KNOWLEDGE, ATTITTUDE AND PRACTICE ABOUT SAFE ABORTION AMONG BOLOSO BOMBE SECONDARY HIGH SCHOOL GIRLS, WOLAITA ETHIOPIA

By:-Abrham Moga

A research Submitted to Jimma University, College of Public Health and Medical Science, Department of Epidemiology and Biostatistics, for the Partial fulfillment of the Degree of Masters in Epidemiology

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JIMMA, ETHIOPIA

JIMMA UNIVERSITY, COLLEGE OF PUBLIC HEALTH AND MEDICAL SCIENCES, DEPARTMENT OF EPIDEMIOLOGY AND BIOSTATISTICS

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ADVISORS:

Abebe Gebremariam (MPH, Prof)

Abdulhalik workichu (MPH, Epid)

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Acronyms

EC	Emergency contraceptive
FGDs	Focus group discussions
FMOH	Federal ministry of Health
HC	Health center
HIV/AIDS	Human immune virus/Acquired immune deficiency virus
IPAS	International project assistance service
JU	Jimma University
KAP	Knowledge, Attitude and Practice
LNMP	Last normal menstrual period
MCH	Maternal and child health
MVA	Manual vacuum aspiration
OR	Odds ratio
PAC	Post abortion care
STDs	Sexually Transmitted Diseases
USD	United states of American dollar
WHO	World health organization

Abstract

Background: Adolescence is a powerfully formative time of transition to adulthood, roughly concurrent with the second decade of life. Globally, As many as 2.5 million adolescent women seek abortion each year, and nearly 70,000 women die from complications related to unsafe abortion, of which almost half are women under the age of 25. Five million out of an estimated total of 50 million induced abortions worldwide occur in women aged 15-19 years.

The aim of this study was to assess the knowledge, attitude, practice and associated factors of adolescent girls about safe abortion in Boloso Bombe high school in October 2013GC

Materials and Methods: School based cross- sectional study design was used and the study was done from September 28 to October 29, 2013. A systematic random sampling technique was used to collect data by a pre tested self administered questionnaire from 278 adolescent girls. The data was analyzed by using SPSS version 20.0, bivariate logistic regressions was done to identify candidate covariates for multivariable logistic regression. Back ward variable elimination method use for identification of the candidate covariates for the final model.

Result: -Out of the sampled 278 adolescent girls, 261 responded to the questionnaire yielding a response rate of 93.9%. One hundred sixteen (44.4%) were knowledgeable about safe abortion while 145 (55.6%) were not knowledgeable about safe abortion. Those adolescent girls who had history of pregnancy were 1.37 times more likely knowledgeable about safe abortion than those who did not have pregnancy history: [AOR (95 %CI) = 1.37 [1.14, 2.81] and those girls who have boy friends were 1.61 times more knowledgeable about safe abortion than those who did not have: [AOR (95 %CI) 1.61(1.02, 2.36]. Out of the total 247adolescents who had heard about abortion, (53%) had favorable and 47% had unfavorable attitude towards safe abortion. Educational back ground of fathers'(Grade 9-12), educational back ground of respondents and previous history of experiencing abortion showed statistically significant association with attitude of adolescents towards safe abortion; [AOR (95 % CI=3.01(1.33,8.95)], [AOR (95 %CI) = 0.42 (0.25,0.75)] and [AOR (95 % CI) = 1.90 (1.42,2.38)]respectively. Total of 49(18.8%) of the adolescents had become pregnant, 34 (13.0%) had faced termination of pregnancy and out of those 34, 21 of them had practiced safe abortion.

Conclusion and recommendation

The knowledge of adolescent girls about safe abortion is insufficient. Sexual and reproductive health education through health extension programs and other school based behavioral change communication channels in the form of mini- media outlets; school health clubs for peer discussion should be secured in school.

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INTRODUCTION

1.1 Back ground

Abortion is termination of pregnancy before fetal viability, which is conventionally taken to be less than 28 weeks from the last normal menstrual period (LNMP). If the LNMP is not known, a birth weight of less than 1000gm is considered as abortion and there are two types of abortions; safe and unsafe the WHO defines an unsafe abortion as "a procedure for terminating an unwanted pregnancy by persons lacking the necessary skills or in an environment lacking the minimal medical standards, or both." When abortion is performed by qualified people using correct techniques in sanitary conditions, it is very safe (1-2).

Abortion is a sensitive and contentious issue with religious, moral, cultural, and political dimensions. Abortion is also a public health concern in many parts of the world. More than one-quarter of the world's people live in countries where the procedure is prohibited or permitted only to save the woman's life. Yet, regardless of legal status, abortions still occur, and nearly half of them are performed by an unskilled practitioner or in less sanitary conditions, or both(2).

Levels of unintended pregnancy vary across societies and over time; however, because no reversible method of birth control is perfect and few human beings use methods perfectly, women will always experience unintended pregnancies. Thus, there will always be a need for abortion, and for safe abortion services. Of an estimated 44 million abortions that take place globally each year, a rising proportion—now about half—are medically unsafe. Virtually all unsafe abortions occur in developing countries, taking a devastating toll on women's health and lives (3).

Over the past two decades, the health evidence, technologies and human rights rationale for providing safe, comprehensive abortion care have evolved greatly. Despite these advances, an estimated 22 million abortions continue to be performed unsafely each year, resulting in the death of an estimated 47 000 women and disabilities for an additional 5 million women (4).

In Arica, out of the 6.4 million abortions carried out in 2008, only 3% were performed under safe conditions and the World Health Organization (WHO) estimates that every year, nearly 5.5 million African women have an unsafe abortion. As many as 36,000 of these women die from the procedure, while millions more experience short- or long-term illness and disability (5, 6).

In Ethiopia, one in seven women dies from pregnancy-related causes and unsafe abortion is a major contributor to the maternal deaths that occur annually. As some literatures indicate throughout Africa, safe abortion services were legally restricted and unavailable. Being aware of

the growing death toll from unsafe abortion and other related causes, advocates, providers and policymakers sought legal reform in Ethiopia and passed the abortion guide and procedure in 2005. The guide and procedure allows safely induced abortion to save the life of the woman, under conditions as rape, incest, and fetal abnormality, physical or mental disabilities and for minors who are unable to raise a child. Following that in 2006, the Ethiopian Ministry of Health issued technical guidelines for safe abortion services (7).

An estimated 215 million women in the developing world have an unmet need for modern contraceptives, meaning they want to avoid pregnancy but are using a low-efficacy traditional family planning method or no method. Some 82% of unintended pregnancies in developing countries occur among women who have an unmet need for modern contraception so that reducing unmet need for modern contraception is an effective way to prevent unintended pregnancies, abortions and unplanned births. Unsafe abortions have significant negative consequences beyond its immediate effects on women's health. For example, complications from unsafe abortion may reduce women's productivity, increasing the economic burden on poor families; cause maternal deaths that leave children motherless; cause long-term health problems, such as infertility; and result in considerable costs to already struggling public health systems.(8)

Safe abortion has the potential to prevent nearly all deaths (70,000) and disabilities (5 million) resulting from unsafe abortion annually. Economically it saves an estimated US$680 million in health-system costs for treating serious complications due to unsafe abortion, US$6 billion to treat post abortion infertility from unsafe abortion and US$930 million to society and individuals in lost income due to death or disability resulting from unsafe abortion. It further allows women and families to address consequences of contraceptive method failure (9).

2 LITERATURE REVIEW

2.1 Magnitude of the problem

The World Health Organization defines unsafe abortion as a procedure for terminating a pregnancy that is performed by an individual lacking the necessary skills, or in an environment that does not conform to minimal medical standards, or both (1).As many as 2.5 million adolescent women seek abortion each year, and nearly 70,000 women die from complications related to unsafe abortion, of which almost half are women under the age of 25(10).

Nearly half of all abortions worldwide are unsafe, and nearly all unsafe abortions (98%) occur in developing countries. In the developing world, 56% of all abortions are unsafe, compared with just 6% in the developed world. The overall abortion rate in Africa, where the vast majority of abortions are illegal and unsafe, showed the Southern Africa sub region, dominated by South Africa, where abortion was legalized in 1997, has the lowest abortion rate of all African sub regions, at 15 per 1,000 women in 2008. East Africa has the highest rate, at 38, followed by Middle Africa at 36, West Africa at 28 and North Africa at 18 no decline between 2003 and 2008, holding at 29 abortions per 1,000 women of childbearing age. More than 50% of the world population is less than 25 years old, with one in three people aged 10-24 years. Five million out of an estimated total of 50 million induced abortions worldwide occur in women aged 15-19 years. In most developing countries, abortion is legally restricted or highly inaccessible, which leads young women to seek abortion services from unskilled practitioners often leading to incomplete, septic abortions and massive bleeding, which can result in permanent injury, infertility, and death(1, 2&10) .When women want to limit or postpone childbearing, but contraception is not used or used ineffectively or they are forced into nonconsensual sex, unintended pregnancies occur: some are terminated by induced abortions while others result in unwanted births. Where abortion laws are restricted or safe abortion services are not widely accessible or are of poor quality, women resort to unskilled providers, risking serious consequences to their health and well-being(3).

A study conducted by Mulugeta K, (2003). To assess what unmarried young girls do when they get pregnant. Shown 104 (52%) of the respondents said they abort the fetus, without stating the method of abortion. Twenty eight (14%) said using traditional methods and 5 (2.5%) said they abort in hospitals. Others said they commit suicide 42 (21%), deliver the child 17 (8.5%), abandon the child and run away, while four (2%) did not have any response (11).

According to KAP study conducted by Lussy J. Paluku and his colleagues on illegal abortion among secondary school girls in a Goma district, Democratic republic of Congo, the different sources of information for abortion were the radio (66.2%, 217), friends (31.7%, 104), parents (1.5%, 5), and the church (0.5%, 2). The health consequences of illegal abortion mentioned were death, infertility, infection and bleeding. Of the participants, 9.8% (32) had experienced an abortion before and 46% (151) knew where to obtain abortion services; 76.2% (250) of participants were against illegal abortion, while 23.8% (78) supported (12). Another study conducted by Nasir T. on 2010, on the assessment of attitude of the adolescents in Jimma town towards the (emergency contraceptive) EC utilization showed that more than 2-thirds of students who knew about EC believed that they would use EC after unprotected sexual intercourse and 63% of them agreed to advice friends or relatives to take emergency contraceptives after unprotected sexual intercourse (13).A study conducted by J. Paluku and his colleagues on Knowledge and attitudes about induced abortions among female youths attending Naguru Teenage Information and Health Centre, Kampala, Uganda, 2013. Show that one hundred seventeen (36%) of the youths had been pregnant before and 66(56.4%) participants had lost or terminated a pregnancy in the past, 49 (74.2%) had undergone abortion (14).A study done by Shimelash B. Knowledge about the legalization of abortion accounting for 48.21% and more than half of the respondents has no knowledge about the legalization of abortion which accounts for 51.79%(15). According to a study done in Kenya by Ayo A. and his colleagues, 1991 on Knowledge, Perceptions, and Practices of adolescent sexuality, same-sex relatives and friends play more important roles in providing access to reproductive health information (16).A study conducted by Yu Fengxue, and his colleagues, on Attitudes toward adolescent pregnancy, induced abortion and supporting health services among high school students in Phuttamonthon district, Nakhon Pathom province, Thailand. March 2013. Shown the level of education significantly associated with attitude toward induced abortion and supporting health services, higher Grade had more positive attitude toward induced abortion and supporting health services than the lower Grade (17).

Since knowledge and utilization of modern contraceptive is one of the major determinants to avoid or reduce unwanted or unintended pregnancies, a study conducted by Dorah U. and his colleagues on this issue in South Africa, 2012. Revealed out of 273 adolescents included in the study, 206(75%) indicated that they had knowledge about the different contraceptive methods (18).

Prevailing beliefs & attitudes, values & norms hinder access of abortion care to adolescents so those Social barriers need to be addressed by providing community leaders & members with accurate & update information, & stimulating discussion on: - the benefits of providing adolescents with safe abortion care as part of an overall package of sexual and reproductive health services and still unsafe abortion is seen as an optional method of terminating pregnancy among many adolescent girls of under developed countries, as revealed by different studies conducted on abortion.

