

**STUDY TITLE: FACTORS CONTRIBUTING TO AN INCREASE IN  
ABORTION IN CHINGOLA**

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**A STUDY TO DETERMINE THE FACTORS CONTRIBUTING TO AN INCREASE IN  
ABORTIONS IN CHINGOLA**

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## **ABBREVIATIONS**

|                   |   |
|-------------------|---|
| <b>AIDS</b> ..... | <b>Acquired Immuno- Deficiency Syndrome</b> |
| <b>CSO</b> .....  | <b>Central statistical office</b>           |
| <b>HIV</b> .....  | <b>Human Immune Deficiency Virus</b>        |
| <b>KCM</b> .....  | <b>Konkola Copper Mines</b>                 |
| <b>MCH</b> .....  | <b>Maternal and Child Health</b>            |
| <b>MOH</b> .....  | <b>Ministry of Health</b>                   |
| <b>MVA</b> .....  | <b>Manual Vacuum Aspiration</b>             |
| <b>PHC</b> .....  | <b>Primary Health Care</b>                  |
| <b>UNZA</b> ..... | <b>University of Zambia</b>                 |
| <b>UTH</b> .....  | <b>University Teaching Hospital</b>         |
| <b>WHO</b> .....  | <b>World Health Organization</b>            |

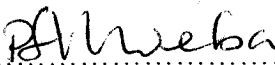
**DECLARATION**

I Georgina Chipowe, declare that the work presented in this study for the partial fulfillment of the Bachelor of Science Degree in Nursing is entirely the result of my own independent investigations. It has not been presented either wholly or partially for any other degree nor is it being currently submitted for any other degree.

Signed .....  .....

Candidate

Date ..... 14/06/11 .....


Approved .....  .....

Supervising Lecturer

Date ..... 14/06/2011 .....

**STATEMENT**

I hereby certify that this research proposal is entirely the result of my own independent investigations. The various sources of information which I used as guide are clearly indicated in the text and references.

Signed .....  .....

Candidate

Date..... 14 | 06 | 11 .....

## **DEDICATION**

This research is dedicated in memory of my late father the late Patrick Musonda, my late brother John Kennedy Musonda, my mother Mrs. Celestina Musonda, all my brothers and sisters; not forgetting their spouses and also my nieces and nephews.

## **ABSTRACT**

Abortion is the death or expulsion of the fetus either spontaneously or by induction before the 26<sup>th</sup> week of pregnancy (Fraser, Cooper and Nolte, 2005). The purpose of this study was to determine the factors that contribute to increase in the number of abortions among the reproductive age group in Chingola district.

Abortions is a major concern both globally and in the African region, Zambia inclusive as it accounts for about 13 percent of all maternal mortality rates. The sub-Saharan Africa records an increased number of unsafe abortions which are associated with multiple complications and even death.

Literature review from global, regional as well as national perspective reviewed similar factors contributing to increase in the number of abortions. The literature showed that some of these factors include stigma associated with single parenthood, unmet family planning needs, early marriages and high school drop out among the adolescents, unstable relationships and many more. It showed that most of the women faced with unwanted or unintended pregnancies resort to unsafe abortions.

To carry out the investigations a descriptive non- intervention, quantitative research design was used. A pilot study was conducted to test the effectiveness of the tool on five respondents. The main study was conducted in November, 2010 at Nchanga North General Hospital with 50 participants. These were interviewed and selected using convenience sampling.

The study findings showed that most of the abortions occurred among the adolescent. Stigma was also the highest factor among the factors contributing to increase in the number of abortions.

It has revealed that sigma is a major factor contributing to increase in the number of unsafe abortions. This is common among the adolescents as well as the older women. It is not acceptable in our Zambian culture for a single woman to become pregnant. This was also

true of all the religious groups. A single woman who falls pregnant is excommunicated and regarded as a sinful person.

Age is also an important factor in this respect. The study also reveals that there is a relationship between age and the number of abortions. This implies that the adolescents are the victims of unsafe abortions resulting from unwanted pregnancies because they become sexually active at an early age and early marriages are still common in Zambia. Teenage pregnancy is precipitated by influences of premarital sexual practices and early marriage practices which are still a social norm of the Zambian societies. Unwanted pregnancies which later lead to increase in abortions have related to gender sexual violence, rape, defilement, gender and women empowerment.

Unstable relationships between the man and the woman have also shown some relationship. This may be attributed to the fact that a lot of women could not really open up concerning their spouses as they feared embarrassment

The major recommendation made include that Ministry of Health should train more nurses and midwives in the provision of reproductive health services, family planning services, counseling as well as provision of safe abortion services.

The public should be educated and sensitized on the availability of safe abortion services and enlightened on their right to access the service.

