DETERMINANTS OF COPING STRATEGIES UTILISED BY WOMEN WHO HAVE EXPERIENCED AN ABORTION

BY

CHAMBATU ALICE (RN, RM)
CHIMFWEMBE RICHARD (RN, RM)
MAYUNDO LILLIAN (RN, RM)
MUSUMALI MARY (RN, RM)

UNZA, DNS ©2013
THE UNIVERSITY OF ZAMBIA
SCHOOL OF MEDICINE
DEPARTMENT OF NURSING SCIENCES

DETERMINANTS OF COPING STRATEGIES UTILISED BY WOMEN WHO HAVE EXPERIENCED AN ABORTION

BY

CHAMBATU ALICE
ZRN (Lusaka-2003), ZRM (Mfulira-2007)

CHIMFWEMBE RICHARD
ZRN (Kasama-2003), ZRM (Kitwe-2007)

MAYUNDO LILLIAN
ZRN (Ndola-2001), ZRM (Ndola-2005)

MUSUMALI MARY
ZRN (Lusaka-1997), ZRM (Lusaka-2005)

A RESEARCH REPORT SUBMITTED IN PARTIAL FULFILMENT FOR THE AWARD OF THE BACHELOR OF SCIENCE DEGREE IN NURSING AT THE UNIVERSITY OF ZAMBIA.

UNZA, DNS
©2013
ACKNOWLEDGEMENTS

We would like first all to thank the almighty God for granting us His grace and for guiding us throughout our studies and this project.

Our appreciation goes to our supervisor Dr. Lonia Mwape whose guidance steered us to the right direction. We are greatly indebted to her understanding, encouragement, support and patience she rendered us through our research project.

Our special thanks go to all the members of staff of the Department of Nursing Sciences (DNS) in the School of Medicine, University of Zambia, for providing the most needed treasure, professional knowledge and their advice which have enriched us with valuable knowledge in nursing.

We would like to thank the members of staff at Chinsali, Ikelenge, Lusaka and Siavonga District Medical Offices (DMOs) for approving our requests to undertake research in their districts.

Special thanks also go to the women who participated in the study, without their cooperation this study could not have been possible.

Thanks to the Ministry of Health (MoH) and Tropical Health and Education Trust/Department For International Development (THET/DFID) for sponsoring us to study at the University of Zambia and conduct this research project.

Our heartfelt gratitude also goes to our family members and friends for their encouragement, prayers and for giving us time to concentrate on our study at the time they needed us most.

Finally we feel highly indebted to our loving and caring spouses, Mr. Enerst N. Kamunu, Mrs. Getrude M. Chimfwembe, Mr. Wezzy K. Chomba and Mr. Fredrick Simwanza for providing emotional and psychological support.
TABLE OF CONTENTS

CONTENT

Acknowledgements........................................................................i
Table of contents........................................................................ii
List of tables................................................................................vii
List of figures..............................................................................viii
Appendices..................................................................................ix
List of abbreviations....................................................................x
Declaration..................................................................................xi
Statement....................................................................................xv
Dedication....................................................................................xix
Abstract.....................................................................................xxiii

CHAPTER ONE

1.0 Introduction.........................................................................1
1.1 Background........................................................................2
1.2 Statement of the problem..................................................3
1.3 Determinants of coping strategies utilised by women who have experienced an abortion..................................................4
1.3.1 Psychological factors .....................................................4
1.3.1.1 Anxiety.................................................................4
1.3.1.2 Stress.................................................................5
1.3.2 Disease-related factors.......................................................... 5
  1.3.2.1 Recurrent abortion......................................................... 5
  1.3.3 Socio-cultural factors....................................................... 5
    1.3.3.1 Stigma........................................................................... 5
  1.3.4 Service related factors..................................................... 6
    1.3.4.1 Attitude by healthcare providers................................... 6
  1.3.5 Economic factors.............................................................. 6
    1.3.5.1 Educational level........................................................ 6
    1.3.5.2 Economic status.......................................................... 6
  1.4 Justification........................................................................... 8
  1.5 Research objectives............................................................. 8
    1.5.1 General objective............................................................ 8
    1.5.2 Specific objectives.......................................................... 9
  1.6 Study hypotheses................................................................. 9
  1.7 Conceptual definitions......................................................... 10
  1.8 Theoretical framework......................................................... 10
    1.8.1 Transactional model of stress and coping......................... 10
  1.9 Study variables...................................................................... 13

CHAPTER TWO

  2.0 Literature review.................................................................... 16
  2.1 Introduction............................................................................ 16
2.2 Overview of coping after an abortion .................................................. 16

2.3 Factors influencing coping strategies ................................................. 17

2.3.1 Stigma ......................................................................................... 17

2.3.2 Stress ......................................................................................... 18

2.3.3 Education level ........................................................................... 18

2.3.4 Recurrent abortion .................................................................... 19

2.3.5 Staff attitude .............................................................................. 20

2.4 Conclusion ..................................................................................... 20

CHAPTER THREE

3.0 Research methodology ..................................................................... 22

3.1 Introduction .................................................................................... 22

3.2 Research design ............................................................................. 22

3.3 Research setting ............................................................................. 23

3.4 Study population ........................................................................... 23

3.5 Sample selection ........................................................................... 23

3.5.1 Inclusion criteria ......................................................................... 24

3.5.2 Exclusion criteria ......................................................................... 24

3.6 Sample size .................................................................................... 24

3.7 Operational definition of study variables ....................................... 24

3.8 Data collection tool ........................................................................ 25

3.8.1 Interview schedule ..................................................................... 26
3.8.2 Validity ......................................................................................................................... 26
3.8.3 Reliability ..................................................................................................................... 27
3.9 Data collection technique ............................................................................................... 27
3.10 Pilot study ....................................................................................................................... 28
3.11 Ethical and legal issues .................................................................................................. 28
3.11.1 Beneficence and maleficence .................................................................................... 29
3.11.2 Respect for persons .................................................................................................... 29
3.11.3 Justice ....................................................................................................................... 30
3.12. Plan for data analysis ................................................................................................... 30
3.13 Plan for dissemination of findings .................................................................................. 30

CHAPTER FOUR

4.0 Presentation of findings .................................................................................................... 31
4.1 Section A: Demographic data ......................................................................................... 31
4.2 Section B: Socio-economic status .................................................................................. 33
4.3 Section C: Past obstetric history ..................................................................................... 34
4.4 Section D: Attitude of healthcare providers .................................................................... 35
4.5 Section E: Socio-cultural factors .................................................................................... 37
4.6 Section F: Stress and anxiety .......................................................................................... 37
4.7 Cross tabulations ............................................................................................................. 39

CHAPTER FIVE

5.0 Discussion of findings ..................................................................................................... 44
## LIST OF TABLES

Table 1.1: Variables and cut of points ......................................................... 14

Table 4.2: Marital status ............................................................................. 32

Table 4.3: Religious denomination .............................................................. 32

Table 4.4: Education level .......................................................................... 33

Table 4.5: Profession/occupation ................................................................. 33

Table 4.6: Income ....................................................................................... 34

Table 4.7: Number of pregnancies ............................................................... 34

Table 4.8: Number of pregnancy losses ...................................................... 34

Table 4.9: Knowledge about abortion .......................................................... 35

Table 4.10: Went to health facility ................................................................. 35

Table 4.11: Reasons for not going to health facility .................................... 36

Table 4.12: Reaction of spouse ................................................................. 37

Table 4.13: Ritual cleansing and restriction ................................................. 37

Table 4.14: Emotional experience ............................................................... 37

Table 4.15: Reasons for coping ................................................................. 38

Table 4.16: Effects on daily activities ......................................................... 38

Table 4.17: Experience after an abortion ..................................................... 39

Table 4.18: Age and coping ................................................................. 39

Table 4.19: Income and coping ................................................................. 40

Table 4.20: Education level and coping ..................................................... 40
Table 4.21: Number of pregnancy losses and coping ............................................. 41
Table 4.22: Staff attitude and coping ................................................................. 41
Table 4.23: Stigma and coping .......................................................... 42
Table 4.24: Stress and coping .......................................................... 43

LIST OF FIGURES

Figure 1.1: Problem analysis diagram .............................................................. 7

Figure 1.2: Relationship of variables using the transaction model .................... 12

Figure 4.1: Age distribution ........................................................................... 31

Figure 4.2: Attitude of health care providers .................................................. 36
APPENDICES

Appendix I: Questionnaire...........................................................................................................60

Appendix II: work plan from June, 2012 to April, 2013.............................................................66

Appendix III: Gantt chart showing various tasks to be undertaken and time required
for each task to be performed from June, 2012 to April, 2013..................................................67

Appendix IV: Budget....................................................................................................................70

Appendix V: Budget justification.................................................................................................72

Appendix VI: Letters of permission...........................................................................................73

Appendix VII: Informed consent.................................................................................................81
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMML:</td>
<td>Christian Mission in Many Lands</td>
</tr>
<tr>
<td>DFID:</td>
<td>Department For International Development</td>
</tr>
<tr>
<td>DMO:</td>
<td>District Medical Office</td>
</tr>
<tr>
<td>DNS:</td>
<td>Department of Nursing Sciences</td>
</tr>
<tr>
<td>FBO:</td>
<td>Faith-Based Organisations</td>
</tr>
<tr>
<td>JCTR:</td>
<td>Jesuit Centre for Theological Reflection</td>
</tr>
<tr>
<td>MoH:</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>NGO:</td>
<td>Non-Governmental Organisations</td>
</tr>
<tr>
<td>PPCC:</td>
<td>Pre-Pregnancy Counselling Clinic</td>
</tr>
<tr>
<td>SPSS:</td>
<td>Statistical Package for Social Scientists</td>
</tr>
<tr>
<td>THET:</td>
<td>Tropical Health and Education Trust</td>
</tr>
</tbody>
</table>
DECLARATION

I, Chambatu Alice, hereby declare that the work on which this research is based is original (except where acknowledgements indicate otherwise) and that neither the whole work nor any part of it has been, is being or is to be submitted for another degree at this or any other university.

Signed: ..........................................................  Date: 6th June, 2013

CANDIDATE

Signed: ..........................................................  Date: 20.06.13

SUPERVISING LECTURER
DECLARATION

I, Chimswembe Richard, hereby declare that the work on which this research is based is original (except where acknowledgements indicate otherwise) and that neither the whole work nor any part of it has been, is being or is to be submitted for another degree at this or any other university.

Signed: ..................................................  Date: 6th June, 2013

CANDIDATE

Signed: ..................................................  Date: 20 06 13

SUPERVISING LECTURER
DECLARATION

I, Mayundo Lillian, hereby declare that the work on which this research is based is original (except where acknowledgements indicate otherwise) and that neither the whole work nor any part of it has been, is being or is to be submitted for another degree at this or any other university.

Signed: Mayundo Lillian

Date: 6th June, 2013

CANDIDATE

Signed: [Signature]

Date: 20.06.13

SUPERVISING LECTURER
DECLARATION

I, Musumali Mary, hereby declare that the work on which this research is based is original (except where acknowledgements indicate otherwise) and that neither the whole work nor any part of it has been, is being or is to be submitted for another degree at this or any other university.

Signed: ..................................................  Date: 6th June 2013

CANDIDATE

Signed: ..................................................  Date: 20.06.13

SUPERVISING LECTURER
STATEMENT

I, Chambatu Alice, hereby certify that this study is entirely the result of my own independent investigation. The various sources to which I am indebted are clearly and gratefully acknowledged in the text and in the references.

Signed: .................................................................

CANDIDATE

Date: 6th June, 2013
STATEMENT

I, Chimfwembe Richard, hereby certify that this study is entirely the result of my own independent investigation. The various sources to which I am indebted are clearly and gratefully acknowledged in the text and in the references.

Signed:.........................................................................................................................

CANDIDATE

Date: 6th June, 2013..........................................................................................
STATEMENT

I, Mayundo Lillian hereby certify that this study is entirely the result of my own independent investigation. The various sources to which I am indebted are clearly and gratefully acknowledged in the text and in the references.

Signed:..................................................................................................................

CANDIDATE

Date: 6th June, 2013...............................................................................................

xvii
STATEMENT

I, Musumali Mary, hereby certify that this study is entirely the result of my own independent investigation. The various sources to which I am indebted are clearly and gratefully acknowledged in the text and in the references.

Signed:.................................................................

CANDIDATE

Date: 6th June, 2013

.................................................................
DEDICATION

I, Chambatu Alice, dedicate this study to my beloved husband Mr. Enerst N. Kamunu and my daughter, Precious Inutu Kamunu who have proved to be a source of encouragement in my life.
DEDICATION

I, Chimfwembe Richard, dedicate this study to my dearly loved wife Getrude M. Chimfwembe, my sons, Richard Chimfwembe Jr. and Nehimunya Blessings Chimfwembe for enduring my absence for the time I spent in the university.
DEDICATION

I, Mayundo Lillian, dedicate this study to my beloved husband Mr. Wezzy Chomba, my children, Wezzy Chomba Jr. and Musole Chomba for their love, encouragement and support in my life.
DEDICATION

I, Musumali Mary, dedicate this study to my caring husband Mr. Fredrick Simwanza and my daughters, Memory, Victorious, Temwani, Wana and Catherine for their prayers throughout my years of study.
ABSTRACT

Problem statement

Mental health problems and ineffective coping in women who have experienced an abortion are common and require specialist care with increased health resource utilization. However, there seems to be paucity of information in Zambia on how women cope psychologically after an abortion. Therefore the study explored determinants for coping strategies utilised by women who had experienced an abortion in Zambia.

