SAFE ABORTION SERVICE UTILIZATION AND ASSOCIATED FACTORS AMONG HOMELESS WOMEN IN THREE TOWNS OF SOUTHWEST ETHIOPIA, A CROSS SECTIONAL MIXED METHODS STUDY.

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A RESEARCH THESIS SUBMITTED TO THE DEPARTMENT OF EPIDEMIOLOGY, FUCULTY OF PUBLIC HEALTH, JIMMA UNIVERSITY; IN PARTIAL FULFILLMENT FOR THE REQUIREMENTS FOR THE MASTERS OF PUBLIC HEALTH (MPH) IN EPIDEMIOLOGY

NOVEMBER, 2021

JIMMA, ETHIOPIA

Safe abortion service utilization and associated factors among homeless women in Southwest Ethiopia, A Cross sectional mixed methods study.

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November, 2021

Jimma, Ethiopia

ABSTRACT

Back ground: *Homeless women are the most vulnerable group for unwanted pregnancy. However, their issues are not being addressed in government plan. Despite the fact that Ethiopia has a penal code regarding safe abortion care, studies show that homeless women low access this service. Therefore, the aim of this study is to assess utilization of safe abortion service and associated factors among homeless women.*

Methods: *Community based cross sectional mixed methods study was done in three towns of southwest Ethiopia (Jimma, Bonga and Mizan-aman) from May 20 to July 2 / 2021 G.C. A total of 122 participants were included in the quantitative part. Participants were chosen by snow balling technique and data was collected through face to face interview. To enter and analyze data, Epi-data 3.1 and SPSS 21 were used, respectively. Descriptive analysis was performed initially and then binary logistic regression. An AOR with 95% CI and P-value <0.05 was used to declare significant association. In-depth interviews on 12 key informants were done for qualitative portion and then data was transcribed and analyzed using thematic content analysis.*

Result: *The magnitude of safe abortion service utilization among homeless women was found to be 34 (27.9%). After controlling for confounders in multiple logistic regressions, average daily income (AOR = 5.873, P-value = 0.003, CI [1.834, 18.801]), poor knowledge towards safe abortion (AOR = 0.256, P-value = 0.037, CI [0.071, 0.920]) and perceived unaffordability of cost of abortion at health facility (AOR = 0.108, P-value = 0.000, CI [0.034, 0.345]) were significantly associated with safe abortion. The qualitative findings of this study revealed that homeless women's personal characteristics, health provider related factor and health system factors all had influence on homeless women's utilization of safe abortion service.*

Conclusion: *Safe abortion service utilization among homeless women in the study area was low. Average daily income, knowledge towards safe abortion and perceived cost of abortion at health facility were significantly associated with safe abortion.*

Key terms: *homeless women, safe abortion, unsafe abortion, associated factors, cross-sectional mixed methods study*

Acknowledgements

Firstly, I am grateful to express my heartfelt thanks to my advisors Mr. Solomon Berhanu (BSc, MPH) and Mr. Lata Fekadu (BSc, MSc) for their constructive comments and advices. Next, I would like to acknowledge Mizan Aman Collage of Health Science and Jimma University, faculty of public health, Epidemiology department for creating this opportunity. I would also like to acknowledge jimma town health office administrators, Bonga town health office administrators and mizan aman town health for giving important information. My special thanks go to my study participants for their willingness to provide information voluntarily.

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Acronyms/Abbreviations

Acronyms/abbreviations	Explanations
AA	Addis Ababa
AOR	Adjusted Odds Ratio
CI	Confidence Interval
COR	Crude Odds Ratio
DRC	Democratic Republic of the Congo
G.C	Gregorian calendar
HEW	Health Extension Worker
IPV	Intimate Partner Violence
JU	Jimma University
LPI	Lifetime Pregnancy Involvement
MCH	Maternal and Child Health
MD	Medical Doctor
MPH	Masters of Public Health
NGOs	Non Governmental Organizations
OR	Odds Ratio
SD	Standard Deviation
SRH	Sexual and Reproductive Health
SPSS	Statistical Package for Social Science
WHO	World Health Organization
VIF	Variance Inflation Factor
YPS	Youth Peer Service

Chapter one: Introduction

1.1. Back ground

An abortion is said to be safe when it is carried out with a method that is recommended by world health organization (WHO); abortion procedures performed at health facilities, when it is appropriate for gestational age and when it is carried out by skilled care provider (1). Unintended pregnancy due to unmet need of contraception and poor access to safe and legal abortion are two main factors that underlie unsafe abortion(2). Homeless women, the women who lacks a fixed, regular and adequate night time residence, are the most vulnerable group for unwanted pregnancy(3,4) This is mainly due to the fact that they are subjected to sexual violence, rape or harassment(5) and low level of contraceptive utilization(6).

Homeless women encounter various barriers to utilize health care services(6,7) Although homeless women has a clear desire to avoid pregnancy while homeless, they faces barriers to access reproductive health care due to lack of secure housing(8). Moreover, majority of women don't have enough awareness about the safe abortion care service provision(9). In addition to this, lack of permanent place and fear of stigma and discrimination further ban homeless women from utilizing these services(10). Thus, in order to avoid perceived shame and stigma associated with obtaining abortion service, homeless women commonly attempt unsafe abortion including self -induced abortions(11,12)

In Ethiopia, abortion has been legalized since 2005 in cases of rape, incest, fetal impairment risk of danger for mother's or her child's life or if the woman is unable to bring up her child due to physical or mental infirmity. However despite this law, unsafe abortion remains a challenge for many Ethiopian women(13,14). The national estimate of induced abortion in 2014 was 620,300 with annual abortion rate of 28 per 1,000 reproductive age women(15). Although there is improvement in availability of safe abortion service provision, about half of all abortions continue to occur outside of health institutions(16,17). Therefore, knowing the magnitude and

factors affecting homeless women's safe abortion service utilization is important to improve homeless women's access to safe abortion care service.

1.2. Statement of the problem

Unsafe abortion is among the major causes of maternal mortality. About 4.7 to 13.2% of maternal deaths are attributable to unsafe abortion and globally abortion-related deaths leave 220,000 children without mother each year. Between 2015-19, globally about 121 million unwanted pregnancies occurred annually, of which 61% ended in abortion (18). Women from developing countries die at higher rate than women in developed countries due to abortion. For example, evidences indicates that an estimated 30 women die per100 000 unsafe abortions in developed countries while in developing countries, 220 deaths per 100 000 unsafe abortions occurs every year. Moreover, about 7 million women per year were treated in health institutions for complications of unsafe abortion such as hemorrhage and sepsis(1,19–21).

Unsafe abortion is higher in developing countries as compared to developed countries. For instance, in western nations, only 3% of abortions are unsafe, whereas in developing nations 55% are unsafe. The highest incidences of abortions that are unsafe occur in Latin America, Africa and South East Asia(19). In Africa, women are affected by mortality from unsafe abortion disproportionately, accounting for 29% of all unsafe abortions and 62% of deaths related to unsafe abortion(22). Therefore, access to legal abortion plays an important role in reducing the level of unsafe abortion and maternal death caused by unsafe abortions, and almost all deaths and complications from unsafe abortion can be prevented through provision of safe and quality abortion service(23).

Pregnant women experiencing homelessness are more prone to physical and mental health risks that affect the mother as well as the baby when compared to general population and in addition to this, lack of access to a safe and clean environment is a major challenge for women who experience abortion while homeless(24). Furthermore, Homeless women seek abortion care later in gestation which further result in increased rate of abortion complications among homeless(25).

More generally, risks common to all pregnancies are more magnified in case of homeless women due to low access to routine health care(26).

Homeless women are usually underrepresented. The number of homeless women in Ethiopia is increasing substantially but their issues are not being addressed in government plans(27). Moreover, only few studies are conducted regarding reproductive health issues of homeless women in Ethiopia(28–30) and although homeless women are at increased risk of unwanted pregnancies than general population, studies that are conducted on safe abortion service utilization mainly focused among general population and students(9,31,32). This study is therefore important to identify the level of and factors related to safe abortion service utilization and provide information which will help to address the reproductive health needs of the homeless women in the study area.

1.3. Significance of the study

This study will provide important information about level of utilization of safe abortion service and factors associated with utilization of safe abortion service among homeless women. It will also generate necessary information for improving provision of safe abortion services for homeless women who seek abortion. In addition to this, the study will provide necessary information for program and policy makers in development of strategies that improve the safe abortion service provision for homeless women in the study area and in general. The study may also provide information for researchers, non-governmental organizations (NGOs) and/or other partners and stakeholders that may initiate them to explore more about social, economic and health system factor which might hinder homeless women from obtaining already available services thereby improving sexual and reproductive health (SRH) of homeless women in the study area and in the country in general.

