IMPEDIMENTS TO CONTRACEPTIVE USE IN WOMEN ADMITTED WITH ABORTION AT THE UNIVERSITY TEACHING HOSPITAL (UTH)

By
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DECLARATION

This dissertation is the original work of Dr. Matimba Mavis Chiko. It has been prepared in accordance with the guidelines for MPH dissertations of the University of Zambia. It has not been submitted either wholly or in part for a degree at this or another university.

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ABSTRACT

Abortion is a major cause of maternal mortality and morbidity in sub-Saharan Africa. This is because many women are, for various reasons that include poor quality of existing services, fear or distrust of methods or conflict between partners about childbearing goals, still not using modern contraceptive methods to prevent unplanned pregnancies (The Alan Guttmacher Institute).

The aim of the study was to determine impediments to contraceptive use in women admitted with abortion at the University Teaching Hospital (UTH). The objective was to find out whether religious influence, spouse/partner opposition and fear of contraceptive side effects are barriers to contraceptive use. Also to assess the accessibility of family planning services in terms of distance from source and the participant's knowledge of the safe period.

A cross sectional study was conducted. A study sample size of 146 was calculated at 95 percent confidence level and adjusted for finite population. Simple random sampling technique was used to select the study participants.

The study participants were selected from women admitted to the UTH gynaecology admission ward CO3, in Lusaka, Zambia.
Data was collected using a structured interview schedule administered by two research assistants.

The results of the study showed that the majority of the women 81 (55.5 percent) were aged 25 years and below, married 110 (75.3 percent), unemployed 110 (75.3 percent), many had poor education 69 (47.3 percent) and lived in high density residential areas 92 (63.0 percent).
Though the source of family planning services was within 30 minutes walking distance to the majority of the women 109 (79.0 percent), 70 (47.9 percent) of these women had never used any family planning method before. 41 (31.3 percent) said they did not prevent this pregnancy because they had no method at hand. Knowledge of the condom as a contraceptive method was low 21 (14.4 percent) in comparison to the ZDHS2001-2002 figure, which was reported to be 94.1 percent in the general population. The majority 110 (75.3 percent) had poor knowledge of the safe period. Partner/spouse approval seemed to increase with the increase in the number of children a woman had. The majority of the study participants lacked autonomy in decision-making on contraceptive usage irrespective of their educational level, employment status, or, parity.

It is evident therefore that, in order to increase contraceptive uptake, there is need to incorporate fertility education in schools from as low as upper primary school. Service providers must discuss side effects of the various contraceptive methods in order to allay unwarranted fear by clients. There is also a great need to educate the women folk of their individual right to decide on the use of contraceptives without having to consult their spouse/partner. After all, it is the woman who suffers the consequences of abortion.

To all those women in Zambia who for various reasons still have unmet need for fertility regulation.

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Finally I would like to express my deepest gratitude to my husband Killian, my son Kozi and my nephew Christopher for having tirelessly taken care of our baby girl Kabaenda who was born shortly before my final examinations.

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LIST OF ABBREVIATIONS

AIDS	Acquired Immuno-Deficiency Syndrome
HIV	Human Immuno Deficiency Virus
FP	Family Planning
IEC	Information Education and Communication
IPPF	International Planned Parenthood Federation
ITG	Integrated Technical Guidelines for Frontline Health Workers
LDHMB	Lusaka District Health Management Board
MOH	Ministry of Health
MVA	Manual Vacuum Aspiration
REC	Research Ethics Committee
TOP	Termination of Pregnancy
UNICEF	United Nations Children's Emergency Fund
UNFPA	United Nations Population Fund
UTH	University Teaching Hospital
WHO	World Health Organizati0n
ZDHS	Zambia Demographic and Health Survey

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CHAPTER 1

1.0 INTRODUCTION

1.1 BACKGROUND INFORMATION

Lusaka District, which also makes up the capital city, is situated in Lusaka province of Zambia. It has a surface area of 360 square kilometers. It shares boarders with the following districts: Chongwe to the east, Mumbwa to the west, Chibombo to the north and Kafue to the south. Its boundaries extend from Zanimuone Motel in the north, Chilanga Township in the south, Garden House Motel in the west and International Airport turn off to the east.

Zambia is a member of the COMESA free – trade – area, rendering Lusaka a hive of all international and inter city trade. The population of Lusaka takes about the fifth of the 10.3 million Zambians (ZDHS 2001-2002). It has a density of 65.4 persons per square kilometer and is still the most urbanized and most densely populated district in the country. The average life expectancy at birth is 50 years for both males and females (CSO 2000). The district is subdivided into four operational areas known as sub-districts to facilitate the administration of the district health care package by Lusaka District Health Management Board (LDHMB). It has 25 health centers under LDHMB offering preventive, promotive and curative services. All the health centers offer family planning services. This is in line with the MOH mission to improve family planning service accessibility to all adults in need of the services (LDHMB 2003).

In 1989 the Government of the Republic of Zambia adopted an explicit National Population Policy as an integral component of its fourth National Development

Plan (1989 – 1993). The overall goal of this policy was to improve the standard of living and quality of life of all Zambians. Its objectives include among others, enhancing people's health and welfare and preventing premature deaths and illness, especially among high-risk groups of mothers and children. Another main objective is ensuring that all couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so. One of the targets of the 1990 Population Policy was to make family planning services available, accessible and affordable to at least 30 percent of all adults in need of such services by the year 2000. Following the adoption of this policy, a comprehensive National Family Planning Program and National Population Information, Education and Communication (IEC) program were prepared for the period 1992 – 2000, to give effect to and achieve the policy objectives. Important strategies include among others;

- Expanding the coverage of family life education to all schools and institutions of higher learning so as to prepare the young people for responsible parenthood.

- Improving the status of women.

- Training various levels of health providers.
- The formulation and implementation of family planning programs within the context of the nation's health care and related systems.

The MOH will support, among others, the following measures and any of their political and service provision implications on behalf of the nation:

- The government shall offer family planning information and services free.

- Men and women of reproductive age shall be eligible for using family planning methods without consent of their spouses, parents or relatives.

- Couples with larger families will be adequately informed and counseled with the option of a permanent method of family planning according to the principles of informed choice and quality of care.

- Young adults as priority groups shall be provided with information, education and communication messages regarding prevention and protection against unwanted pregnancy.

In an effort to improving access to family planning, the MOH has integrated family planning with other reproductive health programs such as Maternal Child Health / safe motherhood and by involving the private sector, non governmental organizations, social marketing programs, community based and employment based programs. In addition, health personnel at all health institutions shall aim at providing the approved family planning method mix to help promote informed choice and client satisfaction. The involvement of community leaders can have a considerable impact on the acceptability and accessibility of various methods of family planning. Therefore, training of all influential community groups has been ensured in order to reduce their negative image, bias or misconceptions related to certain methods (MOH 1997).

Abortion, however, still remains one of the major causes of maternal morbidity and mortality during the antenatal period in Zambia (ITG 1997). This is so despite the many health centers offering family planning services through out the country. As a response to the growing concerns about maternal and child health, family planning is viewed as a critical component of essential package of health intervention. The Ministry of Health [MOH] has also produced the 'Family Planning and Reproductive Health Framework, Strategies and Guidelines.' These 'guidelines' include among others:

- Commitment to guaranteeing that all public, private, and mission health facilities will provide the essential reproductive health services to all in consistent with the level of experience and training of service providers.

- Commitment to providing reproductive health information and services to all regardless of age, gender, marital status or socio-economic status.

- Commitment to taking into account the religion, social and cultural factors in the provision of sexual and reproductive health information and services in the various communities and groups of people (MOH 2000).

In addition the MOH has created and adopted a Logo, the "Family Planning Circle" as a visual symbol of family planning. This logo helps clients to identify locations from where to receive family planning information and services (ITG 1997).

In theory 89 percent of health centers nationwide offer family planning services but the reality is 30 percent, due to shortage of trained staff and contraceptives (ITG 1997).

Knowledge of any contraceptive method is almost universal in Zambia, with 98 percent of all women and men knowing at least one method of contraception. Modern methods are more widely known than traditional methods. The male condom is the most commonly known (94 percent) closely followed by the pill (93 percent). Emergency contraception is the least known, reported by 9 percent of all women (ZDHS 2001-2002). Despite this knowledge, only 24.6 percent of married women in Zambia are currently using a contraceptive method. 19.2 percent of all women of reproductive age group use any method and 11.2 percent use a modern method. There is therefore a significant gap between awareness and use of family planning, which calls for more studies on attitudes and practices to understand why people are not using existing services (ZDHS 2001 - 2002).

