት ውስጥ ተለይቶ እንዲታይ (እንዲገለል) የሚያደርጉ አባባሽ ምክንያቶች ምንድን ናቸው?
9. የፅንስ ማቃረጥ አገልግሎት በጤና ተቃማት ውስጥ እንዲሠጥ በየደረጃው ባሉ የጤና መዋቅሮች ያሉ ዕድሎችና አስቻይ ሁኔታዎች ምንድን ናቸው?
10. የፅንስ Ts[Ø አገልግሎት በጤና ተቃማት ውስጥ እንዲገኝና እንዲሠጥ አገልግሎት ሰጪ የጤና ባለሙያዎችና የፕሮግራም ኤክስፐርቶች ቁልፍ ሚና ኃላፊነት ምን ይመስልዎታል?
11. በጤና ጠቃማት ውስጥ የተማላ የፅንስ Ts[Ø አገልግሎት አሠጣጥን ለማሻሻል ምን ምን እስትራቴጂዎችና ሐሳቦችን ያቀርባሉ?
12. የተማላ የፅንስ Ts[Ø አገልግሎት ጋር ተዛመዶ በሚድርስ መገለል ምክንያት የሚፈጠር የሰራተኞችን ከሰራ መልቀቅ እንዴት ይገመግማሉ?

Miiltoo 3: Gaaffiiwwan walittiqabiinsa odeefannoo waa'ee dhaabbilee fayyaa

Gocha waliigaltee

Seensaa fi yaada waliigaltee Hooggantoota Dhaabbilee fayyaaf

(Ogeessa ragaa waltiqabuun kandubbsamu)

Harkafuune, Maqaankoo (maqaa raga sassabaa/duu) _____ jedhama. Ani ragaa walittiqabaa dhaabbata dhuunfaa tajaajila gorsaa fayyaa fi misooma irratti kennuuf Itoophiyaa keessatti hudeefame fi galmaa'e, "Impacts for Development (I4D)" jedhamuun filatamedha/ramadamedha. I4Diin qo'annoo waa'ee ilaalchaa fi yaada ogeesoti fayyaa dhaabilee fayyaa motummaa keessa hojjetan tajaajila ulfa baasuu irratti qaban ilaalchisee dhaabbata "Ipas Ethiopia" jedhamuuf tajaajila gorsaa kennaa jira. Kayyoon qo'annoo kanaa ilaalchi fi yaadni ogeesotni fayyaa waa'ee ulfa baasuu irratti qaban sadarkaa isaa baruu fi sababa tajaajilicha akka hin kennine isaan dhorku addaan bafachuuf. Kanaafuu, qo'annoon kun odeefannoo/ragaa gahaa fi bu'aa qabeessa ta'e irratti hundaa'uun tarsiimoo fi hojiiwwan ilaalcha fi yaada ogeessotni fayyaa ulfa baasuu irratti qaban foyyeesuu fi mormii isaanii salphisuuf kan gargaarudha. Qo'annoo kanarrtti hirmaachuuf yoomurteesitan gaaffiiwwan tajaajila ulfa baasuu gutuu (CAC) waliin walqabtee ilaalchaa fi yaadakeessan agarsiisan isinii dhiyaatu. Deebiiwwan gaaffiilee kanaa xummuruuf tilmamaan saatii tokko fudhata.

Hirmaannaankeessan fedhii irratti kanhundaa'edha; gaaffii deebisuu hinfeene kamiinuu deebisuuf hindrqsiifamtan. Gaaffii kamiinuu deebisuuf fedhii hinqabdan tanaan, yeroo barbaaddanitti addaan kutuu nidandeessu. Qo'annoo kanarrtti hirmaachuu dhiisuunkeessanm hojiikeessan irratti, tajaajila argachuu qabdanrratti, akkasumas quunnamtiikeessan qaamolee tajajila ulfa baasuu guutuu (CAC)kennan waliin qabdan irratti dhiibbaan fidu hinjiru. Qo'annoon kun haala ittiin iciitii eegu niqabaata. Haaluma kanaan, odeefannoon isin kennitan hudi iciitiin isaa kaneegame ta'e. Maqaankeessan gabaasa keessaattis ta'e kan maxxanfamu keessatti hinibsamu.