Methods

Determinants of coping strategies utilised by women who have experienced an abortion were explored. The study was conducted in Chinsali, Ikelenge, Lusaka and Siavonga Districts with a sample of 200 respondents. Interviews were conducted using semi-structured interview schedules. Two hundred participants were selected using simple random probability sampling methods. Data was entered and analysed using SPSS version 20. Several determinants for coping with an abortion were identified such as education level, staff attitude, stigma, stress and recurrent abortions. The study was guided by the Transactional Model of Stress and Coping based on the work of Lazarous and Folkman.

Results

Out of the above mentioned determinants, only stress was found to have a significant association with coping with the experience of an abortion. Stress was measured by the extent to which the experience of an abortion disturbed normal daily activities.

The results indicated that there was a relationship between stress and coping as confirmed by the p-value 0.00 and chi square 18.86. Respondents whose daily activities were grossly affected due to stress did not cope well.

Conclusion

It was concluded that there was a relationship between stress and coping. However, the other independent variables did not show any relationship with coping.
It was therefore recommended that mental health services be incorporated in reproductive health services at various levels of health care in order to manage stress among women who experienced an abortion to enhance coping well.
CHAPTER 1

1.0 INTRODUCTION

Coping is the ability to deal successfully with a difficult situation. Coping strategies refer to the specific efforts, both behavioural and psychological, that people employ to comprehend, tolerate or minimize stressful events (Taylor, 2008).

There are two broad distinguishable types of coping strategies identified by psychologists; Problem-focused coping and emotion-focused coping. Problem-focused coping tries to deal with negative emotions by taking some actions to modify, avoid or minimize the unpleasant situation. Emotion-focused coping attempts to directly regulate or eliminate unpleasant emotions. Examples of emotion-focused coping include rethinking the situation in a positive way, relaxation, denial and wishful thinking. The purpose of both strategies is to control one’s stress level. Additionally it is revealed that people use both types of strategies to deal with most stressful events. The type of strategy employed by an individual is determined by personality and stressful event. For example, people utilise Problem-focused coping to deal with potential controllable problems such as work-related problems and family-related problems, whereas stressors perceived as less controllable, such as certain kinds of physical health problems arouse more emotion-focused coping (Taylor, 2008).

Additionally other coping strategies are classified as active and avoidant. Active coping strategies are either behavioural or psychological reactions designed to change the nature of stressor itself or how one thinks about it, whereas avoidant coping strategies lead people into deeds (such as alcohol use) or mental states (such as withdrawal) that keep them from directly addressing stressful events. Generally speaking, active coping strategies, whether behavioural or emotional, are thought to be better ways of overcoming stressful events, and avoidant coping strategies appear to be a psychological risk factor or marker for adverse responses to stressful life events (Taylor, 2008). Among such stressful events is the experience of an abortion.
1.1 BACKGROUND INFORMATION

Abortion is the interruption of pregnancy before the 26th week of gestation, after which the foetus is said to be viable (Sellers, 2010). There are two main classifications of abortion which are spontaneous abortion (often called miscarriage) and induced abortion. Spontaneous abortion happens involuntarily and suddenly to women expecting to give birth in a few months, whereas induced abortion is a planned and known event (Broen et al, 2005).

Spontaneous abortion is divided into threatened and inevitable abortion. A pregnancy which is threatened may progress till birth of a viable infant, or it may be missed and end into a blood mole. When abortion is inevitable, all products of conception are expelled (complete abortion), or some may be retained (incomplete abortion). Retained products of conception in this case may lead to infection resulting into a septic abortion. An inevitable abortion may also be missed and may lead to formation of a Blood mole (Fraser et al, 2006):

The causes of spontaneous abortion are unknown, but may be attributed to foetal chromosomal abnormalities, maternal age of above thirty five years, chronic maternal conditions like Diabetes Mellitus, and environmental factors such as excessive consumption of alcohol and cigarette smoking (Fraser & Cooper, 2003). Both spontaneous and induced abortion can potentially cause mental distress to the woman experiencing them (Fraser & Cooper, 2003).

There are many ways in which women react to experience of an abortion. Reactions include guilty feelings, anxiety, depression, anger, and suicidal thoughts (Lawlor, 2012). Reactions lead to increased mental distress morbidity as indicated by Colman (2011) in his study where he found that up to 10 percent of mental health problems among women in general may be caused by a history of abortion. Hence it is important to employ appropriate coping strategies by women who have experienced an abortion.
Women who have experienced an abortion may utilise different coping strategies to deal with the mentioned emotions. These strategies may include repression, denial, anger, dependence on God, eating disorders, child neglect, promiscuous behaviour or substance abuse among others.

There are a number of factors that determine coping strategies used by women who have experienced an abortion, which include stigma, staff attitude, stress, education level and recurrent abortions.

A study in New Zealand on mental health problems following abortion revealed that women who reported negative reactions to abortion were at greater risk of developing mental health problems (Colman, 2009). More than 85 percent of women who experienced an abortion reported at least one negative reaction to abortion, such as sorrow, grief, regret or disappointment and approximately 35 percent reported five or more negative reactions. The risk of mental disorders among women who had negative reactions towards abortion was 40 to 80 percent higher than among women who had not experienced an abortion.

There is scarcity of studies that have been conducted on coping strategies utilised by women who have experienced an abortion as seen from the sources at University Teaching Hospital Gynaecological department.

1.2 STATEMENT OF THE PROBLEM

Coping is the ability to deal successfully with a difficult situation of which abortion is an example. Ideally, all women who have had an abortion should with time accept the situation and apply coping strategies to allow recovery and resolution (Goodwin & Ogden, 2007).

Colman, (2006) argues that approximately 60 percent of women who have experienced an abortion have suicidal ideation, with 28 percent actually attempting suicide. These statistical values are alarming and should be worrisome to a dedicated health care system. This necessitates the need to explore factors influencing coping strategies utilised by women who have experienced an abortion.
A study conducted in Uganda by Babigumira et al (2011) revealed that 57 percent of women who had abortion experienced medical complications as well as many mental health problems which could have been as a result of ineffective coping. These complications required specialist care with increased health resource utilisation. There seems to be paucity of information in Zambia on how women cope psychologically after abortion, coping strategies employed and the determinants for coping strategies utilised.

However, in a situational analysis done by the Ministry of Health (2010) on post abortion care, it was found that 70 percent of abortions resulted into complications that included mental instability among others. Therefore conducting this study would be beneficial to add to literature on factors influencing coping strategies employed by women who have experienced an abortion in Zambia.

The beneficiaries of this study will be women aged between 18 and 55 years after findings and recommendations of the study are reported to Ministry of Health and other stakeholders with the help of relevant authorities.

1.3 DETERMINANTS OF COPING STRATEGIES UTILISED BY WOMEN WHO HAVE EXPERIENCED AN ABORTION

There are a number of factors that can influence coping strategies utilised by women who have experienced an abortion as discussed below.

1.3.1 PSYCHOLOGICAL FACTORS

1.3.1.1 Anxiety

Following abortion, the affected woman is uncertain about the proceeding events in her life; she has no idea if she would be accepted by the spouse, family and society at large. She does not know whether she would recover fully and maintain her fertility. All these may contribute to the woman being anxious. Women who have anxiety may cope poorly compared to their counterparts who have no anxiety because they have a focused mind and think logically.
1.3.1.2 Stress

Pressure from the family and workplace may overwhelm the already stressed woman who has experienced an abortion such that she fails to cope.

1.3.2 DISEASE RELATED FACTORS

1.3.2.1 Recurrent Abortion

It is assumed that women who have had recurrent abortions are likely to cope well because they have developed helpful coping strategies that they might have used in previous abortion. On the other hand having repeated abortions may affect the woman’s coping because it overwhelsm the woman’s coping capacity.

1.3.3 SOCIO-CULTURAL FACTORS

1.3.3.1 Stigma

The manner in which women who have had an abortion are treated by family members, spouses and community may cause depression and isolation. Condemnation by spouse and relatives, especially in-laws may lead to further depression.

Some Zambian traditions believe that a woman who has had an abortion has to undergo certain ritual cleansing procedures and restrictions before being integrated back into the family and society. Most religions label women who have experienced an abortion as having led a promiscuous life and it is assumed that the abortion was induced even if it was spontaneous. Additionally women who have experienced an abortion may feel that they have failed to fulfil the role of child bearing leading to self-pity. Nonetheless, when the relationship between the affected woman and her relatives is favourable, the woman is likely to cope more effectively.
1.3.4 SERVICE RELATED FACTORS

1.3.4.1 Attitude by health care providers

Failure to keep confidentiality on the part of health care providers may cause depression in a woman who has experienced abortion. On the other hand if confidentiality is maintained, the woman would feel secure and may cope more efficiently. In addition women who are not supported socially may end up coping poorly as compared to their counterparts who receive adequate social support such as counselling.

1.3.5 ECONOMIC FACTORS

1.3.5.1 Education level

Women who are literate may understand their condition and abide by instructions leading to better coping strategies, because they are able to read and understand written instructions regarding their condition.

1.3.5.2 Economic status

Women who are affluent may afford standard health care services like hiring a private psychologist who may offer specialised social support and counselling. On the other hand, women of low economic status would rely on public health facilities which are perceived to be of low standards.
Figure 1.1: PROBLEM ANALYSIS DIAGRAM

**Service Related Factors**
- Confidentiality
- Staff Attitude
- Social support

**Psychological Factors**
- Stress
- Anxiety

**Disease Related Factors**
- Recurrent abortions
- Complications following medical management of abortion

**Socio-cultural Factors**
- Stigma

**Socio-economic Factors**
- Education level
- Economic status

Determinants of coping strategies utilised by women who have experienced an abortion
1.4 JUSTIFICATION

Coping with an abortion is one area that has not been explored adequately in Zambia. From the studies done in western countries about coping after an abortion, Colman (2006), found that 30 to 50 percent of women who had experienced an abortion consequently developed sexual dysfunction. Sixty percent of women developed suicidal ideation with 28 percent committing actual suicide. Women are overwhelmed by the traumatic experience of abortion, exhibit defence mechanisms and lose control. It is therefore important to help women cope with the abortion experience by understanding the determinants for coping.

Results of the present study will reveal determinants of coping strategies utilised by women who have experienced abortion. Results will be used to develop educational materials and scale up coping strategies in women who have experienced an abortion. The information from the present study will also be used to make recommendations to relevant authorities such as Ministry of Health so that necessary action could be taken to improve the way women cope with abortion, thereby promoting mental health of women.

1.5 RESEARCH OBJECTIVES

Research objectives are clear, concise, declarative statements that are expressed in the present tense (Burns & Grove, 2005).

1.5.1 General Objective

To explore determinants of coping strategies utilised by women who have experienced an abortion.
1.5.2 Specific Objectives

i. To explore the influence of staff attitude on coping in women who have experienced an abortion.

ii. To investigate effects of recurrent abortions on coping strategies utilised by women who have experienced an abortion.

iii. To determine the influence of stress on coping strategies utilised by women who have experienced an abortion.

iv. To determine whether education level affects coping strategies utilised by women who have experienced an abortion.

v. To identify the relationship between stigma and coping strategies following abortion.

1.6 STUDY HYPOTHESES

i. There is no correlation between staff attitude and coping with the experience of an abortion.

ii. There is a relationship between recurrent abortions and coping with the experience of an abortion.

iii. There is a relationship between stress after abortion and coping.

iv. The higher the education level of a woman who has experienced an abortion, the better she is likely to cope.

v. Women who are stigmatised after experiencing an abortion may cope poorly.
1.7 CONCEPTUAL DEFINITIONS

i. **Coping**: Coping is the ability to deal successfully with a difficult situation (Taylor, 2008).

ii. **Coping strategies**: Coping strategies refer to the specific efforts, both behavioural and psychological, that people employ to comprehend, tolerate or minimize stressful events (Taylor, 2008).

iii. **Counselling**: American Counselling Association (2010) defines counselling as a professional relationship that empowers various individuals, families and groups to achieve mental health, wellness, education and career goals.

iv. **Social support**: Social support refers to the various types of assistance that people receive from others and is generally classified into two or three major categories namely emotional, instrumental (and sometimes informational) support. Emotional support refers to the non-tangible things that people do that make us feel loved and cared for, that augment our sense of self-worth (for example talking over a problem, providing encouragement or positive feedback). Instrumental support refers to the various types of tangible help that others may provide (for example help with childcare, housekeeping, provision of transportation or money). Informational support represents a third type of social support, one that is sometimes included within the instrumental support category, and refers to the help that others may extend through the provision of information (Seeman, 2008).

1.8 THEORETICAL FRAMEWORK

1.8.1 The Transactional Model of Stress and Coping

Research using the Transactional model of stress and coping has explained and predicted a variety of human behaviours since 1984 and is based on the work of Lazarus and Folkman.
This model specifies backgrounds, a refined appraisal phase and a classification of coping strategies based on the motives that may be stimulated by the threatening situation, in this case the experience of having an abortion. The aim of the present study was to explore the determinants of the way women who had experienced an abortion appraise and cope with the inauspicious status quo.

According to Lazarus and Folkman psychological stress is a particular relationship between the person and the environment that is appraised by the person as exhausting or exceeding his or her resources and endangering his or her well-being. This relationship goes through two important stages namely cognitive appraisals and coping (Berjot & Gillet, 2011).