1.2 STATEMENT OF THE PROBLEM

The most commonly reported reason women cite for having an abortion is to postpone or stop child bearing. The second most common reason – socioeconomic concerns – includes disruption of education or employment; lack of support from the father; desire to provide schooling for existing children; and poverty, unemployment or inability to afford additional children. In addition relationship problems with husband or partner and a woman's perception that "she is too young", constitute other important categories of reasons. With few exceptions older

women and married women are the most likely to identify limiting child bearing as their main reason for abortion (Bankole et al 1998).

Abortion is practiced in all cultures, to varying degrees, by women facing unwanted pregnancy. Though a very safe procedure when conducted by trained health personnel, it remains legally restricted in many countries. This restriction leads to women resorting to unsafe abortion, a major cause of maternal injuries, illness and deaths worldwide. An estimate of 20 million unsafe abortions, take place each year accounting for between 50,000 and 100,000 deaths annually (Population Action International 1995). These unwanted pregnancies and induced abortions are symptoms of family planning failure; failure of a contraceptive method; failure of access to family planning services; or failure of a program to assist women and couples in the use of a method that is acceptable to them.

Zambia is no exception to this problem. Despite the wide availability of family planning services, many young women and teenagers fail to prevent pregnancy, and abortion still remains one of the major causes of maternal morbidity and mortality during the antenatal period. The University Teaching Hospital (UTH) being the primary provider of Manual Vacuum Aspiration (MVA) services in Zambia handles 10 to 20 cases, mostly of spontaneous abortion, every day. 15 percent of all maternal deaths result from clandestine or illegally induced abortion. According to 1988 records, for every legal abortion conducted, 25 incomplete abortions were treated. Incomplete abortion patients comprise 35 percent of all gynaecology admissions (UNICEF 1994).

Further more, unpublished UTH records in January 2003 showed that out of a total of 498 patients seen at the gynaecology ward, 223 were abortions, representing 44.8 percent of gynaecology cases. In 1993, MOH records indicated that over 16,000 hospital admissions nationwide were due to illegally performed abortions (Macwan'gi, 1993). In reality, the number is probably much greater, as many cases go unrecorded. Interestingly, the classical causes of maternal mortality in Zambia are decreasing in proportion. For example, from 1974 to 1993, the percentage of deaths from eclampsia decreased from 37 to 6 percent. Deaths from haemorrhage decreased from 24 to 10 percent; from puerperal sepsis, 15 to 11 percent. During the same period, however, the proportion of deaths due to abortion increased from 13 to over 30 percent (UNICEF 1994). Studies conducted in Lesotho, Malawi, Uganda and Zambia revealed that approximately 30 percent of the deaths (Zambia being the highest) were associated with abortion, emphasizing the importance of abortion as a cause of maternal mortality in East, Central and Southern Africa (Likwa 1993).

The challenge lies on the reproductive health providers and researchers to identify the reasons why so many women still fail to prevent unwanted pregnancies and to find solutions so as to further reduce the morbidity and mortality due to abortions.

1.3 STUDY JUSTIFICATION

The researcher was prompted to conduct this study due to the perpetuating problem of unwanted pregnancies ending in abortions. These abortions, which are mostly illegally induced, cause much suffering both physically and psychologically. Severe complications, including poisoning, sepsis, septic shock, aneamia,

haemorrhage, genital trauma, abdominal trauma, perforated uterus, and death, can arise depending on the circumstances of the procedure. Other long-term consequences include chronic pelvic pain, pelvic inflammatory disease and secondary infertility.

With the reported almost universal knowledge of at least one contraceptive method (98%) in Zambia (ZDHS 2001-2002), most of these pregnancies could have been prevented, if only the factors contributing to the low utilization of contraceptives are identified and addressed. This problem does not only affect adolescents, but women in the reproductive age group in general, both single and married. Currently only 24.6% of all women in Zambia are using any method of contraception (ZDHS 2001-2002). There is therefore an urgent need to bridge this gap between knowledge and use of contraceptive methods.

This study will be undertaken as a fulfillment for the Masters in Public Health program. The study results will be used by reproductive health specialists to map out appropriate intervention strategies in order to increase contraceptive accessibility, acceptability and utilization. This will consequently significantly contribute to the lowering of maternal mortality and morbidity related to abortions.

CHAPTER 2

2.0 LITERATURE REVIEW

A review of local literature on barriers to family planning use proved difficult. The few studies that have been published locally deal mainly with adolescents' sexuality and teenage pregnancies. It was reported that parents have negative attitudes towards teenage contraception. The main reasons for this attitude were based on religious beliefs and fear of children becoming promiscuous (Simbuwa 1997). The role of men was found to be predictor for non use (Mpundu 2002) and underutilization of family planning services in Kabwe urban secondary school were due to lack of health education on family planning in schools, religious beliefs and negative attitudes of both family planning method providers and parents (Ngoni 1997). Other in country studies have demonstrated that low literacy levels, early marriage and cultural and traditional practices, particularly in the rural population, lower the status of females and that non use of family planning services was identified as a risk factor for maternal morbidity among adolescents. Abortion contributed to maternal mortality (Likwa 1993). Factors contributing to failure to prevent unwanted pregnancies in women of reproductive age (15-49 years) in general have not really been looked into. The ZDHS (2001-2002) reports only on currently married women's attitudes and reasons for not intending to use any contraceptive method. The reasons were mainly fertility related 63 percent, followed by method related reasons 18 percent. Currently 88 percent of women in Zambia are not using any contraceptive method.

However, studies have been conducted in other countries to try and identify why women would rather opt for abortion as a form of fertility control rather than to use family planning methods and also to identify other impediments to contraceptive use.

Globally, nearly four in 10 pregnancies are unplanned, and two in 10 end in abortion. Given the many social and personal factors that hinder individual effective contraceptive use, and the risk that any contraceptive method may fail, some level of unplanned pregnancy will persist. Consequently so will the need for abortion. Many of the reasons for unplanned pregnancy and abortion transcend geographic boundaries. Many women, married and unmarried, who do not want to be pregnant are not using a contraceptive method or are using a method that provides insufficient protection against pregnancy. In some areas, women have poor access to modern contraceptives, do not know where to obtain them or cannot afford them. In some parts of the world, men, other members of the family or the prevailing religious authorities may discourage or prevent women from wanting or trying to regulate their child bearing. Women's low status and lack of autonomy, especially in developing countries, may impair their ability to avoid unplanned pregnancies by practicing contraception. However, the ability to assert some control over their reproductive lives becomes evident when these same women decide to seek an abortion (The Alan Guttmacher Institute).

Although women in much of the world commonly have sexual intercourse at very early ages and before or outside marriage, child bearing is often considered undesirable in the circumstances. Moreover, married couples almost everywhere

increasingly want small families. Yet, for many reasons – poor quality of existing services, fear or distrust of methods, or conflict between partners about childbearing goals - many women who do not wish to become pregnant are not using an effective contraceptive method. Some of these women faced with unplanned pregnancies decide to have an abortion for reasons that are primarily health related, economic and relationship problems (The Alan Guttmacher Institute). Many sexually active young people who want to avoid pregnancy are not using modern contraceptives for various reasons, including disapproval by health providers. In surveys of reproductive health attitudes and practices, those with an unmet need for family planning are women and men who say they want no more children or want to delay their next birth by more than two years, but are not practicing contraception. A significant portion of unmet need is indicated by the high levels of abortion among young women, as reported from surveys and inferred from hospitalizations after unsafe abortions, as well as by estimates of out of wedlock pregnancies (UNFPA 2003). Data from Bangladesh, the Philippines, and Vietnam show that young women are more likely than older women to be influenced by their husbands and to be inhibited by religious beliefs that prohibit contraceptive use. The inability to negotiate the use of contraceptives was found to be a major barrier for adolescent women, who are less likely to discuss family planning with their partners (Family Planning Services Providers).

Hong Kong, for example, has the highest level of contraceptive use at 86 percent, followed by China with its controversial compulsory family planning policy. Because of China's 'one child policy', a study in Shanghai revealed that the

contraceptive prevalence rose from 20 percent to 75 percent over the years. This reduced the induced abortion rate from 16 per 1000 months of exposure to close to zero. Many Asian and Latin American countries have made significant strides in expanding access to family planning; over 25 developing countries exceeding 50 percent. In some 24 countries, however, the vast majority in Africa, (fewer than 10 percent of women) use family planning (Population Action International 1995). Up to 100 000 maternal deaths annually could be avoided if women who did not want children used effective contraception. When morbidity is also taken into account, it is estimated that preventing unwanted pregnancies would avert a total of 4.6 million disability adjusted life years (DALYs). Effective contraception actually has the potential to contribute to better maternal health beyond simply reducing the proportion of births that are unwanted. Unwanted pregnancies carry a greater risk than those that are wanted. The phrase 'too early, too late, too many and too close,' describes the undesirable aspects of pregnancies that are not planned. Avoiding pregnancies in very young or older women, and increasing the interval between births can also have an impact by reducing the proportion of pregnancies that could be considered high-risk. Unwanted pregnancies may involve increased risk for the woman or her unborn child simply because the woman or her family may be less likely to invest time and money in obtaining prenatal care and skilled help in child birth of an unwanted child (Mastarn and Cleland 2003). Family planning decisions also reflect a range of outside influences, which include, household influences and community norms, information available and access to family planning methods and services. Community and culture affect a person's attitude towards family planning, and whether family planning accords with customs and religious beliefs.