Qo'annoo karratti hirmaachuukeessaniif beenyaan/kafaitiin argattan hinjiru. Qo'annoon kun jalqabarratti odeefannoo/ragaa bu'aaqabeessa ta'e argamsiisuudha. Bu'aan hatattamaan ykn ammatti iniif argamsiisu hin jiru. Haata'u malee qo'annoo kanarratti hirmaachuukeessan iin tajaajila ulfa baasuu biyya kanaa cimsuu fi foyeesuuf toftaa fi tarsiimoo baasuuf nigargaara.

Qo'annoo kana ilaachisee gaaffii ykn yaaddoo yooqabbaattan namoota armaan gadii quunnamuu nidandeessu:

Daawit Geetaachoo, Qo'ataa Ol'anaa, I4D Plc. email at dawitgt2005@gmail.com + (251) 911563531

Baqaaluu Moosee, email at bekalumossie@gmail.com + (251) 911713902

Adeemsaa fi kayyoo qo'annoo kanaa hunda dubbiseera, haaluma barreefameen naagaleera. Qo'anichis anrratis ta'e maatiikoo irratti balaa kanhinqabne ta'uusaa hubadheera.

Akkan ittifufu naaf eyyamta?

1. Eeyyee ☐
2. Lakki ☐

Gaaffiiwwan Madda Odeesaalee Ijo (KII questions)

1. Tajaajiloota ulfa baasuu guutuu (CAC) dhabbilee fayyaa keessatti kennaman ilaalchisee maali beektu?

   Jalqabsiisuu (Probing):
   - Waa'ee tajaajilichaa haala kamiin baruu/beekuu dandeessan
   - Dhaabbata fayyaa keessan keessatti waa'ee raawwii hojii tajaajila ulfa baasuu guutuu akkamitti ilaaltu?

2. Waa'ee Qajeelfama tajaajila ulfa baasuu Ministeeri Eegumsa Fayyaa foyyeesee baasee "The revised Technical and Procedural Guideline on abortion service developed by FMOH" maali natti himuu dandeessu?

   Probing:
   - Seerota tajaajila ulfa baasuu waliin walqabatan nifudhataa/ittigammadaa?
   - Dhaabbata fayyaa keessan keessatti waa'ee hojiirra oolmaa qajeelfamichaa fi haala qabatamaa tajaajila ulfa baasuu akkamitti ilaalta?
3. Dhaabbilee fayyaa keessatti tajaajila ulfa baasuu kennuu irratti waa'ee iaalcha fi yaada tajaajila kennitootaa hubannoonkee maali?
   Probing:
4. Ilaalchi fi yaadni ogeesoti fayyaa tajaajila ulfa baasuu irratti dhiibbaawwan maal qaba jettee yaadda?
5. Oggeesoti fayyaa tajaajila ulfa baasuu guutuu (CAC service) akka hinkennine sababoon isaanii maalfa'i jettee yaadda?
6. Dhaabbilee fayyaa keessatti tajajila ulfa baasuu idileessuu fi akka addaatti akka hinilaalamne gochuuf gaheen tajaajila kennitootaa maal ta'uu qaba jettee yaadda?
7. Dhaabbilee fayyaa kessatti tajaajila ulfa baasuu kennuu irratti rakkoowwani fi gufuuwwan jiran (contributing factors, challenges or barriers) maalfa'i?
8. Dhaabbilee faayyaa keessatti tajaajilli ulfa baasuu ija addaan akka ilaalamu sababoonni taasisan (contributing factors to abortion provision stigma) maalfa'i?
9. Caasaawwan dhaabbilee fayyaa sadarkaa adda addaa jiran keessatti tajaajila ulfabaasuu kennuuf carraawwani fi haalonni dandeesitoota ta'an (opportunities and enabling conditions) maalfaa jira?
10. Dhaabbilee keessatti tajajilli ulfa baasuu akka argamu fi kennamu gochuuf gahee fi dirqamni tajaajila kenitootaa fi ogeesota sagantalee (program experts) maalfa'I jettee yaadda?
11. Tajaajila ulfa baasuu guutuu dhaabbilee fayyaa keessatti babalisuuf/foyyeesuuf tarsiimoowwan/toftaawwan maalfaa dhiyeesittu?
12. Jijjiirraa hojjettootaa sababa maqaa balleessii kenniinsa ulfa baasuu nageenya qabuun walqabatee dhufu akkamitti madaaltu

