

**AN EXPLORATION OF THE CAUSES OF ABORTIONS AMONG ADOLESCENT  
GIRLS IN CHINGOLA AND CHILILABOMBWE DISTRICTS.**

**By**

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**A DISSERTATION SUBMITTED TO THE UNIVERSITY OF ZAMBIA IN  
COLLABOTION WITH ZIMBABWE OPEN UNIVERSITY IN PARTIAL FULFILMRNT  
OF THE REQUIREMENTS FOR THE AWARD OF THE MASTER OF SCIENCE  
DEGREE IN COUNSELLING**

**THE UNIVERSITY OF ZAMBIA  
LUSAKA  
2020**



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## DECLARATION

I **Sishekanu Limpo** do hereby declare that this dissertation represents my own work and has not been previously submitted for a degree at this or any other University. All content and ideas drawn directly or indirectly from external sources have been acknowledged with full references.

Signature ..... Date .....

## APPROVAL

This dissertation of **Sishekanu Limpo** has been approved as partial fulfillment of the requirements for the award of the degree of Master of Science Degree in Counselling by the University of Zambia in conjunction with Zimbabwe Open University.

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## **ABSTRACT**

This study was an investigation on exploration of the causes of abortions among adolescent girls in Chingola and Chililabombwe districts. The objectives of this study were to explore the knowledge about abortion among adolescent girls, describe the current state of abortion among adolescent girls, and describe factors that influence the adolescent girls to undergo unsafe abortion also to explore existing measures against abortion among teenagers. Expert purposive sampling procedure was used to select the 10 counselors who had treated abortion survivors. The health workers were necessary to provide an expert perspective on the causes of and measures to reduce abortion and also recommendations on how safe abortion can be made available to adolescents. The 20 adolescent girls who experienced abortion were picked purposively based on the hospital records and their willingness to participate in the study. The main findings of this research were that To this end the findings outline knowledge levels of abortion and prevalence of abortions among adolescent girls; factors that induce adolescents to opt for unsafe abortions and interventions that aimed at addressing the problem of unsafe abortion. The recommendations were therefore to increase the knowledge levels among adolescents on unsafe abortion, there is need to incorporate it as part of comprehensive sexual and reproductive health in the school curriculum. Those who are not in the school system can be reached through tailor made community awareness campaigns and through the mass media, and it is important to establish specialized safe houses for adolescent girls who fall pregnant where they can be provided with specialized counseling services to guide them in their decisions and also to provide material support for those who are too vulnerable to provide material support for their unborn child. The study therefore concludes that there is need to incorporate abortion issues as part of the curriculum for comprehensive sexual education. It is also necessary to emphasize issues of abortion not just as a medical or social issue, but also as a legal and human rights issue.

**Key Words:** exploration causes, abortions, adolescent girls in Chingola and Chililabombwe districts.

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## **DEDICATION**

I dedicate my work to my family and many friends. A special feeling of gratitude to my loving parents Horace (MHSRIP) and Chuma Sishekanu whose words of encouragement and push for tenacity ring in my ears. My sisters and brother Mbanga have never left my side and are very special.

I also dedicate this report to my church family who has supported me throughout the process. I will always appreciate all they have done, especially Eness Mayondi for helping me develop my technology skills and for the many hours of proofreading. I dedicate this work and give special thanks to my Son Thumelo Phiri for being there for me throughout the entire MSCC program.

## **ACKNOWLEDGEMENTS**

This work would not have been possible without the support of Dr. Francis Simui my project supervisor; who has been supportive of my career goals and who worked actively to provide me with the protected academic time and supervision throughout my project.

I am grateful to each of the lecturers of my counselling programme that have provided me extensive personal and professional guidance and taught me a great deal about both academics and life in general. I would especially like to thank Dr. Daniel Ndhlovu as my lecturer and mentor; he has taught me more than I could ever give him credit. He has shown me, by his example, what a good counselor (and person) should be.

Nobody has been more important to me in the pursuit of this dissertation than the members of my family. I would like to thank my Mother and my siblings, whose love and guidance are with me in whatever I pursue. They are the ultimate role models. Most importantly, I wish to thank my loving and supportive son, Thumelo Phiri, who provides me with unending inspiration.

## **ACRONMYS AND ABBREVIATIONS**

WHO World Health Organization

UK United Kingdom

HIV Human Immune Virus

AIDS Acquired Immune Deficiency Syndrome

SRH Sexual and reproductive health

## **CHAPTER ONE**

### **INTRODUCTION**

#### **1.1 Overview**

This chapter presents the background to the study, statement of the problem, purpose of the study, objectives of the study, research questions, significance and scope of the study. It also presents limitations of the study, theoretical framework, definitions of terms and ethical considerations.

#### **1.2 Background of the study**

Abortion and abortion rights remain a highly controversial matter the world over. The controversy is phrased in the questions: Is abortion a form of murder? Or is it a mere exercise of the reproductive rights of a woman? A strong correlation has been established between the high prevalence of unsafe abortion and social stigma, stringent anti-abortion laws and well as constrained access to contraception and safe/legal abortion services (Berer, 2017; Blystad et.al, 2019). As of 2011, there were approximately 22 million cases of unsafe abortions globally. Unsafe abortion accounted for 4.7-13.2% of maternal mortality in 2014, as reported by the World Health Organization (Say et.al, 2014).

Between 1990-2013, Sub-Saharan Africa has registered a rise in prevalence of unsafe abortion, with 30% of maternal death attributed to this crisis (Singh and Maddow-Zimet, 2016). The incidence of unsafe mortality and its attendant mortality and complication is most prevalent in low income countries, with the largest proportion being among rural based adolescents.

These prevalence trends represent one more dimension of the inequality between low income and high income countries; rural and urban areas with respect to the enjoyment of reproductive rights and access to safe sexual reproductive health services. Nevertheless, the crisis has been relegated in to a peripheral issue in the global sexual and reproductive health agenda (Blystad et.al, 2019). Intense social stigma and negligence of the issue in most health systems has caused unsafe abortion to become a hidden pandemic, whose statistics , causal mechanisms and modes of occurrence or practice remain largely undocumented (Sully et.al, 2018).

A study by (Grimes et.al, 2016) indicated that limited access to legal and safe abortion had triggered a rise in unsafe abortion in low income countries as well as among low income communities in

some countries. Berer (2017) reinforces this view and adds that strong moral and religious objections to abortion in affected communities impair the creation of legal and institutional safeguards against unsafe abortion. There was need therefore, to explore social, economic, political and personal issues that influenced the prevalence and trends of abortion among teenagers in order to obtain first hand experiences and attitudes from survivors, proponents and critics on causes of abortions among adolescent girls in Chingola and Chililabombwe districts of Zambia.

In Zambia, legal abortion is inaccessible to many women making them to resort to illegal abortions, many of which are performed under unsanitary and unsafe conditions. The death toll from these procedures is likely high, and almost all such deaths could be avoided if access to safe abortion was improved and unintended pregnancies were prevented. Abortion is the ending of a pregnancy by removal or expulsion of an embryo or fetus before it can survive outside the uterus (Grimes and Stuart, 2010). In contrast, unsafe abortions (those performed by unskilled individuals, with hazardous equipment, or in unsanitary facilities) cause 47,000 deaths and 5 million hospital admissions each year. The World Health Organization recommends safe and legal abortions are available to all women. (World Health Organization, 2012).

Abortion had previously been widely practiced and legal under common law in early pregnancy until quickening, but the English speaking world passed laws against abortion at all stages of pregnancy. There were a number of factors that contributed to this shift in opinion about abortion in the early 19th century. In some instances, and countries like Zambia, Abortion is permitted to save the life of the woman, to preserve physical health, mental health, in the case of fatal impairment, and for economic or social reasons.

The Termination of Pregnancy Act 26 of 1972 of the Zambian laws permits an abortion to be performed if three registered medical practitioners are of the opinion formed in good faith that; (i) continuation of the pregnancy would involve risk to the life or of injury to the physical or mental health of the pregnant woman, or injury to the physical or mental health of any existing children of the pregnant woman, (ii) risk is greater than if the pregnancy were terminated. Complicated procedural requirements and inadequate services limit the number of legal abortions performed in Zambia. Thus, despite the liberal nature of its abortion law, there is continued reliance on illegal abortions among adolescent girls. To this effect, questions such as what are causes adolescent girls to opt for unsafe abortion, what do adolescent girls know about abortion, what measures are

available to reduce incidences of unsafe abortion among adolescent girls arise. Based on this background, there was need to explore causes of abortions among adolescent girls in Chingola and Chililabombwe districts of Zambia.

### **1.3 Statement of the Problem**

Unsafe abortion is a major cause of maternal mortality in Zambia, with maternal mortality estimated to be approximately 398 per 100,000 live births (CSO, 2014). Unsafe abortion accounts for approximately 30% of such mortality. If available figures reasonably reflect the true situation, then approximately 2300 women die in childbirth or of factors related to pregnancy every year, and 700-1000 deaths are directly attributable to abortion (The World Health Organization, 2012). The prevalence of severe post abortion morbidity is also high accounting for 57.4%, 55.6% and 52.6% of maternal morbidity in 2011, 2012 and 2013 respectively (Banda, 2015).

Research by Creswell et.al (2015) in Central, Lusaka and Copperbelt Provinces shows that even though Zambia has a relatively liberal legislative framework with respect to abortion rights, unsafe abortion continues to induce high mortality and morbidity rates particularly among adolescents 12-18 years of age. The key searching question is, what influences adolescent girls to opt for unsafe abortion? This study therefore sought to elucidate why adolescent girls in Chingola and Chililabombwe districts opt for unsafe abortion.

### **1.4 Purpose of the Study**

The purpose of this study was to explore the causes of abortion among adolescents in Chingola Chililabombwe Districts.

### **1.5 Research Objectives**

The study was guided by the following objectives:

- i. To explore the knowledge about abortion among adolescent girls.
- ii. To describe the current state of abortion among adolescent girls.
- iii. To describe factors that influences the adolescent girls to undergo

unsafe abortion. iv. To explore existing measures against abortion among teenagers.

## **1.6 Research Questions**

In seeking to meet the study objective, the following questions guided the study:

- i. What do adolescent girls know about abortion?
- ii. What is the current state on unsafe abortion phenomenon? iii.  
What factors influence adolescent girls to undergo unsafe abortion?
- iv. What measures are available to reduce incidence of unsafe abortion among adolescent girls?

## **1.7 Significance of the Study**

This study might help to settle some unanswered questions as to why adolescents go for unsafe abortion when safe abortion is legal in Zambia. It might also reveal facts about safe abortions and access to safe abortion services. Understanding what adolescent girls know about unsafe abortion may be useful tool for reducing deaths caused by unsafe abortion.

It is envisioned that findings of this study may be used by guidance teachers in schools to help curb abortions among school going girls. Health care workers involved in provision of safe abortion services may be empowered with accurate data as they provide quality services on abortion to the adolescents. It is also hoped that through findings of this study, local policies may be enforced to mentor adolescents by the guidance teachers, medical personnel at service points in line with the Termination of Pregnancy Act 26 of 1972 of the Zambian laws health and abortion.

## **1.8 Scope of the Study**

The study was focused on knowledge, causal factors and possible solutions with respect to unsafe abortion among female adolescents aged between 12-18 years old. Persons outside this age group were not included. The research was also restricted to the districts of Chingola and Chililabombwe. Only official statistics for the years 2011 to 2019 were used as data.

## **1.9 Limitations of the Study**

Due to scarcity of up to date official statistics regarding unsafe abortion in Chingola and Chililabombwe districts and institutional restriction and confidentiality regulations findings of this study may not be generalized. In addition, due to the qualitative nature of the study, caution needs to be exercised in generalizing its findings.

## **1.10 Definitions of Terms**

**Adolescent Abortion** - For purposed of this study, an abortion is a surgical procedure previously experienced by a teenager aged 12-18 years of age by which the unborn fetus and the materials associated with the unborn fetus are prematurely removed before the full time of gestation has been reached, with our without the consent of the mother, but with her full knowledge.

**Unsafe Abortion** - This study considers an unsafe abortion as one that takes place in an unsanitary environment, using unauthorized tools and techniques, performed in a clandestine manner by an unqualified person or a qualified person who has not followed the legally prescribed conditions for conducting the procedure.

**Adolescent** - In this investigation, an adolescent is a male or female person aged 12-18 years of age. Of special note is an individual of the said age group and who has experienced or not experienced sexual intercourse with or without a consequent pregnancy resulting from the sexual act.

### **1.11 Ethical Considerations**

Ethical considerations are very important when research is conducted. Cohen et al (2002) identify three main areas of ethical issues when interviews that this research adopts, namely informed consent, confidentiality and consequences of the interview. Ethics is a set of moral principles suggested by an individual or group and which is widely accepted, it entails official rules and behavioural expectations about the correct conduct towards experimental subjects and respondents, employers, sponsors, other researchers, assistants and learners (Mmari and Magnami, 2013). In this study the following ethical measures will adhere in the process of data collection, analysis and dissemination.