Community norms also prescribe how much autonomy individuals have in making family planning decisions.

In some cultures women reject contraception because bearing and raising children is the path to respect and dignity in society. In other cases, for example, young people often decide not to seek family planning because they do not want their parents or other adults to know that they are sexually active. Many fear ridicule, disapproval, and hostile attitudes from service providers and others (Jejeebhoy 1999). Individual behavior is also influenced by how a person thinks that others view their behavior (Ruternberg and Watkins 1997). In Nepal, for example, some women said that it was difficult for them to use family planning because their relatives and friends were not using it. These women were reluctant to be the first in their social group to use family planning (Stash 1999). In the Philippines, the main factors found to be associated with unmet need of contraception were the strength of women's reproductive preferences, the fertility preferences of the husband and the perceived detrimental health side effects of contraceptive methods (Casterline et al 2001).

Another study on family planning in Nepal, from the user's and non user's perspective, revealed that the majority of couples that were interviewed at the time had more children than they wanted, and many still had not adopted an effective method of contraception. The reasons given for non-use of contraception were both service and non-service related. Included as service related are reasons such as 'fear of side effects, level of information in the client population about existing family planning services, and the particular images that the services have projected in the

communities. In some cases there were doubts that family planning clinics would help the poor. In other cases the wife was afraid to act without the husband's support, or, afraid of social stigma while some were against family planning for religious or superstitious reasons. Others reported that the doctor or staff of family planning clinics discouraged them. Some of those who requested for sterilization were told to wait until their newborn reached the age of five years but no interim method was suggested. Among the constraints of contraceptive use was also the belief that modern family planning methods endangered ones health or life (Schuler and Goldstein 1985).

Another study conducted on sexual behavior contraceptive practice and reproductive health among Nigerian adolescents showed that a substantial proportion of young unmarried population was sexually active and despite comparative high contraceptive prevalence among that proportion, many still engaged in sexual relation without benefit of contraceptive protection. The reasons for non use of any contraceptive method included insufficient knowledge about family planning, safety concerns, objection of one's partner, lack of availability and reasons such as forgetting or not thinking that a pregnancy was likely to ensue from unprotected intercourse (Douglas et al 1986).

It is not easy to estimate accurately the prevalence of abortion in Africa, although we know from indirect evidence that it is very common in some countries. Community surveys are very difficult to carry out because of the sensitivity of the subject. Therefore, most of the information on the magnitude of the problem comes

from hospital – based studies. Hospital admissions for abortion complications will be the tip of the iceberg in many African countries. This is because a large proportion of people still live beyond reach of modern health services. The high figures of abortions suggest that there's a large unmet need for fertility regulation and that abortion is often used as a method of family planning in the absence of contraception (IPPFA 1994).

3. OBJECTIVES

3.1 GENERAL OBJECTIVES:

To determine impediments or barriers to family planning use in women admitted with abortion at the UTH.

3.2 SPECIFIC OBJECTIVES

- To determine level of knowledge on the ease of conception in abortion patients.
- To determine accessibility of family planning services in abortion patients.
- To assess women's dependency on the male partner or spouse for decision making on the use of family planning methods.
- To determine to what extent religious influence affects family planning use among abortion patients.
- To determine whether fear of side effects of family planning methods contribute to their non-use.
- To make recommendations to reproductive health specialists on how to improve family planning services utilization so as to contribute to lowering of unwanted pregnancies, hence reducing the number of abortions and resulting complications.

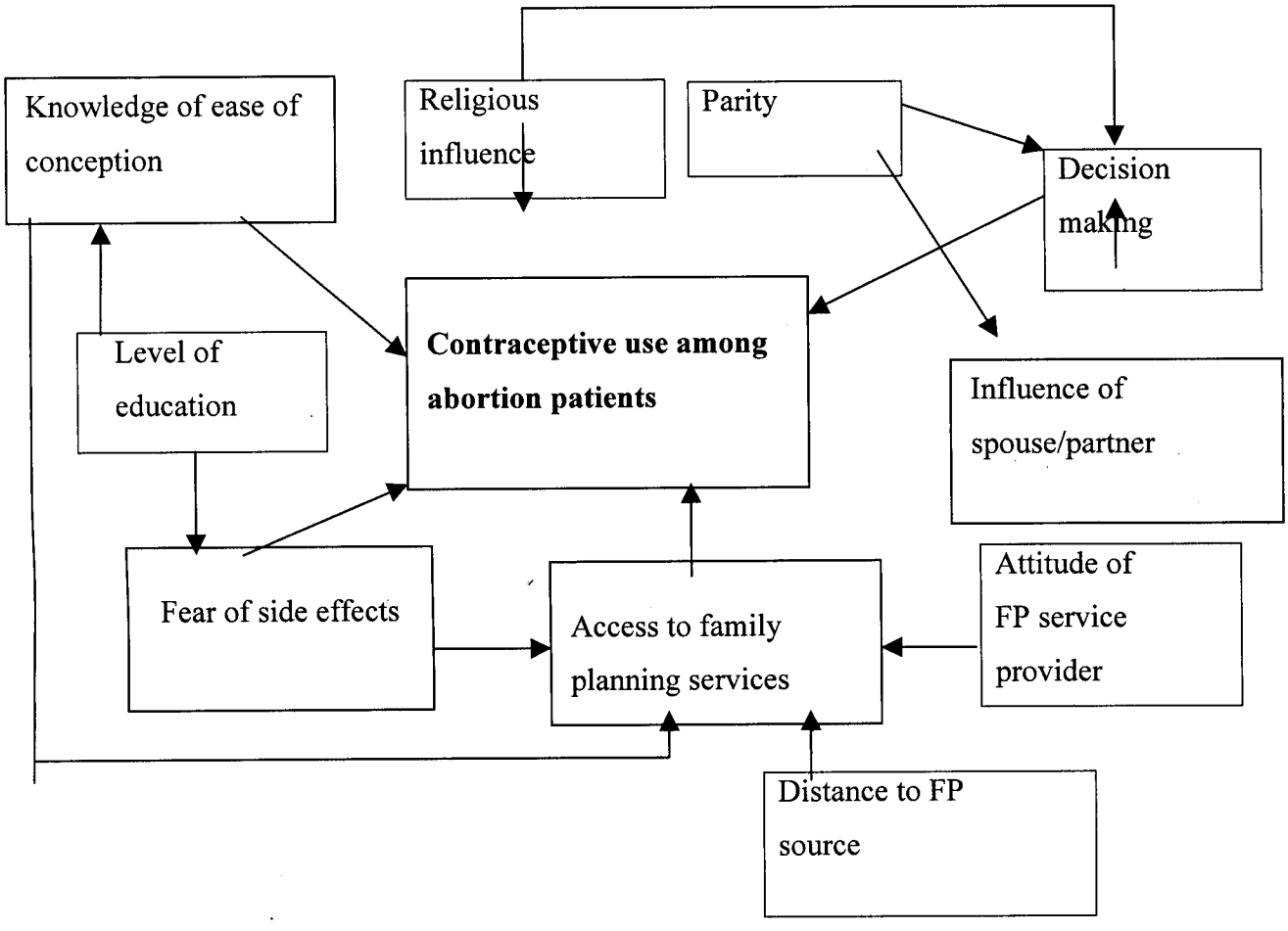
3.3 OPERATIONAL DEFINITIONS

Women in Reproductive Age:	15 – 49 years of age
Abortion:	Termination of pregnancy, expulsion or extraction of embryo or foetus before 28 weeks of gestation.
Contraception:	The prevention of unwanted pregnancy.
Pregnancy:	Being with a child, the condition from conception to expulsion of the foetus.
Residential density:	Low, medium and high density residence as classified by the local government administration and Central Statistics Office.

CHAPTER 4

4.0 METHODOLOGY

4.1 VARIABLES



The diagram shows multiple factors which can influence contraceptive use either directly or indirectly.

4.2 STUDY DESIGN

The purpose of the study was to determine impediments to contraceptive use in women presenting with abortion. A descriptive cross sectional study design was used.

4.3 STUDY SETTING

The study was conducted at the UTH gynaecology admission ward CO3. UTH was chosen as the study setting because it handles all the abortion referrals from the 25 Lusaka district clinics. Lusaka has a population of 1,432,401 out of which 51 percent are females. Of the female population 22 percent are in the reproductive age group (ZDHS 2001-2002).