2.2 Legalization of Abortion

International and national law in most countries protects freedom of thought, conscience and religion and allows health-care providers to refuse to provide abortion services; this must be balanced with governments' obligation to ensure that women have access to providers who are willing to offer safe abortion care. To achieve the balance in between the unmet need of safe abortion care and the existing health service related limitations, in countries where abortion is permitted on broad legal grounds, it is generally safe. Around the world, where abortion is highly restricted, it is not necessarily less common than elsewhere, but is almost always less safe and this is reflected in country levels of pregnancy- related death and disability (19). A literature regarding facts on induced abortion worldwide incidences and trends showed that, both the lowest and highest sub regional abortion rates are in Europe, where abortion is generally legal under broad grounds. In Western Europe, the rate is 12 per 1,000 women, while in Eastern Europe it is 43, the rate is 29 per 1,000 women of childbearing age in Africa and 32 per 1,000 in Latin America regions in which abortion is illegal under most circumstances. East Africa has the highest rate, at 38, followed by Middle Africa at 36, West Africa at 28 and North Africa at 18 per 1,000 women of childbearing age. In South Africa, the abortion rate is15 per 1,000 women of childbearing age and it is generally permitted on broad grounds. In South Africa, the annual number of abortion-related deaths fell by 91 % after the liberalization of the abortion law in 1997 (8 &19).

On May 9, 2005, the Ethiopian parliament revised the country's antiquated penal code, paving the way for major reform of the law related to abortion. According to the new law a woman can legally terminate a pregnancy under the following circumstances: When, pregnancy results from rape or incest, when the health or life of the woman and the fetus are in danger, in cases of fetal abnormalities and for women with physical or mental disabilities and for minors who are physically or psychologically unprepared to raise a child. The revised law also notes that poverty

may be grounds for reducing the criminal penalty for abortion. Although abortion is legal under certain circumstances, it may be still punishable by up to three years in prison (20).

Abortion service seeker women's characteristics are associated with their reasons for having an abortion: With few exceptions, older women and married women are the most likely to identify limiting childbearing as their main reason for abortion (16).

To ensure that women are able to access safe legal services, protective provisions must be put in place by lawmakers, health ministries or health-care professional associations. Providers opposed to abortion who refuse service without oversight from a health system may completely deny women legal abortion. In addition to adopting the standards below, health ministry's should monitor the practice of conscientious refusal to ensure that women have access to safe abortion services regardless of where they live and that facilities are adequately staffed by providers willing to provide service(22).

When the health professionals conscientiously object to provide the abortion care:-

Below are five standards which should be included in the legal or regulatory framework for the Provision of abortion services. As stated by Patty Skuster, Senior Policy Advisor, Ipas.

- If a health professional refuses to provide legal abortion services, that provider then must refer the pregnant woman to a practitioner who is willing to perform the abortion.
- Health-care providers must provide women seeking to terminate a pregnancy with information on legal abortion services.
- Only health professionals directly involved in the provision of abortion are able to object to providing the procedure.
- Health-care providers, regardless of their religious or moral objections, have a duty to perform an abortion if the woman will suffer adverse health consequences if the abortion is not promptly carried out.
- Only individuals—and not institutions—have a right to object to providing abortion service

A study conducted by Neesha Goodman, and his colleagues, about awareness of safe abortion care in Ethiopia. "Awareness is knowledge gained through means of information. Importantly, Ethiopia's educational and community-based initiatives lack a curriculum geared towards educating Ethiopians about reproductive health issues, particularly in rural areas. Until recently, there has been low importance placed on increasing awareness through educational initiatives. In view of the gravity of the current reproductive health problems, and as the Ministry of Education ;(MOE); is the sole responsible body for reproductive health educational initiatives in schools" in Ethiopia to address it to adolescents (23).

2.3 Abortion and maternal health problems

Globally 13% or 1 in 8 maternal deaths were due to unsafe abortion, Worldwide there were 30 unsafe abortion deaths per 100 000 live births, 62% of all deaths (29 000) due to unsafe abortion occurred in the Africa Region .Around the world, Out of 22 million unsafe abortions taking place annually, the estimated 3.2 million unsafe abortions worldwide were in 15-19 year s old. Globally the case–fatality rate is some 350 times higher than the rate associated with legal induced abortions in the USA (0.6 per 100 000 abortions) (23-25).According to WHO, unsafe abortion remains one of the four leading causes of pregnancy- related death and injury around the world, along with hemorrhage, infection and high blood pressure in connection with childbirth. Although great improvements have been seen recently in the global maternal mortality rate, the proportion of deaths attributable to unsafe abortion is holding steady at 13%. This translates to 47,000 deaths each year, almost all occurring in countries with highly restrictive laws. Another eight million women suffer serious and sometimes permanent injury as a result of complications from medically unsafe abortion. Births stemming from unintended pregnancy are also costly to the federal and state government (26).Some estimates claim legalized abortion accounted for as much as 50% of the drop in murder, property crime, and violent crime between 1973 and 2001. Teenage girls, unmarried women, and poor women are more likely to have unintended pregnancies, and since unwanted babies are often raised in poverty, their chances of leading criminal lives in adulthood are increased in9similar way a finding from the Guttamacher institute study on reasons why women get an induced abortion, “according to finding from Zambian study, 81% of women hospitalized for abortion complications were students who did not want the Pregnancy to interrupt their education, similarly, a Ugandan study concluded that the bulk of abortion patients were young, single(21&27).

2.4 Conceptual frame work for safe abortion:

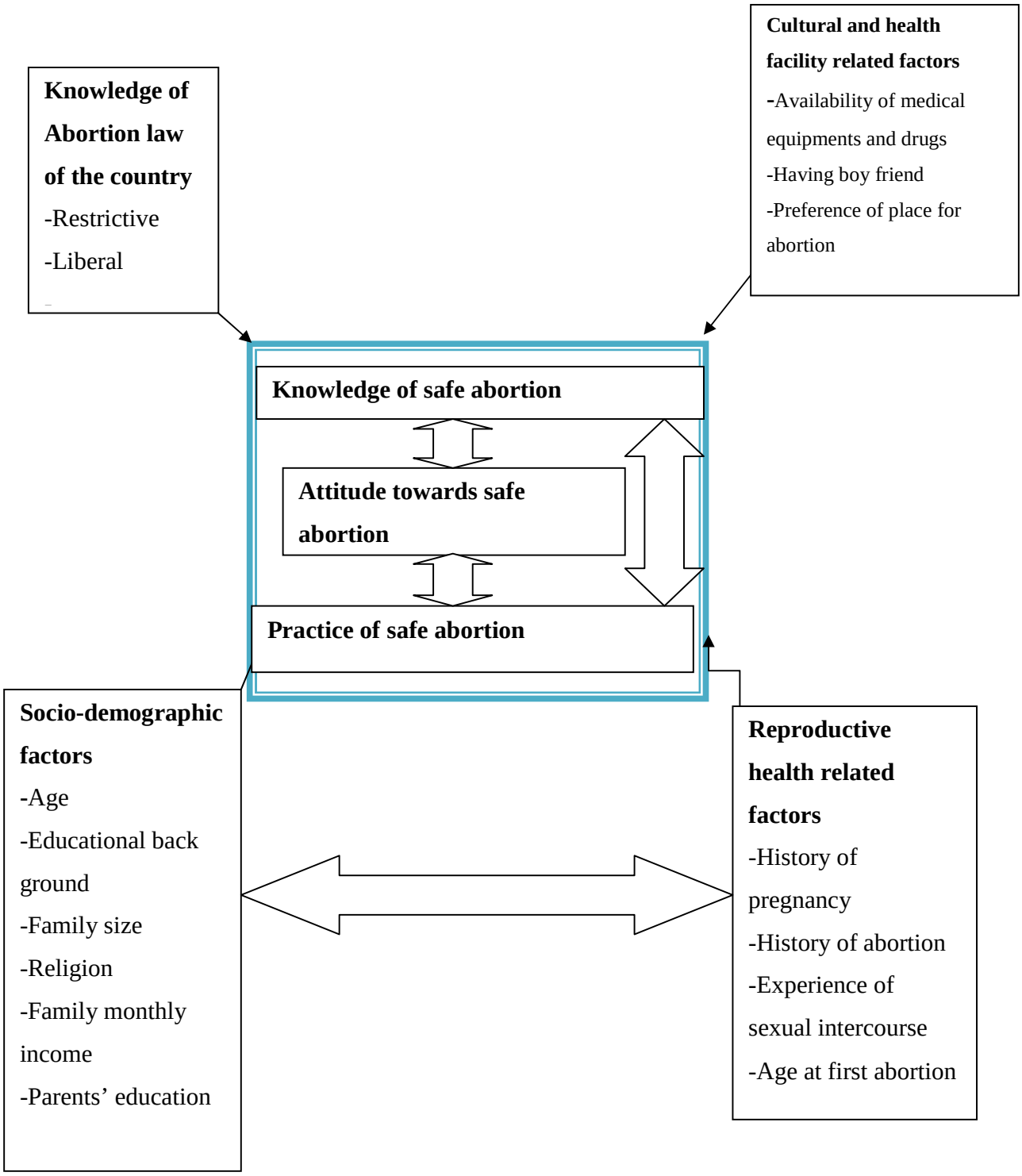

Figure 1: conceptual frame work of factors knowledge, attitude and practice affecting safe abortion

2.5 Rationale of the study

Since the subject of adolescent sexuality remains taboo and hidden in most societies and cultures, there is a widespread ignorance among young people of the risks associated with unprotected sexual activity. Being adolescents is the most sexually active group; adolescent reproductive health problems like teenage pregnancies, abortions, sexually transmitted diseases (STDs), HIV/AIDS, are increasing with serious consequences on the health of adolescents which can result in life time health risk and reduced productivity. So, this study will help:-

- Provide adolescents with access to reproductive health services including essential reproductive health information, education and counseling services that are critical areas to reduce morbidities and mortalities associated with unwanted pregnancy and unsafe abortion among tomorrow mothers.
- Policy makers and program managers identify areas of action for the provision of adolescent reproductive health services based on the gaps identified.
- Put base line information for such study in the study setting or similar setting.

3 OBJECTIVES

To assess knowledge, attitude, practice and associated factors of adolescent girls on safe abortion in Boloso Bombe secondary high school in 2013GC.

3.1 Specific:

To assess the knowledge of female adolescent students regarding safe abortion

To identify the attitude female adolescent students towards safe abortion

To determine the practice of safe abortion among female adolescent students

To identify the associated factors with knowledge, attitude and practice of safe abortion

4 METHODS AND MATERIALS

4.1 Study area

Boloso Bombe is located in Southern Nations Nationalities and Peoples Regional State (SNNPRS) and found in Wolaita Zone, 254km away from Hawassa, capital of SNNPRS & 54km away from Soddo, capital of Wolaita zone. The district has area of 21858km^2& its altitude ranges from 1320 to 2200m.The demographic profile of the year 2005 EFY shows that the total population of 103960 (M= 51252, F= 52708 with sex ratio of 0.97) from which 24512 are women of child bearing age (15-49) and 4061 are expected number of pregnant women. There is one high school named as bombe high school and comprising of grade 9 and 10.There are 4 health centres (HCs) and 17 functional health posts in the district and 1 health centre in the bombe town health centre is providing comprehensive abortion care to surrounding community. About 93% of district population lives in rural areas and the rest 7% lives in semi urban areas (28).

4.2 Study period

The study was conducted from September 28 to October 29, 2013.

4.3 Study design

The school based crosses- sectional study was used.

4.4 Source population

The source populations for this study were all female adolescent students aged greater than 15 years attending Boloso Bombe secondary high school during academic year 2012/2013.

4.5 Study population

The study population were female adolescent students of age in between 15 to 19 years who are attending Boloso Bombe secondary high school during academic year 2012/2013.

4.6 Inclusion –exclusion criteria

Inclusion criteria: female adolescent students in age ranges of 15 up to 19 years**.**

Exclusion criteria: Adolescents who were out of the age range.

4.7 Sample size determination

Sample size was calculated by using the single population proportion formula as follows;

$$n \geq \left[\frac{z_{\alpha/2}}{E}\right]^2 p(1-p)$$

Where n-sample sizes, P- proportion of adolescents have knowledge on safe abortion, $Z_{\alpha/2}$– confidence level and E- desired margin of error

To get a maximum sample size, P =0.5 was used with the assumption that proportion of adolescent girls who practice safe abortion is 50%,since no local study was available showing prevalence of safe abortion, Z=1.96 reliability coefficient for 95% confidence interval for normal distribution and E=0.05 to get maximum sample size and minimize errors related to sampling.