To begin with, participants were reached for participation in the study mostly by face to face whereby they were informed of the purpose of the study. They were also assured about confidentiality before, during and after the research. Secondly, the participants chose the time and date of their convenience. Thirdly, a written permission to conduct the research at the schools was sought. Fourth, in order to guarantee confidentiality, anonymity, non-identifiable and nontraceability of the participants, the researcher used pseudonym instead of codes. To these, Blaxter et al. (2012) add the aspect of being truthful and the desirability of the research. As of this research, it is the responsibility of the researcher to do everything possible to respond to these issues.

## CHAPTER TWO

### REVIEW OF RELATED LITERATURE

#### 2.1 Overview

The chapter present reviewed literature related to the topic on causes of abortions among adolescent girls in Chingola and Chililabombwe Districts of Zambia. The review was guided by the following study questions:

- i. What do adolescent girls know about abortion?
- ii. What is the current state on unsafe abortion phenomenon? iii.  
What factors influence adolescent girls to undergo unsafe abortion?
- iv. What measures are available to reduce incidence of unsafe abortion among adolescent girls?

The presentation of reviewed literature is based on the thematic areas derived from the research questions. However, for purposes of providing conceptual understanding, the chapter begins with the concept of unsafe abortion.

#### 2.2 Concept of Unsafe Abortion

As defined by the World Health Organization, unsafe abortion is a collection of techniques aimed at terminating an unplanned pregnancy, performed by individuals who do not possess the required medical skill or qualification and/or also performed in an environment that falls below minimum standards of hygiene and medical efficacy (WHO, 1992).

The expert meeting on the definition and measurement of unsafe abortion expanded this concept in terms that can be directly measured. It departed from the binary definition of safe verses unsafe abortion and replaced it with a continuum of criteria that would characterize a procedure as safer or less safe. As such the degree of unsafely depends on the prevailing conditions during and after the procedure. The factors that would influence the safety of an abortion are the stage at which the pregnancy has reached, the techniques deployed during termination, the level of access of the

patient to core medical services and support services such as counseling. Peripheral consideration to abortion safety relate to systemic and contextual conditions under which the process is carried out such as the socioeconomic status of the patient, the cost of the procedure, the legal framework regulation abortion together with availability of qualified personnel needed to conduct the procedure in a medically safe and ethical manner (Ganatra, B, 2014; Espinoza et.al, 2020).

The meeting argued that an unsafe abortion can be one conducted by qualified personnel, but under substandard conditions. It could also be one carried out by an untrained individual in an environment that is hygienically risky, even when such a procedure results in no complications. Beyond this an abortion is unsafe when it is incomplete-that is, if the fetus and the fetal material such as the placenta or parts of the fetus are not entirely removed from the womb. Lastly it is an abortion in which the fetus and fetal material is extracted, but results in complications that constitute a medical emergency, requiring further medical attention (Ganatra, B, 2014).

This conceptualization of abortion is comprehensive and provided a means of measuring or operationalizing the concept. As such it is more usable in this research than on that vaguely defines what unsafely is. Additionally, the inclusion of external systemic factors that shape safe/unsafe abortion was useful in providing insights on how ineptitudes in the health system and legal framework may trigger an upswing in unsafe abortion as well as how these challenges may have impaired past interventions to prevent, manage and mitigate the problem.

### **2.3 Knowledge on Abortion among Youths and Adolescents**

Abortion is a sensitive matter which is often treated with a matter of shame and secrecy. One of the main problems this creates is that teenagers who experience an unplanned pregnancy opt to carry out such termination due to fear and lack of knowledge. Research by conducted in 2019 by Espinoza et.al, (2020) reviewed more than 3100 studies related to abortion among teenagers and older youth, that had been published between 2003 and 2019.They surveyed literature from five main data based adopting a key word search methodology as a means of sampling.

Of the 3100+ studies reviewed, five publications were scrutinized with findings on knowledge levels and attitudes towards abortion. The researchers found that teenagers were aware that safe abortion is available in their health centers, but had a low level of knowledge on the legal framework guiding this service and also the safe methods for carrying out the procedure. The first

study conducted in Lagos Nigeria, targeting secondary school girls aged 10-19; indicated that 83% possessed a high level of knowledge on the topic of abortion. Girls aged 10-14 were more knowledgeable about the legal nuances and techniques of both safe and unsafe abortion, compared to girls aged 15-19 years. The younger age group also had a lower level of support for abortion than the older cohort (Abiola et.al, 2016).

Another publication from Ethiopia, reported that 63% of were aware that there are safe methods of pregnancy termination, but had a low level of knowledge on the legality of this service (Kebede, 2016). The third publication from Brazil based on an internet survey revealed that 12-14 year old girls had lower level of knowledge on techniques for safe abortion, than 15-16 years old with the figures being 29 % and 49% respectively. It also reported that adolescents 12-21 years old in Brazil had a lower level of support for abortion due to the conservative nature of their society, with support standing at 56% of respondents (Mitchell et.al, 2014).

One of the publications drawn from the Democratic Republic of Congo indicated that approximately 46 % of adolescents had knowledge of where to access safe abortion services and also that 71 % were aware of at least one person who had done an illegal abortion. The majority were able to cite the health risks associated with unsafe abortions as infertility, excess hemorrhage and death. About 76% of students in this study were against illegal abortion and acknowledged that the only legally valid reason is if the life of the mother is in danger (Paluku et.al, 2010). The A study done in Kenya targeted males and females aged 13-19. It found that disapproval for the termination of unplanned pregnancy was higher among females (91%) than males (87%) and the level of significance for this difference was 0.7% (Adaji et.al, 2010).

From this review Espinoza et.al, (2020) concluded that although females have a general level of knowledge of abortion as a topic, they have a limit level of awareness on the legal issues regulating abortion and also the places where they can access safe abortion services. There is reluctance for them to seek further information on the topic because health care providers do not openly advertise the service or provide knowledge. Their reluctance to seek knowledge especially by teenagers who fall pregnant also raised from the stigma and even hostility that they encounter for seeking these services.

Similar trends were observed in another investigation carried out by Lombe (2014) in Kapri Mposhi, Zambia. The research explored the knowledge levels and attitudes of school girls aged 15-19 with respect to unsafe abortion. Adopting mixed method approach, the study used a sample of 340 respondents who answered self-administered questionnaires and 16 who took part in two focus group discussions. The researcher also established correlation between the independent and dependent variable.

About 36.1% of females in the study stated they had experience pregnancy before the time of the study. The findings also depicted that 41.9 % of respondents who had experienced pregnancy before had attempted an abortion before the time of the study and the methods used were unsafe and unsuccessful. A high percentage (92%) of the girls disapproved abortion and any circumstances where as 50.6% possessed a moderate level of knowledge on unsafe abortion. The weak positive correlation was found between age, previous sexual experience and prior use of contraception with knowledge on unsafe abortion. Qualitative analysis showed that the most of the girls opposed abortion due to religious and moral reasons. The researcher recommended the need for comprehensive sexual education and improved access to sexual and reproductive health services tailor made for adolescent populations (Lombe, 2014).

Review if these studies bring out some weaknesses and knowledge gaps for this study. The major limitation of the survey by Espinoza et al, (2020) was that it was based on secondary data. Furthermore most of the findings were quantitative with very few in-depth explanations, especially on the reason for the low level of information among adolescents, the factors responsible disparity in the levels of knowledge between older and younger adolescents. The survey also does not provide detailed explanation of the attitudes that respondents displayed towards abortion in terms of why they were in support of or against abortion. An additional omission in the cited studies was the lack of or lesser focus on the male perspective. Four out of the five studies only used female respondents. However, males as potential or actual fathers are interested parties in the fate of a pregnancy. In patriarchal societies such as those found in most parts of the developing world, males have significant decision making power in coercing or otherwise influencing female on whether or not to terminate pregnancy as well as where and how the pregnancy will be terminated, for this reason there was need for the researchers to account for levels of awareness and attitude among males as much as they accounted for those of females. Thus despite available literature, what

adolescent girls in Chingola and Chililabombwe knew about safe abortion still remained unknown thereby necessitating a study of this nature.

## **2.4 Global and Regional Prevalence of Unsafe Abortion**

Unsafe abortions remain an endemic problem in all regions of the world. A global survey by the World Health organization in 2017; covering all regions of the world found that in the years 2010-2014, 55.7 million abortions were carried out per year. About 54.9 % of these terminations were safe, 17.1 % moderately unsafe, while 17.1% were classified as extremely unsafe. Therefore, 45.1 % of abortions carried out per year between 2010 and 2014 were unsafe and 97.0% of these unsafe operations were in developing countries. Compared to developed countries poor countries had a significantly higher proportion of unsafe abortions (49.5 % for poor countries in compared to 12.5% in advanced countries). The survey also found that countries with very prohibitive abortion laws has a higher prevalence of unsafe abortion cases compared to those with more liberal abortion legislation (Ganatra et.al, 2017).

Similar findings were revealed in a report by the Guttmacher Institute released in 2017 that showed that in developing countries, there were 36 abortions per year per 1000 women 15-44 years of age a figure higher than that of advanced countries, which were 27 per 1000. The report found that between 1990 and 2014 the unsafe abortion rate in poor countries did not decline to a significant degree. The rate of decline was highest in Eastern Europe due to robust improvement in contraceptive services (Singh et.al, 2017).

Globally, the highest abortion rates were among women aged 20-24 years and generally women in their twenties formed the highest proportion of females who opted for unsafe abortion. It was moreover indicated that developed countries had low adolescent abortion rates whereas similar data for developing countries was unavailable. With respect to the effect of legal restrictions countries where the procedure was banned except in extreme obstetric emergencies manifested a rate of 37 unsafe abortions per 1000 compared with the 34 per 1000 in countries with a more permissive legal framework (Singh et.al, 2017).

In Sub-Saharan Africa, the prevalence of unsafe abortion reported as at 2018 was 99.0% inducing mortality rate of one maternal death for every 150 unsafe abortions and 37 infant deaths per 100,000 live births (for context contrast this with the 23 and 12 in South America and the South Asia respectively). The factors inducing this high rate include restrictive laws against abortion, incapacitated health services coupled with the low level of community awareness (Gebremedhin et.al, 2018). Other systemic factors responsible for high rates of unsafe abortion in the region include high rates of poverty and inequality as well as low level of awareness and realization of women's sexual and reproductive rights (Kulczycki, A, 2016).

The methods used by African women to carry out clandestine and unsafe abortions are the use of oral, injectable or vaginal infused chemical or herbal concoctions, physical pressure to the abdomen and/or insertion of rods into the vagina, cervix or uterus (Grimes et.al, 2006). Approximately 20-50 % of females who use such methods develop medical problems requiring hospital admittance and even surgery. The most common such complications in Africa are sepsis, peritonitis and hemorrhage, accompanied by abdominal, uterine, cervical and vaginal trauma (Rehnstrom et.al, 2015).

The trends above imply that unsafe abortion is a larger problem in developing than in developed countries. This study sought to establish the factors responsible for this higher rate. What systemic challenges do poor countries like Zambia face in mitigating this crisis?

The topic of abortion is both socially and politically very sensitive and this has impaired the quality of research and sensitivity of data generated on the problem. For this reason there are extensive evidential gaps with respect to prevalence, morbidity rates and mortality rates on unsafe abortion (Singh et.al, 2010)

It is evident that the figures provided above were official figures. It is possible that there are a large proportion of unsafe abortions that go unreported. Could this be because of restrictive laws? Apart from restrictive laws, what other factors led to the high prevalence of unsafe abortion and also the under reporting of such cases? Based on available data, how much progress has been made in Zambia to reduce the prevalence of unsafe abortion among adolescents? Key in this review is that the current state or prevalence of unsafe abortions among adolescent girls in Chingola and Chililabombwe districts still remain unknown despite available literature. A study of this nature therefore, becomes necessary.

## **2.5 Causes of Abortion among Teenagers**

Unsafe abortion is not just a systemic and macro-level occurrence. It is experienced first-hand at a personal level. For this reason it is important to gain an understanding on the underlying reasons that drive women to seek abortion from unsafe sources. This aspect was investigated by Faundes (2010), using both Secondary accounts and primary studies done on a global scale the investigator identified the causal determinants for seeking unsafe abortion as absence of the father, financial constraints, the inability to provide good parenting or interference with life prospects, conflict with prevailing social norms, health concerns and a lack of social support.

These insights were similar to those by Olukorede and Oluwaseun (2009) who examined the causes and consequences of induced abortion among university undergraduates in Nigeria. The study collected data from 187 undergraduate students from ten (10) different institutions of higher learning, selected by multi-stage sampling, using self-administered questionnaires. The chi-square tests were used to assess the influence of the identified causes on abortion seeking behavior.

The findings showed that women who were unmarried were 85% more likely to carry out an abortion than those who are married. The strong negative correlation was observed between use of contraception and decision to seek an abortion. Strong negative correlations were also found between level of education, religious devotion, age and marital status (Olukorede and Oluwaseun, 2009).

Qualitative findings showed that the three main reasons that induced adolescents opt for termination of pregnancy were lack of financial support from the fathers of the children or family members, the fear of parental disapproval and wrath and also if the pregnancy was as a result of sexual assault. The fear of and actual experience of social stigma and possible persecution from religious/traditional extremists also forced adolescents to select clandestine and unsafe abortion (Olukorede and Oluwaseun, 2009).