Chapter two: Literature review

2.1. Utilization of safe abortion service among homeless women

Evidences indicate that Safe abortion service utilization among homeless women is very low. For example, study in US show that out of all individuals who obtain safe abortion service in an urban clinic in San Francisco, only 19% of abortions were among homeless(25). In a study in conducted in Ukraine on Lifetime Pregnancy Involvement (LPI) of street youth, 63.3% of respondents reported that their recent pregnancy was unintended and of these 43.2% reported that the pregnancy has ended in induced abortion while 13.9% ended in miscarriage or fetal death(33). In Brazil, the prevalence of abortion among homeless women in 2018 was found to be 10.4%(34).

Study conducted in Democratic Republic of Congo (DRC) revealed that 24.5% of previous pregnancies ended in induced abortion, the higher rate (50%) being among the youngest street girls(35). Study conducted in northern Ethiopia, Bahirdar, showed that out of the total of 96 victims of rape, 19.1% experienced unwanted pregnancy and 13.2% experienced induced abortion(36). Another Study conducted in Dessie town showed that, out of sexually active female street youth, 25% reported that they had a history of unintended pregnancy, out of which only about half (55.5%) of them reported they had history of induced abortion(37).

Result from study conducted in Addis Ababa on reproductive health of street children showed, out of 108 street girls participated in the study, 70.4% reported that they had history of pregnancy, almost all (96%) of pregnancies were unwanted and about 59.4% of these pregnancies resulted in abortion(28).

2.2. Factors associated with safe abortion service utilization

WHO recommends that safe abortion services should be easily available and affordable to all women(23). However, Evidences suggest that barriers to safe abortion are numerous and include legal barriers, health policy barriers, shortages of trained healthcare workers and stigma related to abortion(38). Additional social, economic and health systems barriers and stigma hinder access to safe abortion services even in countries with liberal abortion law(39). In United States, homeless women's abortion experiences and decision making processes are linked with poverty, lack of social support, lack of awareness and perceived violence from family or partners due to their decisions for abortion(40).

Factors that hinder homeless women to access and utilize sexual and reproductive health (SRH) including safe abortion service were categorized under individual level factors (like life style, lack of information, limited income and lack of health insurance), patient- provider interaction (including poor trust on providers, lack respect from providers and fear of stigma) and health care system or organizational factors (such as inflexibility of service delivery, limited clinic hours and long waiting times)(41). Moreover, mandatory pre-abortion counseling is found to be barrier to a number of women for accessing safe abortion services and leads to turn to unsafe abortion(42).

Evidences indicate that in Africa, socio normative factors like gender based power imbalance, lack of awareness and stigma, and structural barriers such as restrictive legal environment, unavailability of service and high costs are major reasons for terminating pregnancies outside health institutions(43–45). For example, in South Africa, concerns about privacy (44%), and mistreatment and stigma from providers (30%) are primarily related to women decision to seek abortion outside health facility(46). There are also barriers on side of care providers like lack of technical guidance, ambiguity about the legal framework, limited training on abortion and misinterpretation of conscientious objection(47–49).

In Ethiopia, study in Axum indicates lack of awareness, lack of permanent residence, fear of stigma and discrimination, previous experience, negligence, lack of social support, religious and

traditional beliefs, poverty and unfriendly care providers are common factors associated with low maternity health care utilization among homeless women(10). Another study conducted among street children in Addis Ababa indicated perceived and actual barriers to SRH service utilization including unaffordable cost, lack of information about services and health facilities, ignorance of the consequence and unfriendly staff (28).

2.3. Conceptual framework

The factors associated with safe abortion service utilization were indicated in the conceptual frame below (figure 1). This conceptual framework is developed after trawling literatures related to the study title and the variables listed under socio demographic, socio economic, individual factors and health system factors were measured quantitatively and supported by qualitative findings whereas health care provider related factors were assessed qualitatively. The solid lines indicate the direct relationship between outcome variable and independent variables whereas the dotted lines indicate the relation between independent variables.

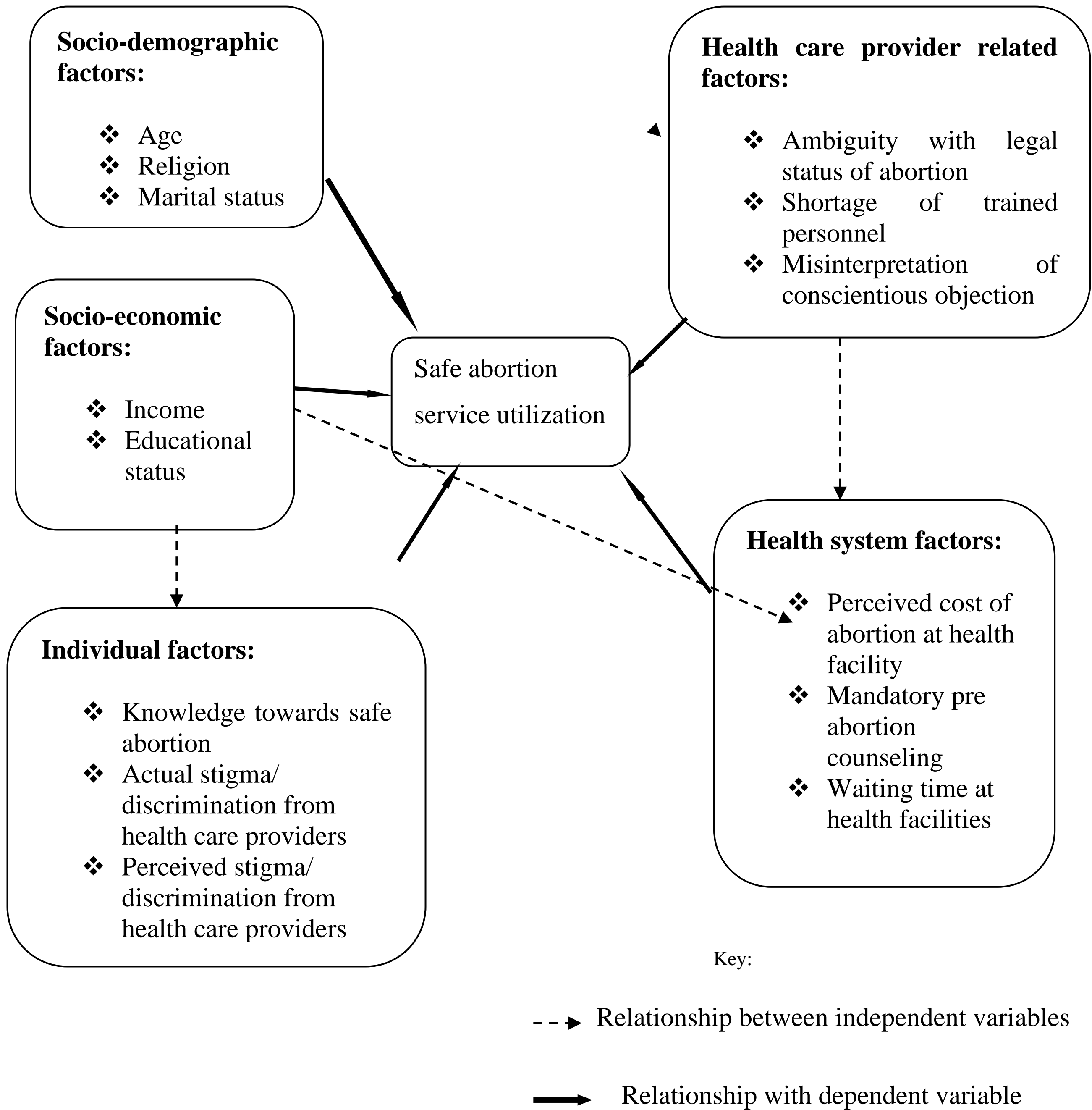

Figure 1- Conceptual framework for utilization of safe abortion service and associated factors among homeless women in Southwest Ethiopia, May-July/ 2021G.C

Chapter three: Objectives

3.1. General objective

To assess utilization of safe abortion service and associated factors among homeless women in southwest Ethiopia from May-July / 2021 G.C

3.2. Specific objectives

- To determine the magnitude of safe abortion service utilization among homeless women in southwest Ethiopia, 2021 G.C
- To identify factors associated with utilization of safe abortion service among homeless women in Southwest Ethiopia, 2021 G.C

Chapter four: Methods and materials

4.1. Study area and period

This study was conducted from May 20 – July 2 / 2021 G.C in three purposively selected towns of southwest Ethiopia; Jimma, Bonga and Mizan-Aman town. Jimma town is the capital city of Jimma zone, Oromia region, located in Southwestern part of Ethiopia. It is found at a distance of 354 km from Addis Ababa, the capital city of Ethiopia. The town has 17 kebeles (13 urban & 4 rural) and based on the 2007 national census, the estimated population of Jimma town in 2020/21 is 220,609; of these, 112,511(51%) are females, however the estimated number of homeless women in the town is not known. There are 4 health centers, 2 public hospitals (1 specialized referral & 1 district), 24 private clinics, 3 private district hospitals, 4 NGO facilities and 17 health posts in the town. Of these health facilities, 13 are known to safe abortion care service provision by the town health office(9).