Then $\boldsymbol{n = 384}$

There are 365 girls in grade-9 and 385 girls in grade-10 (total of 750); and this yields sampling fraction

$$\frac{\boldsymbol{n}}{\boldsymbol{N}} = \frac{\boldsymbol{384}}{\boldsymbol{750}} = \boldsymbol{0.51}$$

Where n is initial sample size and N is source population. Since sampling fraction is larger than 5% (0.51>0.05) finite population correction formula is used as follows

$$\boldsymbol{nf} = \frac{\boldsymbol{no} * \boldsymbol{N}}{\boldsymbol{n} + (\boldsymbol{N} - \boldsymbol{1})}$$

Where nf- is final sample size, no- initial sample size and N- source population size and nf becomes

$$\boldsymbol{nf = 253}$$

To compensate non response rate, adding 10% contingency, sample size becomes

$$\boldsymbol{nf = 278}$$

This sample size (proportion of study subjects) was allocated to both Grades depending on source population size composition.

4.8 Sampling procedure

The sample for this study was drawn from source population by using systematic random sampling. This was done by first calculating sample size and allocating proportion to grade 9 and grade 10 based on population size giving each of them their own rows of seats.

4.8.1 Sampling Frame:

Selection of the study subjects was done by first calculating sample size and allocating proportion to grade 9 and grade 10 and into each class depending on the number of allocated for each grade (see Figure 2).

Schematic presentation of the sampling frame:

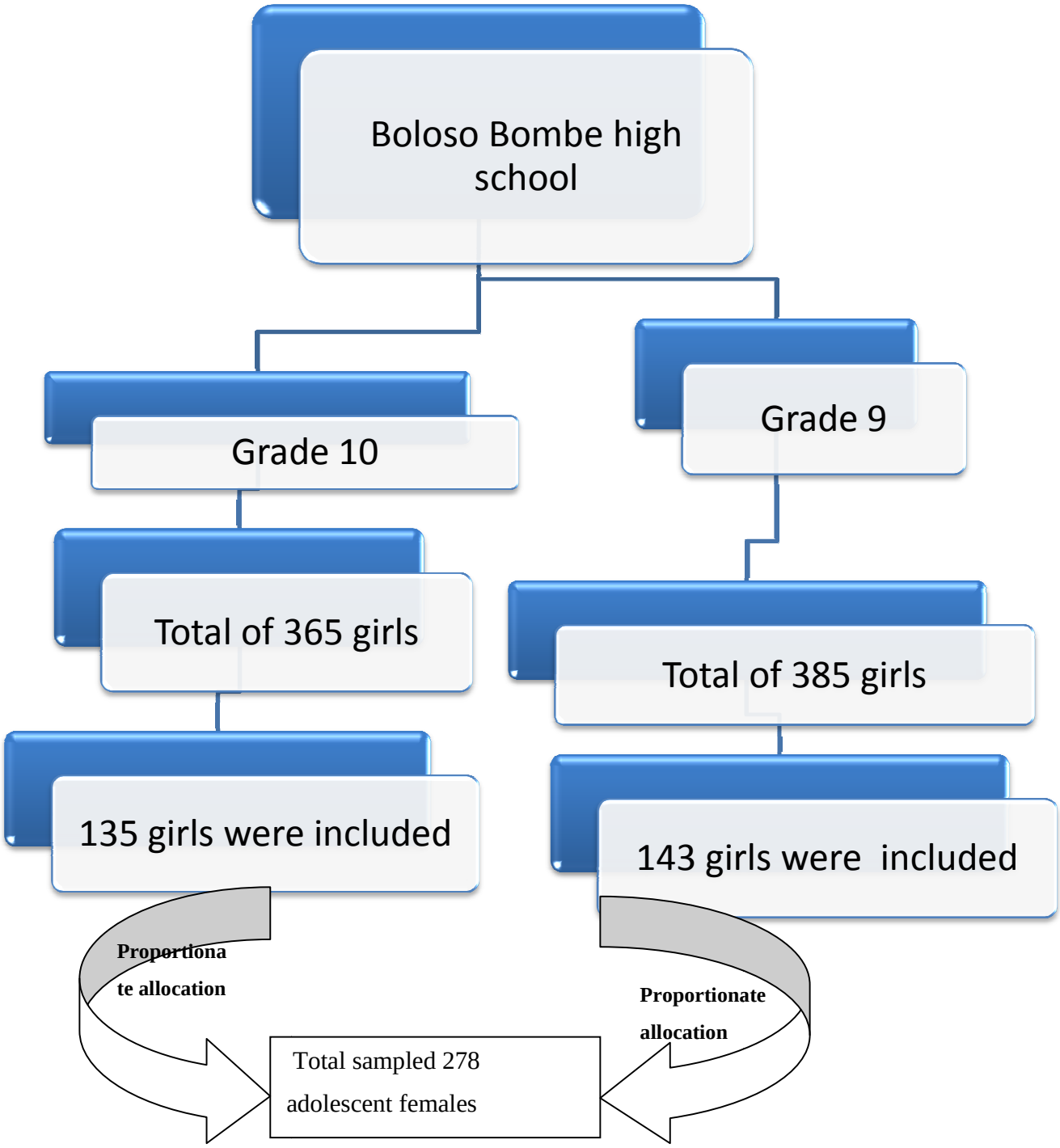

Figure 2: Sampling frame showing the inclusion of study respondents.October2013

4.9 Data collection instruments

A self-administered; structured questionnaire was used for data collection. The questionnaire was prepared first in English and then translated to Amharic language for convenience.

4.10 Data collection procedure

The empty hall was obtained for the respondents who fit the inclusion criteria from both grade 9 and grade 10. Grade 9 and grade 10 were given 2 different rows of seats and the every 5th respondent was selected among each grade as it is the interval determined to include the study subjects, then all of them were oriented over the aim and the procedure how to fill the questionnaires step by step being with the data collection facilitators. Those adolescents bellow the age of 18 years were told the purpose of guardian consent and provided with the readymade consent form asking the consent of their guardian's. Then we appointed them to bring the questionnaires by the next morning after having filled by their own. If they are below the age of 18 years, for those who obtained the parental consent that they can fill the questionnaires unless it is possible for them to return it back to the data collection facilitators.

4.11 Data quality control

Facilitators for data collection were given 2 days of training on how to orient the filling of self administered questionnaires and its ethical concern. Close supervision and follow up were conducted on the time of data collection by the principal investigator. Five percent of the questionnaire was pre- tested in the Areka preparatory and senior secondary school before data collection to check its consistency and convenience. Then after making necessary modification to the data collection tool, data was collected in the study setting by using the modified tools. The data collection instrument was partially adopted from Palestinian family planning and protection association-PFPPA; Baseline survey on safe/unsafe abortion questionnaires (29).

4.12 Operational definitions

Conscientious objection-In the health-care context, conscientious objection is the refusal by health professionals to provide treatment that they oppose on religious or moral grounds.

Knowledgeable - one who answers 6 and above 12 of the questions related to concepts of safe abortion.

Favorable attitude-refers to scores of individual responses having the values greater than the mean score for items of attitude questions as per the Likert's attitude scale measurement**.**

Safe abortion practice - a procedure for terminating an un-wanted pregnancy by adolescent girl by using qualified people using correct techniques under sanitary conditions

Adolescent girl –a girl who is in age range of 15 and 19 and who is attending education in the study setting

4.13 Data processing and analysis

Data entry was done using Epi data version 3.1 then exported to and cleaned, recoded and analyzed by using SPSS version 20.0. Errors related to inconsistency of data were checked and corrected during data cleaning. Univariate analysis such as proportions, percentages, ratios, frequency distributions and appropriate graphic presentations was conducted. Bivariate analysis of each variable like socio-demographic and reproductive health related ones were done for knowledge, attitude and practice of safe abortion by adolescents. And in bivariatete analysis; predictors with the P-value ($\leq$ 0.25) were taken as candidates for multivariable logistic regression analysis. Variables with P-value ($\leq$ 0.25) were entered together to obtain the variables that are to be in the final model and back ward logistic variable elimination method was used. Variables with-P value (< 0.05) are selected and used in building up of the final model and necessary explanations were given based on the 95% CI of the odds ratio.

To categorize the study subjects' knowledge on the basis of their response to knowledge related question items, 12 questions were used and the responses to these knowledge related question items were recorded as "0" for Reponses going not in line with the literature and "1"for those that match with what the literatures say knowledgeable about safe abortion. And the composite variable knowledge was computed for each individual based on her response to 12 items of knowledge question. Then the knowledge of the adolescent students was categorized knowledgeable and not knowledgeable based on their responses to 12 items of question related concepts of abortion. Those adolescent girls who have answered below 6 (50%) of the question items pertaining to what meant by safe abortion in literatures were categorized non knowledge, those who have answered 6 up to 12 of the question items pertaining to what meant by safe abortion in literatures were categorized as knowledgeable.

To measure attitude of adolescent girls towards safe abortion, 9 item different abortion related statements with 1 to 5 scales were used and the scales used to refer to 1 =stronglydisagree,2=disagree,3=indifferent,4=agree and 5= strongly agree as per the likert scale and the statements with the negative sense were converted to above codes by recoding the scales as follows 1 as 5 ,2 as 4 , 3 remained the as it is 4,as 2 and 5 as 1 . After having calculated the attitude score of each respondent from 9 statements each having weight of 15 points, the mean attitude score was obtained. The attitude scores of individuals below the mean score are taken as unfavorable ones and those above the mean score are taken as favorable ones.

The attitude scores of individuals below the mean score were taken as unfavorable ones and those above the mean score were taken as favorable ones

4.14 Variables

4.14.1 Dependent

- Knowledge of safe abortion
- Attitude towards safe abortion
- Practice of safe abortion

4.14.2 Independent variable

- Age
- Educational back ground
- Family monthly income
- History of abortion
- Family educational status
- Knowledge of abortion law
- Source of information
- Having boy friend
- Practice of sexual intercourse
- Contraceptive knowledge

4.15 Ethical clearance

In ensuring the safety of respondents and preventing violation of human rights, permission to carry out the study was obtained from the ethical review Committee of the Jimma University, woreda education office and director of senior secondary school. Informed consent was obtained from each respondent after a full and thorough explanation of the aim and potential benefits of participating in the study. The guardians consent was also obtained for those adolescents age below 18 years before filling the self administered questionnaires sending the consent form to home by those adolescents who are below18 years of age. Anonymity and confidentiality was ensured in that respondents' names did not appear on questionnaires, and information was not shared with people known to participants. Also, the research report was only portraying figures, statistics and discussions without giving any names. The principal, teachers and respondents were given similar explanations of the purpose of the study. The respondents were also informed that participation was voluntary, and that they could withdraw at any time during the process if they felt uncomfortable. The respondents were allowed to complete the questionnaires in a spacious room away from the teachers, and were seated individually to provide privacy and psychological comfort. They were told to be truthful and objective in their responses by the data collection facilitators.

4.16 Dissemination plan

The results of the main findings will be submitted to the Department of Epidemiology and Biostatistics College of Public Health and Medical Sciences (Jimma University).The result of this study also will be presented and submitted to Boloso Bombe woreda Health and Education office. Attempt to publish it in national as well as international journals will be done.

5 RESULT

5.1 Socio-demographic characteristics of study participants

Out of the sampled 278 adolescent girls, 261 had given a complete response to the questionnaires yielding a response rate of 93.9%. One hundred twenty eight (49%) were in grade 9^{th} and 133 (51%) in grade 10^{th}. Majority 182(69.7%) were middle adolescents (in age range of 15-17 years) and the remaining 79(30.3%) were the late adolescents. The median age was 16 years. The majority 229(87.7%), were Wolaita by ethnicity, 156(59.8%) were Protestant Christians. One hundred ninety two (73.6%) were singles. Regarding the family size, majority of the respondents 186(71.2%) were having five and above family members and 75(28.8%) were have below five family member per household. Concerning the average monthly family income, 122(46.7%) of the households had income of less than or equals to (≤ 500) Ethiopian birr per month, 112(42.9%) of the households had income level ranging from 251-500 Ethiopian birr per month and 99 (37.9%) income level ranging from 501-1000 Ethiopian birr per month and 40 (15.3%) income level above (>1000) Ethiopian birr per month. Concerning fathers' educational back ground, 69(26.4%) were illiterate, 30(11.5%) were elementary, 65(26.1%) were secondary, 58 (21.5%) were senior secondary and 38(14.6%) were graduates of college or universities (Table 1).