These results were also seen in research by Dahback et.al, (2007), investigating unsafe abortion among adolescent girls in Lusaka. The purpose was to explore the circumstances that drive women to decide on clandestine, unsafe termination of pregnancy. Thirty-four 13-19 year old girls were

sampled by purposive sampling and data collected using semi-structured questionnaires consisting of open and closed ended questions.

The investigators found that the majority of the adolescent girls who underwent an unsafe abortion had been pregnant for the first time when they attempted to terminate. These girls were unmarried and still in secondary school. They also had low awareness of safe contraceptive methods. They resorted to unsafe abortion due to feelings of remorse at having a pregnancy before marriage. Disapproval from parents and guardians and also pressure to terminate from them also drove them in to unsafe abortion. Additionally, the adolescents cited refusal of responsibility and abandonment by the partner (even those who had accepted responsibility) gave them a reason to terminate pregnancy before birth. There was also a fear of expulsion from school as another decider. The last influencer was the hostility and social stigma they faced in their communities, which led them to carry out unsafe abortions (Dahlback et.al, 2007).

The researchers recommend the need for comprehensive sexual education as well as advocacy for safe and legal abortions for teenagers (Dahlback et.al, 2007).

The investigations discussed in this section have shown that multiple factors shape the personal decision by teenagers to seek an abortion and to do so using unsafe methods. What is required is to enhance the depth of explanation on how these factors produce the observed outcome.

The studies cited above focused on macro-systemic factors that have contributed to unsafe abortion among females of all age groups. The present study shifts focus from the macro factors to the micro-personal factors that drive decisions by adolescents to undertake unsafe termination of pregnancy.

## **2.6 Legislative, Policy & Practice Interventions**

Despite Zambia's relatively progressive abortion law, women continue to seek unsafe, illegal abortions. Four domains of abortion attitudes – support for legalization, immorality, rights, and access to services were measured in 4 communities (Dahlback 2006). A total of 668 people were interviewed. Associations among the 4 domains were inconsistent with expectations. The belief that abortion is immoral was widespread, but was not associated with lack of support for legalization. Instead, it was associated with belief that women need access to safe services. These

findings suggest that increasing awareness about abortion law in Zambia may be important for encouraging more favorable attitudes (World Health Organization 2012).

No national data on abortion are available for Zambia, but hospital records offer some clues to the incidence of safe and unsafe abortion. According to data from five major hospitals across Zambia, a total of 616 women obtained safe induced abortions between 2003 and 2008 (Likwa, 2009). In contrast, the number of women admitted to the hospitals with abortion-related complications (including complications from spontaneous abortion) increased from about 5,600 in 2003 to more than 10,000 in 2008 and totaled 52,791 over the six years. In other words, about 85 times as many women were treated for abortion complications as underwent safe, legal abortion in these five key hospitals. At least half of reported complications were attributable to unsafe abortion.

The situation analysis above demonstrates that interventions to prevent, manage and mitigate impacts of unsafe abortion exist but have been largely been ineffective as adolescent girls continue opting for unsafe abortions. Moreover, there is still need to explore existing measure in Zambia which is meant to reduce incidences of unsafe abortion among the adolescent girls.

## **2.7 Summary of the chapter**

Extensive literature has been reviewed relevant to causes of abortion among adolescent girls in Chingola and Chililabombwe districts of Zambia. Available literature still did not bring out what adolescent girls knew about unsafe abortion, the current state or prevalence on unsafe abortions among the adolescent girls, factors causing the adolescent girls in Chingola and Chililabombwe districts of Zambia to undergo unsafe abortion and existing measures in Zambia to reduce unsafe abortions. These knowledge gaps provide an opportunity for this study to contribute new knowledge on the topic of abortion among adolescent girls in Chingola and Chililabombwe districts of Zambia.

## **CHAPTER THREE**

### **RESEARCH METHODOLOGY**

#### **2.1 Overview**

According to (Walter 2005), research methodology is a broad term which involves all strategies that describe how, when and where data is to be collected and analyzed. It is a system of studying a research. Therefore, this chapter presents the design, the study population, data generation tools, and sample selection.

#### **3.2 Research Design**

This study adopted a case study research design. The case study sought to generate a context specific understanding of unsafe abortion as it occurs among adolescents. It also scrutinized the unique economic, cultural and social factors that shape decisions by adolescent to opt for a safe abortion.

Use of qualitative methodology aided in obtaining an in-depth understanding of the research problem with insights drawn from first hand experiences by the target group. As such this design enabled the investigator to understand the problem as experienced through the eyes of the individuals who have experienced it, while also triangulating this understanding with expert perspectives.

#### **3.2 Research Setting**

This study was conducted at health care facilities in Chingola and Chililabombwe Districts, because it offers the researcher an opportunity to use multiple sources of evidence which increases validity and reliability of the finding. The study was also extended to adolescents at two selected schools in order to gauge knowledge levels and attitudes towards abortion.

#### **3.3 Study Population**

In this study the targeted population consisted of adolescents in the reproductive age group aged 12-18 years and health workers who practiced counselling. The adolescent girls were included in the study because they had experienced abortions and were willing to participate in the study. The health workers were included in the study because they had expert knowledge as they were the ones who provided health and counselling services to the adolescent girls.

### **3.4 Sample Size**

The sample consisted of 70 participants. These were distributed as 10 health workers who practiced counselling and 40 pupils. The 40 pupils consisted of 20 pupils from each school (10 girls and 10 boys from each of the two schools). The size of 10 for health workers who practiced counselling was based on the principle of saturation in qualitative data. The size of 20 was adequate as it was based on the principle of saturation in qualitative data.

### **3.5 Sampling Procedure**

Expert purposive sampling procedure was used to select the 10 counselors who had treated abortion survivors. The health workers were necessary to provide an expert perspective on the causes of and measures to reduce abortion and also recommendations on how safe abortion can be made available to adolescents. The 20 adolescent girls who experienced abortion were picked purposively based on the hospital records and their willingness to participate in the study.

Forty (40) pupils were sampled from two selected-schools. One school was picked from Chingola and Chililabombwe respectively. Pupils were chosen through multi-stage sampling consisting of two stages. In the first stage the schools to be targeted were chosen by simple random sampling. From each of the selected schools purposive sampling was used to select 20 students (10 from Grade 9 and 10 from Grade 12. This is because at the time of data collection only examination classes were active due to the Covid-19 restrictions on school attendance.

From each grade girls were selected. Thus the total number of respondents sampled from the two schools was 40 (with 20 girls and 20 boys). This approach to multistage sampling was used in order to ensure a heterogeneous sample made up of pupils of different age groups and also different genders.

### **3.6 Data Collection Tools**

Data were generated by the use of interview guide, Focus Group Discussion guide, questionnaire and Document Analysis guide.

i) Interview guide

The one-to-one interview guide was chosen because it provided respondents with a stronger level of privacy so that they could more freely discuss their experiences on this sensitive topic.

ii) Focus Group Discussion Guide

This instrument was used to collect data from focused groups of adolescent girls.

iii) Questionnaire

The study also used a questionnaire to examine the knowledge of adolescent survivors and pupils from selected schools. This instrument was used to obtain data from the perspective of individuals on a series of ten (10) items related to counseling and abortion.

iv) Document Analysis Guide

A Document Analysis guide was used to generate data on prevalence on unsafe abortions from official document reports availed to the researcher by the two District Health offices.

### **3.7 Data Collection Technique**

Data from survivors of abortion and care givers/counselors was collected through one to one interviews. Data from adolescents in selected schools was collected through focus group discussion conducted in groups of 10. Thus a total of four focus group discussions were conducted for pupils from each of the selected grades. These techniques had the advantage of providing detailed qualitative information on the subject matter in form of experiences, attitudes and explanations.

### **3.8 Data Analysis**

Numeric data from the study was analyzed using descriptive statistics expressed as percentages, frequencies, and arithmetic-means and expressed by tabulation, charts and graphs.

The qualitative information obtained from the interviews and focus group discussions was analyzed using thematic analysis while data from documents were analyzed using content analysis. The Thematic analysis technique identified the primary ideas derived from each of the respondents and

summarizes them in categories called themes. The main themes presented by each category of respondents were scrutinized and a logical association made between the characteristics of each respondent (for instance gender, age, experience or non-experience of abortion) and the ideas they hold on the subject of abortion. The themes were also compared with the insights provided by experts/care givers and related to existing literature on the subject matter.

Thematic analysis entailed deciphering the meanings from various expressions and discourses recorded from the study in order to get their contextual meaning and also the meaning viewed from the perspective of the speaker, on a particular item (Rehnstrom et.al, 2015). Content analysis was used to understand the data in terms of meanings represented in official documents.

### **3.9 Dissemination of Findings**

Dissemination of findings involves the spread of information and knowledge so that it reaches many people. In this case many copies were made and given to the following: The University of Zambia library, Chingola/Chililabombwe, District Health Centers from which the study will be conducted.

### **3.9 Trustworthiness**

To increase the trustworthiness of the study's findings, the researcher employed strategies suggested by Lincoln and Guba (1985). The researcher decreased threats to credibility by triangulating data. To increase dependability, the researcher provided an audit trail by describing in detail how data was collected, how categories were derived, and how decisions were made throughout the inquiry (Merriam, 1998). The investigator strictly adhered to the sampling and data collection protocols described above.

To increase conformability, the researcher controlled for bias by constantly comparing data, searching the literature for examples of the phenomenon, obtaining multiple viewpoints (Strauss & Corbin, 1998), searching for negative instances of the phenomenon, and checking and rechecking data (Marshall & Rossman, 1989).

Triangulation of data is of critical importance to the trustworthiness of qualitative studies. As the study unfolded and particular pieces of information became known, steps were taken to validate each information item against at least one other source (such as a second interview) and/or a second method (an observation in addition to an interview) (Denzin, 1989; Lincoln & Guba, 1985). Using a second source or a second method can produce more accurate, comprehensive, and objective findings (Silverman, 2006). For this study, interviews and focus group discussions were compared to ensure trustworthiness. Pseudonyms were used to represent all participants

## **CHAPTER FOUR**

### **PRESENTATION OF FINDINGS**

#### **4.1 Overview**

This chapter presents the findings of the study. These findings are organized in subsections with each sub section addressing one objective for this research. To this end the findings outline knowledge levels of abortion and prevalence of abortions among adolescent girls; factors that induce adolescents to opt for unsafe abortions and interventions that aimed at addressing the problem of unsafe abortion.

#### **4.2 Characteristics of the Sample and Summary of Data Collection Process**

The sample surveyed in this study was made up of 70 respondents who took part in one to one researcher administered interviews and Focus Group Discussions. Data collection from these respondents was done in three phases.

##### **a. Phase One**

In this phase one-to-one interviews were conducted with ten (10) counselors and health workers from ten different health centers and hospitals in Chingola and Chililabombwe. These respondents had direct contact with female adolescents who had been treated for abortion related complications.

##### **b. Phase Two**

In this phase the researcher interviewed twenty (20) female adolescents who had fallen pregnant before and had been treated and counseled for abortion related complications in the two year prior to the study. Ten were sourced from Chingola and the other 10 from Chililabombwe. These respondents were targeted to provide information of the determinant factors that induced them to seek unsafe abortion. They also provided insights on the psychological, physiological and physical trauma that they experienced as a result of the procedure and the consequences thereof in the post abortion period. The age distribution for these participants was as follows.

**Table 1: Age Distribution for Adolescents who had Experienced Abortion**

Age Group	Chililabombwe	Chingola	TOTAL
12-14	2	3	<b>5</b>
15-18	8	7	<b>15</b>
<b>TOTAL</b>	<b>10</b>	<b>10</b>	<b>20</b>

Table 1 shows that five (5) of the girls who had been treated and counseled for abortion related complications were aged 12-14 years where as fifteen (15) girls who had been treated and counseled for similar cases were aged 15-18 years.

As such the study obtained perspectives from adolescents at different stages of psychological and physiological development with respect to the reasons that drove them to opt for clandestine, unsafe abortions and also on the consequences they experienced as a result of that procedure.

An interview was also administered to the respondents where they had to give their personal answer on ten items related to abortion and counseling. This provided a private individualized perspective on the subject matter.

### **c. Phase Three**

In this phase, the investigator surveyed the knowledge towards abortion from school going pupils both male and female, who were in a reproductive adolescent age-group of 12-18. One school was selected from Chililabombwe and Chingola respectively. The pupils were selected from grades 9 and 12 respectively.

**Table 2: Distribution of Pupils according to Age Group**

Age Group	Chililabombwe	Chingola	TOTAL
12-14 (Grade 9)	10	10	<b>20</b>
15-18 (Grade 12)	10	10	<b>40</b>
TOTAL	<b>20</b>	<b>20</b>	<b>40</b>

Table 2 shows that twenty pupils (20) were selected from Chililabombwe and twenty (20) from Chingola. Of the selected pupils 13 were sample from grade 9 and were aged 12-14 years of age and Sixteen (16) from grade 12, aged 15-18 years of age.