Bonga town is the capital city of kaffa zone, and is located 105 km and 465 km away from jimma town and from Addis Ababa respectively in southwestern direction. The town has 3 administrative kebeles, and based on the 2012 annual report kaffa zone health department, the total population of Bonga town is estimated to be 27634 of which 13624 (49.3%) are males and 14010 (50.7%) are females. But no statistics is available regarding the number of homeless women in the town. There are one General Hospital, one health center and three private medium level clinics in the town(50).

Mizan-Aman town is the capital city of Bench-sheko zone, and is found 227 km away from Jimma and 574 km from Addis Ababa in southwest direction. Based on 2007 National Census, the estimated total population of town is 48,934 among which 24,956 (51%) were females. The estimate of homeless women in the town is not known. The town was has 5 kebeles. There are one Teaching Hospital, one Health Center and 21 private clinics in the town(51).

4.2. Study design

A cross sectional mixed methods study based on both qualitative and quantitative data was conducted in a community setting. The study used both quantitative and qualitative approaches concurrently to amplify and enhance the results of quantitative findings with the findings from the qualitative part.

4.3. Population

4.3.1. Source population

For quantitative part: all homeless women with abortion experience residing in three selected towns of southwest Ethiopia (Jimma, Bonga and Mizan Aman) were the source population for this study.

For qualitative part: all health care professionals working in private and governmental health facilities that are known as a provider of safe abortion care services and all administrative bodies working in health office and in labor and social affairs office found in three selected towns of southwest Ethiopia (Jimma, Bonga and Mizan Aman) were source population for qualitative section of this study

4.3.2. Study population

The study populations for quantitative part were selected homeless women with abortion experience residing in three selected towns of southwest Ethiopia (jimma, Bonga and Mizan Aman).

For qualitative part, the study populations were purposively selected key informants from health institutions known to provide safe abortion service, town health offices and labor and social affairs offices in three selected towns of southwest Ethiopia (jimma, Bonga and Mizan Aman).

4.4. Eligibility criteria

4.4.1. Inclusion criteria:

All homeless women who have past abortion history while being homeless were eligible to be included in this study. For qualitative part, health care providers and administrative bodies who worked at least for 6 month in the selected health facility or in respective health office were included.

4.4.2. Exclusion criteria:

Homeless women with Abortion history where abortion occurred prior to experiencing homelessness and homeless women with history of spontaneous abortion were excluded.

4.5. Sample size determination

For quantitative part, sample size was determined by using **rule of thumb** of 10 samples per each measurement variable(52–54). Number of predictors to be included (measured) in the quantitative part of this study was 11 and therefore, (10 x 11 = 110) is the minimum sample size required for this study. Since 110 is minimum acceptable sample size, after considering 15% non response rate, the final sample size will be: **127**

For qualitative part, 12 key informants were participated in this study who were selected from; 1 from labor and social affairs, 5 from town health offices (1 from regulatory officer, 2 from health office head, 1 HEW focal person and 1 maternal and child health (MCH) team leader, and 6 from public and private health facilities known by town health office as a provider of safe abortion service.

4.6. Sampling technique and procedure

For quantitative part: Respondents to be participated in this study were selected by using snow balling technique. First eligible homeless women who are willing to participate in this study were identified and the data was collected from them. Then these homeless women were used as

a source to obtain details of other homeless women they know to be included in the study. The data collection continued until many homeless were found and the required sample size has reached.

For qualitative part: key informants from each health facilities and offices were selected purposively based on their duration of stay in health facility/office, work experience in the area and training on safe abortion service provision.

4.7. Data collection technique and procedure

Data was collected using semi structured questionnaires that is developed after reviewing relevant literatures, depending on objectives that can be addressed in this study. For the quantitative part, the questionnaire has closed ended questions and comprises five parts; background information like age, type of homelessness, residence, income etc., pregnancy experience and abortion experience, question to assess utilization of safe abortion service as well as factors associated with safe abortion service utilization including individual factors such as knowledge on safe abortion service and other factors like health system related factors that may hinder utilization of safe abortion service. The data was collected through face to face interview by three health care professionals with supervision from investigator. The purpose of the study was clearly discussed to the respondent and their willingness to participate in the study was asked prior to data collection.

For qualitative part, a questionnaire with open ended questions (In-depth interview guide) was used. In-depth interview was made with key informants by the investigator in order to avoid subjectivity of the response. Before commencing the in-depth interview, explanation of the need to do the interview was made clear to the participants and the participants were asked for their willingness for the interview. During the in-depth interview, data was recorded according to the open ended questions in the questionnaires.

4.8. Study variables

Dependent variable: Safe abortion service utilization

Independent variables:

- Socio demographic variables: age, religion, income, marital status and educational status
- Individual factors: knowledge regarding safe abortion, perceived stigma/ discrimination from health care providers, and actual stigma/ discrimination from health care providers
- Health system related factors: cost of abortion, mandatory pre- abortion counseling and waiting time

4.9. Operational definitions

- Homeless women: women who live or spend most of their time on the street and who depend on the street for their life(36).
- Off- street women: women who depend on the street for their life and sleep on the street(36).
- On- street women: women who depend on the street for their survival, but usually return home at night(36).
- Safe abortion: in this study, a respondent who terminate their pregnancy in the health facility were regarded as to have safe abortion while respondents who sought abortion outside the health facility were regarded as to have unsafe abortion.
- Good knowledge of abortion: if a women had answered 'Yes' to eight knowledge questions above the mean score(55).

4.10. Data analysis procedure

After collection of data, the data was entered into Epi-data version 3.1 on a daily basis and then coded responses was double entered to cross check the data for consistency before analysis and finally the double checked data was exported to SPSS version 21 for further analysis. Descriptive statistics was initially performed to check for the distribution of dependent variable across population and in order to determine the magnitude of dependent variable. The magnitude of dependent variable was described in terms of frequency and percentage. Then binary logistic regression analysis was performed in order to identify factors significantly associated with outcome variable, utilization of safe abortion service. Bivariate analysis was performed first for

each factor and then factors that were significant at P-value of 0.25 with 95% CI were included in multiple logistic regression analysis. Six variables that were found to have significant association with safe abortion service utilization in bivariate analysis (P-value <=0.25), average daily income, perceived stigma/discrimination from health care providers, actual stigma/discrimination from health care providers, knowledge towards safe abortion, long weighting time at health facility and perceived cost of abortion at health facility, were entered into multivariable logistic regression model.

Before drawing conclusions based on logistic regression model, Hosmer-Lemeshow goodness of fit test was checked in order to check whether the data fit assumptions of the model and the result showed that the model has fit the data well (P- value 0.587). Multicolinearity between independent variables was also checked by estimating the variance inflation factor (VIF) and it was found to be negligible (VIF less than 5).

For qualitative part, the Data from in-depth interview was analyzed manually by thematic analysis. The data was manually cleaned initially and then the qualitative findings were narrated and summarized based on thematic areas to support the quantitative findings. The data from in-depth interview was categorized under to three main thematic areas; Personal/behavioral factors, health system factors and health care professional related factors. Responses related to knowledge regarding safe abortion, perceived stigma, life style were categorized under personal/behavioral factors; responses related to ambiguity with legal framework of abortion, contentious objection, shortage of trained personnel were categorized under health professional related factors, and responses related to weighting time, cost of abortion, health policy, planning, and health system approach were categorized under Health system factors

4.11. Data quality management

For quantitative part, the questionnaire was translated to the local languages and re translated back to English to check for consistency. During data collection completeness and consistency of each questionnaire was checked on daily basis and errors were edited as needed. During data entry the template was formatted by following appropriate commands like must entry, legal

values and jump rules to control quality data and by coding for missing value during data analysis.