Table 1: Distribution of Socio-demographic characteristics of studied female adolescents, Boloso Bombe High School, October2013

Respondents' characteristics	**Response**	**Frequency (n=261)**	**Percent (%)**
Educational back ground	Grade 9	128	49.0
	Grade 10	133	51.0
Ethnicity	Wolayta	229	87.7
	Kambata	17	6.5
	Others	15	5.7
Age group	15-17 years	182	69.7
	18-19 years	79	30.3
	Protestant	156	59.8
Religion	Orthodox	83	31.8
	Others	22	8.4
Expected family monthly income	≤250Birr	10	3.8
	251-500 Birr	112	42.9
	501-1000 Birr	99	37.9
	>1000Birr	40	15.3
Educational status of mother	Illiterate	83	31.8
	Grade 1-4	55	21.1
	Grade 5-8	65	24.9
	Grade 9-12	40	15.3
	Graduated from college/ university	18	6.9

5.2 KNOWLEDGE OF ADOLESECENTS ON SAFE ABORTION

Out of the total 261 respondents, 247 (94.6%) had ever heard about the term abortion and 69(26.4%) had heard about it from friends. Out of those 247 respondents those ever heard about abortion, 199(76.2 %) and 211(80.8%) had heard about the term spontaneous abortion and heard about the term induced abortion respectively. Out of 261 respondents, 165 (63.2%) had responded that they had known various contraceptive methods used to avoid unplanned or unintended pregnancies. Regarding the knowledge of circumstances in which National Criminal Code of the Federal Democratic Republic of Ethiopia allows safe abortion,85 (32.5%) responded that they had known the circumstances but a few; 35 (13%) had clearly or correctly identified the conditions in which the Ethiopian Criminal Code allows safe and legal abortion.

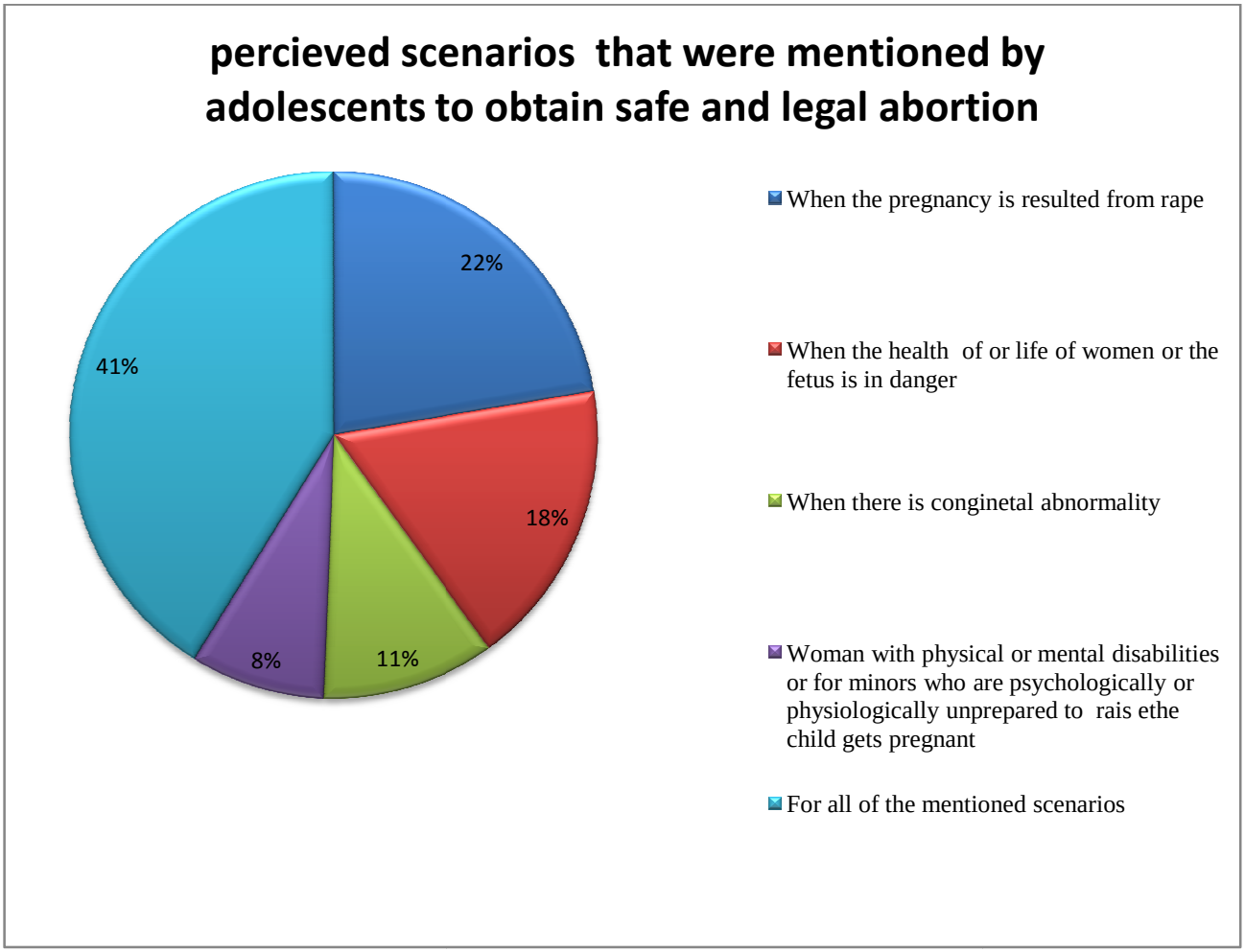

Figure 3: Perceived scenarios that thought by adolescents as to get safe and legal abortion care according to Ethiopian penal

Out of the total 261 adolescent girls, one hundred forty five (55.6%) of them are not knowledgeable about safe abortion and 116 (44.4%) are knowledgeable about safe abortion.

In Binary logistic regression, by bivariate analysis (dependent variable knowledge of safe abortion) with predictor variables are: Educational background of respondents, educational status of fathers, ethnicity, family size having boy friend and history of previous pregnancy, were selected as candidates for multivariable analysis with ($p_{-value} \leq 0.25$).

Those adolescent girls who had history of pregnancy were 1.37 times more likely knowledgeable about safe abortion than those who did not have pregnancy history: [AOR (95 %CI) = 1.37 [1.14, 2.81]and those girls who have boy friends were 1.61 times more knowledgeable about safe abortion than those who did not have: [AOR (95 %CI) 1.61(1.02, 2.36] (Table 3**).**

Table 2; Distribution of responses to knowledge related question items. October, 2013

Question item	Response (n=261)	Frequency (n=261)	Percent (%)
Heard the term abortion	Yes	247	94.6
	No	14	5.4
Heard about the term spontaneous abortion	Yes	199	80.0
	No	48	20.0
Heard about the term induced abortion	Yes	211	89.4
	No	36	9.6
Know the various contraceptive methods to avoid pregnancy	Yes	165	60.2
	No	96	39.8
Termination of pregnancy before the 20th Week of gestation can be called as abortion.	Yes	78	31.5
	No	169	68.5
Health problems like elevated blood pressure, diabetes, heart diseases and other gynecological problems are capable of causing abortion.	Yes	93	37.6
	No	154	62.4
Lack of physical care, psychological problems and young and old age may cause abortion.	Yes	114	46.2
	No	133	53.8
Induced abortion is against the ethics and codes of religion.	Yes	151	61.2
	No	89	39.8
Criminal Code of the Federal Democratic Republic of Ethiopia allows safe abortion care for woman with certain circumstances.	Yes	85	34.4
	No	176	65.6
Now days most of women use medicines for abortion.	Yes	166	67.6
	No	80	32.4
	Yes	150	60.8
	No	97	39.2
The rate abortion is high among teenagers	Yes	106	46.6

No	111	53.4

Table 3: Association of socio-demographic and reproductive health related variables with knowledge of adolescents on safe abortion among, October, 2013

Characteristics	Response category	Frequency (n=261)	Percent	COR[95%CI]	AOR [95%CI]
Educational background	Grade 9	128	49.0	0.65[0.39, 1.06]	0.48 [0.155,1.287]
	Grade 10	133	51.0	1.00	1.00
Ethnicity	Wolayta	229	87.7	*0.36[0.12,1.09]	0.60[0.22,1.10]
	Kambata	17	6.5	0.75[0.16,3.02]	0.56[0.37,1.31]
	Others	15	5.7	1.00	1.00
Average family size	≤5 family members	75	28.7	0.47[0.13,1.76]	2.37[0.55,10.14]
	6-10 family members	175	67.0	*0.43[0.12,1.58]	0.33[0.02,0.62]
	≥11 family members	11	4.2	1.00	1.00
Father's educational status	Illiterate	69	26.4	1.59[0.76, 3.14]	0.84[0.64,1.96]
	Grade 1-4	30	11.5	* 2.06[0.78, 5.46]	0.37[0.06,8.66]
	Grade 5-8	68	26.1	0.96[0.430,2.1]	1.40[0.04,3.89]
	Grade 9-12	58	21.5	* 0.56 [0.25,1.41]	0.92[0.30,1.51]
	Graduated from college/ university	38	14.6	1.00	1.00
Had ever become pregnant	Yes	49	53.3	1.22[0.79,2.80]	**1.37 [1.14, 2.81]
	No	43	46.7	1.00	1.00]
Having boy friend	Yes	70	26.3	1.76 [1.02,2.20]	**1.61[1.02, 2.36]
	No	191	78.7	1.00	1.00

* - Categories with (p value <0.25) in bivariate analysis

** - statistically significant ones in multivariable analysis (p < 0.05)

5.3 Attitude of adolescents towards safe abortion

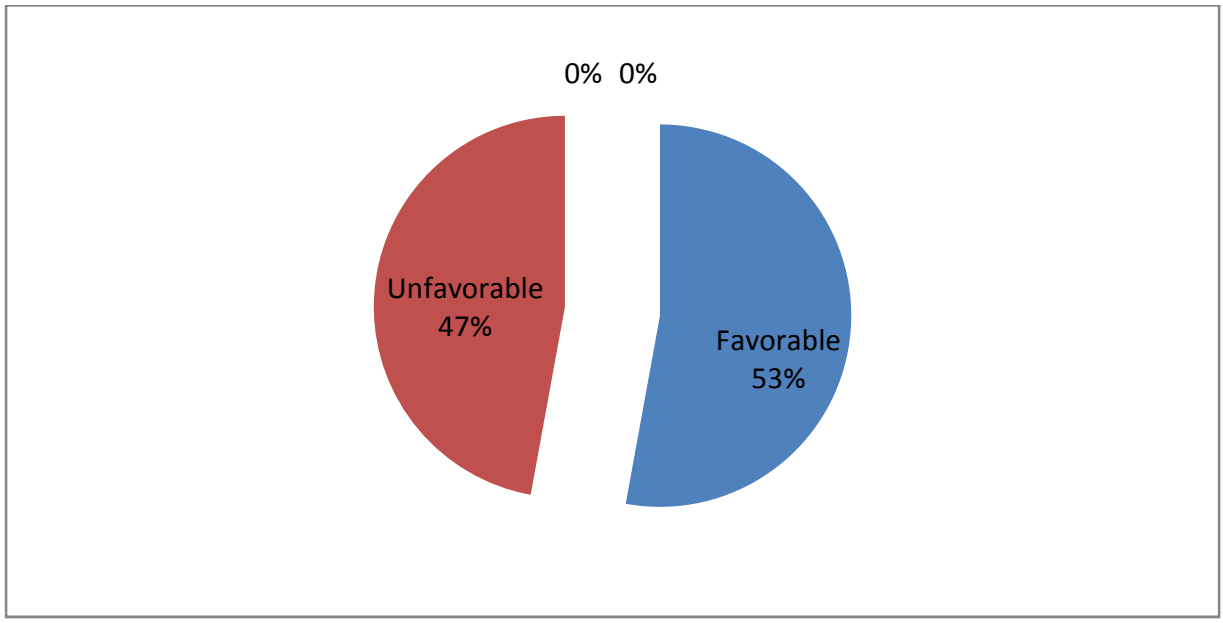

Figure 4: The distribution of attitude of the adolescent girls towards safe. October 2013

In bivariate binary logistic analysis, (dependent variable attitude of adolescent girls towards safe abortion) covariates selected ; Educational background of respondents, family monthly income, fathers' male care takers' educational status , having boy friend and previous history of pregnancy were selected as candidates for multivariable analysis with $p_{\text{-value}} \leq 0.25$.