As such this sample selected pupils at different levels of psychological maturity and also different levels of education the researcher attempted to establish if the type of knowledge presented in the school curriculum influenced the level of knowledge that pupils had with respect to safe/unsafe abortion, sexual reproductive health and contraception.

To provide an assessment of this each of the pupils in the sample were provided a questionnaire where they had to give their personal answer particular item. This provided a private individualized perspective on the subject matter. It ensured that the researcher obtained a private view on the topic from each pupil, before the view would be altered by the group context of a focus group discussion (that is an opinion/ view not distorted by group think or Hawthorne effects)

There after the same pupils took part in Focus Group Discussions. A total of four (4) different FGDs were done. Two FGDs were conducted in Chililabombwe. The first was for Grade 9 pupils aged 12-14 (consisting 10 pupils) and the second for Grade 12 pupils aged 15-18 years (comprising 10 pupils) respectively. In the same way, two Focus Group Discussions were conducted in

Chingola for Grade 9 (comprising 10 pupils) and Grade 12 (consisting of 10 pupils) respectively.

**Table 3: Distribution of Pupils according to Gender**

Gender	Chililabombwe	Chingola	TOTAL
Male	20	20	<b>20</b>
Female	20	20	<b>20</b>
TOTAL	<b>20</b>	<b>20</b>	<b>40</b>

Table 3 indicates that from the pupils sampled in Chingola and Chililabombwe, 20 were male and 20 were female. As such the investigator was able to draw insights from both the male and female perspective on safe and unsafe abortion in Zambia.

#### **4.2.0 Findings of the Study**

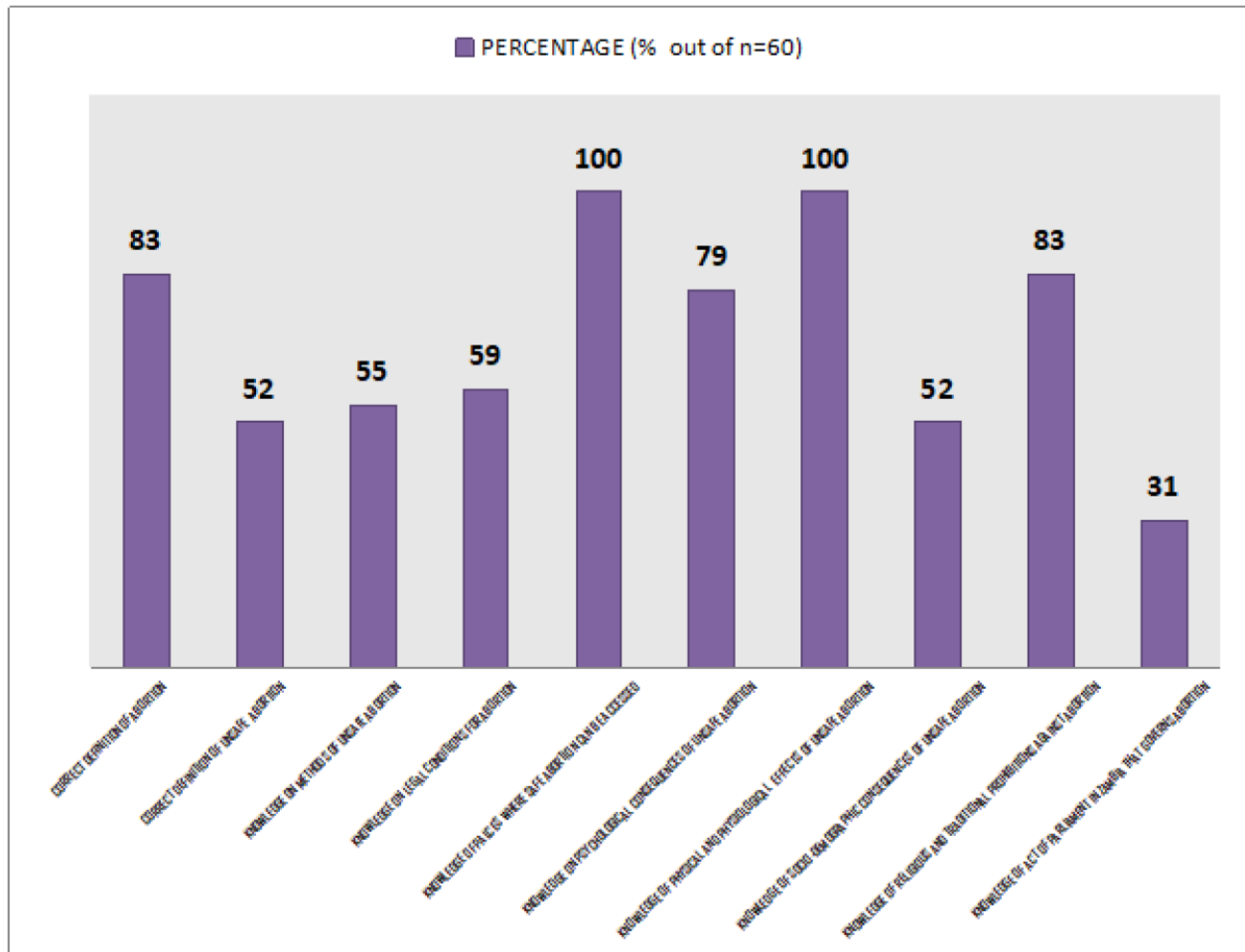
##### **4.2.1 Knowledge Levels on Safe and Unsafe Abortion**

###### **a. Responses from survivors of abortion and pupils**

The researcher interrogated the knowledge on abortion among female survivors of abortion and pupils. To do so, the participants were asked to give their answer on ten (10) items on abortion and unsafe abortion. The level of knowledge was measured using frequencies and arithmetic averages.

The number of respondents, who gave the correct definition on a particular item and also displayed knowledge as stipulated on each item, was recorded. The total number of correct responses on each item was calculated and then expressed as a percentage of 60 (which was the total number of female survivors (20) and pupils (40) from Chililabombwe and Chingola). The arithmetic mean for the total percentages was found. This served as an index for the knowledge level and was designated as the Cumulative Average Percentage (CAP). A CAP of 0-49% would be classified as low, 50-79% is medium and 80-100% would be classified as high. The results are indicated in Figure 2.

**Figure 1: Knowledge Levels of Selected Pupils on Abortion**



From the percentages recorded in Figure 2, the cumulative average percentage for the pupils on knowledge items was 69%. This was a moderate level of knowledge. It should also be noted that there was a low level of knowledge on the contents of the act of parliament regulating abortion Zambia.

A more detailed outlook on knowledge levels was taken during the Focus Group Discussions where the pupils discussed the same items as those in the questionnaire.

When queried on the definition of abortion, Mercy a participant declared that it is the removal of a fetus before the full term of the pregnancy is completed. In this regard some of the notable statements were as follows:

***Abortion is the deliberate removal of the child before the gestation period of the pregnancy is reached. It can also be defined as a medical procedure where a fetus is extracted from the womb with the consent of either the father or mother or both.***

There were varied perspectives on what type of abortion is considered as unsafe and the methods of unsafe abortion. One characterization was that it is a procedure that is done by an unqualified person, using tools that are crude and sanitized such as wooden or metallic probes. As explained by several participants, these tools are inserted in to the womb through the vagina and cervix and used to physically detach and force out the fetus. Herbal concoctions with toxic chemicals, mixed with drugs such as paracetamol, antibiotics and strong spirits are also used. These agents are either ingested orally or inserted through the cervix.

An additional, characterization was that unsafe abortions are those done in secret due to fear of the law. In this case the explanation was that by placing both the practitioner and the client in jeopardy with the law-with a possible fine and custodial sentence, such abortions are unsafe. The respondents moreover argued that an abortion where a fetus is terminated without the consent of the mother is unsafe.

As explained by Mulenga of Chililabombwe, this was because ***it will leave the mother more traumatized psychologically and the emotional damage done by the mother is often irreversible.***

Knowledge of Legal Conditions for Abortion was also outlined by the respondents, who said that girls who fall pregnant as a result of rape can receive legal permission to terminate the pregnancy. It was also stated by participants that in conditions where the child and / or the mother is at risk of death or traumatic damage that may place them in a state of disability, then the law authorizes and abortion.

Rachel one of the participants also declared that the only safe place to conduct an abortion that is safe is at a health centre. In this case the one of the notable was as follows:

***Chililabombwe Hospital has all the facilities and personnel who are trained to competently conduct an abortion and to manage the complications that may arise. It is also the only place where all the legal protocols for termination of pregnancy are followed, there is also a good likelihood that a girl who undergoes an abortion from***

***a hospital will receive counseling and physiotherapy so that they can recover from the procedure.***

Pupils in the focus group discussions explained that unsafe abortion has only negative psychological consequences and no positive psychological consequences. As pointed out by one discussant:

***Mambwe a Pupil in Chingola explained that the idea of killing one's own child is likely to leave a woman with feelings of guilt and depression.*** Mercy a pupil at the same school also explained that

***For me as a young girl who is just beginning to experience life, to go through pregnancy termination under the violent and painful conditions and of a clandestine, is a form of child abuse, on the same level as a rape or other sexual abuse. I feel the memories from such an experience are likely to haunt me for the rest of my life producing depression, fear, and regret among others.***

With respect to physical and physiological effect, the participants gave these and listed these as damage to the vaginal canal, cervix and uterus, fractures and other trauma to the pelvic bones and pelvic joints; the possibility of bacterial infection as well as exposure to cancer. The participants furthermore indicated excessive loss of blood as a common cause of death in the case of an abortion. Mwansa a health worker from chingola said that, ***“unsafe abortions can damage the ovaries and the uterus walls causing the girl to become infertile”.***

Mwansa also declared that unsafe abortion induced a high rate of maternal mortality while also diminishing the future fertility of adolescents and also diminishing the future population growth.

In explaining this, the discussants said the following:

***In my case I think, abortion has led to the death of girls who were initially healthy and who had the possibility of bearing more children in future*** said Jane.

*Madam, every child that is killed in an abortion was a potential father or mother and who knows how many children that child could have produced? For me I think, if unsafe abortion destroys fertility, then it's a threat to the fertility rate of the entire population* added Lumbwe.

Discussants in the study came from a Christian back ground. They therefore cited some biblical scriptures they believed prohibited abortion. Below are some of the scriptures cited. **Table 4: Knowledge on Religious Prohibition against Abortion**

<b>Scriptures Against Abortion</b>
1. Exodus 20:13: "...thou shall not kill"
2. Jeremiah 1:5: "Before I formed you in the womb I knew you, before you were born I set you apart..."

The respondent Mary and friends from Sekele School could not venture any traditional rules against abortion as they did not have knowledge on that aspect.

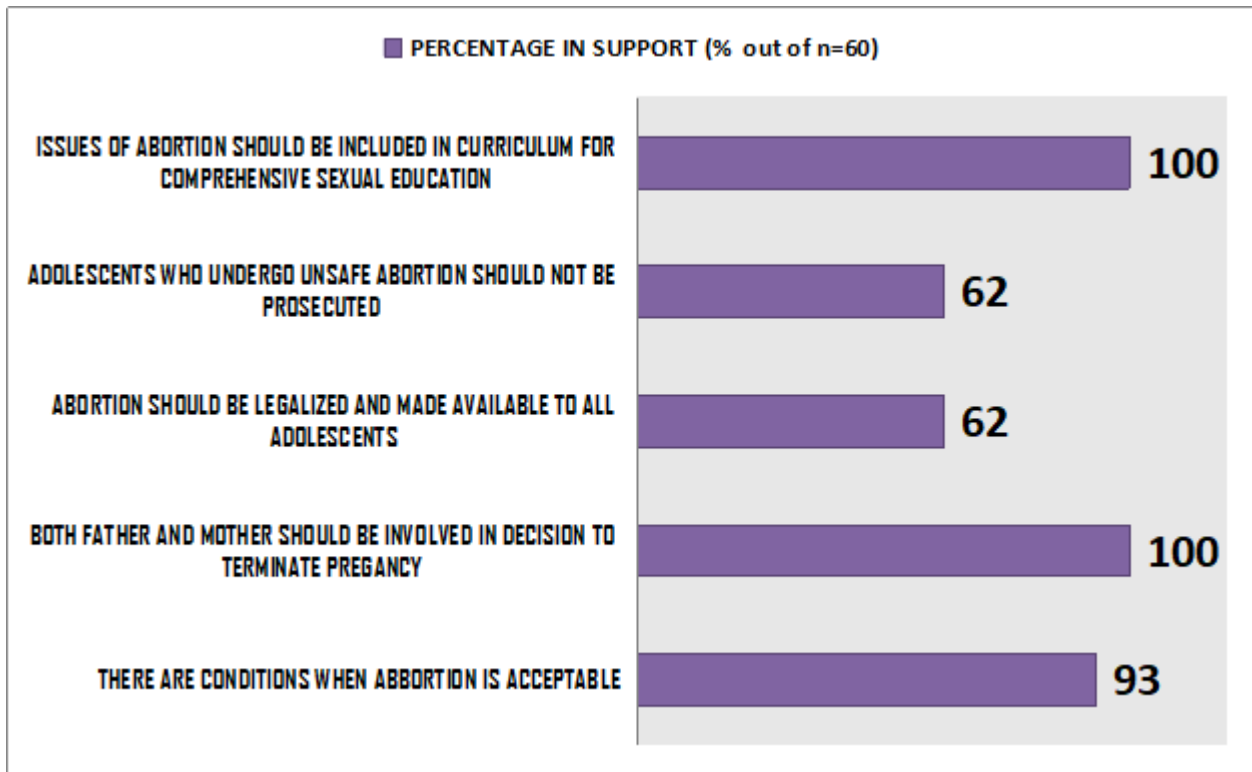
With respect to knowledge of the law the very Mary and friends could indicate the actual Act of parliament that regulates abortion, but had very limited knowledge on the contents of the said Act.