For qualitative part, the open ended questions was translated to the local languages and re translated back to English to check for consistency. The data recorded in the notebook was counter checked with the tape record for consistencies. In order to keep trust-worthiness of the qualitative data triangulation with literatures was done.

4.12. Ethical consideration

Ethical clearance to conduct study was obtained from Jimma University health institute human research ethical committee. Letter of cooperation was also be obtained from JU Epidemiology department for each town health offices in three selected towns in south west Ethiopia and letter of permission was obtained from each health office in order to proceed the study. The participants were informed about the purpose of the study, their right to refuse participating and discontinue the interview. Verbal consent was obtained from each participant prior to interview to confirm willingness for participation. The information obtained from participants was kept confidential throughout the study. Moreover, during the course of data collection, information regarding safe abortion service provision and its legal framework in our country was provided for homeless women who lack information regarding safe abortion. In addition, any identification information including the name of the participants is not written in the study.

4.13. Dissemination plan

The result of the study will be presented to Jimma university epidemiology department. The final draft will be then submitted after possible correction for comments and questions raised during presentation to Jimma university epidemiology department, to Jimma town health office, and jimma zone health bureau, Bonga town health office, kaffa zone health bureau, Mizan-Aman town health office and Bench-Sheko zone health bureau. In order to reach many people who need information from this research, an effort will be made to publish the findings of this research in peer-reviewed journal.

Chapter five: Result

5.1. Socio - demographic characteristics

Total of 122 homeless women with abortion experience were interviewed (96 were from Jimma, 17 from Bonga and 9 from Mizan-Aman), making a response rate of 96%. Out of these, 32 (26.2%) were on-street homeless while the rest 90(73.8%) were off-street homeless women. The mean age of the respondents was 26 years (95% CI: 25.1 – 27.4). About 51 (41.1%) of respondents were Unmarried (Table 1). The average daily income of respondents was 21 birr (95% CI: 20.4 – 22.5). Majority of respondents 103 (84.4%) were primarily engaged in begging only as a source of income while the rest 19 (15.6%) were engaged in occasional work in addition to begging.

Table 1- Socio-demographic information of study participants, southwest Ethiopia, 2021 G.C

Variables	Categories	Safe abortion	
		Yes	No
Age category	<=24	18 (31%)	40 (69%)
	>=25	16 (25%)	48 (75%)
Marital status	Un married	15 (29%)	36 (71%)
	Ever married	19 (27%)	52 (73%)
Religion	Orthodox	13 (25%)	38 (75%)
	Muslim	11 (28%)	28 (72%)
	Protestant	10 (31%)	22 (69%)
Educational level	Never attended school	16 (25%)	47 (75%)
	Primary school	18 (31%)	41 (69%)
Average daily income	<=20 birr per day	13 (15.7%)	70 (84.3%)
	> 20 birr per day	21 (53.8%)	18 (46.2%)

5.2. Safe abortion service utilization

Safe abortion service utilization among homeless women in the study area was found to be 34 (27.9%). The rest 72.1% of total abortion takes place outside health institution under unsafe condition. The most common health institution visited by respondents to obtain safe abortion service were health center 15 (44.1%), private clinic 10 (29.4%) and public hospital 9 (26.5%). (Figure-2) Of total 88 respondents who seek abortion outside health facility, 29 (33%) respond that it is self induced and the rest 59 (67%) respond that abortion takes place in informal setting by traditional provider. Out of total 122 study participants, 52 (42.6%) responded that they ever know women who has abortion experience while the rest 72 (57.4%) responded that they didn't know.

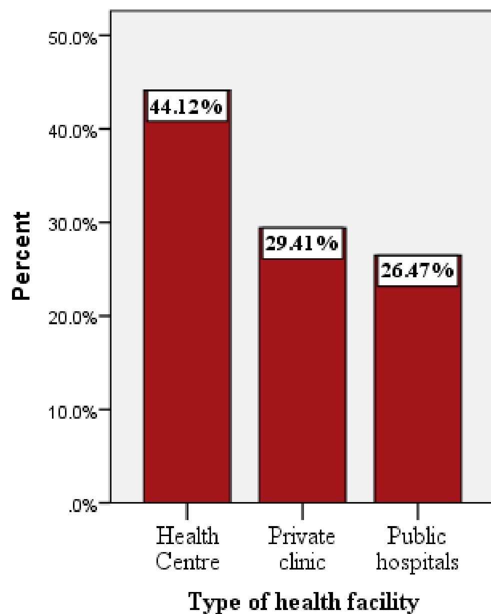

Figure 2- The most common health facilities visited by study participants for safe abortion service among homeless women in southwest Ethiopia, 2021G.C.

5.3. Individual factors

Out of total 122 respondents, 32 (26.2%) respondents have good knowledge regarding abortion while the rest 90 (73.8%) have poor knowledge about abortion. About 37(30%) of respondents reported that they have ever faced stigma/discrimination from health care providers (Table 2).

Table 2- Individual factors in relation to safe abortion service utilization among homeless women in Southwest Ethiopia, 2021 G.C.

Variables	Categories	Safe abortion	
		Yes	No
Think that they might face stigma/ discrimination from health care provider?	Yes	12 (17.9%)	55 (82.1%)
	No	22 (40%)	33 (60 %)
Ever faced stigma/ discrimination from health care providers?	Yes	16 (43.2%)	21 (56.8%)
	No	18 (21.2%)	67 (78.8%)
Knowledge towards safe abortion	Good	20 (62.5%)	12 (37.5%)
	Poor	14 (15.6%)	76 84.4%)

5.4. Health system factors

Out of total 122 respondents, 35 (28.7%) replied that they have been counseled at health facility to continue pregnancy. 43 (35.2%) of study participants responded that they have waited long time at health facility and 41 (33.6%) of total respondents perceive the cost of abortion at health facility is affordable (Table 3).

Table 3 Health system factors in relation to safe abortion service utilization among homeless women in Southwest Ethiopia, 2021 G.C.

Variables	**Categories**	**Safe abortion**	
		Yes	No
Ever counselled in health facility to continue pregnancy?	Yes	12 (34.3%)	23 (65.7%)
	No	22 (25.3%)	65 (74.7%)
Ever waited prolonged time to receive abortion service at health facility?	Yes	21 (48.8%)	22 (51.2%)
	No	13 (16.5%)	66 (83.5%)
Perceived affordability of cost abortion in health facilities	I think it is affordable	22 (53.7%)	19 (46.3%)
	I think it is unaffordable	12 (14.8%)	69 85.2%)

5.5. Independent predictors of safe abortion service utilization

The result of multivariate analysis indicated knowledge category, average daily income and perceived cost of abortion at health facility were found to be the factors significantly associated with safe abortion service utilization among homeless women (Table-4).

Table -4 Independent predictors of safe abortion service utilization among homeless women in southwest Ethiopia, 2021 G.C.

S. N	Variables	Categories	Safe abortion		COR (95% CI)	AOR (95% CI)	P-value
			Yes	No			
1	Average daily income	<=20 birr per day	13 (15.7%)	70 (84.3%)	1	1	
		> 20 birr per day	21 (53.8%)	18 (46.2%)	6.282 (2.647, 14.907)	5.873 (1.834, 18.801)	0.003
2	Think that they might face stigma/ discrimination from health care provider?	Yes	12 (17.9%)	55 (82.1%)	1		
		No	22 (40%)	33 (60 %)	3.056 (1.339, 6.974)	1.769 (0.553, 5.664)	0.336
3	Ever faced stigma/ discrimination from health care providers?	Yes	16 (43.2%)	21 (56.8%)	1	1	
		No	18 (21.2%)	67 (78.8%)	0.353 (0.153, 0.811)	0.737 (0.232, 2.341)	0.605
4	Knowledge towards safe abortion	Good	20 (62.5%)	12 (37.5%)	1	1	
		Poor	14 (15.6%)	76 (84.4%)	0.111 (0.044, 0.276)	0.256 (0.071, 0.920)	0.037
5	Ever waited prolonged time to receive abortion service at health	Yes	21 (48.8%)	22 (51.2%)		1	
		No	13 (16.5%)	66 (83.5%)	0.206 (0.089, 0.480)	0.357 (0.115, 1.106)	.074

	facility?						
6	Cost of abortion at health facility	I think it is affordable	22 (53.7%)	19 (46.3%)	1	1	
		I think it is un affordable	12 (14.8%)	69 (85.2%)	0.150 (0.063, 0.358)	0.108 (0.034, 0.345)	0.000