Cognitive appraisal is the process of classifying an encounter and its various facets, with respect to its significance for health. Before actually coping with a situation, it has to be cognitively evaluated as potentially stressful. Appraisal goes through two cognitive mechanisms namely Primary and Secondary appraisals (Berjot & Gillet, 2011).

Primary appraisal is an evaluation of an event for its personal meaning. If Primary appraisal results in identifying the event or circumstance as a harm, loss, threat or a challenge, then the person experiences stress, if not, the event is benign (Mukwato et al, 2010). Secondary appraisal is an evaluation of coping strategies and answers to the situation or question at hand. It indicates poise in one's ability to cope with the situation because one has the resources to cope with it. Resources can be physical, social, psychological, or material (Berjot & Gillet, 2011).

Lazarus and Folkman proposed that coping serves two major roles. One function is the regulation of emotions or distresses that come with the stressful situation (emotion-focused coping). The other is the management of the problem that is causing the stress by directly altering the elements of the stressful situation (problem-focused coping). Although both forms of coping are used in most stressful encounters, they are nonetheless dependent on the way one appraises the situation and on the antecedents of the model (Berjot & Gillet, 2011).
Figure 1.2: Relationship of variables using the Transactional Model of Stress and Coping

**Primary appraisal**
- Abortion is perceived to be a loss, threat or challenge

**Secondary appraisal**
- Problem-focused coping
- Emotion-focused coping

**Perceived Threat**
- Perception of ability to cope with the threat
- Perception of inability to cope with the threat

**Situation/event**
- Experience of an abortion

**Variables**
- Stigma
- Stress
- Education level
- Recurrent abortion
- Staff attitude

**Source:** Berjot & Gillet, 2011
1.9 STUDY VARIABLES

A variable is a property or characteristic of persons, things or situation that change or vary and are manipulated, measured or controlled in research (Burns & Grove, 2005).

Dependent variable refers to a response, behaviour or outcome that the investigator wants to predict or explain (Burns & Grove, 2005). This study has one dependent variable “coping strategies utilised by women who have experienced an abortion”.

An independent variable is a stimulus or activity that is manipulated or varied by the investigator to create an effect on the dependent variable (Burns & Grove, 2005). The independent variables in this study are; staff attitude, stress, stigma, recurrent abortion and education level.
<table>
<thead>
<tr>
<th>Variable</th>
<th>Cut-off Point</th>
<th>Indicators</th>
<th>Question number</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dependent Variable</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coping with the experience of an abortion</td>
<td>Positive</td>
<td>If a woman who had experienced an abortion was able to carry on with normal activities of daily living, no insomnia, no eating disorders, no anger and no social withdraw.</td>
<td>20-23</td>
</tr>
<tr>
<td></td>
<td>Negative</td>
<td>If a woman who had experienced an abortion was not able to normally carry on with normal activities of daily living, had insomnia, eating disorders, anger and social withdraw.</td>
<td></td>
</tr>
<tr>
<td><strong>Independent Variables</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education level</td>
<td>High</td>
<td>If a woman who had experienced an abortion had reached tertiary education.</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Medium</td>
<td>If a woman who had experienced an abortion had reached secondary education.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Low</td>
<td>If a woman who had experienced an abortion had reached primary education or had never been to school.</td>
<td></td>
</tr>
<tr>
<td>Stress</td>
<td>Positive</td>
<td>If a woman who had experienced an abortion felt relieved.</td>
<td>19</td>
</tr>
<tr>
<td></td>
<td>Negative</td>
<td>If a woman who had experienced an abortion felt angry, anxious and nervous.</td>
<td></td>
</tr>
<tr>
<td>Question number</td>
<td>Indicators</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>If a woman who had experienced an abortion experienced negative reaction from spouse and relative including undergoing rituals and restrictions.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11, 13, 15</td>
<td>If healthcare providers did not give review dates and no counselling.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cut-off Point</th>
<th>Variable</th>
<th>Positive</th>
<th>Negative</th>
<th>Good</th>
<th>Bad</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive</td>
<td>Stigma</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Negative</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Positive</td>
<td>Recurrent abortion</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Negative</td>
<td>Staff attitude</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
CHAPTER 2

2.0 LITERATURE REVIEW

2.1 INTRODUCTION

This literature review provides the reader with an overview of studies that have been conducted, published and peer reviewed on determinants of coping strategies utilized by women who have experienced an abortion. In the present study the following electronic data bases were searched; Pub Med, Hinari, Google Scholar and E-granary for the period 2003 to 2013. Literature reviews are secondary sources, and as such, they do not report any new or original experimental work (Burns & Grove, 2009).

Since the aim of this study was to determine factors influencing coping strategies utilized by women who had experienced an abortion, studies that had been conducted in relation to the study topic were reviewed. Sources of information included books and published articles from journals. The reviewed literature was discussed in relation to dependent variable (coping) and independent variables (staff attitude, educational level, stigma, stress and recurrent abortion). There are many coping strategies utilised by women who have experienced an abortion such as repression, anger, denial and trust in God among others (James & Kristiansen, 2006).

2.2 OVERVIEW OF COPING AFTER ABORTION

As earlier elucidated, coping is the ability to successfully deal with a difficult situation (Lawlor, 2012). Women who have experienced an abortion react differently to the predicament of pregnancy loss. Reactions include guilty feelings, anxiety, depression, anger, and suicidal thoughts (Major et al, 2008). According to Berjot & Gillet (2011), women experience mixed feelings after an abortion with difficulties in coping, which seem to be triggered by a number of factors. Some of the factors may not directly be related to abortion. The capacity of an individual to cope with a major life event may be influenced by their individual make-up as well as the social, cultural, political, and societal context in which they may be living.
In other words, the experience of abortion depends on more than just the woman's feelings, thoughts and personality, but rather, on her ability to access resources when needed such as relationship with significant others, workmates, employers and health workers among others.

According to Stirzinger et al's (2012) study, women who had experienced an abortion were clinically vulnerable to depression or had actual depression and needed treatment. Most of the women showed negative emotions which included self-blame and stress among others. The study further highlighted that women assessed in the first year after spontaneous abortion showed symptoms of stress and high levels of depression symptoms.

2.3 FACTORS INFLUENCING COPING STRATEGIES
The following discussion gave in-depth information of studies on determinants of coping strategies utilised by women who had experienced an abortion.

2.3.1 Stigma

Stigma is defined as a perceived negative attribute that causes someone to devalue or think less of the whole person and affect a person's identity (Kristalý, 2009). Stigmatised individuals are often devalued in society in many situations. Stigma increases the quantity of stressors that stigmatised individuals experience. One of the most evident and frequent consequences of stigmatisation is the discrimination that often comes with it (Berjot & Gillet, 2011).

Major & Gramzow (2012) examined the stigma of abortion and psychological implications of concealment of the experience among 442 women followed for two years from the day of their abortion. The results showed that women who felt stigmatised by abortion were more likely to feel the need to conceal this experience from family and friends. Secrecy was related positively to suppressing thoughts of the abortion. Greater thought suppression was associated with experiencing more intrusive thoughts of the abortion.
Both suppression and intrusive thoughts, in turn, were positively related to increase in psychological distress. On the other hand, disclosure was associated with decrease in distress among women experiencing intrusive thoughts of their abortion and was unrelated to distress among women not experiencing intrusive thoughts.

2.3.2 Stress

Stress is defined as the body’s reaction to change that requires physical, mental or emotional adjustment or response and can come from any situation or thought that makes someone feel frustrated, angry, nervous or anxious (Morrow, 2011). People have diverse responses to stress which include physiological, cognitive, emotional and behavioural responses.

There have been several efforts to differentiate conceptually and empirically among the many responses people have to stress. Some of the important distinctions include contrast between voluntary and involuntary responses, primary versus secondary control coping efforts, active and passive coping as well as cognitive and behavioural coping among others (Stirtzinger et al, 2012).

From the above background it can be seen that pressure from the family and workplace may overwhelm the already stressed woman who has experienced an abortion such that she may fail to cope effectively. Individual women’s coping strategies would be affected by stress.

2.3.3 Education level

James & Kristiansen’s (2006) study findings revealed that 64 percent of the women in the study used cognitive restructuring (problem-focused and emotion-focused coping) as a strategy, and had a reasonable education background. As a result they suffered less adverse reactions than their counterparts who utilised social withdrawal or wishful thinking, most with a humble education background. The study also revealed that women who had knowledge about abortion before the experience utilised less wishful thinking.
Therefore, Women who are elite may understand their condition and abide by instructions leading to better coping strategies, because they are able to reason, read and understand written instructions regarding their condition.

2.3.4 Recurrent abortion

Fraser et al (2008), defines recurrent abortion as loss of three or more successive pregnancies. It affects one percent of all women and the risk of further abortion increases with each pregnancy loss. Miller (2009), states that women who had recurrent abortions expressed feelings of exhaustion, overwhelming sadness, dread, despair, guilt and grief. Anger was ever present and always seemed right at the surface. They were constantly reminded of what they perceived as a complete personal failure by co-workers, family and friends who had successful pregnancies. This resulted in women struggling with feelings of jealousy and guilt.

Miller (2009) further revealed that husbands to the women who had experienced recurrent abortions had difficulty understanding feelings their wives were experiencing such as deep depressions and fears that they might never have a child. The consequences of this were arguments and fights, which caused additional stress to the women. Family and friends who had been supportive with the first loss became almost non-existent as the losses added up. At a time when they needed more support there was no one to provide it.

Similarly, Rowsell et al (2010) investigated the psychological impact of recurrent abortion, and ways in which intervention at a pre-pregnancy counselling clinic (PPCC) influences psychological adaptation. Results were that all of the 37 women who had been referred to the PPCC following two or more abortions exhibited high levels of anxiety, as well as intrusive and avoidant distress. A reduction in both avoidance coping and active coping strategies over time was evident, although the reduction could not be attributed to the counselling intervention. No evidence was found to support the hypothesis that those given medical explanation and follow-up following abortion would show a greater reduction in levels of psychological distress than those who were not given such an explanation.
The former study by Miller (2009) indicated that the experience of repeated abortion negatively affected coping strategies employed by women especially when social support from family and friends diminished as earlier stated. In the later study by Rowsell et al (2010), there was no evidence to support the reduction in distress in women who were offered medical advice after experiencing recurrent abortions.

2.3.5 Staff Attitude

Staff attitude towards women who have experienced an abortion could have an impact on their coping strategies. According to Adolffson et al (2010), structured follow up visits reduced grief by 50 percent, compared to routine reviews at the health facility. Structured follow up visits showed special concern for the women by members of staff. The study further revealed that women who felt abandoned by health care providers after abortion exhibited symptoms of grief.

Conversely in another study, there was little evidence to support efficacy of structured follow up of women who had experienced an abortion. Results showed that there was dissatisfaction with care in some women who had structured follow-ups despite evidence that the care provided in the hospital had significant effects on the experience of the emotional and physical recovery from the abortion experience (Stratton & Lloyd, 2008). The study concluded that staff attitude by means of conforming to structured follow-ups showed no significant correlation with coping after abortion.

2.4 CONCLUSION

With the above discussion this chapter highlighted that some women who experienced an abortion underwent primary appraisal by perceiving that the loss of the pregnancy was a threat or a challenge. They may have had insight of the problem as a threat to psychological wellbeing, but decided to conceal it from family members for fear of stigmatisation and stress.
In addition support from a male partner, parents or health care providers did not seem to affect women's anticipated coping. However, social support emerged as important after the abortion. For example, positive social support helped women who had difficulties in coping. Poor social support and/or stigma caused unexpected poor coping.

Another important finding was that women who experienced an abortion and perceived it to be a threat underwent secondary appraisal where they applied either problem or emotion-focused coping depending on stressors from family members and health care providers. Depending on the magnitude of stressors, women may have coped positively or negatively.

It was interesting to note that reasoning capacity of literate women was better than that of uneducated women. Thus, when faced with a problem, educated women utilised cognitive restructuring leading to positive coping. Surprisingly, other studies indicated that educated women have a possibility of not coping positively due to poor acceptance of their situation.

With regard to repeated abortions affecting coping strategies, the more the occurrence of abortions, the less social support women received from family and healthcare providers leading to poor coping due to isolation and stigma.
CHAPTER 3

3.0 RESEARCH METHODOLOGY

3.1 INTRODUCTION

Research methodology refers to steps, procedures and strategies for gathering and analysing data in research (Polit & Beck, 2008). The purpose of the present study was to explore determinants of coping strategies utilised by women after experiencing an abortion in Zambia. The methodology chapter described the research design employed by the present study. The study setting and study population also formed part of this chapter. Other issues in this chapter were sample selection, sample size, data collection tools, data collection technique, pilot study, validity and reliability, ethical and cultural considerations and plans for dissemination of findings.

3.2 RESEARCH DESIGN

Burns & Groove (2009) define study design as a blue print for conducting research that maximizes control over factors that could interfere with the validity of the findings. It comprises activities which guide collecting, analysing and interpreting data. The correct design helps to isolate items of concern so that they can be examined under known conditions, and it eliminates bias, reduces margin error and enables the investigator to confidently state conclusions on which to base future decisions (Basawanthappa, 2006).