The researcher interrogated the opinions of adolescents on abortion. To do so, the pupils were asked to give their answer on five (5) items on abortion and unsafe abortion. The items used for measuring these were phrased in a manner that implied approval of abortion. Thus respondents had to indicate whether or not they approved of the statement. The number of pupils who indicated approval on a particular statement was recorded. The level of approval was shown by the total number of pupils who approved each item, expressed and a percentage of 70.

The final index was calculated using the same procedure as that described under level of knowledge and following the same form of classification. A CAP of 0-49% would be classified as low level

of approval, 50-79% is medium level of approval and 80-100% would be classified as high level of approval. The results are indicated in Figure 3.

**Figure 2: Pupils' Views in Support of Abortion**



As from the percentages shown in Figure 3, the CAP was 83.4%. Pupils supported abortion on various grounds as shown in figure 2. The highest was that issues of abortion should be included in curriculum for comprehensive sexuality education at 100% and that both father and mother of the adolescent girl should be involved in decision to terminate pregnancy.

The researcher through the pupils of Sekele School inquired if there are conditions when abortion is acceptable and if legal abortion should be made available to adolescents. Discussants in favor argued that abortion is acceptable when it is done to save the life of the mother. It was explained that an adolescent's body especially that of a young adolescent is still under developed. If that be the case, carrying the pregnancy to full term risks her life and future reproduction. Also if the child is found to be severely deformed or under developed such that he or she will be unable to survive after birth, then it is acceptable to terminate the pregnancy.

If the girl is a victim of rape or if the girl feels she does not have the means to support the child. In this regard one participant argued:

*In my view as a pupil, a child of a rape is a child born against the mother’s choice. The mother is too young to be a parent, the rape constitutes a violent disruption of her childhood. Therefore, a child born under such conditions cannot receive the full love of a mother, as she is born from a painful situation...that child will also face social stigma from family and other members of society, therefore termination of pregnancy is acceptable in such a situation.*

Some proponents also argued that if the mother or her family has no means of providing for that child or if they are not motivated to show care, guidance and other parental responsibilities, they must have the choice to terminate the pregnancy.

The opposing view was that the moment that child is conceived, he or she is a human being with the right to life. That right to life must be protected at all costs. There was a strong sense from Mwansa of Chingola that aborting a child under any circumstances is *tantamount to murder*.

Supporters for a more liberal abortion law in Zambia further contended that it is the fear of prosecution under the existing restrictive law that drives adolescents to go for unsafe and secret abortions, with detrimental consequences and with little or no professional counseling. They believed legalizing abortion is a way to reduce such incidences.

Opponents also cited biblical scripture as part of the arguments as explained in Table 7.

**Table 5: Opposition to Abortion on Religious Grounds**

Scripture	Respondents’ Explanation
1. Exodus 20:13: “...thou shall not kill”	All life matters to god including the life of unborn child

<p>2. Jeremiah 1:5: “Before I formed you in the womb I knew you, before you were born I set you apart...”</p>	<p>No child is an accident, every child conceived in the womb has a purpose and so it is wrong to terminate such a child</p>
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It was also eluded by Linda of Chililabombwe School that:

***In my view, it is not always inevitable that a child of a rape will be unloved and it is not always inevitable that that child will suffer for the rest of their life. How one is born does not always affect the life chances that they will experience. A child of rape is a potential president, entrepreneur or scientist etc. Every child conceived must be given a change to live and become who they were meant to be.***

In the event of legal termination of pregnancy, the participants argued that the decision must be made by both the father and mother of the child. It was argued that the child has genes from both parties and so they both have equal right to determine the fate of the child.

An alternative view was that in a situation where the father denies responsibility, only the mother should decide if the pregnancy should be terminated or not. As explained by Linda:

***Men have a tendency of rejecting the child and to disavow all responsibility, it is the mother who will bear the shame of a pregnancy out of wedlock and also the latter responsibility for raising the child. Therefore she must have the stronger right to decide whether or not to go for an abortion.***

There was a third perspective that the decision must be left to a third party other than the mother or father. In this regard, it was explained that both mother and father may be too young to make an informed decision on whether or not to have an abortion. To this end the state, through the social welfare office for instance and through a decree from a court of law should make the decision. In some circumstances, some respondents also said the decision must be made by the legal guardians of the father or mother.

Pupils of Chililabombwe School indicated that adolescents who go through with an abortion should be availed with counseling services and not prosecution. The reasons for this view were that most adolescents end up with unplanned pregnancy because they lack maturity on the implications of such a pregnancy. They therefore should not be punished that error of judgment, but must instead be guided. For this reason counseling will provide them with guidance on how to manage their unplanned pregnancy and child and also provide a sense of mental tranquility to help them recover from the trauma that unplanned pregnancy and abortion had induced.

All the participants agreed that issues of abortion should be integrated as part of comprehensive sexual education as evidenced in the following rationales:

*Mutale a pupil of chingola argued that adolescence is a stage in life when girls are excited about sex and want to explore sexual adventures. This leads to a lot of unplanned pregnancies. Without sufficient knowledge, they may panic and seek unsafe abortion with little regard for the negative consequences that result from it. Lucy a school counsellor added that, even if they don't teach it in class [adolescents] are still exposed to issues of abortion through movies, rumors, or they know someone who did it. In most cases the information they get from these sources is wrong or limited so it's better to get correct information from school through comprehensive sexual education which would help in preventing boys and girls from engaging in unprotected sex.*

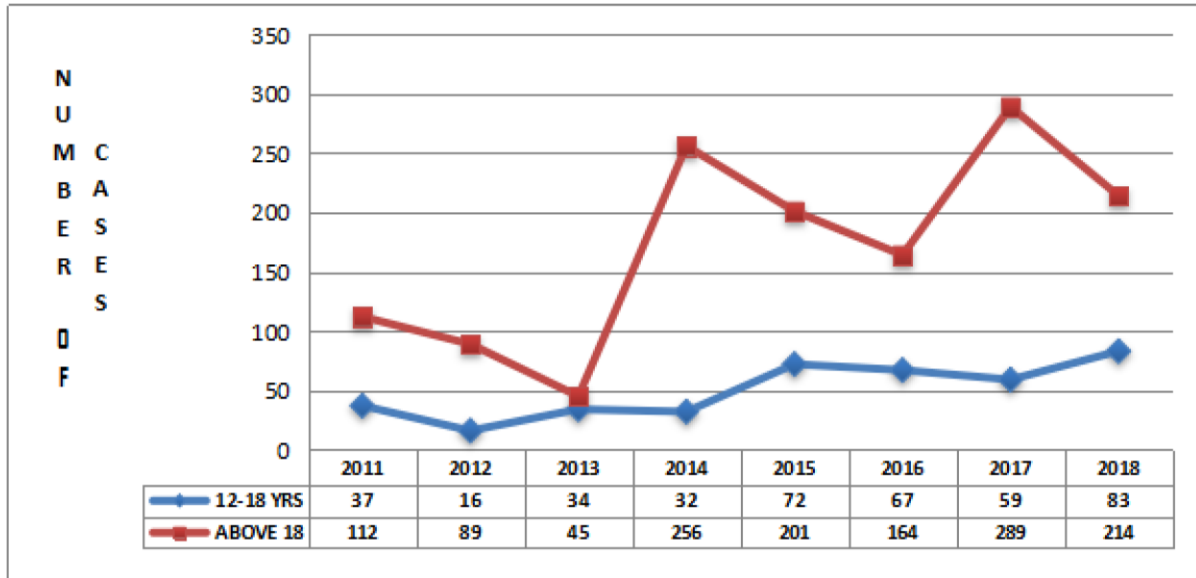
Martha further explained that, *even if they don't teach in school at the moment, youths still have sex, fall pregnant and some do abortion, hiding information on abortion has therefore not prevented unplanned pregnancies, so why not just teach.*

Another pupil Joyce said that, *there is need to stop treating abortion as a secret taboo issue. Including it in the curriculum would demystify the issue and possibly take away the stigma that abortion survivors experience. Therefore, there is need for Zambia to eventually legalize abortion and give adolescents the right of choice for this to happen, the youth need to be well informed on this issue and they must be well informed if they are going to advocate for these rights.*

#### 4.2.2 Current state of unsafe abortion in Chingola and Chililabombwe

The prevalence numbers of unsafe abortion at the time of the study are expressed in Figure 3 below, based on unofficial figures aggregated for the two districts of Chingola and Chililabombwe. **Figure**

**3: Trends in Incidence of Unsafe Abortion 2011-18 in Chingola and Chililabombwe**



As shown in Figure 3, the study found that there number of cases of unsafe abortion has shown an upward trend. The number of patients treated for unsafe abortion was higher among persons aged above 18 years old than those aged 12-14 years old.

Aggregated unofficial figures provided by key informants on the marital status of persons treated for complications related to unsafe abortion in the years 2016-18 are presented in Figure 4.

**Figure 4: Percentage of Persons Treated for Unsafe Abortion by Marital Status for the Years 2016-18**

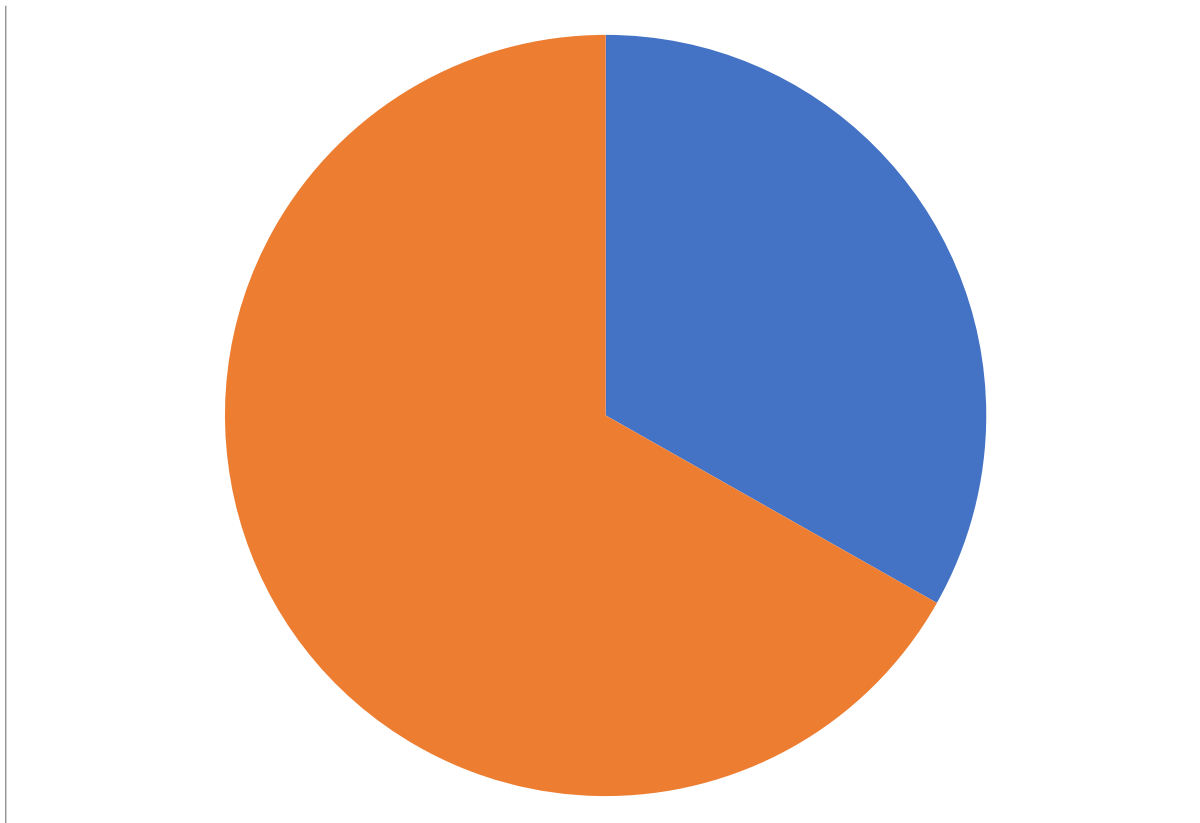


Figure 4 shows that 67% of women treated for complications consequent from unsafe abortion were unmarried where as 33% were married at the time the treatment was administered.

The researcher also explored the morbidity numbers for persons who had carried out or attempted an unsafe abortion in the years 2013-18 base on unofficial figure provided by key informants. This was the number of persons who had developed emergency complications or permanent body damage out of every 100 cases of unsafe abortion treated by personnel at the district hospitals.