Homeless women with average daily income of greater than 20 birr per a day were 5.87 times more likely to seek safe abortion as compared to those who have less than 20 birr per a day (AOR = 5.873, P-value = 0.003, CI [1.834, 18.801]). This supported by qualitative finding:

> " … *Poverty is I think another factor. Due to extreme poverty, they think about how to get food for daily living rather than obtaining health care… their primary purpose is to obtain food..." (27 years old female interviewee)*

Homeless women with poor knowledge towards safe abortion were less likely to obtain safe abortion service by 74.4% as compared to those who have good knowledge (AOR = 0.256, P-value = 0.037, CI [0.071, 0.920]). This finding is supported by qualitative finding:

> *"…The reason for this is primarily Lack of awareness about the availability as well as legal framework of abortion service…" (34 years old female interviewee)*

> *" ... I think there are no concerned bodies to approach and talk to them, to teach them or who tell them different alternatives…." (29 years old female interviewee)*

> *"... As we don't provide health education for them, and also they are far from other sources of information like TV, Radio or social medias… they may lack information about the availability of the service as well as the legal status of abortion…" (30 years old male interviewee)*

Most of interviewees cited street life style as a one of factor that limit homeless women from obtaining information regarding available health services thereby hindering them obtaining the services.

"… Homeless women themselves lack intention to receive information. I see a lot of women with their children begging on street and when we try to provide them health education about family planning, they don't want to hear us because they are accustomed to street lifestyle and focus on begging…"(32 years old Female interviewee)

"…when you try to talk with them, when you approach them majority of them don't want it because they are accustomed to street life, they don't want to come close to us…" (29 years old female interviewee)

"…they thought they have nobody; they feel ashamed to visit health centers because they think they are stigmatized from people…" (35 years old female interviewee)

The odds of safe abortion service utilization among homeless women who think that the cost of abortion at health facility is unaffordable was lower by 89.2% as compared to those who think it is affordable (AOR = 0.108, P-value = 0.000, CI [0.034, 0.345]). This finding is supported by qualitative finding:

"… Cost of abortion is also another factor in private sectors. Abortion is provided for free in public facilities but in private facilities the cost of health care services in general is high and it is difficult not only for homeless even for other individual who have better income…" *(32 years old Female interviewee)*

"…as this is private sector there is payment for the procedure as well as for drugs and supplies. And the cost of abortion differs based on the procedure performed; it ranges from 500-1200 birr…" (29 years old male interviewee)

Most interviewees reported that health system approach like absence of mobile teams to provide services for homeless and absence of specific policy and could limit homeless women from obtaining available services. In addition to this health planning is also not inclusive.

"…the health system neglects these groups. Only when they came to health facilities they can get the service. There is no mobile team to address the health issue of these groups. All approaches are focused towards general population including health education, home visits, campaigns…we never consider them..." (30 years old male interviewee)

"….The health system is not flexible to include these population groups. We just focus on providing service for general population. Even health extension package doesn't consider them. Health education is usually provided for those who live in their homes through home visit rather than for homeless women…" (38 years old female interviewee)

"… There is no specific policy about the reproductive health issue of homeless women…" (34 years old female interviewee)

"…. When services are provided through campaigns, we provide them. But to my knowledge there is no specific policy…" (29 years old female interviewee)

"…Although homeless women are the segment of total population, we don't include them in our plan…" (38 years old female interviewee)

"… We plan for total population in the catchment area but we don't plan specifically for homeless women... we don't include them in our plan. The plan for should be at government level and there is no plan at government level specifically for homeless women…" (32 years old Female interviewee)

Health care provider related factors are also other factors cited by most of interviewees as a factors affecting homeless women's safe abortion service utilization status. These include shortage of trained personnel, misinterpretation of conscientious objection and ambiguity with legal framework of abortion.

"...Another thing is that our approach. We don't go down and work on them, we need to go down and work on them and provide information about the availability of the service…" (32 years old Female interviewee)

"*…We didn't get close to them to understand what their problem is. The problem is that there is no specific service for them. When they visit health facility, we treat them just like ordinary personnel. But homeless are eligible to get safe abortion as they are under extreme poverty. Sometimes we just counsel them to return and continue the pregnancy without deeply asking their reasons or without knowing that they are homeless and later they return with complication of unsafe abortion…."(37 years old male interviewee)*

"... I think majority of health care professionals may not discriminate/stigmatize the homeless women…" (28 years old female interviewee)

.

"... But some may do. Some health care professionals may give priority to the rich people; they respect more the rich people…" (25 years old female interviewee)

"... There are trained personnel. But when the trained personnel are on leave or away for another reason, we experience shortage…" (37 years old male interviewee)

"... I think that a health care provider can refuse to perform safe abortion if it is against his/her personal beliefs or religion…" *(27 years old female interviewee)*

"... But sometimes they refuse to perform the procedure I don't know reason…." *(25 years old female interviewee)*

"….I don't think that health care providers should refuse. But some health care providers say that abortion is prohibited by their religion. But as to me, we have a

responsibility to provide abortion service for the women as long as she fulfills the prerequisite…" (28 years old female interviewee)

"….Maybe those health care providers who receive training on abortion may better know the legal framework of abortion… I can't say surely all health care providers know it…" *29 years old male interviewee)*

"… And not knowing the legal framework has impact on safe abortion service utilization...it may increases rate of unsafe abortion" (27 years old female interviewee)

Chapter six: Discussion

This study aimed to assess magnitude and factors associated with safe abortion service utilization among homeless women in Southwest Ethiopia. The result of this study had indicated that the magnitude of safe abortion service utilization among homeless women was 34 (27.9%). Average daily income, perceived affordability of cost of abortion at health facility and knowledge towards safe abortion were factors that showed significant association with safe abortion service utilization of homeless women after controlling for confounders in multiple logistic regressions.

This study revealed that only about one-quarter abortion 34 (27.9%) among homeless women in the study area was terminated under safe condition, making the rest three- quarter of abortion among homeless women unsafe. This finding is far below the national estimate of unsafe abortion in 2014, which indicate that 47% abortions were unsafe(15). This indicates that the greater proportions of homeless women terminates their pregnancies outside health facilities that might carries significant risks of morbidity and mortality from complications of unsafe abortion.

The magnitude of safe abortion service utilization among homeless women in this study 34 (27.9%) was also lower as compared to the finding of study conducted in Addis Ababa which was 59.4% (28) and in Dessie which is 55.5% (37). The reason for this discrepancy might be due to the deference in their study subjects. This study considered homeless women of reproductive age group while the study conducted in Addis Ababa considered street children aged 10-18 years old and study conducted in Dessie considered street youth aged 10-24 years old as their study subjects.

This study indicated that Homeless women with average daily income of greater than 20 birr per a day were 5.87 times more likely to seek safe abortion as compared to those who have less than 20 birr per a day, indicating that homeless women with higher average daily income are more likely to utilize safe abortion. This finding is consistent with study conducted in Axum town which indicated that all homeless women faced financial limitations to visit health care facilities for maternity care service and a shortage of fees for services that are unavailable at public health facilities (10).

In this study, the odds of safe abortion service utilization among homeless women with poor knowledge towards safe abortion was lower by 74.4% as compared to those who have good knowledge. Poor knowledge of homeless women regarding place to get safe abortion, as well as its legal framework might lead to reduced utilization of already available service. This finding is consistent with the study conducted in Dessie which indicated that lack knowledge about reproduction and sexuality and lack access to reproductive health information lead to increased risk of unsafe abortion (37).

This study indicated that the odds of safe abortion service utilization among homeless women who think that the cost of abortion at health facility is unaffordable was lower by 89.2% as compared to those who think it is affordable. Homeless women perception about the cost of abortion at health facility was one of barriers of safe abortion service utilization that might lead them to sought traditional provider although the service is available at public health facilities for free. This finding is consistent with study conducted in democratic republic of Congo (DCR) which indicated that high costs inhibit access to safe abortion in DRC (35).

Generally, the findings from the qualitative study indicated that safe abortion service utilization among homeless women was not only determined by their personal characteristics, but also health system factors as well as health providers approach. Health care provider related factors such as ambiguity about the legal framework of abortion, limited training on abortion and misinterpretation of conscientious objection are most commonly cited factors affecting safe abortion service utilization among homeless women by most interviewees in this study. This finding is consistent with different studies conducted in various parts of Africa and south America(47–49).