An exploratory study design, which is a non-experimental type of design, was used in the study. It involved collecting descriptions of existing phenomena for the purpose of using the data to justify or assess current conditions or to make plans for improvement of conditions (Lobiondo-Wood & Haber, 2006). An exploratory study is a small-scale study of relatively short duration, which is carried out when there is little known about a situation or a problem (Basawanthappa, 2006).
This was because of the limited resources and time allocated for the study and also considering that there was little known about determinants of coping strategies utilised by women after experiencing an abortion in Zambia.

3.3 RESEARCH SETTING

The research setting is the environment or location where a research study is conducted (Burns & Grove, 2005). Therefore, the study was conducted in both rural and urban Zambia.

It was conducted in Kalene, Chinsali, Siavonga and Lusaka. These sites were conveniently selected because of fewer logistical costs involved and availability of respondents.

3.4 STUDY POPULATION

Study population refers to total category of persons or objects that meet the criteria for the study established by the investigator (Basavanthappa, 2008). In the present study, the study population included all women aged between 18 and 55 who had experienced an abortion.

3.5 SAMPLE SELECTION

Sampling is the process of selecting a subset of a population in order to obtain information regarding a phenomenon in a way that represents the entire population (Basavanthappa, 2008). The participants in the present study were selected using the simple random sampling method which is the most basic of the probability sampling techniques where every member of the population has an equal opportunity of being selected into the sample (Basavanthappa, 2008).
3.5.1 Inclusion criteria

Burns & Grove (2005) define inclusion criteria as the characteristics that the subject or element must possess to be part of the target population. Women who have experienced an abortion either an induced or a spontaneous abortion participated in the study.

3.5.2 Exclusion criteria

Exclusion criteria are those characteristics that can cause a person or element to be removed from the target population (Burns & Grove, 2005). Therefore all those women who had not experienced an abortion were excluded from participating in the study.

3.6 SAMPLE SIZE

Sample size refers to a portion of a population to represent the entire population in order to obtain information regarding a phenomenon (Basavanthappa, 2008). Therefore a total of 200 women who had experienced an abortion were sampled from Kalene, Chinsali, Siavonga and Lusaka. It was also the minimum recommended sample size by the Department of Nursing Sciences.

3.7 OPERATIONAL DEFINITION OF STUDY VARIABLES

i. **Coping:** In the present study coping meant accepting and coming to terms with pregnancy loss. This was measured by assessing how women who had experienced an abortion carried on with activities of daily living. This variable was measured to assess the impact of the independent variables on the women’s adjustment process to pregnancy loss.

ii. **Stress:** Stress referred to undue physical and psychological pressures from family members and the community exerted on a woman who had an abortion. It was measured by assessing the quality of their activities of daily living. This variable was measured so as to assess the equilibrium between what pressures a woman can handle and what she is given to handle.
iii. **Stigma:** Stigma in the present study meant extricating women who had experienced an abortion from other members of a society by family and community. This variable was measured by asking how the woman related with family members and other community members.

iv. **Educational level:** Educational level referred to highest possible qualification attained by a woman who had experienced an abortion. This study considered anyone who had reached grade nine or higher as being educated. This variable was measured in order to determine if women were able to follow written instructions and be able to appreciate literature on their condition.

v. **Staff attitude:** Staff attitude meant a collection of behaviours objectively or subjectively exhibited by health care providers as they rendered health care services to women who had experienced an abortion. This variable was measured by asking women’s opinion and general view of care provided by health workers.

vi. **Recurrent Abortion:** This referred to women who had experienced three or more abortions. This was measured by asking a woman how many pregnancy losses she had. This variable was assessed to compare coping strategies employed at each pregnancy loss and the effectiveness of the coping strategies.

### 3.8 DATA COLLECTION TOOL

This is an instrument used to gather information needed to address a research problem. It may take the form of questionnaire, an interview schedule, checklist, focus group discussion guide or some other type of tool for extricating information (Burns & Grove, 2005). An interview schedule was used to collect data for the present study. It contained both closed and open ended questions which facilitated exploration of determinants of coping strategies of women who had experienced an abortion. The interview schedule was divided into six sections which covered demographic data, socio-economic status of respondents, past obstetric history, health care provider’s attitude, socio-cultural factors and stress respectively. Finally, there was a provision where women were asked to suggest ways of improving their coping strategies.
3.8.1 Interview schedule

According to Lobiondo-Wood & Haber (2006), an interview schedule is a questionnaire that is read to the respondent. Questionnaires refer to paper and pencil instruments designed to collect data from individuals, usually in a written form. In the present study, the interview schedule permitted the investigator to obtain data from those who were able to read and write as well as those who were unable to read and write. Some of the advantages of using an interview schedule included its suitability for those who were able to read and write as well as those who were unable to read and write. It permitted clarification of questions and had a higher response rate than self-administered questionnaire.

On the other hand the influence of the interviewer’s presence, on the responses of the participants could have been one of the disadvantages of an interview schedule.

3.8.2 Validity

Validity refers to whether a measuring instrument accurately establishes what it is supposed to measure (Lobiondo-Wood & Haber, 2006). When an instrument is valid, it truly replicates the concept it is supposed to measure. Validity comprises internal and external validity. Internal validity refers to interpretation of the findings within the study or data collected. It is concerned with the extent to which conclusions can be drawn about the effects of one variable on another.

To ensure validity in the present study, the same questions were asked to all participants, they were simplified, concise and brief. On the other hand, external validity refers to the degree to which other environmental or external factors regulate the results of the study (Basavanthappa, 2008). Selection of an appropriate study design, careful designing and pre-testing of the interview schedule is done to ensure external validity. Validity in general was achieved by conducting a pilot study in Kalene, Chinsali, Siavonga and Lusaka. The pilot study helped to ensure that the instrument measured what it purports to measure. After pre-testing, data collection tool was corrected to make it simple for both the researchers and the respondents.

26
Corrections were made to the tool by removing questions that would confuse respondents on determinants of coping strategies following abortions and modification of questions was done. Open-ended questions ensured validity of the tool as these questions gave participants an opportunity to respond in their own words. Further, this facilitated active listening and also accurate recording participant’s responses.

3.8.3 Reliability

Reliability of the research instrument is the extent to which the instrument yields unchanged results on repeated measures. Reliability is concerned with consistency, accuracy, precision, stability, equivalence and homogeneity (Lobiondo-Wood & Haber, 2006). To ensure reliability of the instrument a pilot study was conducted in a setting with similar characteristics as the actual setting in order to test the degree of accuracy.

3.9 DATA COLLECTION TECHNIQUE

Data collection technique is a method of collecting data needed to address a research problem (Polit & Beck, 2006). Before data collection, clearance was obtained from supervisor and Head of Department in the School of Medicine, Department of Nursing Sciences. Further permission was obtained from the District Medical Officers for Ikelenge, Chinsali, Siavonga and Lusaka districts. Permission was also obtained from Medical Superintendent for Kalene Mission Hospital, Chinsali District Hospital, and Siavonga District Hospital as well as from the sister In-charge for Chipata clinic.

Interview schedule was used to collect data from women who had experienced an abortion as they attended antenatal and post natal clinics. For the purpose of maintaining privacy and confidentiality a room was provided in the respective hospitals. The respondents were welcomed, offered seats and one respondent interviewed at a time.
Respondents were greeted and self-introduction of the investigator to the respondents was done. An explanation of the purpose of the study was given and then consent obtained. The process and duration of the interview were explained to the respondents by the investigators. Respondents were assured of confidentiality, privacy and that no name would be indicated on the interview schedule. The respondents were informed that they would be free to consent or not. The investigators were expected to thank the respondents for their time and information given after the interview.

3.10 PILOT STUDY

A pilot study is a smaller scale of the parent study with similar methods and procedures that yield preliminary data that determine the feasibility of conducting a larger scale study and establish that sufficient scientific evidence exists to justify subsequent, more extensive research (Lobiondo-Wood & Haber, 2006).

The reason for conducting a pilot study was to assess the feasibility of the study and methodology so that necessary adjustments could be made. The pilot study was carried out at Kalene Mission Hospital, Chinsali Hospital, Siavonga Hospital and Chipata Clinic. Participants for the pilot study were selected using simple random sampling. The sample for pilot study was 10 percent of the total sample (200) which was 20.

Therefore, numbers one to 10 were written on pieces of paper and put in a box. After a vigorous shake, participants were asked to pick one piece of paper and 20 participants, five from each study setting who picked odd numbers were included in the pilot study. After the pilot study, amendments were made to the tool.

3.11 ETHICAL AND LEGAL ISSUES

Ethics are systems of moral values that are concerned with the degree to which research procedures conform to the professional, legal and social obligations to the study participants (Polit & Beck, 2006). There are three ethical principles namely; beneficence, respect for human dignity and justice.
3.11.1 Beneficence and non-maleficence

Beneficence is an obligation to do no harm and to maximise possible benefit. An individual’s decisions are respected and efforts are made to ensure their wellbeing (Wood & Haber, 2006). Non-maleficence works together with the principle of beneficence where the harmful risks have to be weighed against the possible benefit. The participants were assured of confidentiality and anonymity and serial numbers were used on questionnaires and not their names except for the consent only. This was done to enable them participate freely and without fear. Questionnaires and consent forms were kept in separate envelopes which were marked ‘answered questionnaires’ and ‘signed consent forms’ to avoid unauthorised access to the information.

Participants were not subjected to any harm as the research did not involve any invasive procedures. The participants were protected from psychological harm by letting them answer questions in a natural setting which had a private space with no public interference at their free time.

3.11.2 Respect for persons

Respect for persons is where people have the right to self-determination and to treatment as autonomous agents (Wood & Haber, 2006). This was explained to the individual participants that they would be given the freedom to participate or not to participate in the study. The respondents were assured of confidentiality of personal information shared with the researcher and that no names would appear on the questionnaire.

Those who took part in the study were requested to sign the consent form while those who refused to participate were also reassured that no privileges would be taken away from them. The participants were also told that they had the right to withdraw from the study at any time and without a penalty. Sensitivity to beliefs, habits and life styles of different individuals was demonstrated during the process of data collection.
3.11.3 Justice

Justice is one of the principles which emphasises that human subjects be treated fairly (Wood & Haber, 2006). In the present study justice was upheld by ensuring that favouritism was not shown to any of the participants as they were all treated equally.

3.12 PLAN FOR DATA ANALYSIS

Data analysis is the process of categorizing, scrutinizing and cross-checking the gathered research data (Basavanthappa, 2007). The data collection tool consisted mainly of quantitative questions, with a few qualitative questions. Quantitative data is defined by Polit & Beck (2008) as information collected in the course of a study that is quantified or in numeric form. Qualitative data is the information collected in the course of a study that is narrative (Polit & Beck, 2008). Data analysis was done using SPSS version 20. Responses to qualitative questions were coded, categorised and analysed together with responses to quantitative questions.

3.13 PLAN FOR DISSEMINATION OF FINDINGS

Dissemination of research findings is the distribution or communication of research findings by presentation and publication to a variety of audiences such as nurses, other health professionals, policy developers and consumers (Burns & Grove, 2005). Bound copies of the research document with findings and recommendations of the study were distributed to School of Medicine of the University of Zambia, Ministry of Health headquarters and to respective District Medical Offices (DMOs) for the study settings.
CHAPTER 4

4.0 PRESENTATION OF FINDINGS

4.1 SECTION A: Demographic data

This section consists of tables and figures on social demographic characteristics of the study respondents. The social demographic characteristics were used to measure their influence on respondents’ coping with the experience of an abortion and they included; age, ritual status, education level, employment status and religious denomination. Two hundred respondents took part in this study which gave a response rate of 100 percent.

Figure 4.1: Age distribution

Figure 4.1 shows that the age of participants ranged between 18 and 55 and the mean age was 31 which indicate that participants in this study were young. The figure also shows that majority of the participants (36%) where aged between 26 and 35 while 8.5 percent where in the age group of 46 to 55.
Table 4.2: Marital status

<table>
<thead>
<tr>
<th>Marital status</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married</td>
<td>148</td>
<td>74</td>
</tr>
<tr>
<td>Never married</td>
<td>15</td>
<td>7.5</td>
</tr>
<tr>
<td>Separated</td>
<td>12</td>
<td>6</td>
</tr>
<tr>
<td>Divorced</td>
<td>15</td>
<td>7.5</td>
</tr>
<tr>
<td>Widowed</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>200</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Results shown in table 4.2 show that most of the respondents (74%) were married and only five percent were widowed, indicating that marriage is common in Zambia.

Table 4.3: Religious denomination

<table>
<thead>
<tr>
<th>Religious denomination</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>African Methodist Church</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>CMML</td>
<td>12</td>
<td>6</td>
</tr>
<tr>
<td>Roman Catholic</td>
<td>48</td>
<td>24</td>
</tr>
<tr>
<td>New Apostolic Church</td>
<td>20</td>
<td>10</td>
</tr>
<tr>
<td>Pentecostal</td>
<td>45</td>
<td>22.5</td>
</tr>
<tr>
<td>No Church</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td>SDA</td>
<td>20</td>
<td>10</td>
</tr>
<tr>
<td>Other (specify)</td>
<td>39</td>
<td>19.5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>200</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Majority of the respondents interviewed (24%) belonged to the Roman Catholic Church. The rest were distributed between CMML, New Apostolic Church, Pentecostal Church, Seventh day Adventist Church and African Methodist Church.
4.2 SECTION B: Socio-economic status

Table 4.4: Education level

<table>
<thead>
<tr>
<th>Education level</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never been to school</td>
<td>31</td>
<td>15.5</td>
</tr>
<tr>
<td>Primary</td>
<td>107</td>
<td>53.5</td>
</tr>
<tr>
<td>Secondary</td>
<td>52</td>
<td>26</td>
</tr>
<tr>
<td>Tertiary</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>200</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Table 4.4 shows that more participants (53.5%) had only attained primary education compared to the five percent who attained tertiary education. Additionally the table shows that 15.5 percent had never been to school signifying that majority of the respondents had not attained significant education.