4.4 STUDY POPULATION

The study comprised of women admitted to UTH with abortion. Unpublished UTH records show that in 2003, an average of 250 abortion cases were attended to every month. 750 was therefore taken as the study population over a three- month period.

4.5 SAMPLING AND SAMPLE SIZE

The study participants were selected from the gynaecology admission ward at UTH using simple random sampling technique of one in every five. The interval for sampling was calculated using the following formula:

$$K = \frac{N}{n}$$

Where K = Interval

N =Study population

n = Sample size

Sample size of 146 was be used. The sample size was calculated using the formula:

$$n = \frac{Z^2\, p\,(100 - p)}{e^2}$$

where n = sample size

p = proportion of contraceptive non-users

Z = Standard normal deviation

e = standard error

According to unpublished UTH records about 250 abortion cases are attended to every month. Given a study period of three months, 750 was taken as the study population. The sample size was calculated at 95 percent confidence level. The proportion of females in the reproductive age group currently not using any contraceptive is 88% nation wide.

$$n = \frac{1.96^2 \times 88\,(100 - 88)}{5^2}$$

$$n = \frac{3.8416 \times 1056}{25}$$

$$n = 162$$

Since the entire population of study was less than 10 000, the final sample estimate (n′) was calculated using the following formula:

$$n' = \frac{n}{1 + \left(\frac{n}{N}\right)}$$

Where:

n′ = the desired sample size (when population is less than 10 000).

n = the desired sample size (when the population is more than 10 000).

N = the estimate of the population size.

$$\text{Therefore: } n' = \frac{162}{1 + \left(\frac{162}{750}\right)} = 131$$

Adjusting for non- response rate of 10 percent gave us a final sample size of:

$$\frac{131}{0.9} = 146$$

4.6 PRE-TESTING OF THE STUDY INSNTRUMENT

Trial of the study instrument was conducted in the gynaecology admission ward C03 to test the completeness of the questionnaire and to detect any flaws in it and also to ensure that the study participants as well as the research assistants understood the questions. Patients that took part in the trial of the study instrument were not included in the study.

4.7 DATA COLLECTION

Data collection was carried out using a structured interview schedule. Two research assistants recruited from the UTH gynaecology ward CO3 were trained to collect data. The study instrument was administered after the participants received treatment but before post abortion counseling as this might have influenced their responses. The interviews were conducted in an identified side room in the admission ward.

4.8 DATA - PROCESSING AND ANALYSIS

Prior to data entry validation of the questionnaires was done. Cleaning of data was done by browsing and frequency range checks on the computer. Errors detected were updated.

Data analysis was done by EPI Info 6 software using column counts, cross tabulation, reflecting frequencies, percentages, chi square and P- values. P-values of 0.05 or less were considered statistically significant.

4.9 ETHICAL CONSIDERATION

Ethical approval was sought from the School of Medicine Research and Ethics Committee. Consent was obtained from the study participants after having explained the purpose of the study to them. The information obtained was treated with strict confidentiality. The informed consent form was signed or thumb printed by the participant or legal guardian.

CHAPTER 5

5.0 PRESENTATION OF FINDINGS AND DATA ANALYSIS

5.1 PRESENTATION OF FINDINGS

The results presented in this chapter were obtained from 146 study participants who were randomly selected from women admitted to the UTH gynaecology admission ward with abortion over a period of six weeks between July and August 2004.

Findings from description data obtained from the study participants are presented in the ensuing pages.

Table 1: Social demographic characteristics of respondents

	Frequency	Percentage (%)
Age		
<=20	34	23.3
21-25	47	32.2
26-30	32	21.9
31-35	16	11.0
>35	17	11.6
Total	**146**	**100.0**
Marital Status		
Married	110	75.3
Not Married	36	24.7
Total	**146**	**100.0**
Parity		
None	44	30.1
1-3	84	57.5
4 and above	18	12.3
Total	**146**	**100.0**
Residence		
Low Density	8	5.5
Medium Density	46	37.0
High Density	92	63.0
Total	**146**	**100.0**
Education Level		
Primary	60	41.1
Secondary	61	41.7
College	15	10.3
University	1	0.7
No education	9	6.2
Total	**146**	**100.0**

Table 1 continued

Church		
Catholic	33	22.6
Liberal Protestants	45	30.8
Strict Protestants	49	33.6
No Religion	19	13.0
Total	**146**	**100.0**
Employment		
Yes	36	24.7
No	110	75.3
Total	**146**	**100.0**

The respondents were aged between 14 and 45. The majority 47 (32.2 percent) were in the 21 to 25 age group followed by those that were aged 20 years and below at 34 (23.3 percent). Of the 146 respondents 110 (75.3 percent) were married women and 36 (24.7 percent) were unmarried. The unmarried category comprised of those that had never been married, the widowed and divorced women. The majority 84 (57.5 percent) had between one to three children and 44 (30.1 percent) had no children. Most of the respondents 92 (63.0 percent) were from high-density residential areas (Mutendere, Kalingalinga, Chawama etc). The majority 61 (41.8 percent) had attained secondary school education and 60 (41.1 percent) had been to primary school. Nine (6.2 percent) had no education at all. The unemployed 110 (75.3 percent) were in the majority.

Table 2A Ever use of contraceptives by marital status

	Marital Status				
Used FP before	**Married**		**Not Married**		**Total**
	N	**%**	**N**	**%**	
Yes	60	(78.9)	16	(21.1)	**76**
No	50	(71.4)	20	(28.6)	**70**
Total	**110**	**(100.0)**	**36**	**(100.0)**	**146**

Chi – square 1.10, P – value 0.292

There was no significant difference in the use of contraceptives between married and unmarried women as shown in table 2A above.

Table 2B Fear of side effects of contraceptives

Not used FP due to Fear of side effects	**Frequency**	**Percentage (%)**
Yes	**37**	**52.9**
No	**33**	**47.1**
Total	**70**	**100**

Out of the 146 respondents, 70 (47.9 percent) had never used any form of contraceptive before and of these, the majority 37 (52.9 percent) gave side effects as their reason for never having used contraceptives. This may be due to lack of information on family planning and the various contraceptives leading to misconceptions and myth

Table 3: Fear of side effects by respondent's age

	Fear of Side Effects				
Age	**Yes**		**No**		**Total**
	N	**%**	**N**	**%**	
<=20	17	(45.9)	14	(42.4)	**31**
>=21	20	(54.1)	19	(57.6)	**39**
Total	**37**	**(100)**	**33**	**(100)**	**70**

Chi – square 0.09, P – value 0.767

There was no association between fear of side effects and the respondents' age. But there were more women in the age group 21 years and above 20 (54.1 percent) that feared side effects of contraceptives than in the younger age group of 20 years and below 17 (45.9 percent). This may be because the older women are more likely to use contraceptives than those in the younger age group.

Table 4: Fear of side effects by respondent's educational level

	Fear Of Side Effects				
Education	**Yes**		**No**		**Total**
	N	**%**	**N**	**%**	
Primary	15	(40.5)	9	(27.3)	**24**
Secondary	17	(46.0)	17	(51.5)	**34**
College	2	(5.4)	3	(9.1)	**5**
University	1	(2.7)	0	(0.0)	**1**
No School	2	(5.4)	4	(12.1)	**6**
Total	**37**	**(100)**	**33**	**(100)**	**70**

Chi – square 3.15, P – value 0.533

Table 4 shows that there was no association between fear of side effects and educational attainment in the 70 women that had never used any contraceptive method before. 64 (91.4 percent) of these participants had secondary school educational level and less. This also includes those that had never been to school. Again this may be due to lack of information about family planning in schools and inadequate youth friendly family planning services.

Table 5: Fear of side effects by respondent's residence

	Fear of Side Effects				
Residence	**Yes**		**No**		**Total**
	N	**%**	**N**	**%**	
Low Density	2	(5.4)	3	(9.1)	**5**
Medium Density	11	(29.7)	10	(30.3)	**21**
High Density	24	(64.9)	20	(60.6)	**44**
Total	**37**	**(100)**	**33**	**(100)**	**70**

Chi – square 0.38, P – value 0.825

Table 5 shows that there was no association between fear of side effects and residence. The majority of the women who had never used contraceptives before because of fear of side effects 24 (64.9 percent) however live in densitresidential areas. Probably this is because these are the same women with low education.