Annex 4: Data collection guide for FGD with RHB, ZHD and Woreda HO coordinators

Consent Form - Focus Group Discussion
ID No._____
Introduction and Consent Script/Form for FGD
(To be read by the FGD participants ONLY AFTER participant has agreed to speak to FGD facilitator)
Who we are and what we are doing: (I4D) which is a private consultancy firm registered in Ethiopia to provide health and development consultancy services. I4D is providing consultancy services for Ipas Ethiopia in conducting an Assessment on Attitudes and perceptions of healthcare providers towards providing Abortion service in public health facilities.

The purpose of the assessment is to explore the level of providers' perceptions and attitudes towards abortion and identify the causes of resistance to providing abortion services. The study will therefore provide invaluable information for designing suitable strategies and interventions related to safe abortion services.

Your participation: If you decide to participate in the study, you will be asked to participate in one to two-hour focus group discussion. The discussions will take place with 6 to 8 professionals from RHB, ZHD and Woreda Health offices. During the discussion, you will provide only your first name. You can choose not to answer any of the questions, and you may leave the focus group at any time. We will take notes during the focus group discussion. Only members of the research team will take the notes. Your name will be replaced with a pseudonym in the note. We will store the notes on a secure place, after which time we will destroy them. You can decide at any time to withdraw from the FGD if you feel unsafe and or don't want to be enrolled in the FGD for any reasons that may also relate to fear of COVID19 transmission.

Risks: Your participation is voluntary and involves no significant risks to you. Whether or not you participate, it will have no effect on your relationship with any organizations. Your decision on whether or not to participate will not affect your current job, any services you get and your relationship with any of the stakeholders working in the provision of Comprehensive Abortion Care (CAC) services. With any study involving FGD, there is always a risk of a breach of confidentiality, meaning that other participants in the group may reveal what was discussed in the focus group, or people outside the research team will see the information you provide. However, the study has procedures to protect your confidentiality as detailed bellow under Confidentiality section. The research team will ensure that study participants use the proper Personal Protecting Equipment (PPEs) and make sure all safety measures are put in place to prevent transmission of COVID 19.

Confidentiality: The information you provide in the focus group discussion will be kept confidential. Your name will not appear in any internal or published reports from the study. However, we would like to be able to quote you using a pseudonym.

Benefits: There is no compensation for participating in this focus group. This study is primarily intended to generate information, and thus offers no immediate benefit to you, but by participating in the study you may help to strengthen and improve the provision of Comprehensive Abortion Care services in the country.

Who to contact if you have any concerns: If you have any questions or concerns about this study, you may contact:

Dawit Getachew, Principal Investigator, I4D Plc. by email at dawitgt2005@gmail.com + (251) 911563531

Bekalu Mossie, by email at bekalumossie@gmail.com + (251) 911713902

I have read all the process and the objective of the study and I have understood the same as written. I understood that the research imposes no risk would be provided to me and families.

Could I have your permission to continue?

1. Yes ☐
2. No ☐

FGD Interview guides

1. Tell me about your observations and experience on the safe abortion service provision in health facilities?

2. Do you know about the revised national procedural and technical guideline on abortion service developed by MOH and the contents in?

3. What is your insight regarding provider's perception and attitudes to providing abortion services in health facilities?

4. What do you think are the effects of provider's perceptions and attitudes on abortion service provision in health facilities?