Table 4.5: Profession/occupation

<table>
<thead>
<tr>
<th>Profession/occupation</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employed</td>
<td>24</td>
<td>12</td>
</tr>
<tr>
<td>Unemployed</td>
<td>50</td>
<td>25</td>
</tr>
<tr>
<td>Self employed</td>
<td>35</td>
<td>17.5</td>
</tr>
<tr>
<td>Peasant farmer</td>
<td>76</td>
<td>38</td>
</tr>
<tr>
<td>student/Pupil</td>
<td>15</td>
<td>7.5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>200</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

It is evident that majority of the respondents (38%) were peasant farmers, 25 percent were unemployed while only 12 percent were employed as shown in table 4.5 above.
Table 4.6: Income

<table>
<thead>
<tr>
<th>Monthly income</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Below K500 000</td>
<td>115</td>
<td>57.5</td>
</tr>
<tr>
<td>Between K500 000 and K1 000 000</td>
<td>57</td>
<td>28.5</td>
</tr>
<tr>
<td>Between K500 000 and K1 000 000</td>
<td>25</td>
<td>12.5</td>
</tr>
<tr>
<td>Above K5 000 000</td>
<td>3</td>
<td>1.5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>200</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

From table 4.6 above, it is evident that the majority of the respondents earned below K500 000 representing 57.5 percent of participants. Only three (1.5%) of respondents earned above K5 000 000.

4.3 SECTION C: Past obstetric history

Table 4.7: Number of pregnancies

<table>
<thead>
<tr>
<th>Pregnancies</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-3</td>
<td>86</td>
<td>43</td>
</tr>
<tr>
<td>4-6</td>
<td>67</td>
<td>33.5</td>
</tr>
<tr>
<td>7-9</td>
<td>35</td>
<td>17.5</td>
</tr>
<tr>
<td>10 and above</td>
<td>12</td>
<td>6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>200</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

The data in table 4.7 indicates that 86 women (43%) had pregnancies ranging between one and three while only 12 (6%) had 10 pregnancies or more.

Table 4.8 Number of pregnancy losses

<table>
<thead>
<tr>
<th>Pregnancy losses</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-2</td>
<td>187</td>
<td>93.5</td>
</tr>
<tr>
<td>3 and above</td>
<td>13</td>
<td>6.5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>200</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Information in table 4.8 shows that most of the participants (93.5%) had pregnancy losses ranging between one and two while the rest of the respondents (6.5%) had at least three pregnancy losses. This implies that few participants had recurrent abortions.
Table 4.9: Knowledge about abortion

<table>
<thead>
<tr>
<th>Knowledge about abortion</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Little</td>
<td>184</td>
<td>92</td>
</tr>
<tr>
<td>Adequate</td>
<td>14</td>
<td>7</td>
</tr>
<tr>
<td>Very adequate</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>200</td>
<td>100</td>
</tr>
</tbody>
</table>

It is evident from the information above (table 4.9) that 92 percent of the participants had little knowledge about abortion while only one percent of the respondents had adequate knowledge about abortion.

4.4 SECTION D: Attitude of health care provider

Table 4.10 Went to health facility

<table>
<thead>
<tr>
<th>Went to health facility</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>164</td>
<td>82</td>
</tr>
<tr>
<td>No</td>
<td>36</td>
<td>18</td>
</tr>
<tr>
<td>Total</td>
<td>200</td>
<td>100</td>
</tr>
</tbody>
</table>

Results in table 4.10 show that most of the respondents (82%) sought medical care after experiencing an abortion while 18 percent did not. This indicates that most participants utilised health facilities after experiencing an abortion.
Figure 4.2 above shows that majority of the respondents (71%) perceived the attitude of health care providers as good, with a small proportion of three percent perceiving the attitude of health care providers as bad. Thirteen percent of the respondents perceived the attitude of health care providers as very bad.

Table 4.11: Reasons for not going to health facility

<table>
<thead>
<tr>
<th>Reasons for not going to health facility</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long distance from home</td>
<td>18</td>
<td>9</td>
</tr>
<tr>
<td>I was okay after an abortion</td>
<td>19</td>
<td>9.5</td>
</tr>
<tr>
<td>Not applicable</td>
<td>163</td>
<td>81.5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>200</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Among those who did not go to health facility after experiencing an abortion, 9.5 percent reported having no complications as the reason for having not gone to the health facility after delivery while nine percent cited long distance as a reason (table 4.11).
4.5 SECTION E: Social and cultural factors

Table 4.12: Reaction of spouse and relatives

<table>
<thead>
<tr>
<th>Reaction</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive</td>
<td>132</td>
<td>66</td>
</tr>
<tr>
<td>Negative</td>
<td>32</td>
<td>16</td>
</tr>
<tr>
<td>Neutral</td>
<td>36</td>
<td>18</td>
</tr>
<tr>
<td>Total</td>
<td>200</td>
<td>100</td>
</tr>
</tbody>
</table>

Majority of the respondents’ spouses and relatives (66%) reacted positively to their abortion while 32 (16%) showed negative reactions, giving an impression that most families supported women who had experience an abortion.

Table 4.13: Ritual cleansing and restrictions

<table>
<thead>
<tr>
<th>Ritual cleansing and restrictions</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>80</td>
<td>40</td>
</tr>
<tr>
<td>No</td>
<td>120</td>
<td>60</td>
</tr>
<tr>
<td>Total</td>
<td>200</td>
<td>100</td>
</tr>
</tbody>
</table>

The table (4.13) above indicates that 80 (40%) of the respondents underwent ritual cleansing and restrictions while 120 (60%) did not, implying that traditional superstitions are still prevalent in the communities.

4.6 SECTION F: Stress and anxiety

Table 4.14: Emotional experience

<table>
<thead>
<tr>
<th>Emotional experience</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angry</td>
<td>68</td>
<td>34</td>
</tr>
<tr>
<td>Anxious</td>
<td>48</td>
<td>24</td>
</tr>
<tr>
<td>Nervous</td>
<td>33</td>
<td>16</td>
</tr>
<tr>
<td>Relieved</td>
<td>15</td>
<td>7.5</td>
</tr>
<tr>
<td>Others (specify)</td>
<td>36</td>
<td>18</td>
</tr>
<tr>
<td>Total</td>
<td>200</td>
<td>100</td>
</tr>
</tbody>
</table>

From table 4.14 above, 68 (34%) respondents reported feelings of anger after an abortion while 15 (7.5%) reported feelings of relief. This indicates that anger is a common reaction following an experience of abortion among the population under study.
Table 4.15: Reasons for coping

<table>
<thead>
<tr>
<th>Reasons for coping</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support from church</td>
<td>64</td>
<td>32</td>
</tr>
<tr>
<td>Support from spouse and family</td>
<td>83</td>
<td>41.5</td>
</tr>
<tr>
<td>Blame by self or others</td>
<td>43</td>
<td>21.5</td>
</tr>
<tr>
<td>Good attitude from health care providers</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>200</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Majority (41.5%) indicated support from the spouse and family as being the main reason for having coped well while only five percent of the respondents cited good attitude by the health care providers as the reason for coping well. This showed that spouses and family members play an important role in helping women who have experienced an abortion to cope.

Table 4.16: Effect on daily activities

<table>
<thead>
<tr>
<th>Daily activities</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did not affect daily activities</td>
<td>86</td>
<td>43</td>
</tr>
<tr>
<td>Affected the daily activities to a minor degree</td>
<td>84</td>
<td>42</td>
</tr>
<tr>
<td>Grossly affected the daily activities</td>
<td>30</td>
<td>15</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>200</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Most of the respondents (43%) reported that their daily activities were not affected by the experience of an abortion whereas 30 (15%) respondents reported having had their daily activities grossly affected. This implies that most women continue with their normal daily activities despite experiencing an abortion.
Table 4.17: Experience after an abortion

<table>
<thead>
<tr>
<th>Experience</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insomnia</td>
<td>49</td>
<td>24.5</td>
</tr>
<tr>
<td>Eating disorders</td>
<td>40</td>
<td>20</td>
</tr>
<tr>
<td>Withdrawal</td>
<td>24</td>
<td>12</td>
</tr>
<tr>
<td>Anger</td>
<td>34</td>
<td>17</td>
</tr>
<tr>
<td>Other (specify)</td>
<td>53</td>
<td>26.5</td>
</tr>
<tr>
<td>Total</td>
<td>200</td>
<td>100</td>
</tr>
</tbody>
</table>

The table above (4.17) shows that 49 (24.5%) respondents experienced insomnia, 40 (20%) had eating disorders, 24 (12%) experienced withdrawal, 34 (17%) experienced anger while 53 (26.5%) had other experiences.

4.7 CROSS TABULATION

Out of the 200 respondents interviewed, 149 coped well where as 51 did not cope well with the experience of an abortion. Therefore various independent variables were cross tabulated in order to determine the association between the dependent and independent variables.

Table 4.18: Age and coping

<table>
<thead>
<tr>
<th>Age</th>
<th>Coping</th>
<th>Chi Square</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Coped well</td>
<td>Did not cope well</td>
</tr>
<tr>
<td>---------</td>
<td>--------------</td>
<td>---------------</td>
</tr>
<tr>
<td>16-25</td>
<td>52(75%)</td>
<td>17(25%)</td>
</tr>
<tr>
<td>26-35</td>
<td>51(71%)</td>
<td>21(29%)</td>
</tr>
<tr>
<td>36-45</td>
<td>33(79%)</td>
<td>9(21%)</td>
</tr>
<tr>
<td>46-55</td>
<td>13(76%)</td>
<td>4(24%)</td>
</tr>
<tr>
<td>Total</td>
<td>149(74.5%)</td>
<td>51(25.5%)</td>
</tr>
</tbody>
</table>

Table 4.18 above shows that out of 149 respondents who coped well, 79 percent were within the age group 36-45 years. Among respondents who did not cope well, 29 percent were from the age group of 26-35 years. Therefore, there is no significant relationship between age and coping with the experience of an abortion (p= 0.82; x² = 0.94).
Table 4.19: Income and coping

<table>
<thead>
<tr>
<th>Income</th>
<th>Coped well</th>
<th>Did not cope well</th>
<th>Total</th>
<th>Chi Square</th>
</tr>
</thead>
<tbody>
<tr>
<td>Below K500 000</td>
<td>84(73%)</td>
<td>31(27%)</td>
<td>115(100%)</td>
<td>$x^2$ 0.56</td>
</tr>
<tr>
<td>Between K500 000 and K1 000 000</td>
<td>44(76%)</td>
<td>14(24%)</td>
<td>58(100%)</td>
<td>p(0.91)</td>
</tr>
<tr>
<td>Between K’1 000 000 and K5 000 000</td>
<td>19(79%)</td>
<td>5(21%)</td>
<td>24(100%)</td>
<td></td>
</tr>
<tr>
<td>Above K5 000 000</td>
<td>2(67%)</td>
<td>1(33%)</td>
<td>3(100%)</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>149(74.5%)</td>
<td>51(25.5%)</td>
<td>200(100%)</td>
<td></td>
</tr>
</tbody>
</table>

A higher proportion of respondents who coped well (79%) earned between K1 000 000 and K5 000 000, while 33 percent of respondents who earned above K5 000 000 coped poorly. There is no significant relationship between income and coping with the experience of an abortion ($p= 0.91; x^2 = 0.56$).

Table 4.20: Education level and coping

<table>
<thead>
<tr>
<th>Education level</th>
<th>Coped well</th>
<th>Did not cope well</th>
<th>Total</th>
<th>Chi Square</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never been to school</td>
<td>25(81%)</td>
<td>6(19%)</td>
<td>31(100%)</td>
<td>$x^2$ 6.10</td>
</tr>
<tr>
<td>Primary</td>
<td>84(79%)</td>
<td>23(21%)</td>
<td>107(100%)</td>
<td>p(0.12)</td>
</tr>
<tr>
<td>Secondary</td>
<td>35(67%)</td>
<td>17(33%)</td>
<td>52(100%)</td>
<td></td>
</tr>
<tr>
<td>Tertiary</td>
<td>5(50%)</td>
<td>5(50%)</td>
<td>10(100%)</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>149(74.5%)</td>
<td>51(25.5%)</td>
<td>200(100%)</td>
<td></td>
</tr>
</tbody>
</table>

The above table (4.20) shows that 84 out of 149 respondents who coped well went up to primary level of education while only 5 went up to tertiary level of education. The result indicate there is no relationship between education level and coping ($p= 0.12; x^2 = 6.14$).
Table 4.21: Number of pregnancy losses and coping

<table>
<thead>
<tr>
<th>Pregnancy losses</th>
<th>Coping</th>
<th>Chi Square</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Coped well</td>
<td>Did not cope</td>
</tr>
<tr>
<td>1-2</td>
<td>142(76%)</td>
<td>45(24%)</td>
</tr>
<tr>
<td>3 and above</td>
<td>7(54%)</td>
<td>6(46%)</td>
</tr>
<tr>
<td>Total</td>
<td>149(74.5%)</td>
<td>51(25.5%)</td>
</tr>
</tbody>
</table>

The data in table 4.21 shows that out of the 187 women who had one or two pregnancy losses, 142 coped well. Among the 13 respondents who had three or more pregnancy losses, seven coped well. The results indicate that there is no significant relationship between number of pregnancy losses and coping with the experience of an abortion ($p=0.08; x^2 = 3.12$).