Table 6: Accessibility of family planning services

Knowledge of FP Method	Frequency Respondents	Percentage (%)
Pills	98	67.1
Injectables	43	29.5
IUD	11	7.5
Condoms	21	14.4
Natural	6	4.1
Norplant	12	8.2
Sterilization	0	0.0
Withdrawal	1	0.7
Lactation Amenorrhoea	0	0.0
Other	2	1.4
Distance to source of FP Services		
Two Hours Walk	13	9.4
One Hour Walk	16	11.6
Thirty Minutes Walk	41	29.7
Fifteen Minutes or Less Walk	68	9.3
Total	**138**	**100.0**
Source of FP method		
Health Center	25	78.1
Chemist	6	18.8
Other	1	3.1
Total	**32**	**100.0**

Table 6 continued

Why Didn't use Method		
Wanted Conception	72	55.0
Had no Method at Hand	41	31.3
I Don't Know	6	4.6
Partner Pressure	11	8.4
Other	1	0.8
Total	**131**	**100.0**
Attitude of FP Providers		
Friendly	62	53.0
Un Friendly	2	1.7
I Don't Know	52	44.4
Other	1	0.9
Total	**117**	**100.0**

Table 6 shows accessibility of family planning services in terms of distance to source of family planning services from the respondents' place of residence, the place where method was obtained from, reasons for not having used a contraceptive method to prevent this pregnancy and the attitude of the health service provider. Knowledge of family planning method was included in this table as it was felt that accessibility was only possible with knowledge of the various contraceptive methods and also to compare the respondents' knowledge of family planning methods to that of the general population.

Table 7: Respondent's knowledge of ease of conception in relation to frequency of unprotected sexual intercourse and the menstrual cycle.

	Frequency	Percentage (%)
You can be pregnant after having unprotected sex once		
Yes	139	95.2
No	4	2.7
I don't Know	3	2.1
Total	**146**	**100.0**
Knows when one gets pregnant in relation to menstrual cycle		
Yes	36	24.7
No	110	75.3
Total	**146**	**100.0**

Table 7 shows the respondents' knowledge on how easily they could fall pregnant. The respondents were asked if they could fall pregnant after having unprotected sex only once and also during which part of the menstrual cycle they were most likely to conceive.

Although the majority of the women 139 (95.2 percent) knew that they could conceive after having unprotected sex only once their knowledge of the fertile period was poor.

Table 8: Religious influence on family planning by respondent's denomination.

	Church Approves FP						
Denomination	**Yes**		**No**		**I Don't Know**		**Total**
	N	**%**	**N**	**%**	**N**	**%**	
Catholic	23	(26.7)	6	(42.9)	4	(14.8)	**33**
Liberal Protestants	30	(34.9)	2	(14.3)	13	(48.2)	**45**
Strict Protestants	33	(38.4)	6	(42.8)	10	(37.0)	**49**
Total	**86**	**(100)**	**14**	**(100)**	**27**	**(100)**	**127**

Chi – square 5.94, P – value 0.203

There was significant difference between the various churches on their stance on the use of family planning. Generally they all had a favorable attitude towards family planning.

Table 9: Religious influence on use of family planning by marital status.

	Church Approves FP						
Marital Status	**Yes**		**No**		**I Don't know**		**Total**
	N	**%**	**N**	**%**	**N**	**%**	
Married	74	(67.3)	15	(13.6)	21	(19.1)	**110 (100%)**
Un Married	25	(69.4)	4	(11.1)	7	(19.4)	**36 (100%)**
Total	**99**		**19**		**28**		**146**

Chi – square 0.02, P – value 0.988

Table 9 shows whether the respondents' church approves or does not approve the use of family planning by marital status. Unmarried included those single, divorced

and widowed. There was no association between church approval and marital status.

Table 10: Influence of partner / spouse on use of family planning by respondent's age.

	Partner Approve FP				
Age	**Yes**		**No**		**Total**
	N	**%**	**N**	**%**	
<=25	37	(44.0)	12	(60.0)	**49**
>25	47	(56.0)	8	(40.0)	**55**
Total	**84**	**(100)**	**20**	**(100)**	**104**

Chi – square 1.56, P – value 0.198

The majority of partners 84 (80.8 percent) approved the use of family planning but this was more so in the age group above 25 years 47 (56.0 percent). This may be related to the number of children the couple had.

Table 11: Influence of partner / spouse on use of family planning by respondent's marital status.

	Partner Approves FP				
Marital Status	**Yes**		**No**		**Total**
	N	**%**	**N**	**%**	
Married	69	(82.1)	15	(75.0)	84
Un Married	15	(17.9)	5	(25.0)	20
Total	**84**	**(100)**	**20**	**(100)**	**104**

Chi – square 0.53, P – value 0.466

Table 11 shows whether the partner / spouse approves the use of family planning by the respondents' marital status.

The majority of married women 69 (82.1 percent) said their partners approved family planning usage. This may mean that there is more dialogue and discussion of family planning issues among married couple. It may also be due to the fact that unmarried women may be viewed as being unfaithful to their partners when they are using contraceptives.

Table 12: Influence of partner / spouse by respondent's parity.

	Partner Approves FP				
Parity	**Yes**		**No**		**Total**
	N	%	N	%	
None	14	(16.7)	8	(40.0)	**22**
1-3	55	(65.5)	11	(55.0)	**66**
4 and above	15	(17.8)	1	(5.0)	**16**
Total	**84**	**(100)**	**20**	**(100)**	**104**

Chi – square 6.17, P – value 0.045

A P- value of 0.045 shows a significant association between the number of children a woman had and partner approval to the use of family planning.

Out of 104 respondents, 84 (80.8 percent) said their partners approved the use of family planning. 55 (65.5 percent) of those whose partners approved the use of family planning had between one to three children. This shows the desire to limit the number or to space children among these couples.

Table 13: Consultation of partner / spouse on use of family planning by respondent's parity.

Parity	Partner Consulted				Total
	Yes		No		
	N	%	N	%	
None	7	(10.0)	4	(36.4)	**11**
One to Three	49	(70.0)	7	(63.6)	**56**
Above Four	14	(20.0)	0	(00.0)	**14**
Total	**70**	**(100)**	**11**	**(100)**	**81**

Chi – square 7.12, P – value 0.028

Table 13 shows whether or not the partner/spouse was consulted on the use of family planning in relation to the respondents' parity. There was a significant association with P- value 0.028.

Out of 81 respondents the majority 70 (86.4 percent) consulted their partners on the use of family planning. Out of these 70, 49 (70.0 percent) had between one to three children. This shows that partner consultation increases with increase in the number of children.

CHAPTER 6

6.0 DISCUSSION OF FINDINGS

6.1 SOCIO-DEMOGRAPHIC CHARACTERISTCS OF WOMEN ADMITTED WITH ABORTION

The purpose of this section is to provide a demographic and socio-economic profile of the 146 respondents. Basic background characteristics including age, marital status, religion, educational level, residence, employment and parity are outlined.

The respondents were aged between 14 to 45 years. The majority 47 (32.2 percent) were in the 21 to 25 age group followed by those aged 20 years and below who were 34 (23.3 percent). The frequency of respondents seemed to rise with increasing age up to the age of 25 then declines after that. Of the 146 respondents 110 (75.3 percent) were married. The unmarried 36 (24.7 percent) comprised of single, divorced and widowed women. 84 (57.5 percent) had between one to three children and 44 (30.1perccent) had no children. Of these that had no children 23 (52.3 percent) were married and 21(47.7 percent) were unmarried.

The majority 92 (63.0 percent) were from high-density residential areas (e.g. Mutendere and Kalingalinga) followed by medium density (e.g. Emmarsdale) and low density (e.g. Kabulonga) with 46 (37.0 percent) and 8 (5.5 percent) respectively. Most of the women 69 (47.3 percent) had either no education at all or had only had primary education and 61 (41.7 percent) had secondary education. Only 16 (11.0 percent) had been to college and university.

The majority 110 (75.3 percent), were unemployed meaning that they were economically disadvantaged. only 36 (24.7 percent) were in gainful employment. There were more strict protestants 49 (33.6 percent) followed by liberal protestants, which includes churches such as Seventh Day Adventists, United Church of Zambia, and Catholics with 45 (30.8 percent) and 33 (22.6 percent) respectively. 19 (13 percent) had no religion.

6.2 FEAR OF SIDE EFECTS AS A BARRIER TO CONTRACEPTIVES USE

Out of the 146 respondents 70 (47.9 percent) had never used any form of contraceptive method. Of these 37 (52.9 percent) responded positively to the reason being fear of side effects of contraceptives as opposed to 33 (47.1 percent) who said they did not fear side effects of contraceptives. The specific methods feared were however not outlined in this study. The results are consistent with those of the general population (ZDHS 2001-2002) which indicate that much of the unmet need for family planning in Zambia results from women's fear of the health side effects associated with contraceptives, especially the pill and injectable methods. Studies conducted in Missouri also indicate that fear of side effects prevents many women from using modern methods of contraception (Population Council 1998).