In multivariate analysis, adolescent girls' educational status, history of having abortion and fathers' educational status were variables found to have statistically significant association ($p_{\text{-value}} < 0.05$). As compared to grade 10, grade 9 adolescents were 0.42 times less likely to have favorable attitude towards safe abortion: [AOR (95 %CI=0.42 (0.25, 0.71)]. Those adolescents whose have attained medium educational level (Grade 9-12) were 3.01 times more likely to have favorable attitude towards safe abortion those with fathers with college or university graduate education level: [AOR (95 %CI) = 0.42 (0.25,0.71)] and those girls who have previous history of abortion were 1.90 times more likely to have to favorable attitude or 90 % of those adolescents who had abortion had favorable attitude towards safe abortion as compared to those who did not face it after in their pregnancy time : [AOR (95 %CI) = 1.90 (1.42,2.38)](Table 4).

Table 4: Association of socio-demographic and reproductive health related variables with attitude towards safe abortion. October2013

Characteristics	Response	Number (n=247)	Percent (%)	COR[95% CI]	AOR[95%CI]
Educational back ground	Grade 9	128	49.0	2.67[1.62,4.41]	**0.42[0.25,0.71]
	Grade 10	133	51.0	1.00	1.00
Family monthly income	≤250Birr	10	3.8	1.01[0.24,4.11]	0.92[0.19,4.30]
	251-500 Birr	112	42.9	*0.60[0.29,1.24]	0.49[0.22,1.07]
	501-1000 Birr	99	37.9	0.33[0.39,1.76]	0.64[0.30,1.44]
	>1000Birr	40	15.3	1.00	
Fathers'/male care takers educational status	Illiterate	69	26.4	1.04[0.47,2.30]	0.98[0.43,2.23]
	Grade 1-4	30	11.5	1.11[0.49,2.6]	0.601[0.33,1.65]
	Grade 5-8	68	26.1	*0.59[0.27,1.32]	1.20[0.51,2.85]
	Grade 9-12	58	21.5	*2.96[1.02,5.32]	*3.01[1.33,8.92]
	Graduated from college/ university	38	14.6	1.00	1.00
History of abortion	Yes	34	66.4	2.01[0.93,4.34]	**1.90[1.42,2.38]
	No	15	33.6	1.00	1.00
History of pregnancy	Yes	49	53.3	1.01[0.51,1.98]	0.58[0.31,1.60]
	No	43	46.7	1.00	1.00
Having boyfriend	Yes	70	26.8	0.57[0.32,1.00]	0.60[0.34,1.60]
	No	191	73.2	1.00	1.00

* - Categories with (p value <0.25) in bivariate analysis
** - statistically significant ones in multivariable analysis ($p < 0.05$)

5.4 Practice of safe abortion

Among 261 study subjects who had given complete responses to questionnaires administered to them, 70 (26.3%) had responded as they ever had boy friend and 92(35.2%) practiced sexual intercourse in their history. Out of these 92 those who had practiced sexual intercourse in their history, 12(13.0%) of them used condom during their sexual intercourse. Out of those 92 adolescent girls who had practiced sexual intercourse in their history, 49(18.8%) had become pregnant and 30 of them had become pregnant once, 18 of had become pregnant twice and 1 of them become pregnant three times. Among those 49 girls who had become pregnant, 34(69.4 %%) of them had history of abortion. As the frequency of abortion is assessed, 30(60.2%) had faced it once and 3(6.1%) had faced it twice. When the reasons that let adolescent girls terminate pregnancies are assessed, out of the total 34 causes who had faced termination of pregnancy, 8(23.5%) ,6(17.6%),5(14.7%),4(11.8%),3(8.8%),3(8.8%),2(5.5%) and 2(5.5%) were due to fear of family, to continue education, fear of society, rape-resulted pregnancy, too young to bear child, more than 1 of these reasons, it was spontaneous and it was resulted from incent respectively. Abortions conducted by trained nurses or health officers account for (47.1%) by traditional abortionists, 8(23.5%) by medical doctors, 6 (17.6%), by parent 1(2.9%) and by girl herself 1(2.9%). Out of those 34 adolescents who had history of abortion, 24(70.6%) had responded as they faced health problems. The commonest problem mentioned were heavy bleeding 13(66.5%) followed by 4(17.4 %) incomplete removal of abortion related products. Only 6 (17.6 %) adolescents used post abortion care and 4 (66.7%) of the adolescents used the service treatment of incomplete abortion and only 2(33.3 of them had got family planning as component of post abortion care.

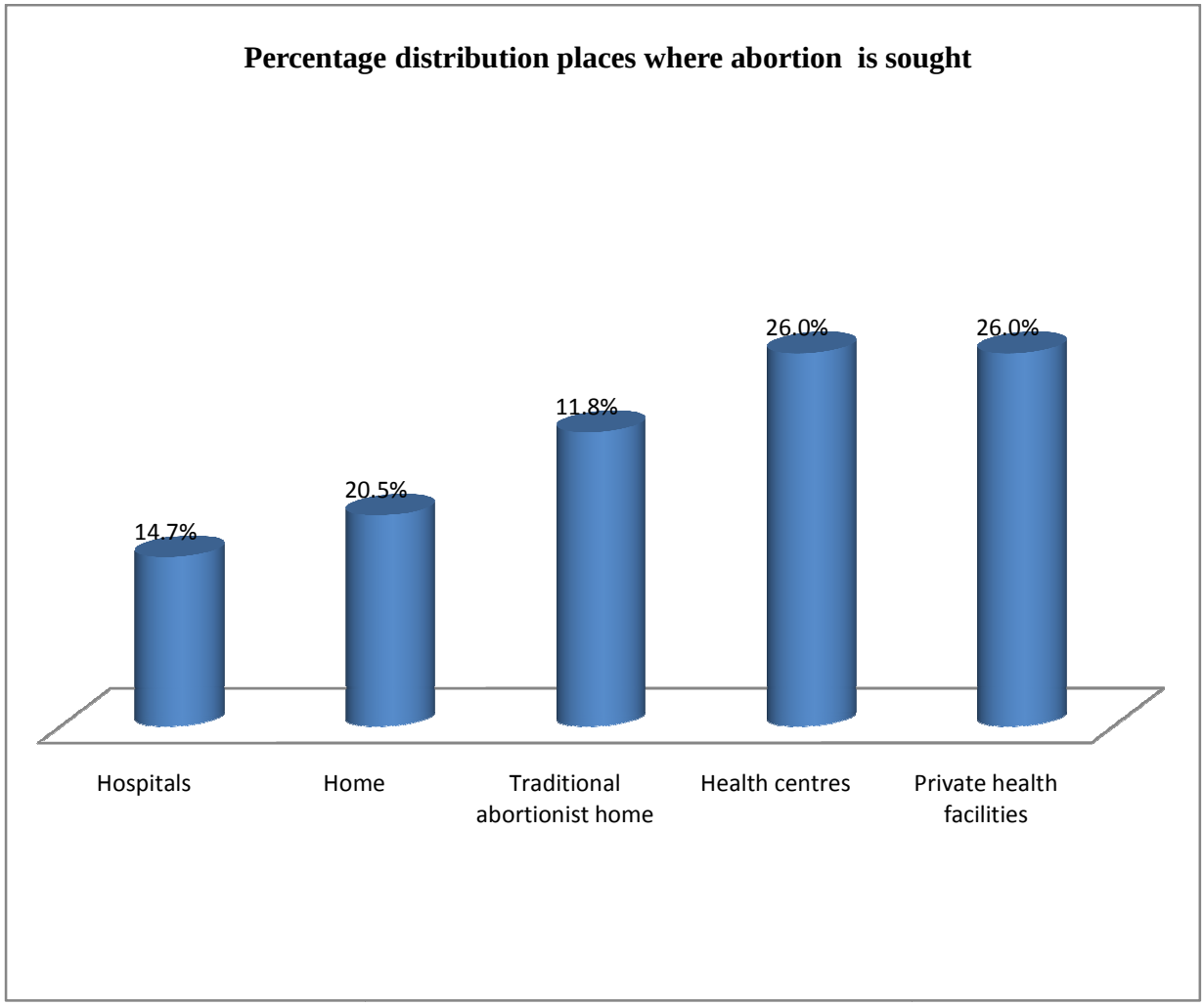

Figure 6: Percentage distribution of abortion cases versus the place where abortions had taken. October 2013

Out of total 34 abortions identified, 30 were induced, 2 were spontaneous. Out of 34 cases faced abortion , 22(64.7%) were conducted in health facilities(in private health facilities, governmental health centers and hospitals).Twenty-two(64.7%) were conducted by health professionals (by nurses or health officers and medical doctors) by using variety of methods (by taking drugs orally and vaginal placement of white tablets, health worker assisted by medical equipment/VA, by curettage and dilatation and intra-vaginal placement of white tablets or plastic tubing) and the variable computed as safe abortion has 21 cases or can be said as those fulfilling the operational definition for safe abortion. Among 22 adolescent girls who had induced their abortion in health facilities 5(22.72%0) of them had faced a sort of objections from the service providers. In case of conducting logistic regression the case to variable ratio is low and as result was not conducted.

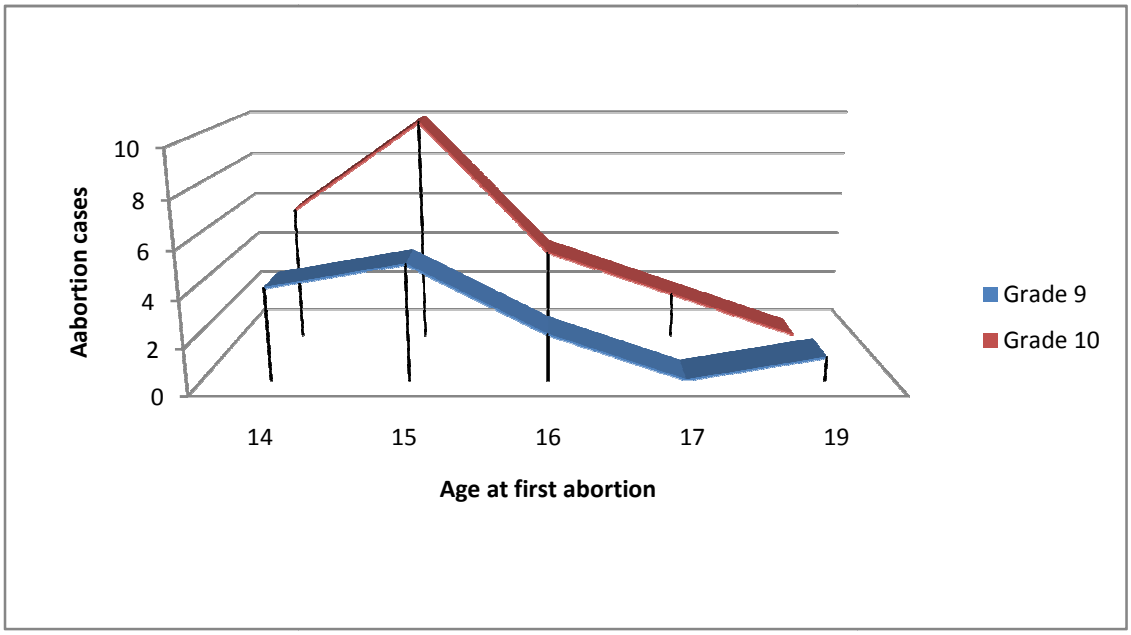

Figure 5 Distribution age at first abortion versus educational back ground of the respondents of Boloso Bombe high school adolescent girls. October 2013.

Table 5: Distribution of responses to adolescent reproductive health related questions for adolescents of Boloso Bombe high school girls. October 2013

Question item	Response category	Frequency (n=261)	Percent
Ever had boy friend	Yes	70	26.3
	No	191	78.7
Ever practiced sex	Yes	92	35.2.0
	No	169	64.8
Used condom during their sexual intercourse	Yes	12	13.0
	No	80	87.0
Had ever become pregnant	Yes	49	67.1
	No	24	32.9
Have you ever had a pregnancy terminated before complete gestation	Yes	34	69.4
	No	15	33.6
Did you any objection from the health professionals if your abortion is conducted by them	Yes	5	22.7
	No	17	77.3
Faced any problem after that abortion	Yes	24	70.6
	No	10	29.4
Ever received post abortion care [PAC]	Yes	6	17.6
	No	28	82.4

6 DISSCUSIO OF THE FINDINGS

In this study, over three fourth of the study subjects (94.6%) ever heard about the term abortion. Less than half (44.4%) were knowledgeable on about safe abortion. A knowledge, attitude and practice study conducted on illegal (induced) abortion among secondary school girls in a Goma district, Democratic republic of Congo, 2010.Shown that 201(61.3%) of the participants knew what abortion meant 74 (22.6%)) of them did not, and 53(16.1 %) of them were unsure.