It is also important that it is the two facilities (Nchanga North General Hospital and Chingola District Office) should ensure proper functioning youth friendly services with well equipped personnel behind them so as to help young women prevent unwanted pregnancies. Nchanga north hospital should train more health personnel in the provision of reproductive health services, family planning and safe abortion services to reduce the number of unsafe abortions.

## **CHAPTER ONE**

### **1.0 INTRODUCTION**

#### **1.1 BACKGROUND**

Zambia is a landlocked country located in Southern Africa. It covers an area of 752,612 square kilometers and shares boundaries with the Democratic Republic of Congo and Tanzania in the north, Malawi and Mozambique in the east, Zimbabwe and Botswana in the South, Namibia in the south-western and Angola in the west. The country is divided into nine provinces. Zambia depends on copper as its main export commodity. As time went on, the prices of copper went down, the health service infrastructure could not be renovated and new equipment could not be bought. This led to the country having poor health service provision which prompted the government to review its health care provision after independence.

The government recognized deterioration of health services. In 1981 the government decided to start the Primary Health Care (PHC) vision which was meant to revamp the state of the health service delivery system.

##### **1.1.1 Health services in Zambia**

During the 1980s and 1990s, the Zambian Government was faced with overwhelming challenges in the health care. These included; making services more accessible to more people, making pregnancy safe and eliminating unnecessary pregnant related deaths among women (CSO, 2002). The Zambian government implemented Primary Health Care in 1981 in order to promote equity in the delivery of health services to individuals, families and communities (CSO, 2002).

According to (CSO 2003), there are approximately 11 million people in Zambia of which 22 percent of the total population are women in the reproductive age group (15-49 years). The total of all women on modern contraceptives is 24.6 percent, while that of married women on contraceptives is 34.2 percent.

Safe motherhood services have the following components; family planning services, antenatal care services, clean and safe delivery service, essential obstetric care, primary health care and post abortal care. These services have been provided in rural areas as well as in urban areas.

They promote equity for women in the country in order to improve accessibility of reproductive health.

Zambia's fertility continues to decline though comparatively slow and Government policy on contraceptive use is direct support provided through free and easy access to contraceptives. Despite the decline in total fertility rate, fertility in Zambia remains one of the highest in sub-Saharan Africa (CSO, 2003). Therefore it is evident that this is a large group which should receive attention and hence the reason the government in conjunction with the health system tries to bring in several measures to promote the well being of women in the reproductive age group.

Through the reproductive health the wellbeing of women in the reproductive age group was addressed with safe motherhood as one of the means to improve maternal wellbeing. The health delivery system in Zambia recognizes the need to improve Reproductive Health (MOH, 1997). Ngoma (2003) reports that reproductive health addresses responsibility to enhance the wellbeing of men, women and young people as it concerns their reproductive function. In most of the Zambian health centres, the reproductive health services are integrated and offered on a daily basis as supermarket at each level of health care in the public health institutions.

Components of reproductive health include; safe motherhood, adolescent health, sexually transmitted infections and HIV/AIDS, infertility, gender violence, male involvement, abortion and other reproductive health issues such as cancer of the cervix and prostate, prevention of unwanted pregnancies, and other issues of sexual violence through the provision of services such as free family planning, youth friendly corners and many others (MOH, 2008). In youth friendly services, youths are entitled to accurate information on sexual matters and treatment of sexually transmitted infection, counseling services, access to family planning and post abortal services. The field of reproductive health has also been supported by cooperating partners such as Planned Parent hood Association of Zambia in the supply and distribution of contraceptives in the country.

Despite the efforts made by the Government to improve reproductive health by initiating safe motherhood, it is clear that the women are still dying from preventable causes such as abortion complications. Ipas (2008) reports that the number of abortions are rising in Africa and most of

them are in unsafe manner by non professional people. Unsafe abortions are a major concern for they account for about 13 percent of maternal deaths. Chingola District in Zambia has recorded increased numbers of unsafe abortions despite the efforts by the government to prevent unwanted pregnancies/unsafe abortions through provision of free modern family planning methods and provision of equitable and quality comprehensive abortion services as close to the family as possible (Nchanga North General Hospital, 2006). Therefore this research proposal will explore the factors leading to increase in abortions among the reproductive age group in Chingola district.

## **1.2 STATEMENT OF THE PROBLEM**

It is estimated that 42 million abortions are estimated to take place annually world wide with 20 out of the 42 million conducted unsafely. Maternal mortality usually results from unsafe abortions. These result in 70,000 deaths and five million disabilities per year. One of the main determinants of the availability of safe abortions is the legality of the procedure. Forty percent of the world's women are able to access therapeutic and elective abortions within gestational limits. The frequency of abortions is, however, similar whether or not access is restricted (Wikipedia, 2010).