In this study, of the 70 women that had never used any contraceptive method 37 (52.9 percent) did not use them due to fear of side effects. Although out of these 37, 20 (54.1 percent) were aged 21years and above compared to 17(45.9 percent) aged 20 years and below, there seemed to be a general fear of side

effects that was irrespective of age. The women in the older age group are, however, most likely among the married ones and are therefore more exposed to sex and at a higher risk of falling pregnant in the absence of contraception.

Level of education seemed to have an impact on the use of family planning methods in the respondents that had not gone beyond secondary school. Of the 37 women that had never used family planning due to fear of side effects, 34 (91.1 percent) had only been to primary, secondary or to no school at all. Fear of side effects in this group may be due to lack of information and myths on family planning and also due to inadequate youth friendly reproductive health clinics where the youth could get information on family planning.

This is in contrast to a study conducted in Missouri in women seeking pregnancy tests where educated women expressed greater concern about side effects than less educated women (Marjorie et al 1997).

It was also observed in this study that fear of side effects of contraceptives increased with the increase in density of the respondents' residential area (see table 5). This is most probably because the women living in these residential areas are the same ones with little or no education. There is also more interaction amongst community members in high-density residential areas and therefore there is more influence from friends and family members on individual's attitudes and behavior including their attitude to family planning.

6.3 ACCESSIBILITY OF FAMILY PLANNING SEVICES

Knowledge of the existence of a service is essential in order for it to be accessed. Table 6 shows knowledge of various contraceptive methods in the respondents in comparison to the 2001 census findings. Whereas the ZDHS 2001-2002 reports that the knowledge of the condom was 94.1 percent, the pill 92.1 percent and the injectable contraceptive 81.4 percent, this study revealed that the pill was the most widely known 98 (67.1 percent) followed by injectable contraceptives 43 (29.5 percent). Only 21(14.4 percent) of the women knew the condom as a contraceptive method. This is probably because of the wide campaign against HIV/AIDS in which health education messages are promoting the use of condoms for the prevention and control of the spread of HIV and other sexually transmitted infection and not for prevention of pregnancy as well.

There are 25 health centers in Lusaka district offering preventive, promotive and curative services. All the health centers offer family planning services in line with the Ministry of Health mission to improve family planning services accessibility to all adults in need of the services (LDHMB 2003). Because of this deliberate move to make health services accessible to all, the majority of the respondents were within easy reach of family planning services. 68 (49.3 percent) were within 15 minutes walk and 41 (29.7 percent) were within 30 minutes walk to the source of family planning services. Despite the accessibility of these family planning services in terms of distance, 70 (47.9 percent) of the 146 respondents had never used any method of family planning.

Of those that had used family planning before 25 (78.1 percent) obtained the method from the local health center. The attitude of the family planning service providers was found to be generally friendly by those that had used the services before. Out of 131 respondents 72 (55.0 percent) did not use any form of contraceptive method because they had wanted to conceive. But 41 (31.3 percent) of them did not use any family planning method to prevent this particular pregnancy because they had no method at hand. This may also indicate that in the absence of modern contraceptive methods, some women are unable to use natural family planning methods such as the safe period or withdrawal methods.

6.4 RESPONDENT' KNOWLEDGE ON HOW EASILY THEY CAN FALL PREGNANT IN RELATION TO THE MENSTRUAL CYCLE AND FREQUENCY OF UNPROTECTED SEXUAL INTERCOURSE

In assessing women's knowledge on how easily they could fall pregnant after having unprotected sexual intercourse the respondents were asked if it was possible to fall pregnant after having unprotected sex only once. The majority 139 (95.2 percent) said they could. They were then asked if they knew at what period of the menstrual cycle they were most likely to fall pregnant. The options for the menstrual cycle were, immediately after a period, half way between two periods, just before a period and don't know. Only 36 (24.7 percent) answered correctly i.e. midway between two periods. The remaining 110 (75.3 percent) are those that answered wrongly and those that didn't know.

It is evident from the findings that despite the majority of the respondents knowing that they can easily fall pregnant by having unprotected sex, their

knowledge of the safe period is poor. These women are therefore unable to practice natural family planning methods correctly in the absence of any other methods.

In other studies carried out in Shangai, China, among married couples- over 7500 'just married' showed that nearly half of the couples with one child had experienced one or more unintended pregnancies following the birth of their first child. It was shown that in a third of these cases, miscalculating the safe period was to blame (WHO 2002). Natural family planning will have a high failure rate. It is therefore recommended to promote usage of oral contraceptives, IUCD, injectables and implants in our family planning programs particularly in rural areas where the majority of our women are illiterate.

6.5 RELIGIOUS INFLUENCE ON THE USE OF FAMILY PLANNING

It was observed that the different denominations all had a favorable attitude to the use of family planning. 23 (26.7 percent) catholics, 30 (34.9 percent) liberal protestants and 33 (38.4 percent) strict protestants said their church approved the use of family planning. This is a good and positive finding as the churches have a considerable influence on their following. Out of 110 married women 74 (67.3 percent) said the church approved family planning usage and out of 36 unmarried women 25 (69.4 percent) said the church approved the use of family planning. It is encouraging to note that the church seems to approve family planning use irrespective of marital status as one would have thought the church

would promote sexual abstinence in unmarried women. Although Amin et al (1997), found that levels of contraceptive use are lower in more devout communities where religion may be a barrier to contraceptive use because it may represent a collective resistance to new ideas and that more devout communities may be reluctant to accept the changes in women's roles that are connected to the use of modern contraceptives, the findings in this study show that religious influence is not a barrier to contraceptive use. This is also supported by the findings in the general population where religious prohibition as a reason for not intending to use contraceptive was found to be 1.8 percent (ZDHS 2001-2002).

6.6 INFLUENCE OF PARTNER / SPOUSE ON THE USE OF FAMILY PLANNING

The influence of the male partner on the use of contraceptives appeared to be less with advance in the woman's age. Out of 84 respondents whose partners approved the use of family planning 47 (56.0 percent) were above 25 years of age and 37 (44.0 percent) were aged 25 years and below. This may be related to the women's parity and marital status as well. The older women are most likely among the married women and also among those with a higher number of children and therefore partner opposition to contraceptive use is less because of the desire to either space or limit childbirth.

Influence of partner differed with the respondents' marital status. Out of 104, 84 (80.8 percent) said their partners approved the use of family planning. 69 (82.1 percent) of these were married women. There seemed to be less partner

opposition in married women as compared to the unmarried ones. This may mean that there is more dialogue regarding contraceptive usage among married couples. It may also be due the fact that unmarried women may be viewed as being unfaithful to their partners if they are using contraceptives. Partner opposition to family planning use in this study was found to be less than in other studies conducted elsewhere. Studies carried out in Uganda revealed that partner opposition reduces female contraceptive use by over 50 percent and causes a shift from modern to traditional methods (Wolf et al 2000). The conclusion to draw from the study findings is that, generally partners approve family planning use irrespective of marital status. This is encouraging in that males are supportive.

There was a significant association with P- value 0.028 between the number of children a woman had and whether or not they consulted their partner on contraceptive use. The more the number of children the more the women seemed to consult their partners on family planning. There was also a significant association with P-value 0.045 between the respondents' parity and partner approving family planning. Partner objection to contraceptive use seemed to decline with increasing number of children a woman had. Out of 81 respondents, the majority 70 (86.4 percent) consulted their partners on the use of family planning. Out of these 70, 49 (70.0 percent) had between one to three children. This shows that partner consultation increases with increase in the number of children. These findings may however indicate a lack of autonomy

in decision-making on family planning among these women even though they have a right as individuals to decide on their own.

It is evident from these findings that despite the government's effort to ensure that individuals have a basic right to decide freely the number and spacing of their children, most women are still not empowered enough to make their own decisions on family planning. Most women still consult their partners on the use of family planning despite their eligibility as individuals to use family planning methods without the consent of their partners (MOH 1997). The findings are also in line with studies conducted in other parts of the world that women's lack of autonomy, especially in developing countries, may impair their ability to avoid unplanned pregnancies by practicing contraception (The Allan Guttmacher Institute). In addition to the barriers that poor and other disadvantaged people face in accessing health services, generally, women lack decision-making power related to sex and reproduction (WHO 2004). Women should be educated and made aware of their individual rights in decision-making in matters relating to family planning use. They should be empowered enough to be able to decide on their own when to use contraceptives irrespective of their age, marital status, or, parity in order to either postpone or stop child bearing.

CHAPTER 7

7.0 CONCLUSION AND RECOMENDATTIONS

7.1 CONCLUSION

This study showed that the majority of women admitted with abortion are 25 years old and below, live in high-density residential areas, have poor education, are unemployed, married and most already having between one to three children.