The findings of the two studies are not similar, the possible cause of the difference could be differences in age range and the big sample size included in the Ugandan study (12).

In this study, out of 247 respondents who have heard about the term abortion, only 85 (34.4) had responded as they know the scenarios in which the Ethiopian penal code allows safe abortion, but only 35 of the adolescents had correctly identified the scenarios or situations in which safe and legal abortion is allowed in the country's national penal code. While a study done by B. Shimelash and his colleges on knowledge and attitude of women of childbearing age towards the legalization of abortion, in Gedeo zone. SNNPRS,Y/Cheffe.2013. Revealed the Knowledge of women about the legalization of abortion accounting for 48.21%, more than half among the total respondents has no knowledge about the legalization of abortion which accounts for51.79%.

The results of 2 studies do not have the same result and the possible explanation for this significant difference could be due the variation of the respondents by their socio –demographic variables like age, educational status, residential area and other reproductive health related ones. (15).

A study in south Africa shown that, out of 273 adolescents included in the study, 206(75%) indicated that they had knowledge about the different contraceptive methods. In this study the proportion of students who had indicated as they had knowledge about various modern contraceptive methods to prevent or avoid unwanted or unintended pregnancies is 165 (63.2%) (18).

The finding of South African study indicated higher result than this finding and the possible explanation could be the difference in socio demographic and cultural factors in between the two countries.

In this study, concerning the attitude of adolescents towards safe abortion, 53% of the respondents have favourable and 47% have unfavourable attitude towards safe abortion.

A study done by Yu Fengxue in Phuttamonthon district,Nakhon Pathom province, Thailand.2013. More than half of respondents had positive attitude toward induced abortion (56.7%) and less than half had negative attitude (17).

This result is almost similar to the result of this study. In this study, combined the "agree" and "strongly agree" responses from the questionnaire, it is found that 142(57.2%) of the female adolescent students thought that unwanted pregnancies should be aborted rather than having unwanted child. Combined the "disagree" and "strongly disagree" responses of the study subjects; majority 219 (88.7%) of the respondents thought that the information they have currently is not enough to make decisions regarding legal and safe abortion and combined the "agree" and "strongly agree" responses for the questionnaire to the statement that say more "should be done to make scenarios/situations clear and familiar that abortion is legally allowed in the country'' , 157(63.9%) responded that they want further clarification and familiarity to the National penal code regarding safe abortion. In the same way combined the "agree" and "strongly agree" responses for the questionnaire to the statements quoted as preferring "abortion to be induced by trained health worker and to be conducted in health facilities" if the service is needed, as responded by majority 218(88.3%) and 151(64.2%) of study subjects respectively. In multivariable analysis respondents characteristics like; having boy friend had faced abortion and educational back grounds have statistically significant association with the attitude of adolescents towards safe abortion.

Grade 9 adolescents were 0.42 times less likely to have favourable attitude towards safe abortion: [AOR (95 % CI=0.42 (0.25, 0.71)]. Those adolescents whose father attained educational level of Grade 9-12 were 3.01 times more likely to have favourable attitude towards safe abortion than those whose fathers attained college or university level education : [AOR (95 %CI) = 3.01 (1.33,8.92)] and those girls who had ever faced abortion were 1.90 times more likely to have to favourable attitude or 18 % of the respondents who experienced abortion have favourable attitude towards safe abortion as compared to those who did not experienced it after in their pregnancy time : [AOR (95 %CI) = 1.90 (1.42,2.38)].

In the same way a study conducted by Yu Fengxue; in Phuttamonthon district, Nakhon Pathom province, Thailand,level of education is significantly associated with attitude toward induced abortion and supporting health services, higher Grade had more positive attitude toward induced abortion and supporting health services than the low fathers' and mothers' education significantly associated with attitude toward supporting health services, students whose

father/mother had middle level of education, but family education has no significant association with students attitude in my study (17).

Of the total 261 adolescents involved in this study, 925(35.2%) had practiced sexual intercourse in their history and 49(18.8) of them had become pregnant. Among those 49 girls who had become pregnant, 34 (13.0%) of them had faced abortion.

According to a study conducted by Yu Fengxu.2013, only 79 (20.26%) have a history of induced abortion but the remaining 311 (79.74%) has no history of induced abortion. For those having histories of induced abortion 45 (56.96%), abort at their home but 34(43.04%) abort at health institutions. For those having induced abortion, the main reason is maternal health problem 45 (56.96%), 17 (21.52%) because of an economic problem, 16 (20.25%) due to social cultural problems & for the remaining 10 (12.16%) the reason is they did not want to have children (17).

The results of these 2 findings are not similar and the difference in the patterns of adolescent pregnancy could be due cross cultural variations and those adolescents involved in the Thailand study are from grade 9 up to grade 12 adolescent girls.

Another study done by Paluku J. and his colleges; on Knowledge and attitude of schoolgirls about illegal abortions in Goma, Democratic Republic of Congo March 2010, the study found that 9.7% of the participants reported having had an abortion before, among which 96.9% of them had induced the abortion (12).

According to the study conducted in Uganda, One hundred and seventeen (36%) of youths had been pregnant before and 66 (56.4%) participants had lost or terminated a pregnancy in the past. Among participants who had lost or terminated a pregnancy in the past, 49(74.2%) had undergone an induced abortion (12).The proportion of students practiced abortion in DR Congo study was slightly similar to the proportion of adolescent practiced abortion in this study but it is higher in the Ugandan study the difference could be due to the difference in sample size included in both cases and the difference in socio-demography for both countries.

In multivariate analysis, those adolescents who had boyfriend were 1.83 times more likely to have likely had practiced safe abortion than those who did not have boyfriends: [AOR (95 %CI) = 1.83 (1.12, 2.26)] and 35% of those girls who had knowledge of various contraceptives to avoid pregnancy were less likely to have practiced safe abortion than those who did not know it: [AOR (95 %CI) = 0.65(0.29, 0.98)]. Since the access to, and knowledge of adolescents' on contraceptives is limited, it obvious that having boy friend means more likely to experience sexual intercourse as result they can become pregnant and the pregnancies occurred in them could have initiated them to use abortion than those do not had boyfriends.

7 LIMITATIONS OF THE STUDY

As the topic under the study is sensitive, some respondents might have hidden their responses to the question so that it could have affected the results. Secondly since the study used a cross-sectional study design, it is impossible to find a cause-effect relationship.

8 Conclusion

- The proportion of adolescent girls who were knowledgeable about safe abortion were (44.4%)
- The proportion of adolescent girls who had mentioned correctly the scenarios in which the Ethiopian national penal code allows safe and legal abortion is very low 35(13%).
- More than half 131(53%) of studied subjects had favorable attitude towards safe abortion.
- Among those 49 adolescents who had ever become pregnant, 34 had faced termination of their pregnancies and 21 of them had got it done in safe way.
- The proportion of adolescents who know various modern contraceptive methods used to prevent unwanted pregnancies which in turn can result in induced abortion is low 63.5%
- Attention should be focused on educating adolescents as it is found to improve knowledge on and attitude towards safe abortion by adolescents.

9 RCOMMENDATION

Based on findings of this study; the following recommendations were forwarded to the organizations and individuals dedicated to resolve morbidity and mortality of today and tomorrow mothers from health risks related to unsafe abortion;

1. The Schools should have to Organize BCC (behavioural change communication) programs to deliver sexual and reproductive health education to adolescent girls to improve their awareness and knowledge on safe abortion.
2. Information on abortion law to improve the adolescents' awareness and Knowledge of safe and legal abortion should be considered in schools and health facilities like health posts and health centres informs of sexual and reproductive health education.
3. Information on and access to modern contraceptives like emergency contraceptives, safe abortion, and safe sex should get priority emphasis in a school sexual health education.

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11 Annexes

11.1 Consent form

To be filled by adolescent girl students of Boloso Bombe secondary high school.

Informed consent statement

Greetings:

Dear students!

In ensuring the health of adolescents is one of the most inappropriately addressed issues, this study tries to assess knowledge, attitude and practice of adolescent girls about safe abortion in Boloso Bombe secondary high school and you are chosen to participate in this study. The choice was dome randomly. The purpose of this study is to generate information about knowledge; attitude and practice of adolescent girls about safe abortion in Boloso Bombe secondary high school in 2013.The study will involve various intimate and private life questions. In order to attain effective goal, I ask your honest and genuine answer. There is no need to put your name. No individual response will be reported. This is to keep absolute confidentiality. It is your full right to participate or refuse in the study. Anybody who doesn't want to participate in the study can inform the facilitator and put down the questionnaire. If there is anything not clear, don’t hesitate to ask the facilitator for clarification. And thank you very much for your genuine response to each question.

To show your agreement or disagreement in the study please thick in the box.

Do you wish to participate in the study?

☐ Yes, I want to participate in the study. (Please go to the next page)

☐ No, I don't want to participate in the study.

11.2 Guardian consent form

Informed consent statement;

Dear guardian! Since addressing the reproductive health related issues of adolescents appropriately is one of the most crucial steps to reduce adolescent health risks, maternal morbidity and mortality, this study tries to assess knowledge, attitude and practice of adolescent girls about safe abortion in Boloso Bombe secondary high schoolsince the age for legal basis according to Ethiopian penal code is below 18 years, and it is important to obtain your consent for inclusion of your daughter in this study. The choice of her was dome random. The purpose of this study is to generate information about knowledge, attitude and practice of adolescent girls about safe abortion inBoloso Bombe secondary high school in 2013 .The study will involve various intimate and private life questions and I assure you that individual's response will not be reported. This is to keep absolute confidentiality. It is your full right to allow your daughter to participate or refuse her inclusion in the study. And I thank you very much for your genuine response to my request to show your agreement or disagreement in allowing the participation of your daughter in the study please thick in the box.

Do you allow her to participate in the study?

☐ Yes, I want her to participate in the study.

☐ No, I don't her want to participate in the study.

11.3 Questionnaire (English)

Part one: self administered questionnaire

Section one1: Scio- demographic characteristics (back ground information)

Instruction: for each of the following questions please circles the number of alternative(s) that fit for your response or write it in a legible way.

1**. Background information:-**

No	Questions	Coding category	Code	Skip
101	What is your age in years	_____		
102	What is your kebele	_____		
103	What is your educational background (Grade)	**a. Grade 9** **b.Grade 10**	**1** **2**	
104	What is your ethnicity	**a. Wolaita** **b. Amhara** **c. Kambata** **d. Hadiya** **e. Other**	**1** **2** **3** **4** **5**	
105	What is your religion	**a. Protestant** **b. Orthodox** **c. catholic** **d. Muslim** **e. other**	**1** **2** **3** **4** **5**	
106	What is your marital status	**. Married** **. Single** **. Divorced** **. Widowed**	**1** **2** **3** **4**	
107	What is your estimated personal monthly income in Birr	_____		
108	What is your estimated family monthly income in Birr	_____		
109	Number of family members	_____		

110	Educational status of mother or care taker	**. Illiterate . Grade1-4 . Grade5-8 . Grade9-12 . Graduated from college or university**	**1 2 3 4 5**	
111	Educational status of father or care taker	**. Illiterate . Grade1-4 . Grade5-8 Grade9-12 . Graduated from college or university**	**1 2 3 4 5**	

2. Knowledge about safe abortion

201	Have you heard about the term abortion?	**a. Yes b. No**	**1 2**	If no skip to Q no 210
201	If yes, where did you get the information?	**Radio School Health facility Friends Church family Other_ specify**	**1 2 3 4 5 6 7**	
203	Have you heard about the term spontaneous abortion?	**a. Yes b. No**	**1 2**	
204	Have you heard about the term induced abortion?	**a. Yes b. No**	**1 2**	
205	Is the termination of pregnancy before 20th week of gestation can be called as abortion?	**a. Yes b. No**	**1 2**	
206	Are health problems like elevated blood pressure, diabetes, heart diseases and other gynecological problems are capable of causing abortion?	**a. Yes b. No**	**1 2**	
207	Do you accept that the lack of physical care, psychological problems and young and old age may cause abortion?	**a. Yes b. No**	**1 2**	
208	Do you think that the induced abortion is against the ethics and codes of religion?	**a. Yes b. No**	**1 2**	

209	Do you know that the Criminal Code of the Federal DemocraticRepublic of Ethiopia allows safe abortion care for woman with certain circumstances?	**a. Yes** **b. No**	**1** **2** **3**	If your answer is not yes, skip to Question no 211
210	Do you know the various contraceptive methods to avoid pregnancy?	**a. Yes** **b. No**	**1** **2**	
211	If your answer is yes to Q No209, for which of the mentioned reasons do you think it is legally allowed?	**When:** **. Pregnancy results from rape or incest** **. the health or life of the woman and the fetus are in danger** **. There is fetal abnormalities** **. women with physical or mental disabilities and for minors who are physically or psychologically unprepared to raise a child** **. for all of the above reasons**	**1** **2** **3** **4** **5**	
212	Do you know that most of women use medicines for abortion now days?	**a. Yes** **b. No**	**1** **2**	
213	Can we say that the abortion rate is increasing today?	**a. Yes** **b. No**	**1** **2**	If the answer is no, skip to Question no 214
214	If yes, is the rate more among teenage girls?	**a. Yes** **b. No**	**1** **2**	

3. **Attitude towards safe abortion**

			Strongly agree	Agree	Indifferent	Disagree	Strongly disagree
		Codes	5	4	3	2	1
301	Having abortion is better than having unwanted child.						
302	Ending pregnancies which occurred in school adolescents who are unable to raise the new born is solution to continue their education						
303	Pregnancy taken place outside of marriage in school age adolescents should be aborted.						
304	Adolescents induce abortion to conceal their involvedness in sexual activity from parents and others.						
305	It is preferable to induce abortion by trained health professionals than others.						
306	It is preferable to induce abortion in health facilities than home or other places outside of health facilities						
307	Safe abortion services should be more accessible than the current level.						
308	More should be done to make you clear and familiar with legal status of safe abortion care						
309	The information you have now is not enough to make decisions regarding safe abortion.						