5. In your opinion, what are the reasons for provider's resistance in provision of safe abortion service in health facilities?

6. What roles should health providers play in normalizing and destigmatizing the safe abortion care services in health facilities

7. What are the contributing factors, challenges or barriers on provision of safe abortion services in health facilities?

8. What are the contributing factors to abortion provision stigma in health facilities?

9. What are the opportunities and enabling conditions at each level of the health system for the provision of abortion services in health facilities?

10. What do you think are the key roles and responsibilities of providers and program experts in availing and providing safe abortion service in health facilities?

11. What do you recommend and suggest strategies to enhance the provision of safe abortion service in health facilities?

አባሪ 4: ከክልል፣ ከዞንና ከወረዳ ባለሙያዎችጋር በሚደረግ የቡድን ወይይት የመረጃ አሰባሰብ መመሪያ

የስምምነት ቅጽ- የቡድን ውይይት

የመለያ ቁ._____

መግቢያና የስምምነት ጽሑፍ/የቡድን ወይይት

(ተሳታፊዎች በቡድን ውይይቱ ላይ ለመሳተፍ **መስማማታቸውን** ለወይይቱ አሰተባባሪ **ካረጋገጡ በኃላ** በተሳታፊዎች የሚነበብ)

እኛ ማን ነን፣ ምን እየሠራን ነው: ስማችን "ኢምፓክትስ ፎር ደቨሎፕመንት" (I4D) ይባላል:: አይፎርዲ (I4D) በኢትዮጵያ የተs sመና በጤናና በልማት ጉዳዮች ላይ የማማከር አገልግሎት የሚሠጥ የግል ድርጅት ነው:: በአሁኑ ጊዜም አይ,ፓስ ኢትዮጵያ ለተባለ ድርጅት የጤና ባለሙያዎች በጽንስ Ts[Ø አገልግሎት ላይ ባላቸው አመለካከትና እይታ ላይ ለሚያካሄደው ጥናት የማማከር አገልግሎት በመስጠት ላይ ይገኛል:: የጥናቱ ዓላማም አገልግሎት ሰጪ የሆኑ የጤና ባለሙያዎች በፅንስ ማቋረጥ ላይ ያላቸውን የአመለካከትና እይታ ደረጃ በማወቅ አገለግሎቱን እንዳይሰጡ የሚከለክሉ ምክንያቶችን ለመለየት ነው:: በመሆኑም ጥናቱ አመቺ እስትራቴጂዎችንና የመፍትሔ አቅጣጫዎችን ለመቅረጽ የሚረዱ ጠቃሚ መረጃዎችን በማሰገኘት አገልግሎት ሰጪ የጤና ባለሙያዎች በፅንስ Ts[Ø አገልግሎት አሰጣጥ ላይ ያላቸውን አሉታዊ አመለካከትና እይታ ለማሻሻልና እንቅፋትነታቸውን ለመቀነስ ያስችላል ተብሎ የታሰበ ነው::

ስለተሳትፎ: በጥናቱ ላይ ለመሳተፍ ከወሰኑ ከ1-2 ሰዓት በሚፈጅ የቡድን ወይይት ላይ እንዲሳተፉ ይጠየቃሉ፤ የቡድን ወይይቱ ከ6 – 8 በሚሆኑና ከክልል ጤና ቢሮ፣ ከዞን ጤና መምሪያና ከወረዳ ጤና ጽ/ቤት በተውጠቱ ባለሙያዎች የሚካሄድ ነው:: በውይይቱ ላይ የመጀመሪያ ስምዎን ብቻ ነው የሚገልጹት:: የተወሰኑ ጥያቄዎችን ላለመመለስ ሊመርጡ ይችላሉ፤ የቡድን ወይይቱንም በማንኛውም ጊዜ ማቃረጥ ይላሉ:: በወይይቱ ላይ እኛ ማስታወሻ እንይዛለን:: ማስታወሻ ለመያዝ የሚችሉት የጥናት ቡድኑ አባላት ብቻ ናቸው:: በማስታወሻችን ላይ ስምዎ በብዕር ስም ይተካል:: መረጃዎች በሙሉ ምስጢራዊነታቸው በተጠበቁ ቦታዎች ይቀመጣሉ፤ ሥራ ላይ ከዋሉ በኃላ ደግሞ ይወገዳሉ:: ደህንነት ካልተሰማዎት በማንኛውም ጊዜ የቡድን ውይይቱን ለማቃረጥ መወሰንና በማንኛውም ምክንያት ለምሳሌ ኮሮናን (COVID19) በመፍራት ማቃረጥ