### **1.2.1 Abortions – general perspective**

Abortion was conducted even in very old times. Various methods have been used such as herbal abortifacients, sharpened tools, physical trauma, and other traditional methods. Contemporary medicine utilizes medications and surgical procedures to induce abortion. The legality, prevalence, and cultural views on abortion vary substantially around the world. In many parts of the world there is prominent and divisive public controversy over the ethical and legal issues of abortion. Abortion and abortion-related issues feature prominently in the national politics in many nations (Wikipedia, 2010).

According to Stoppler (2010) between 10 percent and 50 percent of pregnancies end in clinically apparent miscarriage depending upon the age and health of the pregnant woman. Most miscarriages may occur in early pregnancy. In most cases, they may occur so early in the pregnancy that the woman is not even aware that she was pregnant.

The increase in abortions contributes to the already stressed health care systems in terms of manpower, resources, equipment and finances. Abortions have numerous consequences associated with them. Among them are sepsis, haemorrhage and death. Such consequences endanger the health of the women.

### **1.2.2 Abortions – specific perspective**

Abortions have been a major contributing factor to increased morbidity in women of child bearing age in Zambia (MoH, 2004). The complications were the leading cause of maternal mortality during the antenatal period in Zambia to about 58.9 percent of the total maternal deaths occurring in the country (MoH 1998).

Abortions among the reproductive age group (15-49 years) have been a problem which is widely distributed in Zambia for many years (MOH, 2007). However, despite the effects of abortions which most people are aware of, the numbers of abortions have been increasing in Chingola District; from 503 in 2003 to 589 in 2009 (Nchanga North General Hospital, 2007).

The hospital acknowledges therefore that the number of abortions has increased over the years (Nchanga North General Hospital, 2007).

Statistics from the University Teaching Hospital reveal that a total number of 4,175 in 2005 and 4,297 abortion cases in 2007 cases of abortions were admitted. Of the total number of abortion cases admitted, 2,940 were admitted as acute gynecological cases arising from incomplete abortions. In the same year, 28 deaths resulting from complications of abortions were recorded in gynecological ward (UTH facility records, 2006).

Similarly the current situation at Nchanga North General Hospital shows that in 2006 a total number of 530 patients were admitted to Gynecology ward while in 2008, 560 cases of abortions were admitted to gynecology ward (Nchanga North General Hospital, 2009). Both spontaneous and induced abortions have been reported.

Different causes may be attributed to the increasing numbers of abortions. These may include conditions related to ill health of the woman, such as severe malaria, severe anaemia or tuberculosis. Maternal conditions such as cervical incompetence and blood incompatibility may

also contribute to abortions. Other women tend to have abortions due to unplanned pregnancies in order to maintain their place in school or at work (Wikipedia, 2010).

Bankole (2006) reveals that 49.6 percent of the women abort to postpone child bearing while 41.3 percent in order not to disrupt education or job. About 3.8 percent abort in order not to have any more children, 2.9 percent as a result of unstable relationships while 3.4 percent due to maternal risks.

So far no research on abortions has been conducted in Chingola district. Therefore, this research study will explore factors contributing to abortions in the district. Research findings will be communicated to policy makers and appropriate actions implemented to address the problem.

### **1.3 FACTORS LEADING TO INCREASE IN ABORTIONS AMONG THE REPRODUCTIVE AGE GROUP**

Abortion may be influenced by several factors such as maternal diseases, stigma and women faced with unwanted pregnancies due to a vast number of reasons. These reasons may include financial instability and unstable relationships. Other factors which may lead to abortions may include poor attitude from health workers and the women's attitudes toward the use of modern family planning methods.

#### **1.3.1 Diseases**

Most abortions may result from untreated and poorly managed medical conditions hence the emphasis on good antenatal services in the health set up. These medical conditions include maternal illnesses like syphilis, HIV/AIDS, severe malaria and also chronic conditions such as Tuberculosis, diabetes mellitus and hypertension. These may lead to spontaneous abortions.

A major cause of abortion in the developing world is malaria. In areas of epidemic, adult women without a significant level of immunity against malaria usually become ill once infected with *Plasmodium falciparum*, the primary infective agent. Pregnant women living in endemic areas have greater risk of having abortion due to severe malaria when compared to the risk of pregnant women living in the non endemic area (Curtis, 2010).

### **1.3.1.1 Positive HIV Status**

Women who have tested HIV positive may consider abortion for fear of transmitting the HIV virus to the unborn child. Those with symptoms may also resort to abortion once they realize they are pregnant for fear of developing opportunistic infections as a result of weak immunity in pregnancy. In the developed and developing world, HIV types 1 and 2 (HIV-1 and HIV-2) are assumed to be common causative agents for abortion (Curtis, 2010). Both HIV-1 and HIV-2 have the same modes of transmission and are associated with similar opportunistic infections and AIDS. Women who are HIV-positive have a greater risk of spontaneous abortion because HIV damages the placenta and interferes with the normal transfer of nutrients to the fetus, which causes either abnormal development or fetal death and expulsion. HIV-1 may also cause injury or abnormalities to the fetal thymus gland, resulting in the altered production of enzymes. These enzymes create a hostile uterine environment that may disrupt the pregnancy (Curtis, 2010).