4. Practice of safe abortion:

401	Have you ever had boy friend?	**a. Yes** **b. No**	**1** **2**	
402	Have you ever practiced sex?	**. Yes** **. No**	**1** **2**	If no, stop filing
403	If yes, was the sex by using condom?	**a. Yes** **b. No**	**1** **2**	
404	Have you ever had pregnancy?	**a. Yes** **b. No**	**1** **2**	If no, stop filling
405	If you had pregnancy, how many times?	_____		
406	Have you ever had a pregnancy terminated before complete gestation?	**a. Yes** **b. No**	**1** **2**	
407	If you had abortion, how many times?	_____		
408	How old were you when you had your first abortion?	**Age in years**_____		
409	What was/were reason/s that let you to decide to terminate pregnancy?	a. Too young to have a child b. Fear of family c. Fear of society d. Became pregnant after rape e. Attending school f. Have had bleeding g. It happened from incest h. It was just spontaneous **i.** Other-specify _____	**1** **2** **3** **4** **5** **6** **7** **8**	
410	Who induced that abortion?	**a. My self** **b. Traditional abortionist** **c. Relative** **d. Nurse** **e. Medical doctor** **f. Nobody** **g. Other-specify _____**	**1** **2** **3** **4** **5** **6** **7**	
411	Where was that abortion induced	**a. Home** **b. Abortionist home** **c. Hospital** **d. Health center** **e. Private health facility** **f. Other-specify _____**	**1** **2** **3** **4** **5** **6**	
412	If your answer to Q No 410 is in health facility, is there any health service provider who objected your decision to abortion?	**a. Yes** **b. No**	**1** **2**	

413	If that abortion was not induced by appropriate health personnel then how it was conducted	**Insertion of physical objects placed intra vaginally (sharp object & wooden stick etc.)** **By taking antibiotic over dose** **Drink homemade drinks such as (tea, herbs, seeds, oils)** **Voluntary trauma (jump from a height, lift heavy objects)** **Other-specify_____**	**1** **2** **3** **4** **5**	
414	If the abortion was induced by trained health professional, by what method was it done	**Give injections only** **Oral medicine and vaginal placement of white tablets** **vacuum aspiration** **curettage and dilation** **Intra-vaginal placement of white tablets or plastic tubing**	**1** **2** **3** **4** **5**	
414	Did you face any problem after that abortion?	**Yes** **No**	**1** **2**	
415	If yes what were problems?	**Heavy bleeding** **Abdominal pain** **Fever** **Incomplete abortion** **Other-specify _____**	**1** **2** **3** **4** **5**	
416	Have you ever received post abortion care (PAC)	**Yes** **No**	**1** **2**	
417	If yes, what are the services you received?	**Counseling** **Treatment of incomplete and unsafe abortion** **FP services** **Other- specify _____**	**1** **2** **3** **4**	

THANK YOU!!!

Table for: Frequency distribution of responses to statements related tosafe abortion. October 2013.

Statements related to safe abortion	Response category	Frequency (n=247)	Percent
Having abortion is better than having unwanted child.	Strongly disagree	23	9.3
	Disagree	77	31.2
	Indifferent	5	2.0
	Agree	28	11.3
	Strongly agree	114	46.2
Ending pregnancies which occurred in school adolescents who are unable to raise the new born Safely is solution to continue their education.	Strongly disagree	14	5.7
	Disagree	46	18.6
	Indifferent	33	13.4
	Agree	77	31.2
	Strongly agree	77	31.2
Pregnancy taken place outside of marriage in school age adolescents should be aborted	Strongly disagree	14	5.7
	Disagree	62	25.1
	Indifferent	19	7.7
	Agree	63	25.5
	Strongly agree	89	36.0
Adolescents induce abortion to conceal their involvedness in sexual activity from parents and others.	Strongly disagree	22	8.9
	Disagree	69	27.9
	Indifferent	42	17.0
	Agree	68	27.5
	Strongly agree	46	18.6
It is preferable to induce abortion by trained health professionals than others.	Strongly disagree	2	.8
	Disagree	1	.4
	Indifferent	26	10.5
	Agree	118	47.8
	Strongly agree	100	40.5
It is preferable to induce abortion in health facilities	Strongly disagree	12	4.9

than home or other places outside of health facilities.	Disagree	53	21.5
	Indifferent	21	8.5
	Agree	88	35.6
	Strongly agree	73	29.6
Safe abortion services should be more accessible than the current level.	Strongly disagree	14	5.7
	Disagree	32	13.0
	Indifferent	24	9.7
	Agree	114	46.2
	Strongly agree	63	25.5
More should be done to make you clear and familiar with legal status of safe abortion care.	Strongly disagree	3	1.2
	Disagree	61	24.7
	Indifferent	25	10.1
	Agree	111	44.9
	Strongly agree	47	19.0
The information you have now is enough to make decisions regarding safe abortion.	Strongly disagree	18	7.3
	Disagree	201	81.4
	Indifferent	3	1.2
	Agree	17	6.9
	Strongly agree	8	3.2

11.4 በጥናትውስጥየተሳትፎመጠየቂያቅጽ

በጥናቱ ተሳታፊዎች የሚሞላ

የስምምነት ማጠየቂያ ቅጽ

በቅድምያ ሠላምታዬን እያቀረብኩኝ

ወድ ተሚሪዎች፤ - እኔ አቶ አብርሃም ሞጋ በጂማ ኒቨረሲቲ የድህሬ ምረቃ ተሚሪ ሲሆን ፤ በወጣት ሴት ተሚሪዎች ደህንነቱ የተበቀ የወርጃ/ጽንስ የሚደረጥ ዕወቀት፤ ዝንባለ እና ተሞክሮን የመዳሠሥ ዕቅድ ያለው የመመረቂያ ለማዘጋጀት ነው፡፡ የወጣት ሴቶች የጠፍ አጠባበቅ ጉዳይ ተገቢወን ትኩረት አለማግኘቱ የሚታወቅ ነው፡፡በመሆኑም ይህ ጥናት የቦ/ቦ/ከ/ሁ/ደ/ት/ቤት ሴት ተሚሪዎች ደህንነቱ የተበቀ የወርጃ/ጽንስ የሚደረጥ ዕወቀት፤ ዝንባለ እና ተሞክሮን የመዳሠሥ ዕቅድ ያለው ሲሆን አንችም በጥናቱ እንድትካተች ተመርጠሻል፡፡ የተመረጥሽወም በአጋጣሚ ነው፡፡

የጥናቱ ዓላማ ወጣት ሴቶች ደህንነቱ የተበቀ የወርጃ/ጽንስ የሚደረጥ ዕወቀት፤ ዝንባለ እና ተሞክሮን በተመለከተ መረጃን ለማግኘትና አገልግሎቱን ለሚሻሻል አቅጣጫዎችን ለማከፋም ነው፡፡በጥያቄዎች የተለያዩ ግላዊ እና ሌሎችም ቅርበት ያላቸው ጉዳዮች ተካተዋል፡፡ስለሆነም ጥናቱ የተሟላ መረጃ ላይ የተመሠረተ እንድሆን ትከክለናና ተዓማንነት ያለወን መልስ መስጠት ይጠበቃል፡፡ሥማችሁ አይጻፍበትም፤የማንኛወም ሰው ሪፖረት አይደረግም፡፡በጥናቱ መሳተፍ ሚይፈልግ በየትኛወም ግዜ የጥያቄ ወረቀቱን ጥያቀወን ለሚያስሞላው ሰው ተነግሮ ሜዳምና ወረቀቱን በማስቀመጥ መተው ይችላል፡፡

ለሰጣችሁኝ ለትክክለናኛ መልሶቻችሁ አመሰግናለሁኝ፡፡መሰማማት አለመሰማማታችሁን ለመግለጽ ከዝህ በታች በተጠቀሰው ባዶ ቦታ ምልክት በሚድረግ ይገለጽ፤ -

በጥናቱ መሳተፍ ትፈልግያለሽ?

☐ አወን፤ መሳተፍ እፈልጋለሁኝ

☐ አይ፤ መሳተፍ አልፈልግም

11.4.1 የአባት /የእናት /የአሳዳጊየጥናትተሳትፎፍቃድመጠየቂያቅጽ

የስ ምምነ ትማጠየ ቂያ ቅጽ

በቅድምያ ሠላምታዬን እያቀረብኩኝ፤

ወድ የተሜሪዋ/ዎች ቤተሰቦች፤ በቅድሚያ የሜክበር ሠላምታዬን እያቀረብኩኝ፤ እኔ ተሜሪ አብርሃም ሞጋ በጂማ ኒቨረሲቲ የድህሬ ምረቃ ተሜሪ ሲሆን ፤ በወጣት ሴት ተሜሪዎች ደህንነቱ የተበቀ የወርጃ/ጽንስ የሜቋረጥ ዕወቀት፤ ዝንባለ እና ተሞክሮን የመዳሠሥ ዕቅድ ያለው የመመረቂያ ለማዘጋጀት ነው፡፡ በመሆኑም የወጣት ሴቶች የጠፍ አጠባበቅ ጉዳይ ተገቢወን ትኩረት አለማግኘቱ የሚታወቅ ነው፡፡ጥናቱ የቦ/ቦ/ከ/ሁ/ደ/ት/ቤት ሴት ተሜሪዎች ደህንነቱ የተበቀ የወርጃ/ጽንስ የሜቋረጥ ዕወቀት፤ ዝንባለ እና ተሞክሮን የመዳሠሥ ዕቅድ ያለው ሲሆን ልጆዎም በጥናቱ እንድተት ተመርጣለች፡፡ የተመረጡቹ ወም በአጋጣሚ ነው፡፡የጥናቱ ዓላማ ወጣት ሴቶች ደህንነቱ የተበቀ የወርጃ/ጽንስ የሜቋረጥ ዕወቀት፤ ዝንባለ እና ተሞክሮን በተመለከተ መረጃን ለማግኘትና አገልግሎቱን ለሜሻሻል አቅጭጫዎችን ለማጠቆም ነው፡፡በጥያቄዎች የተለያዩ ግላዊ እና ሌሎችም ቅርበት ያላቸው ጉዳዮች ተካተዋል፡፡ስለሆነ ም ጥናቱ የተሟለ መረጃ ላይ የተመሠረተ እንዲሆን ትክክለኛና ተዓማንነት ያለወን መልስ ከተሳታፊወች ለማግኘት የተሳታፊዎች ዕድሜ ከ18 ዓመት በታች ከሆኔ በኢትዮጵያ ወንጀል መቅጫ ህግ መሠረት ተሳታዋ ያለወላጆቿ ፈቀድ በራሷ መሳተፍ ስለማትችል ፈቃድ ከርሶዎ ማግኘት አስፈላጊ ሆኖ ተገኝቷል፡፡ በሪፖርቱም ስም አይጻፍበትም፤የማንኛውም ሰው መልስ ሪፖረት አይደረግም፡፡

ልጆዎም ብትሆን በጥናቱየሜሳተፈው በፍላጎቷ ነው፡፡መሳማማት አለመሳማማታችሁን ለመግለጽ ከዝህ በታች በተጠቀሰው ባዶ ቦታ ምልክት በሜድረግ ይገለጹ፤ -በጥናቱ መሳተፍ ተፈቅዶላታል?