የአደጋ ስጋት: ተሳትፎዎ በፈቃደኝነት ላይ የተመሰረተ ነው፤ የሚያስከትልቦት አደጋ አይኖርም:: ቢሳተፉም ባይሳተፉም ከየትኛውም ድርጅት ጋር ባሎት ግንኙነት ላይ ምንም ተፅኖ አይኖረውም:: ለመሳተፍም ሆነ ላለመሰተፍ የሚወስኑት ውሳኔ አሁን በሚሠሩት ሥራ፣ በሚያገኙት አገልግሎት፣ ከእርሰዎ ጋር ግንኙነት ካላቸውና የፅንስ ማቃረጥ አገልግሎት በሚሠጡ አካላት ላይ ምንም ተፅዕኖ አያሳድርም::

የቡድን ውይይትን ባካተተ ማንኛውም ጥናት ላይ የምስጢር መሹለኪያ ቀዳዳ ሊያጋጥም ይችላል፤ የቡድን ውይይቱ ተሳታፊዎች በውይይቱ ጊዜ በምን ላይ እንደተወየዩ ለሌላ ሰው ሊገልጹ ይችላሉ:: ወይም ከጥናት ቡድኑ አባላት ውጪ የሆኑ ሰዎች እናንተ የሠጣችሁትን መረጃ ሊያዩ ይችላሉ::. ይሁን እንጂ ጥናቱ ምስጢርዎን የሚጠብቅባቸው ዘዴዎች አሉት:: የሚሠጡት መረጃ ሁሉ ምስጢራዊነቸው የተጠበቀ ነው ይህም ምስጢር ምጠበቅ በሚለው ከፍል ሥር በዝርዝር ተመልከታል ::የቡድን ውይይቱ ተሳታፊዎች እራሳቸውን የሚጠብቁበት ግላዊ የራስ መጠበቂያ ቁሳቁስ እንደሚኖራችሁ የጥናት ቡድኑ ያረጋግጡላችኃል:: ኮሮናን ለመከላከል ሁሉም ዝግጅቶች ተደርገዋል::

ምስጢር መጠበቅ: በቡድን ውይይቱ ላይ የምትሠጡት መረጃ በሙሉ በምስጢር ይያዛሉ:: ስምዎ በውስጣዊውም በሚታተሙ ሪፖርቶች ላይ አይጠቀስም:: ይሁን እንጂ የብዕር ስም ተጠቅመን ልንጠቅስዎት እንችላለን::

ከጥናቱ ስለሚገኝ ጥቅም: በዚህ ጥናት ላይ በመሳተፍዎ የሚያገኙት ክፍያ የለም:: ይህ ጥናት ከመነሻውም የታቀደው ጠቃሚ መረጃዎችን እንዲያስገኝ በመሆኑ አሁኑኑ የሚያስተርፉት ጥቅም የለም:: ይሁን እንጂ በዚህ ጥናት ላይ መሳተፍዎ በአገሪቱ የተማላ የፅንስ አገልግሎት አሠጣጥን ለማሻሻልና ለማጠናከር ሊያግዝ ይችላል::

ከዚህ ጥናት ጋር በተያያዘ ጥያቄና የሚያሳስቦት ጉዳይ ካለ ስማቸው ከዚህ በታች የተመለከተውን ማናገር ይችላሉ::

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የጥናቱን ዓላማና ሂደት ሁሉ በተጻፈው መሠረት አንብቤ ተረድቻለሁ፤ ጥናቱ በኔም፣ በቤተሰቦቼም ላይ ምንም አደጋ እንደማያስከትል ተረድቻለሁ::

እንድቀጥል መልካም ፈቃድዎ ነው?