Even though most women 109 (79.0 percent) were within 30 minutes walking distance to the source of family planning services, 70 (47.9 percent) had never used any family planning method before. There was no significant difference in the use of family planning between married and unmarried women. The main reason for not having used a family planning method before was the fear of side effects of contraceptives. Contraceptive side effects need to be discussed as they are one of the most important factors in clients' decisions about family planning. Fear of side effects is pervasive. It is often grounded in real experiences (Stash S. 1999). Misinformation and unfounded beliefs also are wide spread. Anticipation of side effects may discourage people from adopting certain family planning methods, while experiencing side effects may lead women to discontinue a method (Cotton et al 1992). Providers often avoid discussing contraceptive side effects because they think that negative information will scare clients away (Kim Y. M. et al 1998). This strategy is however, self-defeating, since women learn about side effects from their family and friends. Clients may also fear the worst if they experience side effects without warning and without understanding.

The respondents' knowledge of the safe period was poor and the majority still consulted their partners/spouses on the use of family planning. Partner opposition to contraceptive use reduced with increase in the number of children a woman had. Very few of the respondents mentioned the condom as a contraceptive method.

There is need to improve the educational status of girls and women so as to improve their socio-economic status. It has been shown that frequently low social status of girls and women result in low levels of control over their own lives, particularly their sexual and reproductive lives (WHO GENEVA 2004). Therefore there is a need to empower women economically and also intensify IEC in areas of family planning. Women's empowerment would also reduce their dependency on their partners/spouses on decision-making in matters relating to the use of family planning.

7.2 RECOMMENDATIONS

- The Ministry of Education should incorporate Fertility education in schools from as low as upper primary school level.
- The Ministry of Health together with co-operating partners should include the role of the condom as a method of contraception in all the HIV/AIDS prevention IEC messages.
- To train family planning service providers not to avoid discussing contraceptive side effects with their clients for fear of scaring them away since women learn about side effect from their family and friends.
- Reduction of abortion through the increased use of contraceptives should be made an explicit program goal rather than a by-product of contraceptive practice.
- Because of poor knowledge of the safe period, there should be more emphasis on the promotion of other family planning methods while at the same time intensifying fertility education.
- To educate the girls and women on their rights as individuals to decide on the use of family planning without having to consult their partner/spouse.
- As no contraceptive is 100 percent effective, to place more emphasis on emergency contraception.
- Reproductive Health specialists and service providers should work in collaboration with religious groups in the communities to improve further the uptake of contraceptives.

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GHANT CHART

S/NO	TASK	PERSONNEL	Feb 2004	Mar 2004	Apr 2004	May 2004	Jun 2004	Jul 2004	Aug 2004	Sept 2004	Oct 2004	Nov 2004	Mar 2005
1	Finalize Research proposal writing	Researcher	X										
2	Seek for permission from relevant authorities	Researcher		X									
3	Pre-test	Researcher				X							
4	Recruit and train research assistants	Researcher		X									
5	Print Questionnaire	Researcher		X									
6	Data Collection	Researcher & Research Assistants				X	X	X					
7	Data Analysis	Researcher & Research Assistants							X	X	X		
8	Report writing	Researcher										X	
9	Submission of Report	Researcher										X	
10	Correction of marked report	Researcher										X	
11	Submission of corrected Report	Researcher											X

BUDGET

No	ITEM	UNIT COST IN ZAMBIAN KWACHA K N	QUANTITY	TOTAL COST K N
A	**STATIONERY**			
1	Duplicating paper	38,000.00	2	76,000.00
2	Paper	24,000.00	4	96,000.00
3	Pencils	500.00	10	5,000.00
4	Rubbers	500.00	4	2,000.00
5	Pens	700.00	10	7,000.00
6	Typing /setting	Per copy 30,000.00	25 copies	750,000.00
7	Binding services	Per copy 50,000.00	5 copies	250,000.00
	SUB TOTAL			**1,186,000.00**
B	**SECRETARIAL SERVICES**			
8	Typing services	Per page 3,000.00	100 pages	300,000.00
9	Duplicating services	Per page 1,000.00	100 pages	100,000.00
10	Data Entry	700,000.00	1	700,000.00
11	Analysis	1,000,000.00	1	1,000,000.00
	SUBTOTAL			**2,100,000.00**
C	**PERSONNEL**			
12	Principal Researcher	1	30,000 x 30 days	900,000.00
	Research Assistants	2	30,000 x 2 x 30 days	1,800,000.00
	Meal Allowance			
	Daily data collection	3	10,000/day x 30 x 3	900,000.00
	SUB TOTAL			**3,600,000.00**
D 13	Application fee to REC	250,000	1	250,000.00
	SUB TOTAL			**250,000.0**
	TOTAL			**7,386,000.00**
	10% CONTIGENCY			**738,600.00**
	GRAND TOTAL			K **8,124,600.00**

QUESTIONNAIRE

TITLE: A STUDY TO DETERMINE IMPEDIMENTS TO FAMILY PLANNING USE IN WOMEN PRESENTING WITH ABORTION AT UTH.

DATE:..... CLIENT NUMBER | | | |

INTERVIEWER'S NAME:.....

1. What is your age? | | |

2. What is your marital status?

   a) Single
   b) Married
   c) Divorced
   d) Co-Habiting
   e) Widow

3. What is your educational level?

   a) Primary
   b) Secondary
   c) College
   d) University
   e) No Schooling

4. Where do you reside?

   .....

   .....

5. Are you in employment?

   a) Yes
   b) No

6. If yes to question 5, what type of employment?

   .....

7. What are your plans for the future?

   .....

RELIGIOUS INFLUENCE

8. What is your religion?

a) Christian
b) Moslem
c) None
d) Other (Specify)

.....

9. Which church do you go to?

a) Catholic
b) UCZ
c) SDA
d) Anglican
e) Other (Specify)

10. Does your church approve of use of family planning methods?

a) Yes
b) No
c) I don't know
d) Not applicable

11. How many children do you have?

a) None
b) 1 – 3
c) 4 – 6
d) 7 and above

FEAR OF SIDE EFFECTS

12. Do you know of any family planning methods?

a) Yes (go to Q13) (b) No.

13. Which family planning methods do you know?

a) Pill
b) Injectables
c) Intra-uterine device (IUD)
d) Condom

e) Natural Family planning
f) Norplant
g) Sterilization
h) Withdrawal
i) Lactational amenorrhoea
j) Other
(specify).....

14. Have you used any family planning method before?

a) Yes (Go to Q16)
b) No (Go to Q15)

15. Have you never used any family planning method because of fear of side effects?

a) Yes
b) No

16. Were you using a family planning method when you fell pregnant?

a) Yes
b) No

17. If yes to question 16, which method?

.....

18. What do you think is the reason for Method failure?

.....

ACCESSIBILITY OF FAMILY PLANNING SERVICES

19. Where did you obtain this method?

a) Health Center
b) Hospital
c) Chemist
d) Friend
e) Traditional healer
f) Other (specify).....

20. Do you know where to go for family planning services?

a) Yes
b) No

21. How far is this place from where you live?

a) Two hours walk
b) One hour walk
c) Thirty minutes walk
d) Fifteen minutes or less

22. What problems have you experienced in obtaining your family planning method?

.....

.....

.....

23. What is the attitude of your family planning service provider?

a) Friendly
b) Unfriendly
c) I don't know
d) Other (Specify)

.....

.....

INFLUENCE OF SPOUSE ON DECISION MAKING

24. Why did you not use a contraceptive method to prevent this pregnancy?

a) Wanted to conceive
b) Had no method at hand
c) I don't know
d) Other

(Specify).....

25. Does your husband/partner know that you were using a family planning method?

a) Yes
b) No
c) Not applicable

26. Does your husband/partner approve of your using a family planning method?

a) Yes
b) No
c) Not applicable

27. Did you consult your husband/partner before you decided to use a family planning method?

a) Yes
b) No
c) Not applicable

KNOWLEDGE OF EASE OF CONCEPTION

28. After a monthly period, when is a woman most likely to get pregnant if she has unprotected sexual intercourse?

a) Immediately after menses
b) At mid cycle
c) Immediately before the next menses
d) I don't know
e) Other (Specify)
.....

29. Can a woman get pregnant after having sexual intercourse only once?

a) Yes
b) No (Go to Q30)
c) I don't know

30. Approximately how many times should a woman have sexual intercourse before she gets pregnant?

.....

.....

Thank you for your co-operation.

IMPEDIMENT TO CONTRACEPTIVE USE IN WOMEN ADMITTED WITH ABORTION AT THE UNIVERSITY TEACHING HOSPITAL (UTH)

Participant information

Dear participant,

You are invited to participate in our research relating to factors contributing to the non- use of family planning. Your participation will contribute greatly to the provision of valuable information that will help reproductive health specialists and care providers in mapping out appropriate programmes to improve contraceptive use. This will in turn reduce the number of unplanned pregnancies and consequently reduce maternal complications from abortions.