Finding from qualitative data also showed that the inflexibility of health system had made the service delivery difficult to the homeless. In addition to this, absence of specific policy regarding homeless women’s issue and health planning which is not inclusive of homeless women had reduced the focus of service delivery for homeless.

Chapter seven: Conclusion

According to the findings of this study, only about quarters of homeless women in the study area had used a safe abortion. This study had showed that average daily income, knowledge category respondents and perceived cost of abortion at health facility were significantly associated with safe abortion service utilization among homeless women. The qualitative findings of this study revealed that the use of safe abortion service among homeless women was affected by their personal characteristics as well as health provider related factors and health system factors such as health system approach, health policy and planning.

Chapter eight: Strength and Limitations of the study

Strength

The investigator had directly involved in data collection processes so that the reliability of data could be maintained. In addition to this, the study combines both quantitative and qualitative data in order to triangulate the findings.

Limitation

The total number of homeless women as well as the number homeless women with abortion experience in all three towns was not known. This requires conducting complete enumeration of homeless women before commencing data collection. However, complete enumeration was not done due to the need for additional resource. In addition to this, the sample size when calculated by using single population proportion was very large which 422 was and it is difficult to find this much participants as the study population for this study are of rare type (homeless women with abortion experience). And also as the number of homeless women with abortion experience is unknown; it is not possible to use correction formula in order to reduce the number of study participants to be included in the study and therefore the rule of thumb was used to determine sample size in order to reduce the number of study participants.

In addition to this, proportional allocation for three towns was not done as a total number of homeless women with abortion experience in the study areas were not known. The baseline data about homeless women's safe abortion service utilization was not available, and hence making difficult for comparison of the finding. Moreover, biases like under-coverage bias might be introduced due to small sample size used. The finding from this study might also lack generalizablity particularly due to sampling technique used. Since the educational status of majority of homeless women was under category of never attended school and primary school level, the finding may be subjected to recall bias. The sensitive nature of the study might have led to socially desirability bias.

Chapter nine: Recommendation

Government

To meet the SRH need of homeless women, the government should improve urban health extension package. The government guideline, plans and strategies should be developed in such a way that they can address the SRH needs of homeless women allowing these population groups readily and preferably for free, access SRH services.

Health bureaus

Respective zonal health bureaus and town health offices should work on awareness creation regarding safe abortion service provision and its legal framework as well as other SRH issue, especially regarding family planning in order to prevent unwanted pregnancy among these population groups. Besides providing free health care services, additional effort should be made to dig out and address the social, cultural as well as environmental factors that restrict access to safe abortion service.

Higher institutions

Higher institutions (Jimma University, Mizan Tepi University and Bonga University) should help homeless women to undertake income generating activities by providing properties and facilitating capitals through community based education program.

Researchers

Understanding of the SRH status and other health issues of homeless women has a paramount importance to formulate necessary policies, strategies and programs as well as to plan for health services for these vulnerable groups. This study only focused on safe abortion service and hence further study is needed to examine other SRH issues of homeless women. In addition to this, Moreover, this study covered only three towns of south west Ethiopia, and therefore further studies should be carried out in different parts of the country to provide comprehensive understanding of the SRH status of homeless women in national context.

Furthermore, there are additional variables that were explored by qualitative part of this study such as health system factors including health policy and health planning, health provider related factors like misinterpretation of conscientious objection and ambiguity with legal framework of abortion, and homeless women personal characteristics like street lifestyle. There are also additional variables that are not covered under this study. Therefore further study should be carried out to address variables that are not covered under this study and to quantitatively measures variables that are identified qualitatively.

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Annex –I: English version questionnaire

THIS QUESTIONNAIRE IS PREPARED FOR COLLECTING INFORMATION ON UTILIZATION OF SAFE ABORTION SERVICE AND ASSOCIATED FACTORS AMONG HOMELESS WOMEN IN SOUTHWEST ETHIOPIA

Questionnaire code: _______

Good morning/ good afternoon/ good evening.

My name is_________________________

We are conducting research entitled with utilization of safe abortion service and associated factors among homeless women.

I promise to keep confidentiality of your response. Your name is not included in any data processing in the research and will never be used in connection with any of the information you give. You are kindly requested to answer every question and you may stop responding the questions at any time you want to. However, your honest answers to these questions will help for better understanding of this study. There can be more than one answer as given on the alternative choices or opinions. The total time needed for responding this questionnaire is about thirty minutes. So, I kindly request you to participate in genuinely answering the interview.

Are you voluntary to participate? Yes ----- No -----

If yes put your Signature -------------- date -------/ -------- /------------

If No thank you

Part I- Socio demographic questions

1. Age: _______
2. Residence
   a. Jimma
   b. Bonga
   c. Mizan-aman
3. Type of homelessness
   a. I depend on the street for my life and return home at night (On-street).
   b. I depend on the street for my life and sleep on the street (Off-street).
4. Religion:
   a. Orthodox
   b. Muslim
   c. Protestant
   d. Catholic
   e. Other (specify) _____________
5. Marital status:
   a. Single
   b. Married
   c. Widowed
   d. Divorced
6. Ethnic group
   a. Oromo
   b. Dawro
   c. Kaffa
   d. Amhara
   e. Yem
   f. Others (specify) ______________
7. Educational status
   a. Never attend school

b. Primary school
c. High school
d. Collage and above

8. Average income ____________________
9. Source of income ___________________

Pregnancy and abortion experience

10. Have you ever had history of pregnancy?
    a. Yes
    b. No
11. If yes, how many? ______
12. Is your recent pregnancy wanted?
    a. Yes
    b. No
13. Have you ever know the one who has abortion experience?
    a. Yes
    b. No
14. What about you? Have you ever had abortion experience?
    a. Yes
    b. No
15. If yes, what type of abortion is it?
    a. Induced
    b. Spontaneous

Part II- Questions to assess knowledge

16. Do you know that safe abortion is provided in health facilities?

a. Yes
b. No

17. Have you ever heard about the current abortion law of Ethiopian?
    a. Yes
    b. No
18. What do you know about abortion law in Ethiopia?
    a. Abortion is legal in Ethiopia and provided on request
    b. Abortion is illegal in Ethiopia
    c. Abortion is legal for some selected reasons
    d. Don't know

If your answer for Q19 is 3, in what do you think are prerequisites for abortion?

19. Fetal malformation
    a. Yes
    b. No
20. Continuing pregnancy endanger woman's life
    a. Yes
    b. No
21. Pregnancy at age below 18 years
    a. Yes
    b. No
22. Pregnancy results from rape or incents
    a. Yes
    b. No
23. If mother can't bring up her child due to physical or mental illness
    a. Yes
    b. No
24. If mother can't bring up her child due extreme poverty
    a. Yes
    b. No

Part III- Individual and health system related questions

25. Have you ever faced stigma/ discrimination from health care providers?
    a. Yes
    b. No
26. Do you think that you might face stigma/ discrimination from health care provider?
    a. Yes
    b. No
27. Have you ever had pre-abortion counseling at health facility?
    a. Yes
    b. No
28. Have you ever counseled to continue pregnancy at health facility
    a. Yes
    b. No
29. Have you ever waited prolonged time to receive abortion service at health facility?
    a. Yes
    b. No
30. How do you rate the cost abortion in health facilities?
    a. I think it is Affordable
    b. I think it is unaffordable

Part IV- Questions to assess safe abortion service utilization

31. What is your reason to induce abortion
    a. Unwanted pregnancy
    b. Economical reason
    c. Medical condition

d. Other (specify) _______________

32. Where did abortion takes place

a. Health institution
b. Outside health institution

33. If in health institution, which one?

a. Health center
b. Private clinics
c. Public hospitals
d. Private hospitals

34. If outside health institution, where?

a. Self induced
b. In informal setting by traditional provider
c. Others (specify) __________________

In-depth interview guide

Back-ground information

Age ________________

Sex _________________

Educational status and qualification__________________________

Work experience in the area____________

Position (responsibility)________

Question on safe abortion service provision and associated factors (for health care providers)

1. Do homeless women visit your health facility for safe abortion service? Please describe in comparison with their housed counterparts.
2. What factors do you think hinder homeless women from utilizing safe abortion service? Please describe.
3. Is there a condition in which a homeless woman wanted an abortion service at your health facility but returned back without being served? Please describe the reason.
4. Do you think that all health care professionals provide abortion care for homeless without any discrimination or stigma?
5. Do you think that all health care providers know legal status of abortion in Ethiopia? Do you think that ambiguity of legal framework of abortion among providers can affect safe abortion service utilization?