Table 4.22 Staff Attitude and coping

<table>
<thead>
<tr>
<th>Staff Attitude</th>
<th>Coping</th>
<th>Chi Square</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Coped well</td>
<td>Did not cope</td>
</tr>
<tr>
<td>Very good</td>
<td>15(68%)</td>
<td>7(32%)</td>
</tr>
<tr>
<td>Good</td>
<td>91(76%)</td>
<td>29(24%)</td>
</tr>
<tr>
<td>Bad</td>
<td>13(72%)</td>
<td>5(28%)</td>
</tr>
<tr>
<td>Very bad</td>
<td>4(80%)</td>
<td>1(20%)</td>
</tr>
<tr>
<td>Not applicable</td>
<td>26(74%)</td>
<td>9(26%)</td>
</tr>
<tr>
<td>Total</td>
<td>149(74.5%)</td>
<td>51(25.5%)</td>
</tr>
</tbody>
</table>

Table 4.22 above indicates that 91 out of 149 respondents who coped well reported that staff attitude was good while 4 out of 149 respondents reported that staff attitude was very bad. The results show there is no significant relationship between the attitude of health care providers and coping ($p = 0.95; x^2 = 0.70$).
Table 4.23: Stigma and coping

<table>
<thead>
<tr>
<th>Reaction of spouse/ family members</th>
<th>Coping</th>
<th>Chi Square</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Coped well</td>
<td>Did not cope well</td>
</tr>
<tr>
<td>Positive</td>
<td>99(75%)</td>
<td>33(25%)</td>
</tr>
<tr>
<td>Negative</td>
<td>20(63%)</td>
<td>12(37%)</td>
</tr>
<tr>
<td>Neutral</td>
<td>30(83%)</td>
<td>6(17%)</td>
</tr>
<tr>
<td>Total</td>
<td>149(74.5%)</td>
<td>51(25.5%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ritual cleansing</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>60(75%)</td>
<td>20(25%)</td>
</tr>
<tr>
<td>No</td>
<td>89(74%)</td>
<td>31(26%)</td>
</tr>
<tr>
<td>Total</td>
<td>149(74.5%)</td>
<td>51(25.5%)</td>
</tr>
</tbody>
</table>

Table 4.23 above indicates that 83 percent of respondents who reported neutral reaction from their spouses and family members coped well while 37 percent of respondents who reported negative reaction from their spouses and family members did not cope well. Moreover, respondents who underwent ritual cleansing coped better than their counterparts who did not undergo ritual cleansing (75% and 74% respectively). Therefore, there is no significant relationship between reaction from spouse and family members, ritual cleansing and coping (p = 0.14; x^2 = 0.90, chi squares 3.92 and 0.02 respectively).
### Table 4.24: Stress and coping

<table>
<thead>
<tr>
<th>Daily activities</th>
<th>Coping</th>
<th></th>
<th>Chi Square</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Coped well</td>
<td>Did not cope well</td>
<td>Total</td>
</tr>
<tr>
<td>Did not affect daily activities</td>
<td>77(90%)</td>
<td>9(10%)</td>
<td>86(100%)</td>
</tr>
<tr>
<td>Affected the daily activities to a minor degree</td>
<td>55(66%)</td>
<td>29(34%)</td>
<td>84(100%)</td>
</tr>
<tr>
<td>Grossly affected the daily activities</td>
<td>17(57%)</td>
<td>13(43%)</td>
<td>30(100%)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>149(74.5%)</td>
<td>51(25.5%)</td>
<td>200(100%)</td>
</tr>
</tbody>
</table>

The results in table 4.24 above show that 77 out of 86 respondents whose daily activities were not affected coped well, while 13 of 30 respondents whose daily activities were grossly affected did not cope well. This implies that there is a significant relationship between the effects of daily activities and coping (p = 0.00; $x^2 = 18.86$).
CHAPTER 5

5.0 DISCUSSION OF FINDINGS

5.1 INTRODUCTION

The purpose of the study was to explore determinants for coping strategies utilised by women who have experienced an abortion in Zambia. Not many studies have been done in Zambia with regard to coping following abortion. The discussion is based on the findings of the study from 200 participants who had experienced an abortion. The dependent variable (coping with the experience of an abortion) was measured against independent variables education level, recurrent abortions, staff attitude, stigma and stress. SPSS version 20 was used to analyse the data and chi square to determine the significance of the relationships among independent variables with the dependent variable.

5.2 CHARACTERISTICS OF THE SAMPLE

The sample included women who had experienced an abortion aged between 18 and 55. The majority of the respondents (36%) were aged between 26 and 35, while the minority (8.5%) were in the age group 46 to 55 as shown in figure 4.1. The mean age was 31 years signifying that the population under study was young.

Marital status showed that most of the respondents (74%) were married while only five percent were widowed giving a perception that marriage is common in Zambia (table 4.2). In addition, 95 percent of respondents were Christians and belonging to different congregations except for five percent of the respondents who did not belong to any church. This implies that religion is highly regarded in Zambian communities (JCTR, 2012). Education level showed that 53.3 percent of respondents went up to primary level of education in comparison to only five percent who attained tertiary education (table 4.4). This is in line with the study by James and Kristiansen (2006) who found low number of women who attained tertiary education.
In terms of monthly income, majority (57.5%) of the respondents earned below K500 000 and only 1.5 percent earned above K5 000 000 (table 4.6), indicating that most women in Zambia are living below the cost of food basket of about K3 500 000 in urban areas and K1 500 000 in rural areas (JCTR, 2012).

Further, 43 percent of respondents had pregnancies ranging between one and three while six percent had 10 pregnancies. Few participants (6.5%) had at least three pregnancy losses indicating low prevalence of recurrent abortions as shown in table 4.8.

5.3 DISCUSSION OF VARIABLES

Numerous factors may influence women’s coping mechanisms after an abortion. The study examined some basic socio-economic, socio-cultural, psychological, service and disease-related variables for any association with coping. Association between coping with the experience of an abortion and education level, staff attitude, stigma, stress, recurrent abortions was explored whose details are highlighted below.

5.3.1 Educational Level and Coping

The present study results showed no significant relationship between educational level and coping as shown in table 4.21 (p = 0.12; $\chi^2 = 6.10$). These results contradict James and Kristiansen (2006), whose study revealed a relationship between education level and coping. More than half of the women who had attained formal education used better cognitive restructuring as a strategy for coping after experiencing an abortion. The differences in the findings of the present study and those of James & Kristiansen, (2006) could be because their study had a larger sample size of 657 respondents and was conducted in an urban setting. On the other hand, the present study had a sample size of 200 respondents who were predominantly from the rural setting. James & Kristiansen, (2006) further indicated that most women who had prior knowledge about abortion were those who had formal education and as a result suffered less adverse reactions than those who had no formal education.
The similarities between the present study and James & kristiansen's (2006) study are evident in the study design used which is the exploratory design, sampling method which is simple random and data collecting tool which is the interview schedule. The differences in findings may be attributed to the difference in the two study settings which are rural and urban respectively. The rural setting is unlikely to have more women with tertiary education. This could have led to having a small number (10 respondents) of those who attained tertiary education out of the total sample of 200 respondents. Possible explanation for the results may be attributed to the relatively few women in the sample who reported to have attained tertiary education but yet did not cope well. Therefore, further exploration of the relationship between education level and coping with the experience of an abortion would provide insight to why these findings are different to earlier studies.

5.3.2 Staff Attitude and Coping

Majority of respondents sought medical care after experiencing an abortion indicating that most women recognised the significance of seeking medical care when unwell. Staff attitude was assessed through health care providers giving the review date, advice and social support to the patient. The present study findings revealed no significant relationship between staff attitude and coping ($p = 0.95; \chi^2 = 0.70$). The results support the findings by Adolfsson et al’s (2006) study which revealed that staff attitude does not influence women’s coping with miscarriage. Stratton & Lloyd, (2008) further support the findings of the present study by concluding that clients who were visited by staff after experiencing an abortion coped well.

Contrary to the above results, Chan et al’s (2009) study results indicated that attitude of nursing staff can influence recovery from a pregnancy loss and that nurses with positive attitudes to bereavement care can help grieving parents to cope during their grieving period. In addition, the Miscarriage Association (2013) found that the type of care that women or couples receive from hospitals or community can enhance coping with the experience of pregnancy loss.

46
This is because every client desires noble medical care, therefore, kindness, understanding, provision of clear information and use of sensitive language on the part of health care providers are just some of the ways that doctors, nurses and midwives can help women cope with miscarriage.

The difference between the present study results and those by Chan et al.'s (2009) study results might be attributed to differences in research methods used, sample size and setting where the study was conducted. In Chan et al.'s (2009) study a sample size of 657 respondents was used in an urban setting while the present study used only 200 participants predominantly from the rural setting. Information biases could have been due to respondents giving partial information to the investigator for fear of victimisation because the investigators were health workers from the same study setting. Therefore, it is suggested that a study should be conducted in both rural and urban setting with a larger sample size to establish whether staff attitude can influence coping.

5.3.3 Stigma and Coping

In the present study, stigma was measured through reaction of spouses and family members to the abortion. Ritual cleansing and restrictions of a woman after an abortion where also used to measure stigma. Most respondents reported positive reactions from their spouse and family members. The women who had positive reaction from their spouses and family members coped well. However, the present study showed there to be no significant relationship between coping and reaction from spouse and family members ($p = 0.14; \chi^2 = 3.92$). Ritual cleansing and coping also showed no significant relationship ($p = 0.90; \chi^2 = 0.02$). Conversely Neville's (2005) study revealed that positive reaction from spouse, relatives and friends help women who have experienced an abortion to cope better. In addition, findings by Sharon and Abigail (2007), found that a woman copes well with abortion when she receives positive reaction from significant others. The differences between the present study results and those by Neville's (2005) and Sharon & Abigail (2007) could be attributed to cultural differences in the study settings.
Women in the present study setting conceal mistreatment from spouses and relatives (JCTR, 2012), while those from the setting where Neville (2005) drew the sample speak freely about domestic disputes (Neville, 2005). Therefore most respondents being from the rural setting could have concealed mistreatment from their significant others in order to avoid embarrassment. It is for this reason that in-depth studies should be conducted among women to explore their perspectives on what they perceive to be positive treatment and negative treatment by spouses and family members.

5.3.4 Stress and Coping

Stress was measured by the extent to which the experience of an abortion disturbed normal daily activities. The present study results revealed a significant relationship between stress and coping. \( p=0.00; \chi^2=18.86 \) Respondents whose daily activities were grossly affected due to stress did not cope well.

These results are in line with Giraki et al’s (2010) findings which showed that women who were stressed coped poorly showing a relationship between stress and coping. The results also support Nivelle’s (2005) findings which showed that miscarriage results in high level of anxiety and grief which has an effect on normal daily activities, consequently leading to a woman’s failure to cope. The findings further tally with Major et al’s (2008) study results on abortion and coping who stated that abortion in itself is a stressful life event especially if coupled with a stressful environment and can cause difficulties in coping. Research should be conducted to further investigate the most common stressors in women who experience abortions. Separate studies should be conducted in rural areas and urban areas in order to identify different stressors peculiar to each setting.
5.3.5 Recurrent Abortion and Coping

Recurrent abortion was measured by the number of abortions experienced. The findings in the present study show no significant relationship between recurrent abortions and coping (p = 0.08; $\chi^2 = 3.12$). The results tally with Rowsell et al’s (2010) study findings that there is no difference in coping between women with one abortion and those with three or more abortions.

However, the present study findings contradict Ockhuijsen et al (2013) that women remain more positive about future pregnancies after one abortion, but two or more miscarriages change the woman's mental perspective and affect coping. Further, Holly & Danny (2009) found recurrent abortion to be physically and emotionally demanding for women resulting in poor coping.

In future investigations, it would be beneficial to use other data collection techniques like focussed group discussion which would allow women to express themselves freely yielding comprehensive findings.

5.4 IMPLICATION TO THE HEALTH CARE SYSTEM

Implications of the study findings have been discussed under four main domains of nursing, which are related to the topic. These domains include are nursing education, nursing practice, nursing administration and nursing research.

5.4.1 Nursing Education

Nurse educators should educate students on issues related to delivery of culturally sensitive bereavement care in perinatal settings. The nursing school curricula should emphasise issues of social support and effects of stress on coping to women who have experienced an abortion. In addition, there is need to conduct regular refresher courses for nurses, midwives and community lay counsellors so that they are kept abreast with latest information so that they can offer stress management education in reproductive health care.
5.4.2 Nursing Practice

Most of the health centres in Zambia have inadequate policies that promote activities aimed at increasing awareness and accessibility of mental health for women who have experienced an abortion. Therefore there is need to strengthen psychosocial counselling in managing women who have experienced an abortion and to scale up follow up programmes in order to find out how women who have experienced an abortion are coping.

There is also need for nurses to offer technical support to lay counsellors in the provision of reproductive health and counselling services within communities. Social support systems should be strengthened to encourage women who have experienced abortion cope positively.