Additionally, the study explored obtained the mortality numbers for persons who had carried out or attempted an unsafe abortion in the years 2013-18. This was the number of persons who had died out of every 100 cases of unsafe abortion treated by personnel at the district hospitals. The results are summarized in Figure 4.

**Figure 5: Aggregated Morbidity and Mortality Numbers 2013-18**

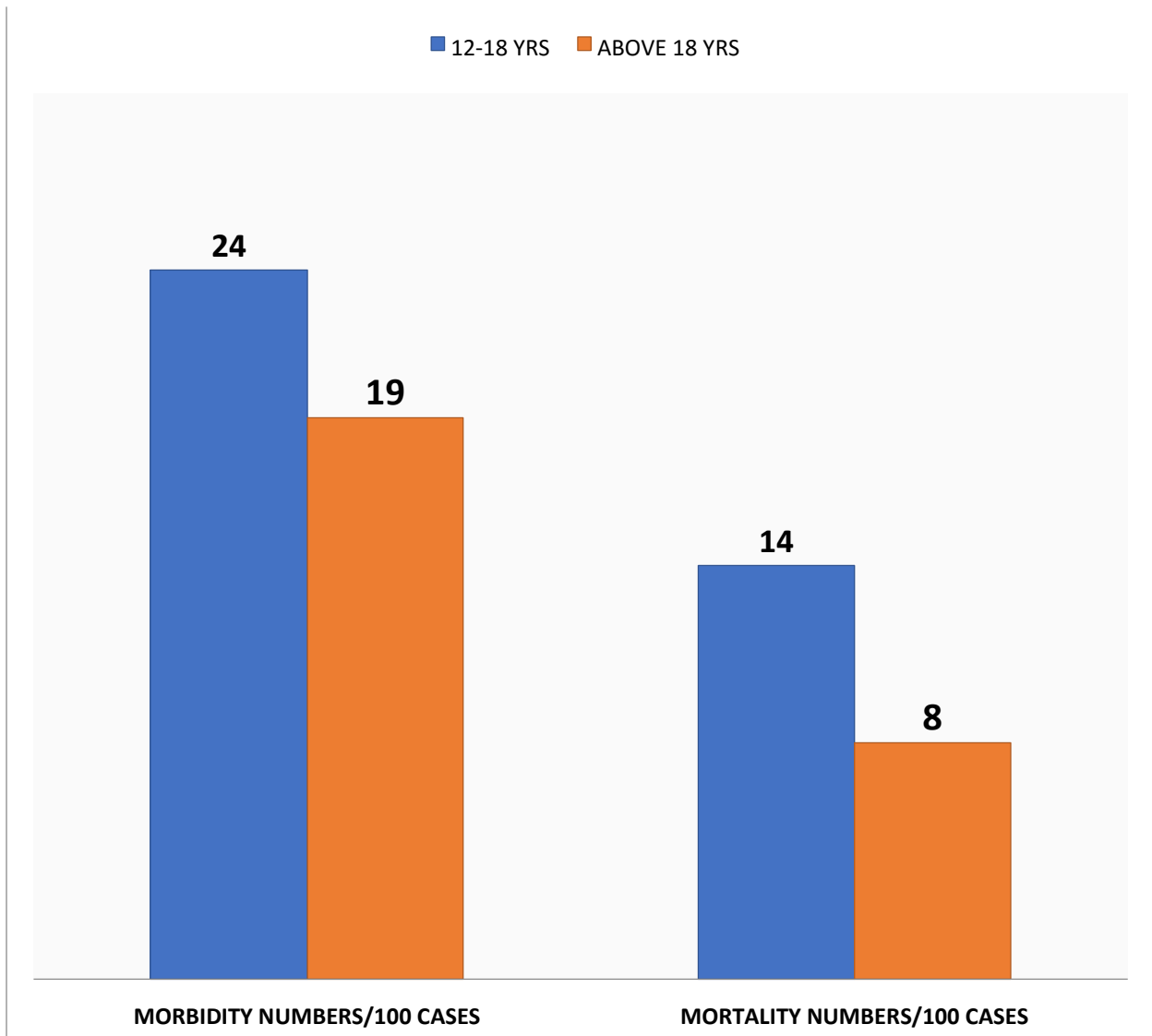


Figure 4 shows that among adolescents 12-18 years, the morbidity numbers were 24/100 (or 24%) and that for patients above 18 years was 19/100 (or 19%). The mortality numbers were 14/100 (or 14%) for adolescents aged 12-18 years and 8/100 (or 8%) for persons aged above 18 years.

### **4.2.3 Factors that Influence Female Adolescents to Undergo Abortion**

Interviews were conducted with survivors of unsafe abortion to get an understanding of the reasons that drive them to seek clandestine and unsafe abortion. These were categorized as: Psychological; Relational; Economic; Social and Medical.

#### **a. Psychological Determinants**

Psychological determinants are those which had to do with personal mental distress that adolescents face upon realizing they were pregnant. The strong negative emotions elicited when the mother found out they were pregnant and the thought processes that emerged from such thoughts were motive enough to make them choose to commit an unsafe abortion. This type of anxiety was evident in the following explanations:

*Naomi of Chingola School said that, I found out I was pregnant two months after my first encounter with my boyfriend and it was my first time to be pregnant.*

*I was afraid and it did not know what to do so I opted for abortion.*

*In my case, I felt guilty, because I was principled and a Christian up-bringing. I had also felt shame because I had broken my own vow not to be a mother till in was married narrated Suzan of Chililabombwe School.*

*I kept having feelings of anxiety and sadness...worried about the future of my child and was also angry with the father of my child for forcing me to have sex and abandoning me like I meant nothing to him, said Jane of Chililabombwe School.*

#### **b. Relational Determinants**

Relational determinants that drove girls towards unsafe abortion concerned fears by the mother to lose a relationship that was important to them. The decision before the mother was to choose between losing a relationship they felt was important to them and terminating the pregnancy.

For example in one of the interviews the participant explained that her boyfriend gave her an ultimatum to terminate the relationship or terminate the pregnancy. She explained that she loved the boyfriend so much as he was her first. She believed she could not endure to lose him. So because of the love she felt for him, she opted to terminate the pregnancy.

In another Interview the girl was living with her mother and step father. The step father was angry at the news of her pregnancy and her mother blamed her for embarrassing her and putting her marriage at risk. The interviewee saw this response as a form of rejection of herself and her baby by her close family. She felt the need to terminate the pregnancy as a way of restoring the lost trust and relationship with her parents. She further reasons, ***“what is the point of bringing an unwanted child in to the world.”*** A similar motive was deduced from a state where the mother did not feel a connection to the child she was carrying. In this case, she believed there will be no positive relationship between herself and the child as narrated below:

***Kantu a pupil at Chililabombwe School said that, I was raped and about a month later i knew I was pregnant I did not want the child. How can I be a mother to a child I did not want? How can I relate to a child forced on me by a strange man? These thoughts kept on coming in my mind and I thought it was better to remove the pregnancy, I did not feel that much of a connection to that baby.***

Anxiety about future relationships was an additional reason for choosing an unsafe abortion. For instance, in one other Interview the subject had been due to get engaged. However, she acquired pregnancy through a sexual relationship with a man who was not her fiancé. The fear of the broken engagement is what motivated her to terminate. There was also the fear that after the broken engagement, no other man would want to marry her if she already had a child out of wedlock. The subject reasoned that having an abortion was preferable to ***“becoming undesirable to other men and dying lonely”***

### **c. Social Determinants**

Social determinants were based on concerns by the subject about their personal reputation and the reputation of their families in the society in which they lived. The subjects believed that other members of society would despise and stigmatize them for becoming mothers out of wedlock.

The statements below illustrate such a view:

*Ruth of Sekele School of Chingola narrated that, I was pregnant for a fellow member of our church choir so I could not bear to think of what people will say since I was a well-known church member, some people called me prophetic, my thought was, what if they saw me pregnant what would they say? What will my pastor think of me? So I decided to abort.*

*For me, my parents were strict, we are a Christian family and my father is an elder in our church, people praised me as a well behaved girl hence falling pregnant caused me to be laughed at and gossiped about, my pregnancy was an embarrassment to my parents.* Said Kukenga of Chingola School

There was additionally, an expectation that they would be expelled from their school. For example one interviewee narrated their experience as follows:

*In my case, I was due to write my final exam in 7 months' time when I fell pregnant. My school is run by [a named church] and it is a girl's school with very strict rules on sex outside marriage and pregnancy so I aborted because I did not want to be expelled and miss my chance to write my exam.* Loveness of Chililabombwe School said.

*Wina of Chingola School, a pupil in Grade nine, my teacher was very disappointed with me, even the head mistress; I thought I was going to be expelled if I don't abort.*

### **d. Economic Determinants**

Economic determinants concern the mother's ability (or inability) to meet the material and financial needs of the child during pregnancy and after birth. When the adolescent mother reasons that she

cannot meet these needs or if they do not have any other person to provide the required support such as the father of the child and/or family member, they will opt for a termination of pregnancy. This form of reasoning is indicated in the exemplars quoted below:

*With me, my boyfriend who was the father of my child told me that he was a married man with a family, I was not working and no one was going to support the child, so i felt pressured and i just remove the pregnancy.* Said Joy of Chingola School.

Idah of Chingola School said that, *times were hard and it was not a good time to bring a child in the world so I made a mistake by thinking that my baby should not be born in a world of suffering.*

*In my case, my uncle just dumped me at my boyfriends place...we had no money to take care of the baby so I aborted.* Said Peace of Chililabombwe School.

#### **4.2.4 Existing Measures against Abortion among Teenagers**

The researcher inquired from counselors on the weaknesses in the response systems against abortion and how they can be rectified.

##### **a. Religious Prohibitions Taught To Women With Respect to Contraceptive Usage and Abortion**

Religion is an important social institution among the Zambian populace. Nevertheless, there tends to be a stigma attached to teaching adolescents about contraceptive usage as a means of preventing unplanned pregnancies. The Christian faith, which is the dominant religion in the target area, forbids abortion.

One counselor from a faith based organization cited several scriptures from the bible three of which are presented below as quoted from the King James Version of the bible:

Genesis 1: 28:

***“God said unto them ‘Be fruitful and multiply and replenish the earth’”***

Psalms 127:3-5

***Lo, children arena heritage of the LORD: and the fruit of the womb is his reward. As arrows are in the hand of a mighty man; so are children of the youth. Happy is the man that hath his quiver full of them: they shall not be ashamed, but they shall speak with the enemies in the gate.***

Psalms 128:3

***Thy wife shall be as a fruitful vine by the sides of thine house: thy children like olive plants round about thy table.***

In interpreting these scriptures the counselor explained that it is the will of God that people bear children and children are a blessing no matter the conditions in which they were born. It was argued that contraception violates the ***“gift of motherhood granted by God to all females regardless of their age or the conditions under which the pregnancy was acquired.”*** The respondent held that an adolescent who aborts a child violates the law of GOD. The leader concluded that ***“only God has the power to decide who should be born and who should not be born”***.

To elaborate further, another counselor declared that within Catholicism, the primary purpose of marriage and sexual intercourse is procreation. Every act of intercourse must remain open to conception. Contraception destroys any potential to produce new life and violates the principal purpose of reproduction and multiplication to ***“fill the earth as GOD intended”***.

This argument was emphasized with a story from the book of *Genesis 38: 8-10* about a man who “deliberately spilled his seed” [a biblical euphemism for ejaculating outside the woman] and was killed by GOD for doing so. It was explained that life is very valuable to God even before conception and so use of contraception such as condoms is a sin because it amounts to spilling the seed. For this reason the clergyman declared that teaching adolescents that pre-marital sex with contraception is acceptable violates the teaching of the scriptures.

As such under Christian teachings Abstinence before marriage is the only officially approved approach to prevent pregnancy. In Catholicism, new life is treated as a person from the moment of conception. All forms of abortion are prohibited except for measures normally taken to save a mother that result in the death of the fetus.

This view was opposed by other experts as it was argued that it was ineffective in preventing young persons from engaging in premarital sex.

Counselor Mary of Chingola Health Center argued that:

*Communicating messages about contraceptive use in the Church removes the binary between what the State advocates in terms of family planning and the message of the Church that advocate abstinence before marriage. State programme advocating condom use may thus be accompanied by silence or ambivalence from the church regarding that particular form of contraception, thus, creating confusion in people's minds.*

An addition from Jane counselor from the social welfare office in Chingola intoned that:

*In churches, condoms are not spoken about, so churches should start educating young people about condoms. There should be workshops in church that educate the youth that if they cannot abstain, they must use protection. it is impractical for churches to just stick to the message of abstinence when young people are exposed to sex, curious about sex and are having sex, they are getting pregnant and some are having unsafe abortions in secret it is unrealistic for the church to pretend this is happening.*

Therefore based on the findings above, it can be argued that churches and other religious entities need to relax their prohibitions on contraception and abortion. These religious institutions have to reform their teachings in line with modern principles of sexual liberty and reproductive rights. A dogmatic approach to abortion has to be replaced by a more pragmatic approach. Religion is a social construct formed must serve the needs of society. By their strict rules against abortion and contraception, religious institutions are not serving the needs of society in a way that benefits all

members of society—including adolescents. If religion is to be an agent to change in mitigating unsafe abortion its teachings on contraception and abortion must change. Religious beliefs against abortion were made by men and men have the power to suit the needs of the situation. Pragmatism must take precedence over dogma.