6. Is there a condition when your health facility experienced shortage of trained personnel on safe abortion? Did this cause homeless women to return without being getting the service?
7. How much is the cost of abortion in your health facility including cost for procedure, drugs and other supplies?
8. Do you think that a provider can refuse to perform safe abortion because of his/her personal beliefs (Conscientious objection)? Is there a condition in wich your co-worker refused to provide or assist provision of abortion of because of his/her personal beliefs or religion.

Question on safe abortion service provision and associated factors (for administrative bodies and RH experts)

1. What do you think about safe abortion service utilization among homeless women in your catchment area? Please describe in comparison with their housed counterparts.
2. In your perception, what are the reasons for this?
3. In your opinion, what factors hinder homeless women from utilizing safe abortion service? Please describe factors from side of homeless women, health professional and government/policy.
4. You know that Homeless women are the most vulnerable groups for violence and unwanted pregnancy. Is there RH issue in policies specifically outlined regarding homeless women? If "yes" please describe. Do you think health care providers and other responsible bodies are aware of it?
5. Is there anything being done or planned in your area for improving SA or other RH service utilization for homeless?
6. What do you suggest for homeless women, health professionals or government to improve utilization of Safe Abortion service among homeless

Annex –II: Amharic version questionnaire

ይህ ቃለ መጠይቅ የተዘጋጀዉ ስለ ጎዳና ተዳዳሪ በሆኑ ሴቶች በጤና ተቋም ውስጥ ስለሚሰጠዉ ደህንነቱ የተጠበቀ ፅንስ ማስወረድ አገልግሎት አጠቃቀም እና ተያያዥ ምክንያቶች ለማወቅ ነዉ።

በምርምሩ ለመሳተፍ የፍቃደኝነት ፎርም

የ ቃለመጠይቁ መለያ ቁጥር__________________

እንምን አደሩ/ እንደምን ዋሉ/ እደምን አመሹ

እኔ ስሜ _____________ እባላለሁ። በጅማ ዩኒቨርስቲ የማህበረሰብ ጤና አጠባበቅ ክፍል የ 2 ኛ ድግሪ ተመራቂ ተማሪ ስሆን የ ጎዳና ተዳዳሪ በሆኑ ሴቶች መካከል በጤና ተቋም ውስጥ ስለሚሰጠዉ ደህንነቱ የተጠበቀ ፅንስ ማስወረድ አገልግሎት አጠቃቀም እና ተያያዥ ምክንያቶች ለማወቅ ጥናት በማካሄድ ላይ እገኛለሁ። እርሶም በዝህ መጠይቅ እንዲሳተፉ በቅድሚያ ትብብሮን እጠይቃለሁ። በመጠይቁ ወቅት የሚሰጡት መረጃዎች በሙሉ በሚስጥር የተጠበቁ ይሆናል። ስምዎት በመጠይቁ ላይ ሆነ በማንኛዉም የሚሰጡን መረጃ ላይ አይጠቀስም። ይሁን እንጂ የሚሰጡን መረጃዎች ለጥናታችን ትልቅ ፋይዳ ስላለዉ እዉነታዉን እንዲነግሩን እንጠይቃለን። በዚህ የጥናት ምርምር ላለመካፈልና በጥያቄ መሃል ለማቆም በማንኛዉም ጊዜ መብትዎ ነዉ። መጠይቁ በአጠቃይ ከ 30 ደቂቃ በላይ አይፈጅም። ስለዚህ በዚህ ጥናት ምርምር ላይ እንዲሳተፉ በትህትና እንጠይቃን።

ለመሳተፍ ፍቃደኛ ነዎት?

አዎን ____________________

አይደለሁም ________________

ፍቃደኛ ከሆኑ፡ ቀን ____/ ____/ ________

ፊርማ ___________________

አመሰግናለሁ!!

I-የተሳታፊዉን ሁኔታ የሚገልጽ መረጃ

1. እድሜ፡ __________
2. አድራሻ ፡
   a. ጅማ
   b. ቦንጋ
   c. ሚዛን -አማን
3. የ ጎዳና ተዳዳሪነት ዓይነት
   a. በቀን የጎዳና ህይወት እኖራለሁ ፣ በማታ ግን ወደ ቤት እመለሳለሁ
   b. በጎዳና ሕይወት ላይ ሙሉ በሙሉ ጥገኛ ነ እና በመንገድ ላይ እተኛለሁ
4. ሃይማኖት፡
   a. ኦርቶዶክስ
   b. ሙስሊም
   c. ፕሮቴስታንት
   d. ካቶሊክ
   e. ሌላ__________________________
5. የጋብቻ ሁኔታ፡
   a. ያላገባች
   b. ያገባች
   c. በሞት የተለያየ

d. የፈታች

6. ብሔር፡

   a. ኦሮሞ

   b. ዳውሮ

   c. ካፋ

   d. አማራ

   e. የም

   f. ሌላ________________________________

7. የትምህርት ደረጃ፡

   a. ያልተማረች

   b. የመጀመርያ ደረጃ

   c. የሁለተኛ ደረጃ

   d. ኮሌጅና ከዛ በላይ

8. የበቀን ገቢ(በብር) ______________________________________

9. የገቢ ምንጭ ____

የእርግዝና እና የውርጃ ተሞክሮ

10. እርግዝና አጋጥሞዎት ያውቃል?

    a. .አዎ

    b. አይ

11. አዎ ከሆነ ስንት? _________

12. የቅርብ እርግዝናዎ የተፈለገ ነው?

    a. አዎ

    b. አይደለም

13. የማስወረድ ልምድ ያለው ሰው ያውቁ ኖሯል?

   a. አዎ

   b. አይ

14. እርስዎስ? ፅንስ ማስወረድ ተሞክሮ አጋጥሞዎት ያውቃል?

   a. አዎ

   b. አይ

15. አዎ ከሆነ ፣ ምን ዓይነት ውርጃ ነው?

   a. ፅንሱ እንዲቋረጥ ተደርጓል

   b. የፅንስ መጨንገፍ (በራሱ ጊዜ)

የእውቀት መለኪያ ጥያቄዎች

16. በጤና ተቋማት ውስጥ ደህንነቱ የተጠበቀ ውርጃ እንደሚሰጥ ያውቃሉ?

   a. አዎ

   b. አይ

17. ስለአሁኑ የኢትዮጵያ ውርጃ ሕግ ሰምተው ያውቃሉ?

   a. አዎ

   b. አይ

18. በኢትዮጵያ ውስጥ ስለ ውርጃ ሕግ ምን ያውቃሉ?

   a. ፅንስ ማስወረድ በኢትዮጵያ ሙሉ በሙሉ ሕጋዊ ሲሆን አገልግሎት በመጠየቅ ማግኘት ይቻላል

   b. በኢትዮጵያ ፅንስ ማስወረድ ሕገወጥ ነው

   c. ለአንዳንድ የተመረጡ ምክንያቶች ፅንስ ማስወረድ ሕጋዊ ነው

   d. አላውቅም

ለቁ 18 መልስዎ 3 ከሆነ ፣ ፅንስ ማስወረድ ቅድመ -ሁኔታዎች ምን ይመስላሉ?

19. የፅንስ መዛባት(የፅንሱ ጤናማ አለመሆን)

   a. አዎ

   b. አይደለም

20. እርግዝናን መቀጠል የእናቲቱን ሕይወት አደጋ ላይ የሚጥል ከሆነ

   a. አዎ

   b. አይደለም

21. እርግዝና የተከሰተዉ ከ 18 ዓመት በታች በሆነች ሴት ላይ

   a. አዎ

   b. አይደለም

22. የእርግዝና ውጤት ከአስገድዶ መድፈር ወይም ማበረታቻ

   a. አዎ

   b. አይደለም

23. እናት በአካላዊ ወይም በአእምሮ ሕመም ምክንያት ልጁን ማሳደግ ካልቻለች

   a. አዎ

   b. አይደለም

24. እናት በከፍተኛ ድህነት ምክንያት ልጁን ማሳደግ ካልቻለች

   a. አዎ

   b. አይደለም

የግለሰብዊ ምክንያቶችን እና ከጤና ተቋማት ስርዓት ጋር የተዛመዱ ምክንያቶችን መለኪያ ጥያቄዎች

25. ከጤና ባለሙያዎች መገለል/ መድልዎ ሊደርስብኝ ይችላል ብለው ያስባሉ (ይፈራሉ?

   a. አዎ

b. አይ

26. ከጤና ባለሙያዎች መገለል/ መድልዎ አጋጥሞዎት ያውቃል?