5.4.3 Nursing Administration

Leadership is critical for the mental health of women who have experienced an abortion. Accountability of resources for supporting mental health and feedback to all stakeholders on progress of the utilization of the available services by women is cardinal. Management should also ensure that women in the communities are sensitized on the availability of counselling services for stress management through awareness campaigns using dramas and focused group discussions. Hospital management should sensitise members of staff within the health facilities on the need to treat women who have experienced an abortion with courtesy, confidentiality and privacy.

5.4.4 Nursing Research

There are few studies that have been conducted to determine the coping strategies utilised by women who have experienced an abortion in Zambia. It is therefore important that further research is conducted. In-depth interviews on the relationship between staff attitude, stigma and recurrent abortions and coping with the experience of an abortion should be conducted to allow women who have experienced an abortion to freely discuss their views.
Further the Ministry of Health can incorporate stakeholders like Non-Governmental Organisations (NGOs) and Faith Based Organisations (FBOs) who can complement its efforts increasing accessibility and utilisation of mental health service. Future studies should focus on exploring coping capabilities of women who have had an abortion with different education levels. This would give a comprehensive result on whether education level influences coping and if so to what extent.

Further in-depth interviews should be conducted to explore whether clients know what to expect from health care providers in order to differentiate between bad and good attitude. In-depth interviews should also be conducted among women to explore their perspectives on what they perceive to be positive treatment and negative treatment by spouses and family members. Further research should be done to investigate the most common stressors in women who have experienced an abortion. Separate studies should be conducted in rural areas and urban areas because there could be different stressors pertinent to each setting.

5.5 RECOMMENDATIONS

These would be made to stakeholders in women’s physical and mental health, which include the Ministry of Health and respective District Health management Teams among others.

5.5.1 Ministry of Health

Ministry of Health as a policy making body should ensure that deliberate programmes are put in place to support women’s mental health programmes at national, provincial, district and community levels. Strategies should include a mental health component in sensitisation programs on national media. There is also need to improve funding to health institutions to enable integration of mental health programmes such as enhancing counselling services. There should also be a directorate of mental health services at the headquarters to oversee mental health activities and research.
Research should be conducted on other variables to explore their relationship with coping with the experience of an abortion. The studies should be conducted and analysed in different settings such as urban areas and rural areas independently.

5.5.2 Chinsali, Ikelenge, Lusaka and Siavonga District Medical Offices

A coordinator for mental health services and research at district level should be appointed who should be trained in the field of mental health. Deliberate programmes on community sensitisation on the need for women who have experienced an abortion to seek services such as counselling should be intensified and follow up after initial management is necessary. Medical staff should be trained in basic counselling skills so that they manage women who have experienced an abortion to reduce stress.

5.6 DISSEMINATION OF FINDINGS

Dissemination of research findings involves communication of findings through publication and presentation to various audiences such as policy makers, programme managers, District Medical Offices and health professionals. The findings of the present study will be printed and bound into reports. Copies of the research report will be disseminated to the University of Zambia Department of Nursing Sciences and medical library to be used as reference by educators and students. Copies will be sent to Chinsali, Ikelenge, Lusaka and Siavonga District Medical Offices as study sites for management and health care providers to refer to as they care for women who have experienced an abortion. Ministry of Health headquarters and Tropical Health and Education Trust (THET) as sponsors of this study will also be provided with a copy each. The investigators will also retain a copy each.
5.7 LIMITATIONS OF THE STUDY

The research design that was used in this study, where most of the respondents in the sample were from the rural setting might have contributed to lack of significance in relationship between most independent variables with coping with the experience of an abortion. The sample size which was relatively small was less representative of the study population.

The study was mostly quantitative, therefore, in-depth interview would yield more insight into stress experienced after an abortion have been more applicable because elaborative responses from respondents were going to be helpful. Other constraints were time and financial resources which were not enough for the study. Exclusion of women under the age of 18 years due to ethical reasons was another constraint as the majority of women who had experienced an abortion in the rural setting were below this age and are more prone to stress than older women.

5.8 CONCLUSION

This study, explored the determinants for coping strategies utilised by women who have experienced an abortion in Chinsali, Ikelenge, Lusaka and Siavonga. Determinants for coping strategies of 200 respondents who had experienced an abortion were examined. The determinants were drawn from; socio-economic, socio-cultural, disease related, service related and psychological factors. The variables included education level, stigma, recurrent abortions, staff attitude and stress. The results of this study indicated that there was no significant relationship among most of these variables and coping with the experience of an abortion except stress.

Therefore, it is important to reduce stress among women who have experienced an abortion in order to help them cope well. After an abortion is would be helpful to allow women enough time to recover physically and psychologically. Family members and spouse should be educated on the need to support women who have experienced an abortion.
REFERENCES


Appendix I: Questionnaire

THE UNIVERSITY OF ZAMBIA

SCHOOL OF MEDICINE

DEPARTMENT OF NURSING SCIENCES

STRUCTURED INTERVIEW SCHEDULE

TOPIC: DETERMINANTS OF COPING STRATEGIES UTILISED BY WOMEN WHO HAVE EXPERIENCED AN ABORTION

DATE OF INTERVIEW: ...........................................

PLACE OF INTERVIEW: .........................................

NAME OF INTERVIEWER: ......................................

INSTRUCTIONS TO INTERVIEWER

1. Introduce yourself to the respondent.
2. Explain the purpose of the interview.
3. Get written consent from the respondent and do not force them to be interviewed.
4. Assure the respondent that her names and/or addresses will not be written on the interview schedule and that all responses will be held in shared confidentiality to ensure privacy and anonymity.
5. Indicate response by ticking in the appropriate space for closed ended questions.
6. Indicate response by filling in the spaces provided for open ended questions.
7. Give the respondent an opportunity to ask questions at the end of the interview.
8. Thank the respondent at the end of interview.
SECTION A: Demographic data

Official Use

1. Age

2. Marital status
   a) Never Married
   b) Married
   c) Separated
   d) Divorced
   e) Widowed

3. Religion/denomination
   a) African Methodist Church
   b) CMML
   c) Roman Catholic
   d) New Apostolic Church
   e) Pentecostal
   f) Seventh Day Adventist
   g) No Church
   h) Others (specify)

SECTION B: Socio-economic status

4. Highest education level
   a) Never been to school
   b) Primary
   c) Secondary
   d) Tertiary
5. Occupation
   a. Employed (formal) [ ]
   b. Peasant farmer [ ]
   c. Self-employed [ ]
   d. Unemployed [ ]
   e. Student/pupil [ ]

6. Monthly income
   a. Below K500,000 [ ]
   b. Between K500,000 and K1,000,000 [ ]
   c. Between K1,000,000 and K5,000,000 [ ]
   d. Above K5,000,000 [ ]

SECTION C: Questions relating to past obstetric history

7. How many pregnancies have you ever had?
   ..................... [ ]

8. How many pregnancy losses have you had?
   ..................... [ ]

9. How much do you know about abortions?
   a. Little [ ]
   b. Adequate [ ]
   c. Very knowledgeable [ ]
SECTION D: Client perception of attitude of health care providers towards them

10. When you experienced an abortion did you go to the health facility?
   a. Yes [ ]
   b. No [ ]

11. If yes to question 10 how do you rate the attitude of health care providers?
   a. Very good [ ]
   b. Good [ ]
   c. Bad [ ]
   d. Very bad [ ]

12. If no to question 10 explain why....................................................
.............................................................

13. After being attended to following abortion, were you given a review date?
   a. Yes [ ]
   b. No [ ]

14. If yes to question 13, did you come?
   a. Yes [ ]
   b. No [ ]

63
15. If yes to question 14 what was the advice? ..............................................................
..............................................................

16. If no to question 14 why? ....................................................................................
..............................................................................................

SECTION E: Social and cultural factors affecting their coping strategies

17. How did you perceive the reaction of spouse and relatives towards you after pregnancy loss?

a. Positive [ ]
b. Negative [ ]
c. Neutral [ ]

18. Did you undergo any ritual cleansing and restrictions following an abortion?

a. Yes [ ]
b. No [ ]

SECTION F: Questions related to stress and anxiety after pregnancy loss

19. How did you feel emotionally after experiencing an abortion?

a. Angry [ ]
b. Anxious [ ]
c. Nervous [ ]
d. Relieved [ ]
e. Other (specify [ ]
20. How did you cope with the experience of an abortion? ..........................................................

21. What do you think made you cope the way you did? ..........................................................

22. To what extent did the experience of an abortion disturb your normal activities?
   a. Did not affect my daily activities [ ]
   b. Affected the activities to a minor degree [ ]
   c. Grossly affected the activities [ ]

23. Did you experience any of the following?
   a. Insomnia [ ]
   b. Eating disorders [ ]
   c. Withdrawal [ ]
   d. Anger [ ]
   e. Other (specify)............ [ ]

24. Please give suggestions on how women who have experienced an abortion could be supported for them to cope well..................................................

THANK YOU FOR YOUR PARTICIPATION

65
# APPENDIX II: WORK PLAN FROM JUNE, 2012 TO APRIL, 2013

<table>
<thead>
<tr>
<th>Task to be performed</th>
<th>Responsible person (s)</th>
<th>Dates</th>
<th>Time required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developing proposal</td>
<td>Investigators four (4)</td>
<td>04.06.2012 - 08.06.2012</td>
<td>25 Days</td>
</tr>
<tr>
<td></td>
<td>Supervisor one (1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Literature review</td>
<td>Investigators four (4)</td>
<td>Continuous</td>
<td>Continuous</td>
</tr>
<tr>
<td></td>
<td>Supervisor one (1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Compiling research proposal</td>
<td>Investigators four (4)</td>
<td>03.09.2012 - 19.09.2012</td>
<td>8 Weeks</td>
</tr>
<tr>
<td>Pilot study and adjustments to the data collection tool</td>
<td>Investigators four (4)</td>
<td>08.10.2012 - 09.10.2012</td>
<td>8 Days</td>
</tr>
<tr>
<td>Data collection</td>
<td>Investigators four (4)</td>
<td>10.10.2012 - 31.10.2012</td>
<td>8 weeks</td>
</tr>
<tr>
<td>Data Analysis</td>
<td>Investigators four (4)</td>
<td>05.11.2012 - 22.11.2012</td>
<td>8 Weeks</td>
</tr>
<tr>
<td>Finalization of Report</td>
<td>Investigators four (4)</td>
<td>07.01.2013 - 15.02.2013</td>
<td>8 Weeks</td>
</tr>
<tr>
<td>Monitoring and evaluation</td>
<td>Investigators four (4)</td>
<td>Continuous</td>
<td>Continuous</td>
</tr>
<tr>
<td></td>
<td>Supervisor one (1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dissemination of results</td>
<td>Investigators four (4)</td>
<td>18.02.2013 - 05.04.2013</td>
<td>5 weeks</td>
</tr>
</tbody>
</table>
# APPENDIX III

GANTT CHART SHOWING VARIOUS TASKS TO BE UNDERTAKEN AND TIME REQUIRED FOR EACH TASK TO BE PERFORMED FROM JUNE, 2012 TO APRIL, 2013

<table>
<thead>
<tr>
<th>MONTHS</th>
<th>JUNE</th>
<th>JULY</th>
<th>AUG</th>
<th>SEPT</th>
<th>OCT</th>
<th>NOV</th>
<th>DEC</th>
<th>JAN</th>
<th>FEB</th>
<th>MAR</th>
<th>APRIL</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of weeks per month</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Task to be performed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Person responsible</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Developing proposal</td>
<td>Researchers (4)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Supervisor (1)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Literature review</td>
<td>Researchers (4)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Supervisor (1)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Task</td>
<td>Responsible Party</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>-------------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Compiling research proposal</td>
<td>Researchers (4)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clearance from school</td>
<td>Researchers (4)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supervisor (1)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pilot study/adjustments to the data collection tool</td>
<td>Researchers (4)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data collection</td>
<td>Researchers (4)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Data Analysis</td>
<td>Researchers (4)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Task</td>
<td>Assignment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Report Writing</td>
<td>Researchers (4)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Draft Report to DNS</td>
<td>Researchers (4)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Finalization of Report</td>
<td>Researchers (4)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monitoring &amp; evaluation</td>
<td>Researchers (4)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Supervisor (1)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dissemination of results</td>
<td>Researchers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## APPENDIX IV