1. አዎ ☐

2. አይደለም

የቡድን ቃለምልልስ *መመሪያ*

1. በጤና ተsማት የተማላ የፅንስ Ts[Ø አገልግሎት አሠጣጥ ላይ ያላቹትን አጠቃላይ ምለከታና ልምድ ይነግሩኛል?

2. ደህንነቱ የተጠበቀ የፅንስ Ts[Ø አገልግሎት ለመስጠት የጤና ጥበቃ ሚኒስቴር ስላዘጋጀውና ስለተሻሻለው የአፈፃፀም *መመሪያ* (Technical and Procedural Guideline) እና ስለይዘቱ ታውቃላችውን?

3. አገልግሎት ሰጪ የጤና ባለሙያዎች በሚሠጡት የፅንስ Ts[Ø አገልግሎት ላይ ስላላቸው እይታና አመለካከት የእናንተ ግንዛቤ ምንድነው?
4. አገልግሎት ሰጪ የጤና ባለሙያዎች በፅንስ Ts[Ø አገልግሎት ላይ ያላቸው እይታና አመለካከት በአልግሎት አሠጣጡ ላይ የሚኖረው ተፅዕኖ ምን ይመስላችኃል?
5. በእናንተ አስተያየት አገልግሎት ሰጪ የጤና ባለሙያዎች የፅንስ Ts[Ø አገልግሎት ለመስጠት የማይፈልጉበት (እንቅፋት የሚሆኑበት) ምክንያት ምን ይመስላችኃል?
6. የፅንስ Ts[Ø አገልግሎት በጤና ተsማት ውስጥ መደበኛ ሆኖ እንዲሠጥና ከሌላ አገልግሎት ተለይቶ እንዳይታይ አገልግሎት ሰጪ የጤና ባለሙያዎች ምን ሚና መጫወት አለባቸው?
7. የፅንስ Ts[Ø አገልግሎት በጤና ተsማት ውስጥ እንዳይሠጥ የሚያደርጉ ችግሮች፣ እንቅፋቶችና አባባሽ ምክንያቶች ምንድን ናቸው?

8. የፅንስ ማቃረጥ አገልግሎት በጤና ተቃማት ውስጥ ተለይቶ እንዲታይ (እንዲገለል) የሚያደርጉ አባባሽ ምክንያቶች ምንድን ናቸው?
9. የፅንስ Ts[Ø አገልግሎት በጤና ተቃማት ውስጥ እንዲሠጥ በየደረጃው ባሉ የጤና መዋቅሮች ያሉ ዕድሎችና አስቻይ ሁኔታዎች ምንድን ናቸው?
10. የፅንስ Ts[Ø አገልግሎት በጤና ተቃማት ውስጥ እንዲገኝና እንዲሠጥ አገልግሎት ሰጪ የጤና ባለሙያዎችና የፕሮግራም ኤክስፐርቶች ቁልፍ ሚና ኃላፊነት ምን ይመስልዎታል?
11. በጤና ተsማት ውስጥ የተማላ የፅንስ Ts[Ø አገልግሎት አሠጣጥን ለማሻሻል ምን ምን እስትራቴጂዎችና ሐሳቦችን ታቀርባላችሁ?