አ☐ ትሳተፍ!

አ☐ እንድትሳተፍ አልፈቅድም!

11.5 Questionnaire (Amharic)

መሠረታዊመረጃ

ተ.ቁ	ማጠይቆች	የኮዶችስያሜ	መላያ/ኮድ	ወደቀጣዩማ ለፍያ
101	ዕድሜ	_____		
102	ቀበሌ	_____		
103	የትምህርትደረጃ (ክፍል)	_____		
104	ብሔር	ሀ.ወላይታ ለ.አማራ ሐ. ካምጣታ መ. ሀዲያ ሠ.ሌላ _____	1 2 3 4 5	
105	ሐይማኖት	ሀ.ፕሮቴስታንት ለ.አርቶዶክስ ሐ.ካቶሊክ መ.ሚኪልም ሠ.ሌላ _____	1 2 3 4 5	
106	የጋብቻሁኔታ	.ሀያገባች ለ.ያላገባች ሐ.የፈታች መ.የሞተባት	1 2 3 4	
107	የወርገቢ (የግል)	_____		
108	የወርገቢ (የቤተሰብ)	_____		
109	የቤተሰብአባላትብዛት	_____		
110	የእናት (የአሳዳጊ) የትህርትደረጃ	ሀ.ያልተማረች ለ.ከ1-4 ሐ.5-8 መ.9-12 ሠ.የኮሌጅ/የዩኒቨረሲቲተመራቂ	1 2 3 4 5	
111	የአበት (የአሳዳጊ) የትህርትደረጃ	ሀ.ያልተማረች ለ.ከ1-4 ሐ.5-8 መ.9-12	1 2 3 4	

		ሠ.የኮሌጅ/የዩኒቨረሲቲተማሪቂ	5	

2.ስለወርጃያለእወቀት

201	ስለወርጃሰምተሽታወቅያለሽ?	ሀ.አዎን ለ. አልሰማሁም	1 2	
202	ሜልስሽአዎንከሆነ ፡ ከየትሰምተሻል?	ሀ.ከረዲዮ ለ.ከትህርትቤት ሐ.ከጠፍተቋም መ.ከጓደኞቼ ሠ.ከቤተክርስቲያን ረ.ሌላምካለ _____	1 2 3 4 5 6	
203	ስለድነ ገ ተኛወርጃሰምተሽታወቅያለሽ?	ሀ.አዎን ለ.አልሰማሁም	1 2	
204	በሰዎችፍላጎ ትስለሜደረገ ወወርጃሰምተሽታወቅያለሽ?	ሀ.አዎን ለ.አልሰማሁም	1 2	
205	ፅንስእንዳይከሰትየ ሚዱየ ቤተሰብምጣጬ አገ ልግሎቶችን ታወቅያለሽ?	ሀ.አዎን ለ.አላወቅም	1 2	
205	ፅንስከ20 ሳምንትበፊትየ ሜቋረጥከሆነ ወርጃነ ውብለሽትቀበዪያለሽ?	ሀ.አዎን ለ.አልቀበልም	1 2	
206	ከፍተኛየ ደምግፍት፡ የስኳርበሽታ፡ የልብሀመምና ለሎችም ወርጃንሊያስከትሉእንደሜቻሉታወቅያለሽ?	ሀ.አዎን ወቅም	1 2	
207	ድጋፍያለመኖር፡ የመንፈስጫቆትናበጣምልጅመሆንወይም ሜርጀትወርጃእንደሜያስከትልታወቅያለሽ?	ሀ.አዎን ለ.አላወቅም	1 2	
208	በሰዎችፍላጎ ትሜደረገ ወዓ ወርጃከስነ - ምግባርናከሃይሜኖትጋርይጋጫልብለሽታምኛለሽ?	ሀ.አዎን ለ.አላምንም	1 2	
209	የኢትዮጵያፌደራላዊደሞክራሲዊፓብልከየ ወንጀልመቅ ጫህግደህንነ ቱየ ተጠበቀጽንስየ ሜቋረታዎችበተወሰኑሁኔ ተዎችለሴቶችእንደሜፈቅድታወቂያለሽ?	ሀ.አዎን ለ.አላወቅም ሐ.ርግጥኛአይደለሁም	1 2 3	ሜልሱአዎን ካልሆነ ወዴ ጥያቄቁ. 211 እለፊ
210	ሜልስሽለ209ኛጥያቄአዎንከሆኔ ፣ በምንዓይነ ትሁኔ ተዎ ችናመፎየ ሜፈቅድይሜላል?	ሀ.ፅንሱከዘመድ/የአስገድዶመድፈርከሆ ኔ ለ.የእናትናየህጻኑጤነ ትአደጋላይየ ሚ ወድቅከሆነ ሐ.የጽንስጠፍሜየለመሆንስኖር	1 2 3	

		መ.የእናትየስነ - ልቦናዊ፤ የአካላዊወይንምየስነ - አዕምሯዊየሆነህጻንንያለማእደግችግርስ ኖር ሠ.ከላይበተጠቀሱበሁሉምምክንያቶች	4 5	
211	በአሁኑሰዓትበአብዘኛውሴቶችለወርጃመድሃኒትይጠቀማሉ ?	ሀ.አዎን ለ.አይጠቀማም	1 2	
212	በአሁኑግዜየ ወርጃሁኔታእየ ጨመረነ መሞላትእንችላለን?	ሀ.አዎን ለ.አይጨምርም	1 2	
213	አዎንካልሽቁጥሩበወጣቶችከፍይላልትይያለሽ?	ሀ.አዎን ለ.አላስብም	1 2	

3.ስለወሮጃያለአጫካከት

			በጣም እስማማለሁ	እስማማለሁ	በተለየ አያለሁ	አልስማማም	በጣም አልስማማም
		ኮድ	5	4	3	2	1
301	ያልታቀደ/ያልተፈለገ ህጻንን ከማሕደግ ማህወረድ ይሻላል፡፡						
302	ማሕደግ በሚችሉ በወጡት በተሟሪዎች ላይ የሚሰተወን እርግዝና ማህወረዱ ትምህርት ለመቀጠል መበትሔ ነው፡፡						
303	በመሟ ላይ ባሉና በላገቡ በወጣት ሴቶች የተከሰተ ጽንሰ መቋረጥ አለበት፡፡						
304	ወጣትሴቶች ጽንስ የሚቋረጡት የግበረ-ሥጋ ግኑኝነት መድረጋቸው በቢሰተሰብ እና በሌሎችም ዘንድ እነደዳይታወቅ በሚለግ ነው፡፡						
305	በስለተኑ ጠፍ ባለሞያዎች ጽንስን መቋረጥ በሌሎች ከመቋረጥ የተሸለ ነው፡፡						
306	ወሮጃን በጠፍ ተቋማት መድግ በሌሎች በታዎች ከመድረግና ቤት ከመድረግ ይሚጣል፡፡						
307	ደህንነቱ የተጠበቀ የወሮጃ አገልግሎት አሁን ካለበት ማሳፋፍት አለበት						
308	ደህንነቱ የተጠበቀ ወሮጃ ህጋዊነትን በማህወቅ ረገድ ብዙ ማህራት ይጠበቃል፡፡						
309	ደህንነቱ ስለተተበቀ ወሮጃ ያለሸ ሚጃ ወሳኔ ለመሰን በቂሸ አይደለም ፡፡						

4.ወሮጃንስለሚጸም -

ተ.ቁ	**ማጠይቆች**	**የኮዶችስያሜ**	**ማሳያ/ኮድ**	**ወደቀጣዩ ማሸፍያ**
401	ከዚህበፊትየ ወንድጓደኛነ በረሸ?	ሀ.አዎን ለ.አልነ በረኝም	1 2	
402	የ ግብረ-ሥጋአድርገ ሸታወቅያለሸ?	ሀ.አዎን ለ.አላወቅም	1 2	
403	አዎንካልሸበወቅቱኮንዶምተጠቅማቹሀነ በር?	ሀ.አዎን	1	

		ለ.አልተጠቀምንም	2	
404	ከዚህበፊትአርግዘሽታውቅያለሽ?	ሀ.አዎን ለ.አላወቅም	1 2	
405	አዎንካልሽለምንያህልጊዜ?	_____		
406	ከዚህበፊትወርጃገ ጥሞሽያውቃል?	ሀ.አዎን ለ.አልገጠመኝም	1 2	
407	አዎንካልሽለምንያህልጊዜ?	_____		
408	በወቅቱለወርጃወምክንያትየነበረወምንድንነው?	ሀ.በጣምልጅ ነበርኩ ለ.ቤተሰብን ፈርቼ ሐ.ሕበረተሰብን ፈርቼ መ.ስለተደፈርኩ ሠ.ትምህርቴንላለመተው ረ.ደምስለሜፈስ ሸ.ከዘመድስላረገዝኩ ቀ.በራሱ ገዜ ያለምንም ምክንያት በ.ሌላምካለ _____	1 2 3 4 5 6 7 8 9	
409	በወቅቱበማንእገዛነበርያስወረድሽው?	ሀ.ብቻዬን ለ.በባህላዊመንገድበሚያስወርዱት ሐ.ዘመድ መ.ነርስ ሠ.የህክምናዶክተር ረ .ያለማንም እገዛ በራሱ ጊዜ ሰ.ሌላምካለ _____	1 2 3 4 5 6 7	
410	የትነበርያስወረድሽው?	ሀ.ቤት ለ.በባህላዊመንገድበሚያስወርዱትቤት ሐ.ሆስፒታል መ.ጠፍጣቢያ ሠ.በግልጠፍተቋም ረ.ሌላምካለ _____	1 2 3 4 5 6	ወደጥያቄቁጥር 412 እለፈምላሹኮደሀእና ለከሆኑ
411	ለጥያቄቁጥር 412 ምላሽሽየጠፍተቋምከሆነ፡የጽንስየማስወረድውሳነሽን በወቅቱየተቃወሞጠፍባለመያነበር?	ሀ.አዎን ለ.አልነበረም	1 2	
412	የጽንስየማስወረድሂደቱየተፈፀመመብሰለጠነየጠፍባለ መያካልሆነበምንመልኩነበር?	ሀ.ስለታምነገሮችንብልትወስጥበማተ ት	1	

		ለ.የአንቲ - ባዮቲክመድሀኒቶችንያለባለመጀተዕዛዝ በከፍተኛዶዝበመመሰድ ሐ.በባህላዊመንገድየተዘጋጁነገሮችን በማጣጣት መ..ከከፍታብመዘለልናበመወደቅበመጎ ዳት ሠ.ሌላምካለ_____	2 3 4 5	
413	የጽንስየሞክወረድሂደቱየተፈፀመመብሰለጠነየጠፍባለ መጀከሆነ በምንመልኩነ በር?	ሀ.መድኃኒትበመርፈበማጠትብቻ ለ.መድኃኒትበማዋጥናመኃኒትበብልትው ስጥበማክቀመጥ ሐ. የጠፍባለመጀው/ዋበህክምናመሣሪያታግ ዞ/ዛ መ. በሕክምናመጎሪያቆርጣ/ጦጽንስንአወጥ ታላች	1 2 3 4	
414	ካስወረድሽበኋላምንየገጠመቸችግርነበረ?	ሀ.አዎን ለ.አልገጠመኝም	1 2	
415	አዎንካልሽምንምንገጠመ?	ሀ.የደምመፍሰስ ለ.የሆድቁርጠት ሐ.ትኩሳት መ.መሉበመሉያለመወጣት ሠ.ሌላምካለ_____	1 2 3 4 5	
415	የድህረ-ጽንስማክወረድአገልግሎትተጠቅመቸነበር?	ሀ.አወን ለ.አልተተቀምኩም	1 2	
416	ከተጠቅምሽምን፤ ምንአገልግሎቶችን?	ሀ.የምክር ለ.ያልተጠናቀቀወይምደህንነቱያልተጠ በቀወር ጃህክምና ሐ.የቤተሰብምጣጌ መ. ለሌችአገልግሎቶችናወደሌላቦታሪፈራል	1 2 3 4	