### BUDGET

<table>
<thead>
<tr>
<th>No.</th>
<th>Item</th>
<th>Unit cost (ZMK)</th>
<th>Quantity</th>
<th>Total (ZMK)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td><strong>STATIONERY</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Reams of paper</td>
<td>35,000.00</td>
<td>2 Reams</td>
<td>70,000.00</td>
</tr>
<tr>
<td></td>
<td>Ball pens</td>
<td>1,000.00</td>
<td>8</td>
<td>8,000.00</td>
</tr>
<tr>
<td></td>
<td>Pencils</td>
<td>500.00</td>
<td>4</td>
<td>2,000.00</td>
</tr>
<tr>
<td></td>
<td>Tipex</td>
<td>5,500.00</td>
<td>4</td>
<td>22,000.00</td>
</tr>
<tr>
<td></td>
<td>Note book</td>
<td>15,000.00</td>
<td>4</td>
<td>60,000.00</td>
</tr>
<tr>
<td></td>
<td>Stapler</td>
<td>35,000.00</td>
<td>4</td>
<td>140,000.00</td>
</tr>
<tr>
<td></td>
<td>Staples</td>
<td>5,000.00</td>
<td>4 Boxes</td>
<td>20,000.00</td>
</tr>
<tr>
<td></td>
<td>Scientific calculator</td>
<td>120,000.00</td>
<td>4</td>
<td>480,000.00</td>
</tr>
<tr>
<td></td>
<td>Perforator</td>
<td>20,000.00</td>
<td>4</td>
<td>80,000.00</td>
</tr>
<tr>
<td></td>
<td>Spiral binders</td>
<td>3,000.00</td>
<td>3</td>
<td>9,000.00</td>
</tr>
<tr>
<td></td>
<td>Front and back hard covers</td>
<td>1,500.00</td>
<td>3</td>
<td>4,500.00</td>
</tr>
<tr>
<td></td>
<td>Markers</td>
<td>3,000.00</td>
<td>4</td>
<td>12,000.00</td>
</tr>
<tr>
<td></td>
<td>Bag for stationery</td>
<td>25,000.00</td>
<td>4</td>
<td>100,000.00</td>
</tr>
<tr>
<td></td>
<td>Flip Chart</td>
<td>65,000.00</td>
<td>1</td>
<td>65,000.00</td>
</tr>
<tr>
<td></td>
<td>Bolstic</td>
<td>15,000.00</td>
<td>1</td>
<td>15,000.00</td>
</tr>
<tr>
<td></td>
<td>Sellotape</td>
<td>5,000.00</td>
<td>4</td>
<td>20,000.00</td>
</tr>
<tr>
<td></td>
<td><strong>SUB-TOTAL</strong></td>
<td></td>
<td></td>
<td><strong>1,107,500.00</strong></td>
</tr>
</tbody>
</table>

70
<table>
<thead>
<tr>
<th></th>
<th>SECRETARIAL SERVICES</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Typing and printing research proposal</td>
<td>2,500.00</td>
<td>50 pages</td>
<td>125,000.00</td>
</tr>
<tr>
<td></td>
<td>Typing and printing research questionnaire</td>
<td>2,500.00</td>
<td>10 pages</td>
<td>25,000.00</td>
</tr>
<tr>
<td></td>
<td>Photocopying questionnaire</td>
<td>2,000.00</td>
<td>230 copies</td>
<td>460,000.00</td>
</tr>
<tr>
<td></td>
<td>Typing and printing draft research report</td>
<td>140,000.00</td>
<td>1 copy</td>
<td>140,000.00</td>
</tr>
<tr>
<td></td>
<td>Typing and printing final research report</td>
<td>212,500.00</td>
<td>5 copies</td>
<td>1,062,500.00</td>
</tr>
<tr>
<td></td>
<td>Binding final report</td>
<td>100,000.00</td>
<td>5 copies</td>
<td>500,000.00</td>
</tr>
<tr>
<td></td>
<td><strong>SUB-TOTAL</strong></td>
<td></td>
<td></td>
<td><strong>2,312,500.00</strong></td>
</tr>
<tr>
<td>3</td>
<td>PERSONNEL</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>a) Lunch Allowance-Researchers (4)</td>
<td>50,000.00 per day</td>
<td>56 days</td>
<td>2,800,000.00</td>
</tr>
<tr>
<td></td>
<td>b) Transport-Researchers</td>
<td>10,000.00 per day</td>
<td>56 days</td>
<td>560,000.00</td>
</tr>
<tr>
<td></td>
<td><strong>SUB-TOTAL</strong></td>
<td></td>
<td></td>
<td><strong>3,360,000.00</strong></td>
</tr>
<tr>
<td>4</td>
<td>Total Contingency (10%)</td>
<td></td>
<td></td>
<td><strong>678,000.00</strong></td>
</tr>
<tr>
<td></td>
<td><strong>GRAND TOTAL</strong></td>
<td></td>
<td></td>
<td><strong>7,458,000.00</strong></td>
</tr>
</tbody>
</table>
APPENDIX V

BUDGET JUSTIFICATION

Stationery

To conduct a study effectively and professionally, stationery was needed such as reams of papers for printing downloaded documents and drafts. Ball pens, pencils for writing notes, tipex for erasing mistakes, a research bag for carrying questionnaires during data collection, stapler for stapling documents. A notebook was also needed for note taking record keeping during data collection and analysis. The scientific calculator was required for data analysis.

Secretarial services

Funds for typing work were required to pay a hired secretary, photocopying, printing and binding of final documents so that the findings are presented and to keep the information safe were required.

Personnel

The investigators needed transport money to ease movements to and from the areas of data collection. There was need for lunch allowances during the data collection period because of long stay in the field.

Contingency fund

Ten percent of the total budget (contingency fund) was required in case of any unforeseen eventualities requiring expenditure during the period of research.
Dear Sir/Madam,

RE: REQUEST FOR PERMISSION TO CARRY OUT A PILOT STUDY

I am a 5th year student at the University of Zambia, School of Medicine in the Department of Nursing Sciences pursuing a Bachelor of Sciences (BSc) in Nursing.

I am required to conduct a research study in partial fulfilment of this programme. The title of the study is "Determinants for coping strategies utilised by women who have experienced an abortion in Zambia". I therefore, write to request for permission to carry out a pilot study in your district. I am expected to conduct the pilot study between 4th to 5th October, 2012.

Your consideration will be highly appreciated.

Yours faithfully,

Chambatu Alice
The University of Zambia  
School of Medicine  
Department of Nursing Sciences  
P.O. Box 50110  
LUSAKA  

28th September, 2012

The District Medical Officer  
Siaovonga District Medical Office  
P.O. Box 16  
SIAVONGA

Ms: The Head  
Department of Nursing Sciences  
The University of Zambia  
School of Medicine  
P.O. Box 50110  
LUSAKA

Dear Sir/Madam,

RE: REQUEST FOR PERMISSION TO CARRY OUT A STUDY

I am a 5th year student at the University of Zambia, School of Medicine in the Department of Nursing Sciences pursuing a Bachelor of Sciences (BSc) in Nursing.

I am required to conduct a research study in partial fulfilment of this programme. The title of the study is "Determinants for coping strategies utilised by women who have experienced an abortion in Zambia". I therefore, write to request for permission to carry out a study in your district. I am expected to conduct the pilot study between 8th October to 9th November, 2012.

Your consideration will be highly appreciated.

Yours faithfully,

Chambatu Alice
Dear Sir/Madam,

RE: REQUEST FOR PERMISSION TO CARRY OUT A PILOT STUDY

I am a 5th year student at the University of Zambia, School of Medicine in the Department of Nursing Sciences pursuing a Bachelor of Sciences (BSc) in Nursing.

I am required to conduct a research study in partial fulfilment of this programme. The title of the study is “Determinants for coping strategies utilised by women who have experienced an abortion in Zambia”. I therefore, write to request for permission to carry out a pilot study in your district. I am expected to conduct the pilot study between 1st to 5th October, 2012.

Your consideration will be highly appreciated.

Yours faithfully,

Chimfwembe Richard
Dear Sir/Madam,

Subject: REQUEST FOR PERMISSION TO CARRY OUT A STUDY

I am a 5th year student at the University of Zambia, School of Medicine in the Department of Nursing Sciences pursuing a Bachelor of Science Degree in Nursing. I am required to conduct a research study in partial fulfilment of this programme. The title of the study is "Determinants for coping strategies utilised by women who have experienced an abortion in Zambia". I therefore, write to request for permission to carry out a study in our district. I am expected to conduct the pilot study between 10th October to 31st October, 2012.

Your consideration will be highly appreciated.

Yours faithfully,

Chimfwembe Richard
Thursday, October 18, 2012.

Dr. Lonia Mwape for Head – DNS.  
University of Zambia  
School of Medicine  
Department of Nursing Sciences,  
LUSAKA.

Dear Dr. Mwape,

RE: PERMISSION FOR BSc NURSING STUDENTS TO COLLECT DATA IN LUSAKA DISTRICT.

We are in receipt of your letter dated 28th September, 2012, received on 1st October, 2012, in which you requested for permission to carry a study.

Permission has been granted for your students to carry out a study in Lusaka District Health facilities on “Determinants for coping strategies utilized by women who have experienced an abortion in Zambia”.

Lusaka District Health Office will also expect a copy of the findings to be submitted at the end of the exercise.

By copy of this letter the Health centre In-charges are herewith informed.

Yours sincerely,

[Signature]

DR. M. MASANINGA  
ACTING DISTRICT MEDICAL OFFICER.

C.c.: The Health centre In-charges.  
C.c.: Ms. Lillian Mayundo, Ms. Alice Chambatu, Ms. Mary Musumali and Mr. Richard Chimfwembe  
C.c.: Dean – SOM.
The University of Zambia
School of Medicine
Department of Nursing Sciences
P.O. Box 50110
LUSAKA

28th September, 2012

The District Medical Officer
Lusaka Urban District Medical Office
P.O. Box 50827
LUSAKA

Subject: The Head
Department of Nursing Sciences
The University of Zambia
School of Medicine
P.O. Box 50110
LUSAKA

Dear Sir/Madam,

I am a 5th year student at the University of Zambia, School of Medicine in the Department of Nursing Sciences pursuing a Bachelor of Sciences (BSc) in Nursing.

I am required to conduct a research study in partial fulfilment of this programme. The title of the study is “Determinants for coping strategies utilised by women who have experienced an abortion in Zambia”. I therefore, write to request for permission to carry out a pilot study in your district. I am expected to conduct the pilot study between 1st to 5th October, 2012.

Your consideration will be highly appreciated.

Yours faithfully,

Nyundo Lillian
The University of Zambia  
School of Medicine  
Department of Nursing Sciences  
P.O. Box 50110  
LUSAKA  

28th September, 2012

The District Medical Officer  
Lusaka Urban District Medical Office  
P.O. Box 50827  
LUSAKA  

Ms. The Head  
Department of Nursing Sciences  
The University of Zambia  
School of Medicine  
P.O. Box 50110  
LUSAKA  

Dear Sir/Madam,

RE: REQUEST FOR PERMISSION TO CARRY OUT A STUDY

I am a 5th year student at the University of Zambia, School of Medicine in the Department of Nursing Sciences pursuing a Bachelor of Sciences (BSc) in Nursing. I am required to conduct a research study in partial fulfilment of this programme. The title of the study is "Determinants for coping strategies utilised by women who have experienced an abortion in Zambia". I therefore, write to request for permission to carry out a study in your District. I am expected to conduct the pilot study between 8th October to 9th November, 2012.

Your consideration will be highly appreciated.

Yours faithfully,

P. Ayundo Lillian
APPENDIX VI
The University of Zambia
School of Medicine
Department of Nursing Sciences
P.O. Box 50110
LUSAKA

28th September, 2012.

The District Medical Officer
Ikelenge District Medical Office
P.O. Box 10
IKELENGE

Usf: The Head
Department of Nursing Sciences
The University of Zambia
School of Medicine
P.O. Box 50110
LUSAKA

Dear Sir/Madam,

RE: REQUEST FOR PERMISSION TO CARRY OUT A PILOT STUDY

I am a 5th year student at the University of Zambia, School of Medicine in the Department of Nursing Sciences pursuing a Bachelor of Science Degree (BSc) in Nursing.

I am required to conduct a research study in partial fulfilment of this programme. The title of the study is "Determinants for coping strategies utilised by women who have experienced an abortion in Zambia". I therefore, write to request for permission to carry out a pilot study in your district. I am expected to conduct the pilot study between 8th October to 9th October, 2012.

Your consideration will be highly appreciated.

Yours faithfully,

Musumali Mary
APPENDIX VI

The University of Zambia
School of Medicine
Department of Nursing Sciences
P.O. Box 50110
LUSAKA

28th September, 2012.

The District Medical Officer
Ikelenge District Medical Office
P.O. Box 10
IKELENGE

usf: The Head
Department of Nursing Sciences
The University of Zambia
School of Medicine
P.O. Box 50110
LUSAKA

Dear Sir/Madam,

RE: REQUEST FOR PERMISSION TO CARRY OUT A STUDY

I am a 5th year student at the University of Zambia, School of Medicine in the Department of Nursing Sciences pursuing a Bachelor of Science Degree (BSc) in Nursing.

I am required to conduct a research study in partial fulfilment of this programme. The title of the study is "Determinants for coping strategies utilised by women who have experienced an abortion in Zambia". I therefore, write to request for permission to carry out a study in your district. I am expected to conduct the pilot study between 10th October to 31st October, 2012.

Your consideration will be highly appreciated.

Yours faithfully,

Musumali Mary

S. L. Maunde
District Community Medical Officer

[Permission Granted]
APPENDIX VII

INFORMED CONSENT

Dear Participant,

My name is ........................................; I am a student pursuing Bachelor of Science degree in Nursing in the Department of Nursing Sciences at the School of Medicine, University of Zambia.

I partial fulfilment of the Bachelor of Science in Nursing degree, I am required to undertake a research study. My study topic is “Determinants of coping strategies utilised by women who have experienced abortion”.

You have been randomly selected to participant in this study and I wish to inform you that participation is voluntary and you are free to withdraw at any stage of the study if you so wish. You will be asked questions about coping with the experience of an abortion. Any information you give will be kept confidential and no name will be written on the questionnaire.

You will not receive direct benefit or monetary gain from the study. The information you give will help the health care team to come up with a teaching plan that will enhance coping through regular sensitisation program thereby improving mental health.

I ........................................ hereby called the participant understand the purpose of this study and am willing to participate in the study.

Date ..........................................................

Signature/thumb print of respondent ........................................

Signature of interviewer .....................................................