Miiltoo/Hordoftuu 4: Qajeelfama Walittiqabiinsa Odeefannoo Marii Gareetiin

Gucha waliigaltee

Lakk. ID._____

Seensaa fi yaada waliigaltee marii gareetiif

(Hirmaatota Marii Gareetiin kandubbifamu, ERGA hirmaatonni waliigaltee isaanii mijeessaa marii gareetiif mirkaneesanii BOODA)

Nuti Eenyu, maal hojechaa jirra: Dhaabanni keenya "Impacts for Development (I4D)" jedhama; dhaabbata dhuunfaa tajaajila gorsaa fayyaa fi misooma irratti kennuuf Itoophiyaa keessatti hudeefame fi galmaa'edha. I4Diin qo'annoo waa'ee ilaalchaa fi yaada ogeesoti fayyaa dhaabilee fayyaa motummaa keessa hojjetan tajaajila ulfa baasuu irratti qaban irratti dhaabbata "Ipas Ethiopia" jedhamuuf tajaajila gorsaa kennaa jira. Kayyoon qo'annoo kanaa ilaalchi fi yaadni ogeesotni fayyaa waa'ee ulfa baasuu irratti qaban sadarkaa isaa baruu fi sababa tajaajilicha akka hin kennine isaan dhoowu addan bafachuuf. Kanaafuu, qo'annoon kun odeefannoo/ragaa gahaa fi bu'aa qabeessa ta'e irratti hundaa'uun tarsiimoo fi hojiiwwan ilaalcha fi yaada ogeessotni fayyaa ulfa baasuu irratti qaban foyyeesuu fi mormii isaanii salphisuuf kan gargaarudha.

Waa'ee hirmannaa: Qo'annoo kanarrtti hirmaachuuf yoomurteesitan, marii garee saatii 1-2 hirmaatu. Mariin kun ogeessota 6-8 ta'anii fi Biroo Fayaa Naannoo, Qajeelcha Fayyaa Godina fi Wajjira Fayyaa Aanaa irraa walitti dhafaniin adeemsifama. Yeroo mariin kun adeemsifamu maqaa keessan isa jalqabaa qofa himtu. Gaaffii kamiinu deebisuu dhiisuuf mirga qabdu. Marichas yeroo kamiinuu addaan kutuu nidandeesu. Marii kana irratti nuti yaadannoo niqabanna. Miseensota garee qo'annoo kanaa qofatu yadannoo qabata. Maqaan keessan maqaa biraatiin (penname) bakka bu'a. Odeefannoo argamu bakka iciitiinsaa eegametti kuusama, erga ittifayyadamnee boodamoo nihaqama. Nageenyi isinitti hindhagahamu tanaan garuu yeroo kamiyyuu marii garee kana addaan kutuu nidandeessu, fakkeenyaf yoo koronaa (COVID19) sodattan.

Balaa (Risks): Hirmaannaankeessan fedhii irratti kanhundaa'edha; balaa isinitti fidu hinqabu. Marii kanarratti hirmaachuun ykn hirmaachuu dhisuun hojiikeessan irratti, tajaajila argachuu qabdan irratti, akkasumas quunnamtii qaamolee tajajila ulfa baasuu guutuu (CAC) kennean waliin qabdan irratti dhiibbaan isinitti fidu hinjiru .Qo'annoowwan marii garee hirmachisan hunda irratti, balaan iciitii miliqee bahuu ni qunnama; hirmaatonni tokko tokko maltu akka mari'atame baasuu ykn nomootni garee qonnoo kanaan ala ta'an odeefannoo isin keennitan arguu nidanda'u ta'a. Haata'u malee qo'annoon kun haala ittiin iciitii eeggatu niqabaata. Kunis kutaa Iciitii (confidentiality) jalatti ibsameera. Hirmatonni qo'annoo kanaa hundi Meshaalee Dhuunfaa Ofeeggannoo (Personal Protecting Equipment -PPEs) akka fayyadaman gareen qo'annoo kanaa kan isiniif mirkaneesu yota'u Koronaa (COVID 19) irraa ofittisuufis qphiin barbaachisaa ta'e godhamuusaa nibeeksifna. .

: Qo’annoo kanarrtti hirmaachuuf yoomurteesitan, gaaffiiwwan tajaajila ulfa baasuu gutuu (CAC) waliin walqabtee ilaalchaa fi yaada keessa agarsiisan isiniif dhiyaatu. Deebiiwwan gaaffiilee kanaa xummuruuf tilmamaan saatii tokko fudhata.