#### **b. Traditional Cultural Factors**

Cultural factors shaped by ethnic beliefs and the patriarchal attitudes in society were also cited by experts interviewed. It was pointed out that men are the ones who mostly decide when to have children, how many and what mode of sexual intercourse is most pleasurable. It was explained that most men are reluctant to use contraception. As opined by a traditional counselor X of Chililabombwe:

*As a counsellor I think young girls often times date older men on whom they depend for material needs hence some are promised marriage. They have unprotected sex to please the man because they are afraid of losing the man if they do not give him unprotected intercourse as a result when they fall pregnant it is the same man that forces them to abort with my experience this situation is common and represents a situation where men in society have more power to decide the form of sexual intercourse they find pleasurable and to make the sole decision on whether or not the female should have the child or terminate the pregnancy.*

The early marriage was further indicated as a social problem that can be linked to adolescents seeking unsafe abortion. A social worker in the study argued that adolescent girls are taught by society to look forward to marriage and to prepare for motherhood. Low income families tend to have many dependents and hence early child marriage is used as their way of reducing such a dependency burden. It was explained that adolescent girls conceive at an early age either as a way of inducing a man to marry them. Yet if the man refuses to marry them or the man gives them the ultimatum to choose between terminating the pregnancy and retaining their new marriage, adolescent wives opt for the former.

Adolescent wives moreover are placed under pressure to deliver male children. Therefore, it was argued that females carry out unsafe abortions as act of femicide, provided the sex of the child they

are bearing is confirmed. As explained by one health worker, who has counseled abortion survivors:

*I feel not only is giving birth is important, but bearing sons increases the value and worth of a woman in Zambian culture...where women did not bear sons, their husbands were likely to marry second wives in an attempt to have sons who are considered to be heirs and bearers of the family name. As such, terminating a female child is one of the ways in which adolescent wives try to protect their marriages.*

Another traditional counselor W of Chingola corroborated this view by describing the pressures placed in an adolescent bride in a polygamous marriage setting and how this induces femicidal abortion. It was promulgated that Zambian society is patrilineal and in line with such a culture, males maintain the family lineage and inherit from their fathers. Traditionally, inheritance is bequeathed to male children as female children are expected to get married and contribute to the lineage of their husbands. It was emphasized that women were only validated once they bore sons.

In their attempts to bear sons, women ended up with up to seven children, of which only one might be a son. This creates a large family that exceeds the economic means to take care of children. For this reason any additional pregnancy is taken as an extra burden and would need to be aborted.

These arguments entail that patriarchal culture predisposes adolescents to conduct unsafe abortions. Therefore it is needful to increase advocacy, awareness creation and sensitization on women's sexual and reproductive rights. Such a campaigns need to target the custodians of tradition in society and those actors involved in socializing adolescents on traditional matters. In this case the actors that can be engaged include Traditional Leaders, Traditional Elders and Marriage Counselors in addition to Parents and Guardians. These agents should not just be engaged, but must be involved in the process of creating and sensitizing adolescents on their sexual and reproductive rights.

In these campaigns, the focus should not just be on female adolescents, but also on males. This is because, as shown in the findings, both males (as fathers to the unborn child) and the affected females are involved in making the final decision on pregnancy termination.

It is also vital to use the school curriculum as a means of infusing this knowledge and mindset change. In this regard matters of abortion rights need to be embedded in different subjects at different levels such as biology, social development studies, social and moral education, civic studies and also comprehensive sexual education.

Nevertheless, caution should be taken to ensure that curriculum content is not so liberal as to clash with the predominant cultural traditions. There is a perception that liberal abortion rights are a western cultural invasion in to conservative African culture. This perception is likely to stir intense resistance from society. To this effect the inclusion of abortion issues in to the school curriculum should be done in a harmonized and coordinated manner with the campaigns described above that targeted traditional authorities, guardians and parents.

In all these, measures there is need to indicate why a pro-abortion cultural revolution is the most pragmatic approach to solving the crisis of unsafe abortions. Indicating its practical value would eliminate the suspicion that it is western influence that is imposing its values-with in a superiority complex- by trying to alter African cultural beliefs with regard to abortion and with regard to teaching young persons on abortion.

### **c. Inadequacies in Medical and Counseling Systems**

Counseling professionals in this study identified systemic weaknesses in the counseling services with respect to assisting survivors of abortion. The first problem identified in this respect is the shortage of trained counselors with the requisite expertise for helping adolescents cope and recover from unsafe abortion. The first responders in the event of an unsafe abortion are trained nurses / clinicians and not necessarily trained counselors. At best they have received low level training in psycho-social counseling. It was argued that an unsafe abortion is an intensely traumatic experience that creates deep seated psychological problems in adolescents. These problems require more advanced specialists in counseling who are capable of combining psychotherapy and psychiatric therapeutic techniques. Respondents argued that there is a scarcity of specialist counselors who can manage post-abortion recovery in adolescents.

The second, challenge indicated by key informants was the scarcity of specialist abortion clinics in Zambia, where adolescents who have unplanned pregnancy can access safe abortion procedures. Adolescents with abortion related complications are referred to emergency obstetric treatment at general healthcare facilities. While personnel are competent enough to deal with the medical aspects of such complications, there is a lack of follow up once the girls are discharged.

The girls are left to deal with the trauma with untrained persons who may give comforting advice or they may be left to deal with the situation on their own. This state of affairs is because general obstetric facilities do not have a well-funded, adequately staffed and comprehensively structured post-abortion counseling protocols and post abortion recovery facilities accompanying facilities. Hence the medical part is well developed, but the post treatment rehabilitation part is underdeveloped.

The shortage of staff and facilities has also created a situation where existing therapy systems are either rushed or inconsistently implemented. Assigned counselors and therapists are overwhelmed by the large number of abortion survivors that seek their services in addition to clients facing other equally traumatic crises. Patients recovering from an unsafe abortion require over a year of continuous therapy sessions, with a minimum of three sessions a week, each running a minimum of two hours. They also need both personalized attention and group therapy sessions with other survivors. The shortage of staff means that these minimum requirements are not met and also that the protocols for aiding recovery are not fully implemented or even completed.

An offshoot of the challenges cited above is that survivors who may not access quality counseling services from the public health system may have to access said services from private practitioners. However such services are too expensive for those survivors from low income background.

#### **d. Highly Restrictive Anti-Abortion Law**

According to counselors in the study, The Termination of Pregnancy Act was formulated with the influence of the Christian perspective on abortion. As a result the law places a narrow range of conditions under which it is legal to terminate a Pregnancy. This influence emanates from the fact

that Zambia considers itself a Christian nation. As a result the declaration , which is enshrined in the constitution demands all laws that are of a social nature up hold the alleged biblical teachings on abortion (as discussed in part (a) of this section).

It was explained that the restrictive nature of these laws creates a demand for unsafe abortion. Legally, medical facilities are not given enough leeway in carrying out abortion on demand under any conditions. While sexual, reproductive rights are generally acknowledged, abortion rights as espoused by the pro-choice movement are not fully recognized. Abortion is not a universal and ubiquitous right, but instead it is a special case medical procedure, to be utilized only under emergency conditions.

An additional view was that the Termination of Abortion Act was ambiguous in some of its provisions. This creates legal loop holes that the pro-life (who advocate abortion restriction) and the pro-choice (who advocate liberal abortion rights) movement use to promote their agenda. The ambiguity also creates ethical and human rights dilemmas that would make its proper enforcement to be problematic. Respondents cited the following provisions to illustrate such ambiguity.

**Table 6: Ambiguities in the Termination of Pregnancy Act**

Legal Provision	Explanation of Ambiguity by Counselors
<p><i>Cap 3(a) ii</i></p> <p><i>“risk of injury to...mental health”</i></p>	<p>The use of the word “risk” creates a high level of ambiguity. This is because there is no way of directly measuring risk. How risky the pregnancy is going to be is therefore more of a subjective interpretation by the medical practitioners.</p> <p>It is possible that one practitioner can judge the risk insufficient and another judge it to be sufficient depending on their interest which may be financial or based on their pro-choice movement agenda.</p> <p>Moreover, risk to physical injury is directly traceable; where as a risk of mental injury is more speculative. The mind is a complex abstract entity and as such its dynamics are not always reliably predictable.</p>
<p><i>Cap 3 (a) iii</i></p> <p><i>“...risk of injury... mental health of any existing children of the pregnant woman”</i></p>	<p>It is more speculative to attempt to predict how a pregnancy will risk injury to other children. The term “risk” it is speculative in itself. Additionally the “existing children” are more of third parties such that the way they will respond to a new child is not directly measurable or traceable.</p> <p>Also it appears to justify terminating a pregnancy on socio-economic grounds such as if the parent’s judge that the family is too large for them to maintain.</p>

	<p>Additionally, one can argue that this is a form of social Darwinism, that allows parents to decide which of their children is worthy of life and which one is not. The unborn child has a right to life which is equal in worth to the “existing children”. Such a reason is therefore a violation of the universal right to life for every child conceived; a right which is universal and inalienable.</p>
<p><i>Cap 4. (1)</i>  <i>“...conscientious objection”</i></p>	<p>Every citizen has a guaranteed freedom of conscience. This is the right to act in conformity with their beliefs, provided that beliefs are not repugnant to human morality.</p> <p>The problem is the freedom of conscience in the Act is confined only to the practitioner. It is also biased towards those who are opposed to abortion. Yet the freedom of conscience principle can be applied to both proponents of free abortion without restriction as well as those of no abortion at all.</p> <p>Additionally the patient must be given the option to have an abortion if their conscience allows it or to oppose it under all circumstances, if their conscience does not allow it. The law therefore, creates an ethical and human rights dilemma.</p> <p>An argument can be made that if life begins at conception, then they have the same freedom of conscience, even though they cannot yet exercise it. Terminating the pregnancy is as such an abrupt and premature removal of the child’s freedom of choice as to whether they live or die.</p>

The above study summaries that there is need to make abortion legally permissible and accessible as part of their broader sexual and reproductive rights. It was argued that doing so would eliminate most of the ambiguities present in the Termination of Pregnancy Act in its current form. The argument was that the contradictions in the present law exist because of the desire to compromise between pro-abortion liberalism and anti-abortion conservatism. Just as in the case of religious and traditional influences, pragmatism should take precedence over values and the most pragmatic approach is to make abortion free for all without restriction, while also leaving the freedom of choice to both the parents of the unborn child. Eliminating the restrictions and granting universal access to abortion services would also eliminate the demand for unsafe abortion.

## CHAPTER FIVE

### DISCUSSION OF FINDINGS

#### 5.1 Overview

This chapter presents discussions of the findings. This discussion is guided by the following objectives.

- i. To ascertain the knowledge about abortion among adolescent girls.
- ii. To establish the current state of abortion among adolescent girls
- iii. To explore factors that influences the adolescent girls to undergo unsafe abortion.
- iv. To explore existing measures against abortion among teenagers.

#### 5.2 Knowledge Levels on Safe and Unsafe Abortion

The findings from this study have shown that all the adolescents interviewed were aware that the only designated institution for accessing safe abortion are health centers in the private or public sector licensed by the government to carry out the said procedure. Similar conclusions were evident in studies conducted by Espinoza et.al, (2020) in Ethiopia. It contrasts what Adaji et.al, (2010) reported from the democratic republic of Congo. Yet like the information obtained from Adaji et.al, (2010) adolescents in the present investigation were widely aware of the health risks that result from unsafe termination of pregnancy.

The contrast between Zambian and Congolese adolescents with respect to places where safe abortion is available, could have arisen because the latter live in a country where the health system is less developed due to decades of corruption and civil war. It is likely that the reason the Congolese adolescents had low awareness was that health centers providing absent or scarce in their immediate area of access. Conversely it is possible that the Zambian health system provides greater access to adolescents who require abortion services. The greater access in Zambia is possibly because of more health facilities available to the nearest adolescent and also the greater level of information availed to this age group by the educational system and community awareness channels.

Also similar to Espinoza (2020) was the low level of knowledge that adolescents had with respect to the legal framework governing abortion to corroborate what was reported by Kebede, (2016) in

Ethiopia. This low level of knowledge was likely because of the topic of abortion has been treated as a taboo issue by educational institutions and in youth advocate and awareness campaigns leading to minimal effort to provide knowledge on the legality of abortion or the lack thereof. The problem may also be the fact that abortion rights in the two countries have not been recognized, such that the legal framework governing the issue has not been sufficiently highlighted to the general public and adolescents in particular.