A questionnaire has been prepared and we request that you answer all questions as truthfully as possible. The questions shall be translated into a local language that you understand best if you so wish.

Your participation is purely voluntary and your withdrawal from the study shall not in any way involve any penalty or loss of benefits to which you may be entitled. All information given will be treated with strict confidentiality. Your name will not appear on any of our records.

Your participation is free of any risks to you. Besides asking you few questions pertaining to this study you will have no other involvement. Please note that you have the right to refuse to answer any question if you so wish. There is no direct benefit to you. But the information provided by you will be very crucial in preventing unwanted pregnancies and abortions.

Should you have any questions regarding the research and your rights as a participant please feel free to contact the principal investigator (Doctor Matimba Chiko) on Telephone: 095 764486
Postal Address: P.O. Box 50428 Lusaka, Zambia.

CONSENT FORM:

The information pertaining to the study purpose and procedure has been clearly explained to me and I fully understand. I hereby consent to take part in the study.

Name of participant:.....

Signature / thumb print of participant: .....

Name of witness: .....

Signature of witness:.....

Date: .....Place.....

THE UNIVERSITY OF ZAMBIA
SCHOOL OF MEDICINE

Telephone: +260 1 252641
Fax: +260 1 250753

MEDICINE

DEPARTMENT OF COMMUNITY

P.O. Box 50110 Lusaka, Zambia.

Our Ref:
Your Ref:

23rd October 2003

The Managing Director
UTH Board of Management
LUSAKA

Dear Sir

Re: **DR MATIMBA M CHIKO: MPH STUDENT**

The above named is an MPH student in the department of Community Medicine, School of Medicine, UNZA. The student is undertaking a research as partial fulfillment of the above mentioned Masters degree.

The Study subject is " **Impediments to contraceptive use in women admitted with abortion at the University Teaching Hospital (UTH).**

We shall be grateful if you could access the student to information and/Participants for the study.

Yours sincerely

Dr S H Nzala

THE UNIVERSITY OF ZAMBIA

RESEARCH ETHICS COMMITTEE

Telephone: 256067
Telegrams: UNZA, LUSAKA
Telex: UNZALU ZA 44370
Fax: + 260-1-250753
E-mail: unzarec@zamtel.zm

Dean's Office
P.O. Box 50110
Lusaka, Zambia

Assurance No. FWA00000338
IRB00001131 of IOR G0000774

1 July, 2004
Ref: 001-03-04

Dr Matimba Mavis Chiko
School of Medicine
University of Zambia
LUSAKA

Dear Dr Chiko,

RE: SUBMITTED RESEARCH PROPOSAL

The following research proposal was presented to the Research Ethics Committee Meeting on 31 March, 2004 where changes were recommended. We would like to acknowledge receipt of the corrected version. The proposal has now been approved. Congratulations!

Title of proposal: **'Impediments to contraceptive use in women admitted with abortion at the University Teaching Hospital'**

Conditions:

- This approval is based strictly on your submitted proposal. Should there be need for you to modify or change the study design or methodology, you will need to seek clearance from the Research Ethics Committee.
- If you have need for further clarification please consult this office. Please note that it is mandatory that you submit a detailed progress report of your study to this committee every six months and a final copy of your report at the end of the study.

Yours sincerely

Prof. J.T. Karashani, MB, ChB, PhD
CHAIRMAN
RESEARCH ETHICS COMMITTEE

Date of approval: 1 July, 2004 Date of Expiry: 30 June, 2005
Please note that when your approval expires you may need to request for renewal. The request should be accompanied by a progress report (Progress Report Forms can be obtained from the Secretariat).

THE UNIVERSITY OF ZAMBIA
SCHOOL OF MEDICINE

INTERNAL MEMORANDUM

TO : Dr. Mavis Chiko Matimba

FROM : Assistant Dean, Postgraduate, Medicine

DATE : 2nd November 2004

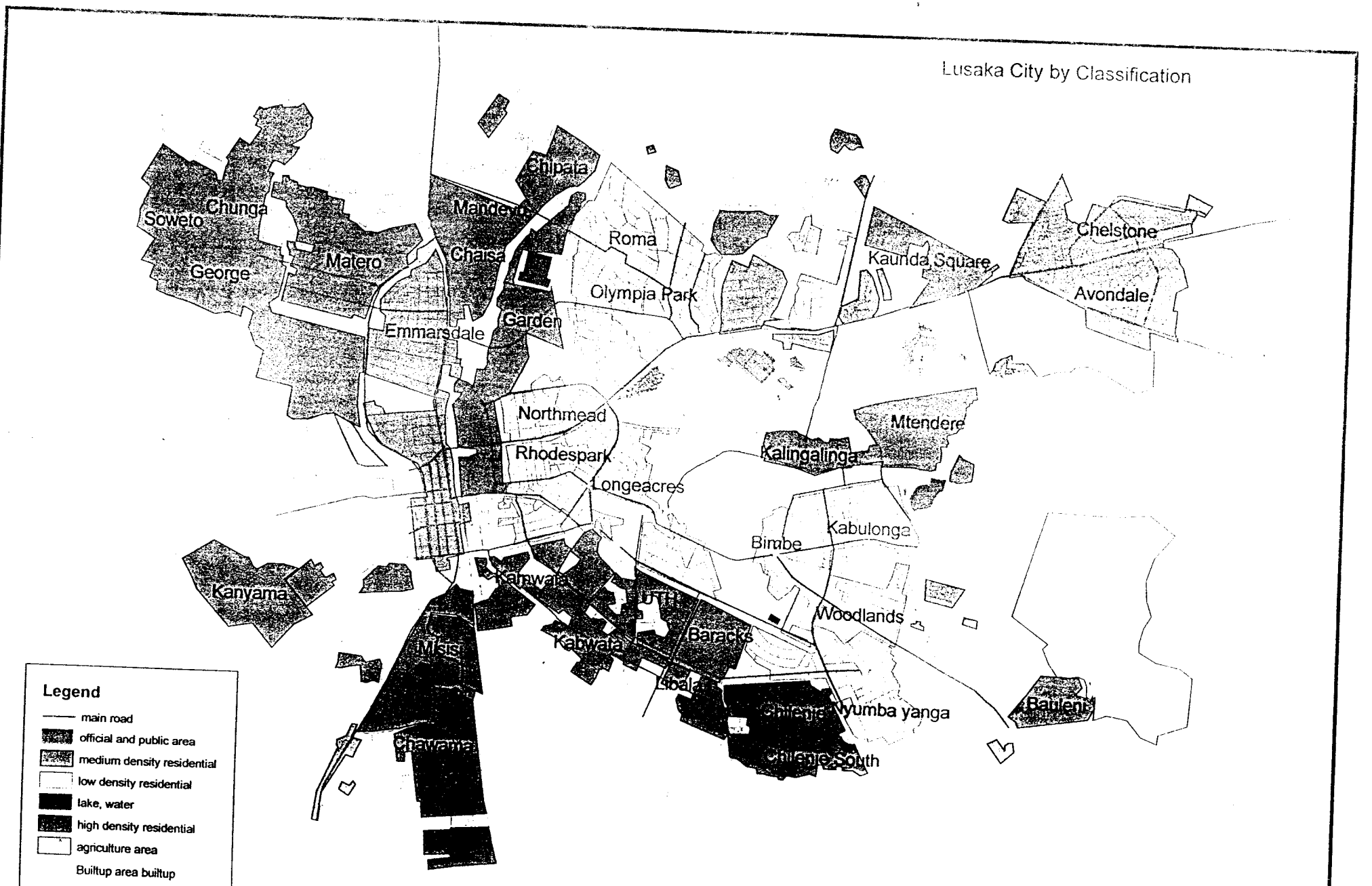
SUBJECT : **Research Proposal**

Your research proposal entitled "Impediments to contraceptive use in women admitted with abortion at the UTH" was discussed at the last Graduate Studies Committee of the School.

The proposal was approved and you may proceed with the research component of your study.

Prof. Y. Mulla
ASSISTANT DEAN, POSTGRADUATE

CC: The Director, Directorate of Research and Graduate Studies
The Head, Department of Community Medicine
File


Lusaka City by Classification
Chipata
Chunga
Soweto
Matero
George
Chaisa
Roma
Olympia Park
Kaunda Square
Chelstone
Avondale
Emmarsdale
Garden
Northmead
Rhodespark
Longeacres
Mtendere
Kalingalinga
Kabulonga
Bimbe
Kanyama
Kamwala
Woodlands
Kabwata
Baracks
Chilenje
Chawama
Chilenje South
Legend
main road
official and public area
medium density residential
low density residential
lake, water
high density residential
agriculture area
Builtup area builtup