    a. አዎ

    b. አይ

27. በጤና ተቋም ውስጥ የቅድመ ፅንስ ማስወረድ ምክር አገልግሎት ተሰቶት ያውቃል?

    a. አዎ

    b. አይ

28. በጤና ተቋሙ ውስጥ እርግዝናን እንዲቀጥሉ ምክር ሰጥቶታል

    a. አዎ

    b. አይ

29. በጤና ጣቢያ ፅንስ የማስወረድ አገልግሎትን ለማግኘት ረዘም ያለ ጊዜ ጠብቀው ያውቃሉ?

    a. አዎ

    b. አይ

30. በጤና ተቋማት ውስጥ ፅንስ የማስወረድ አገልግሎትን ለማግኘት የሚያስፈገዉን ወጪ (ክፍያ)

    እንዴት ይገመግሙታል?

    a. ተመጣጣኝ ይመስለኛል

    b. ተመጣጣኝ ያልሆነ (ከፍተኛ) ይመስለኛል

ፅንስ ማስወረድ አገልግሎት አጠቃቀም የተመለከቱ ጥያቄዎች

31. ፅንስ እንዲቋረጥ ተደርጓል ከሆነ ፣ ፅንስ ለማስወረድ ምክንያትዎ ምንድነው?

    a. ያልተፈለገ እርግዝና

    b. ኢኮኖሚ

    c. የጤና ሁኔታ

d. ሌላ (ይግለጹ) ___________________

32. ፅንስ ማስወረድ የት ተከናወነ

a. ጤና ተቋም

b. ከጤና ተቋም ውጭ

33. በጤና ተቋም ውስጥ ከሆነ ፣ የትኛው ነው?

a. ጤና ጣቢያ

b. የግል ክሊኒኮች

c. የመንግስት ሆስፒታሎች

d. የግል ሆስፒታሎች

34. ከጤና ተቋም ውጭ ከሆነ የት?

a. በራስ

b. በባህላዊ ባለሙያ

c. ሌሎች (ይግለጹ) __________________

Amharic version in-depth interview guide

የተሳታፊዉን ሁኔታ የሚገልጽ መረጃ

ዕድሜ ____________

ጾታ _____________

የትምህርት ደረጃ እና የሙያ ዘርፍ____________________

በአካባቢው የሥራ ልምድ_________

ኃላፊነት)______

የ ጎዳና ተዳዳሪ በሆኑ ሴቶች መካከል በጤና ተቋም ውስጥ ስለሚሰጠዉ ደህንነቱ የተጠበቀ ፅንስ ማስወረድ አገልግሎት(safe abortion service utilization) አጠቃቀም እና ተያያዥ ምክንያቶችን የሚመለከት ጥያቄ (ለጤና ባለሙያዎች)

1. የ ጎዳና ተዳዳሪ የሆኑ ሴቶች ለፅንስ ማስወረድ አገልግሎት የጤና ተቋምዎን ይጎበኛሉ? እባክዎን በቤታቸው ከሚኖሩ አቻዎቻቸው ጋር በማነፃፀር ይግለጹ።
2. የ ጎዳና ተዳዳሪ የሆኑ ሴቶች በጤና ተቋም ውስጥ የሚሰጠዉን ደህንነቱ የተጠበቀ ውርጃ አገልግሎትን (safe abortion service) እንዳይጠቀሙ የሚያግዳቸው ምን ይመስልዎታል? እባክዎን በዝርዝር ይግለጹ።
3. የ ጎዳና ተዳዳሪ የሆኑ ሴቶች ለፅንስ ማስወረድ አገልግሎት በጤና ተቋምዎ መተዉ ነገር ግን አገልግሎቱን ሳያገኙ የተመለሰበት ሁኔታ ነበር? እባክዎን ምክንያቱን ይግለጹ።

4. ሁሉም የጤና ባለሙያዎች ፅንስ የማስወረድ አገልግሎትን ለጎዳና ተዳዳሪ ለሆኑ ሴቶች ያለ ምንም አድልዎ ወይም ሳያገሉ ይሰጣሉ ብለው ያስባሉ?
5. ሁሉም የጤና ባለሙያዎች የኢትዮጵያ የፅንስ ማስወረድ የሕግ ማዕቀፍ ያውቃሉ ብለው ያስባሉ? የጤና ባለሙያዎች የኢትዮጵያ የፅንስ ማስወረድ የሕግ ማዕቀፍን ማወቅ ወይም አለማወቅ የአገልግሎቱ አጠቃቀም ላይ ተጽዕኖ ሊያሳድር ይችላል ብለው ያስባሉ?
6. በጤና ተቋምዎ በፅንስ ማስወረድ ዙሪያ የሰለጠኑ ሠራተኞች እጥረት አጋጥሞት ያውቃል? ይህ የ ጎዳና ተዳዳሪ የሆኑ ሴቶች አገልግሎቱን ሳያገኙ እንዲመለሱ ምክንያት ሆኖ ያውቃልን?
7. በጤና ተቋምዎ ውስጥ የአሠራር ፣ የመድኃኒት እና የሌሎች አቅርቦቶች ዋጋን ጨምሮ የፅንስ ማስወረድ ወጪ (cost) ምን ያህል ነው?
8. አንድ የጤና ባለሙያ በግል እምነቱ ወይም በሃይማኖቱ ምክንያት የፅንስ ማስወረድን አለመሥራት ወይም እምቢ ማለት የሚችል ይመስልዎታል? የሥራ ባልደረባዎ በግል እምነቱ ወይም በሃይማኖቱ ምክንያት ፅንስ ማስወረድ ለማቅረብ ወይም ለመርዳት ፈቃደኛ ያልሆነበት ሁኔታ አለ?

የ ጎዳና ተዳዳሪ በሆኑ ሴቶች መካከል በጤና ተቋም ውስጥ ስለሚሰጠዉ ደህንነቱ የተጠበቀ ፅንስ ማስወረድ አገልግሎት (safe abortion service utilization) አጠቃቀም እና ተያያዥ ምክንያቶችን የሚመለከት ጥያቄ (ለጤና ባለስልናት እና ለስነ ተዋልዶ ባለሙያዎች)

1. በአካባቢዎ የጎዳና ተዳዳሪ ሴቶች በጤና ተቋም የሚሰጠዉን የውርጃ አገልግሎት አጠቃቀም ምን ይመስላል? እባክዎን በቤታቸው ከሚኖሩ አቻዎቻቸው ጋር በማነፃፀር ይግለጹ።
2. በእርሶ አስተያየት ለዚህ ምክንያቶች ምንድናቸው?

3. በአንተ አስተያየት የጎዳና ተዳዳሪ ሴቶች በጤና ተቋም የሚሰጠዉን የውርጃ አገልግሎት እንዳይጠቀሙ የሚያግዳቸው ነገሮች ምንድን ናቸው? ከጎዳና ተዳዳሪ ሴቶች ፣ ከጤና ባለሙያ እና ከመንግስት/ፖሊሲ ጋር በማያያዝ ምክንያቶችን ይግለጹ።
4. የጎዳና ተዳዳሪ ሴቶች ለጥቃት እና ላልተፈለገ እርግዝና በጣም ተጋላጭ ቡድኖች እንደሆኑ ይታወቃል። የጎዳና ተዳዳሪ ሴቶችን የስነ ተዋልዶ ጤና በተመለከተ የተቀመጠ ፖሊሲ አለ? ካለ እባክዎን ይግለጹ። የጤና ባለሙያዎች እና ሌሎች ኃላፊነት ያላቸው አካላት የሚያውቁት ስለዚህ ፖሊሲ ይመስልዎታል?
5. በአካባቢዎ የበጤና ተቋም የሚሰጠዉን የውርጃ አገልግሎት ወይም ሌላ የስነ ተዋልዶ አገልግሎት አጠቃቀም ለማሻሻል የታቀደ ነገር አለ?
6. የበጤና ተቋም የሚሰጠዉን የውርጃ አገልግሎት ለማሻሻል ለጎዳና ተዳዳሪ ሴቶች ፣ ለጤና ባለሙያዎች ወይም ለመንግሥት ምን ይጠቁማሉ?

Annex III: Declaration

I, the undersigned, declare that this thesis is my original work, has not been presented for a degree in this or any other university and that all sources of materials used for the thesis have been fully acknowledged.

Name: ______________________________

Signature: ___________________________

Name of the institution: _________________

Date of submission: ____________________

This thesis has been submitted for examination with my approval as university advisor

Name and Signature of the first advisor ____________________________________

Name and Signature of the second advisor ____________________________________