However, unlike results reported by Mitchell et.al, (2014) in Brazil and Abiola et.al, (2016) in Nigeria, the present study however did not conclusively detect significant age based differences and gender differences in terms of knowledge and attitudes. This was due to methodological differences between the Nigerian study and the current study. The former was a quantitative survey with a large, randomly selected sample whose purpose was to establish statistical inferences. The present study on the other hand was not inferential, but more descriptive, in-depth and context specific. The purpose was not to generalize findings to the wider population, but to create an understanding of the issue from the perspective of persons who had firsthand experience of the problem (that is survivors and care givers on unsafe abortion). The pupils were a secondary target group to provide an additional understanding on knowledge levels in general, without disaggregating the trends by age or gender. They were added in the interests of triangulating the information obtained from the first target group.

The study also showed that the pupils had a high level of support for legalization of abortion and providing universal access to all who needed it on demand in line with what was detected by Mitchell et.al, (2014) among Brazilian adolescents, but at variance with what was reported in the Democratic Republic of Congo by Adaji et.al, (2010). The rationale for this support is that the decision to restrict abortion is more value based than pragmatic. Values alone cannot arrest the high rate of unsafe abortion among adolescents. The restrictive abortion policies and laws have not effectively stop or minimized adolescent unsafe abortion, but rather they have served to create a demand for unsafe, clandestine abortion. It is for this reason that adolescents are in support of a more liberal approach to abortion. Furthermore, unlike what was reported in Kenya and by Lombe, (2014) in Kapiri Mposhi, the research did not find any major differences in in support for abortion

or lack thereof. Can be attributed by differences in methodological approached and sample sizes between the present investigation and the two studies cited above.

In this study the observation from the focus group discussion was that adolescents were curious to obtain knowledge on abortion and were widely in support of any intent to include it as part of their curriculum. This is different from the conclusion drawn by Espinoza (2020), who declared that there is reluctance for them to seek further information on the topic.

### **5.3 Current State of Unsafe Abortion in Chingola and Chililabombwe**

The research has indicated that the number of cases of unsafe abortion treated at the districts hospitals of Chingola and Chililabombwe had been raising from 2011 to 2018. This upward trend was manifest for females in the 12-18 age group and the age groups above 18 years. The numbers were higher for persons above 18 than those below 18. It is possible from these trends that females in the former age group had a higher fertility than the latter age group. This is because the persons in the older age group were involved in more intimate sexual relationships because they were less encumbered by guardians or parents, had more financial freedom, and were at a stage in life that is normally associated with the pursuit of romantic relationship and starting a new family of their own.

The older age group is also more likely to be in a marital relationship (since the legal age for marriage in Zambia was 18 and above). Persons below 18 were more likely less financially independent and more under the restrictions of their parents or guardians, which reduced their opportunity for intimate sexual relationships.

Information further outlined that the majority (about 67%) of persons treated for complications arising from an unsafe abortion were unmarried and the minority (about 33%) were married. This indicates that marital commitment has an influence on the decision by a woman to seek an unsafe abortion. The figures imply that women who are married are less likely to seek termination of pregnancy (a similar argument was made in research by Olukorede and Oluwaseun (2009); Andersen, et.al, (2015) and Arambepola et.al, (2016).

The reasons for this may be that in Zambian culture, having a child in a marriage is a way of strengthening the marital relationship by proving that the couple is fertile and also because the child is a symbol of oneness between the husband and wife. For this reason terminating a pregnancy

is not within the best interests of the woman or her spouse. By contrast, unmarried women are unencumbered by such obligations; which makes the decision to seek an unsafe abortion much easier for them.

The investigation also revealed that the morbidity rate and mortality rate arising from an unsafe termination of pregnancy was higher among adolescents than adults. This trend can be attributed to the possibility that the bodies adolescents are biologically and physiologically less developed to survive the complication of pregnancy and also less capable of handling the complications arising from an unsafe abortion as argued in a study by (Dahlbäck et.al, 2007).

#### **5.4 Factors that Influence the Adolescent to Undergo Unsafe Abortion**

With respect to the factors that induce adolescents to utilize unsafe abortion, the study identified similar factors as Faundes (2010); (Olukorede and Oluwaseun, 2009) such as absence of the father, financial constraints, the inability to provide good parenting or interference with life prospects, conflict with prevailing social norms, health concerns and a lack of social support. They also support what was indicated by Dahlbäck et.al, (2007) among adolescents in Lusaka. However due to methodological differences, the present research did not provide statistical inferences that could be generalized to the larger population on matters such as strength and direction of correlation between level of education, religious devotion, age and marital status as presented by Olukorede and Oluwaseun (2009).

Yet, just like (Olukorede and Oluwaseun, 2009) this current study indicated that religious and cultural norms influenced decisions to conduct abortions in a clandestine unsafe context rather than the openly available and safe context. There is a strong influence of the Christian faith and ethnic Zambian traditions promote a sacrosanct attitude towards all life –including unborn life. This sacrosanct attitude discourages young persons of reproductive age from opting for secret and unsafe abortion.

## **5.5 Existing Measures against Unsafe Abortion among Teenagers**

The analysis of findings on this demonstrates that the effectiveness of current interventions to prevent, manage and mitigate impacts of unsafe abortion have been stifled by several systemic and methodological factors. The value laden policy and legislative frameworks on abortion have had a low level of efficacy in managing impact and minimizing negative impacts of unsafe abortion amongst the adolescent age groups, because it is not bold enough to accept full and universal access to abortion for all adolescents.

This problem has been worsened by ambiguities in the existing law of abortion that has complicated the interpretation of the law and the practical application thereof. For this reason, it is needful to make the law more liberal towards abortion rights, in order to eliminate the ambiguities and inherent contradictions. These legal reforms should also be harmonized with similar reforms in religious, cultural and social attitudes through greater advocacy, awareness creation and sensitization targeting religious institutions, traditional establishments, families and individuals. Increased access to low cost safe abortion for teenagers coupled with low cost comprehensive counseling in the pre-pregnancy, pre-abortion and post-abortion situation is also required. This can be achieved through increased training and capacity building for abortion care providers together with improved funding, staffing and establishment of health facilities dedicated to providing these services.

## CHAPTER SIX

### CONCLUSIONS AND RECOMMENDATIONS

#### 6.1 Overview

Based on the findings, the purpose of this study was to explore the causes of abortion among adolescents in Chingola Chililabombwe Districts. The study sought to explore the causes of unsafe abortions among adolescents. Based on the findings the study concludes that;

- i. Knowledge levels on safe and unsafe abortion among adolescents
- ii. Current state of unsafe abortion in Chingola/Chililabombwe District
- iii. Existing measures against abortion among teenagers

#### 6.1 Conclusions

This study has found a moderate level of knowledge on abortion amongst adolescents of school going ages, which are also in the reproductive age group. However, there was a low level of knowledge on the contents of the act of parliament regulating abortion Zambia. Most of the knowledge obtained on abortion was obtained from the general social settings that pupils are exposed to such as mass media, peers, family members and direct experience. There is need therefore, to incorporate abortion issues as part of the curriculum for comprehensive sexual education. It is also necessary to emphasize issues of abortion not just as a medical or social issue, but also as a legal and human rights issue.

It is also important to address the determinant factors that induce adolescents to go for unsafe abortion. These determinant factors are economic, social, relational and psychological. The multidimensional nature of these determinants means that there is need for an integrated set of solutions to the issue. This solution must target social changes at in terms of mindsets of members of society. The main influencers on abortion policy are religious institutions as well as the traditional belief frameworks, all of which are anti-abortion. These systems must be engaged to reform their value systems with respect to the right to life and the right to safe abortion. They must be involved as partners in advocating for safe access to abortion.

The solution must also targeted changes in existing legal and policy frameworks from an antiabortion to a pro-abortion orientation. Also needed is are improvements in treatment systems for abortion survivors, in terms of creating dedicated services for providing safe abortion and increasing funding, staffing and protocol changes in post-abortion, counseling protocols. In all these changes Dogmatic and extremists perspectives on abortion need to be substituted by a more pragmatic approach.

## **6.2 Recommendations for Policy and Practice**

1. To increase the knowledge levels among adolescents on unsafe abortion, there is need to incorporate it as part of comprehensive sexual and reproductive health in the school curriculum. Those who are not in the school system can be reached through tailor made community awareness campaigns and through the mass media
2. It is important to establish specialized safe houses for adolescent girls who fall pregnant where they can be provided with specialized counseling services to guide them in their decisions and also to provide material support for those who are too vulnerable to provide material support for their unborn child.
3. Because of the observed negative attitude towards legalization of safe abortion it is necessary to revise abortion laws and policies to ensure universal access to safe and legal abortion to all adolescents on demand. This would negate the demand for clandestine unsafe abortions.

## **6.3 Areas of Further Study**

The following topics are recommended as areas for further research:

- 1) An assessment of the role of faith based organizations in promoting comprehensive sexual reproductive health and abortion rights.
- 2) The efficacy of traditional ethnic counseling systems in promoting pre and post abortion recovery and rehabilitation.
- 3) The attitude of parents and guardians towards the content of Comprehensive Sexual Education proposed in Zambian schools.
- 4) An assessment of the effectiveness of counseling system in rehabilitation child victims of defilement and other sexual assault.

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## **APPENDICES**

### **APPENDIX I: FOCUSED GROUP DISCUSSION GUIDE**

1. Are you aware of what unsafe abortion is?
2. Could you please describe the most common forms of unsafe abortion in your community?
3. For the different forms of unsafe abortion that you have highlighted above, could you please highlight how they are done?
4. What causes girls to undergo unsafe abortion?
5. Are there any circumstances that make unsafe abortion acceptable?
6. Are safe abortion services available in your community?
7. Where (who) can you go for safe abortion information and services?
8. What does the community think about safe and unsafe abortion?
9. Does the community's idea about unsafe abortion have an impact on the practice?
10. Who are the people in the community that can help to educate and prevent unsafe abortion?
11. What are some of the things that can be done to help stop unsafe abortion?
12. Are you aware of campaigns that organizations use to create awareness on safe abortion?  
Which messages have been passed on to the community?
13. In your opinion, how have these messages been useful? In what way?
14. In what ways can the community be greater involved in prevention and response to unsafe abortion?
15. What kind of activities do you undertake in the school to combat unsafe abortion?
16. What do you think should be done to victims of unsafe abortion?



Unsafe abortion happens because girl wants to remove the shame of unintended pregnancy 1)  
( ) 2) ( ) 3) ( ) 4) ( ) 5) ( )

Lack of health services in the communities gives rise to unsafe abortion among girls  
1) ( ) 2) ( ) 3) ( ) 4) ( ) 5) ( )

Unsafe abortion methods vary in degree and intensity according to the specific period of the pregnancy

1) ( ) 2) ( ) 3) ( ) 4) ( ) 5) ( )

Adolescents do unsafe abortions as a way to ensure they pursue their future dreams

1) ( ) 2) ( ) 3) ( ) 4) ( ) 5) ( )

Abortion is not exclusively a man's concern

1) ( ) 2) ( ) 3) ( ) 4) ( ) 5) ( )

**PART C: COMBATING UNSAFE ABORTIONS**

11. Have you noticed any increased attention from the ministry of health to issue related to unsafe abortion recently? Yes ( ) No ( )

12. Are you undertaken any activities to combat unsafe abortion as a health profession?

Yes ( ) No ( )

13. If yes to the question above, what activities are being done?

.....  
.....  
.....

14. Have you participated in any activities related to combating unsafe abortion in the past three months? Yes ( ) No ( )

15. What kinds of activities are being undertaken in the community to combat unsafe abortion (please check all that apply)

Workshop (group) ( )

Outreach (individual) ( )

Clinical services ( )

Others, specify .....  
.....  
.....

16. Kindly indicate your level of agreement with the following statements on initiatives to address perception of unsafe abortion. Use a scale of 1-5 where 1=Strongly disagree, 2=Disagree, 3=Neutral, 4=Agree and 5=Strongly Agree.

Initiative to address perception of unsafe abortion  
Statements 1 2 3 4 5

Increasing girl's access to income and productive resources so that they don't engage in sexual activities that can result to unwanted pregnancies

1) ( ) 2) ( ) 3) ( ) 4) ( ) 5) ( )

Engaging boys and girls to be using contraceptives to avoid pregnancies in order to prevent unsafe abortion

1) ( ) 2) ( ) 3) ( ) 4) ( ) 5) ( )

Increasing health services to address the issues of unsafe abortion

1) ( ) 2) ( ) 3) ( ) 4) ( ) 5) ( )

Increasing awareness on girls on the negative effect of unsafe abortion

1) ( ) 2) ( ) 3) ( ) 4) ( ) 5) ( )

17. What do you think should be done to those who engage in unsafe abortion? Kindly tick appropriately.

- a) Educated ( )
- b) Resolved by community leaders ( )
- c) Arrested and charged ( )
- d) Guidance and counseling ( )

Other (Specify) .....  
.....  
.....

### **APPENDIX III: CONSENT FORM**

Dear respondents,

The information you give is for an academic research study on the effect of unsafe abortions. The interviews and focus group discussion will only be used exclusively for academic purposes.

All information collected here will be treated as private and confidential. Your responses will also be used to find ways of making counseling effective on abortion victims. Your participation is voluntary and your responses will be confidential and your name will not be mentioned in the final report.

Your kind co-operation will be highly appreciated.

Thank you.