Iciitii eeguu (Confidentiality): Qo’annoon kun haala ittiin iciitii eegu niqabaata. Haaluma kanaan, odeefannoon isin marii garee kana irratti kennitan hudi iciitiin isaa kaneegame ta’e. Maqaankeessan gabaasa keessaas ta’e kan maxxanfamu keessatti hinibsamu. Hata’u malee maqaa biraatti (pseudonym) or [penname] itti fayyadamuun yaadni keessan ni ibsama.

Fayyidaa (benefits): Marii Garee kanarratti hirmaachuukeessaniif beenyaan argattan hinjiru. Qo’annoon kun jalqabarratti odeefannoo/ragaa bu’aaqabeessa ta’e argamsiisuudha. Bu’aan hatattamaan siif argamsiisu hin jiru. Haata’u malee qo’annoo kanarratti hirmaachuukeetiin tajaajila ulfa baasuu biyya kanaa cimsuu fi foyeesuuf nigargaara..

Qo’annoo kana ilaachisee gaaffii ykn yaaddoo yooqabbaattan namoota armaan gadii quunnamuu nidandeessu:
Dawit Getachew, Principal Investigator, I4D Plc. by email at dawitgt2005@gmail.com + (251) 911563531
Bekalu Mossie, by email at bekalumossie@gmail.com + (251) 911713902
Adeemsaa fi kayyoo qo’annoo kanaa hunda dubbiseera, haaluma barreefameen naagaleera. Qo’anichis anrratis ta’e maatiikoo irratti balaa kanhinqabne ta’uusaa hubadheera.
Akkan ittifufu naaf eyyamta?

1. Eeyyee ☐
2. Lakki ☐

Qajeelfama Marii Garee (FGD Interview guides)

1. Dhaabbilee fayyaa keessatti tajaajila ulfa baasuu guutuu (CAC) ilaalchisee hubannoo fi muuxannoon qabdan maali? Meenaaf ibsaa.
2. Waa'ee Qajeelfama tajaajila ulfa baasuu Ministeeri Eegumsa Fayyaa foyyeesee baasee fi qabiyeesaa "The revised Technical and Procedural Guideline on abortion service developed by FMOH" beektuu?
3. Dhaabbilee fayyaa keessatti tajaajila ulfa baasuu kennuu irratti waa'ee iaalcha fi yaada tajaajila kennitootaa hubannoonkeessan maali?
4. Ilaalchi fi yaadni ogeesoti fayyaa tajaajila ulfa baasuu irratti dhiibbaawwan maal qaba jettanii yaaddu?
5. Oggeesoti fayyaa tajaajila ulfa baasuu guutuu (CAC service) akka hinkennine sababoon isaanii maalfa'i jettanii yaaddu?
6. Dhaabbilee fayyaa keessatti tajajila ulfa baasuu idileessuu fi akka addaatti akka hinilaalamne gochuuf gaheen tajaajila kennitootaa maal ta'uu qaba jettanii yaaddu?
7. Dhaabbilee fayyaa kessatti tajaajila ulfa baasuu kennuu irratti rakkoowwani fi gufuuwwan jiran (contributing factors, challenges or barriers) maalfa'i?
8. Dhaabbilee faayyaa keessatti tajaajilli ulfa baasuu ija addaan akka ilaalamu sababoonni taasisan (contributing factors to abortion provision stigma) maalfa'i?
9. Caasaawwan dhaabbilee fayyaa sadarkaa adda addaa jiran keessatti tajaajila ulfabaasuu kennuuf carraawwani fi haalonni dandeesitoota ta'an (opportunities and enabling conditions) maalfaa jira?
10. Dhaabbilee keessatti tajajilli ulfa baasuu akka argamu fi kennamu gochuuf gahee fi dirqamni tajaajila kenitootaa fi ogeesota sagantalee (program experts) maalfa'I jettee yaadda?
11. Tajaajila ulfa baasuu guutuu dhaabbilee fayyaa keessatti babalisuuf/foyyeesuuf tarsiimoowwan/toftaawwan maalfaa dhiyeesittu?