Depression of the maternal immune system encourages the ascension of opportunistic bacteria and viruses from the lower genital tract to the uterus, causing placental infection and ultimately fetal death (Curtis, 2010).

According to World Health Organization (2006) women with HIV in Africa were 1.47 times more likely to have a miscarriage than HIV-negative women. In Italy, a cohort study of 423 women from 12 cities found a 67 percent increase in risk for miscarriage among HIV-1-positive women.

### **1.3.2 Risky Life Styles**

These include habits like smoking in pregnancy severe alcoholism and emotional stress in pregnancy

Excessive consumption of alcohol and coffee along with cigarette smoking, including passive exposure to cigarette smoke may increase the risk of miscarriage (Myles, 2005).

Emotional Stress includes conditions like severe grief and severe pain. Such emotional upsets may trigger abortions in many instances as the mother does not have the time to nurture the infant through proper feeding and healthy leaving

### **1.3.3 Maternal Congenital Abnormalities**

Congenital abnormality in a mother such as cervical incompetence, congenital cervical weakness, or short cervix may predisposes the woman to spontaneous abortions, as the cervix fails to hold the pregnancy to a normal term of gestation. This may lead to recurrent habitual abortions (Frazer and Cooper, 2005).

### **1.3.4 Fetal abnormalities**

Fetal abnormality may also predispose to spontaneous abortion in that the uterus tries to reject that which is not normal (Myles, 2003) this is usually as a result of chromosomal abnormalities. In this case the mother's immune system rejects the conceptus as a foreign body due to chromosomal defects which are not similar to that of the mother.

### **1.3.5 Maternal age**

Maternal age may be another contributing factor to abortion. This is because when a woman is too young, the reproductive organs are not fully developed to support the growing fetus (Myles, 2003). Therefore the uterus may contract prematurely leading to abortion. On the other hand if a woman is over 49 years of age, she may also be predisposed to premature uterine contractions due to over distension of the uterus (Myles, 2003). This too may end in abortion.

### **1.3.6 Social-Cultural Factors**

#### **1.3.6.1 Unplanned pregnancies**

Unplanned pregnancies as a possible factor leading to abortion is multi face led. Some women may have none or limited knowledge on effective use of contraceptives and so end up conceiving even when they are on contraceptives as they do not follow the instructions as prescribed (Mesce, 2010). In this effect they may resort to abortion because they may not be ready to bear the stress of pregnancy. Other women including those who are educated have no knowledge on the emergence contraceptives and when they have unplanned sex they do not know what to do and they end up with the pregnancy which they later on terminate as they are not ready for it. This happens even in the case of rape (Mesce, 2010).

There are a lot of myths surrounding both oral and injectable contraceptives. Most women may believe that contraceptives lead to infertility. For the same reasons some women may prefer to use traditional family planning methods. These may have a high failure rate leading to unplanned pregnancy which consequently may lead to abortion.

The other aspect which may be contributing to increase in the number of abortions is culture. Traditionally it is unacceptable for parents to discuss sex matters with their children. Therefore because of misinformation women may end up with unwanted pregnancies which may lead to abortions.

However some women may be faced with situations where they become pregnant but they are in unstable relationships and so may decide to abort for fear of facing the responsibility of parenthood alone. These may seek abortion (Wikipedia, 2010). The unstable relationships may include casual relationships where the couple has no intentions of marrying or one part is already married and when these end with unplanned pregnancy they resort to abortion for fear of facing the consequences of their action. They also run away from stigma associated with pregnancy outside wedlock. Most religions and cultural norms do not accept a single woman who gets pregnant. Others once pregnant especially if they are well known in the congregation may resort to abortion for fear of being labeled at church and for fear of embarrassment.

Certain schools settings like the school of nursing students may be told to discontinue once they conceive and resume school later on and this may cause students when they conceive unintentionally to resort to abortion.

Other work places also may not grant a maternity leave to their employees but demand a resignation and so once these women conceive unintentionally they may resort to abortion in order to maintain their job, for example the civil service permits a lawful maternity leave after attaining two years in employment.

Some religious beliefs like the Catholic Church preach against the use of contraceptives. On the contrary they promote the use of natural family planning method which may not be reliable. It

has a high failure rate because it requires a lot of discipline. It may therefore result in unplanned pregnancies which may lead to abortions.

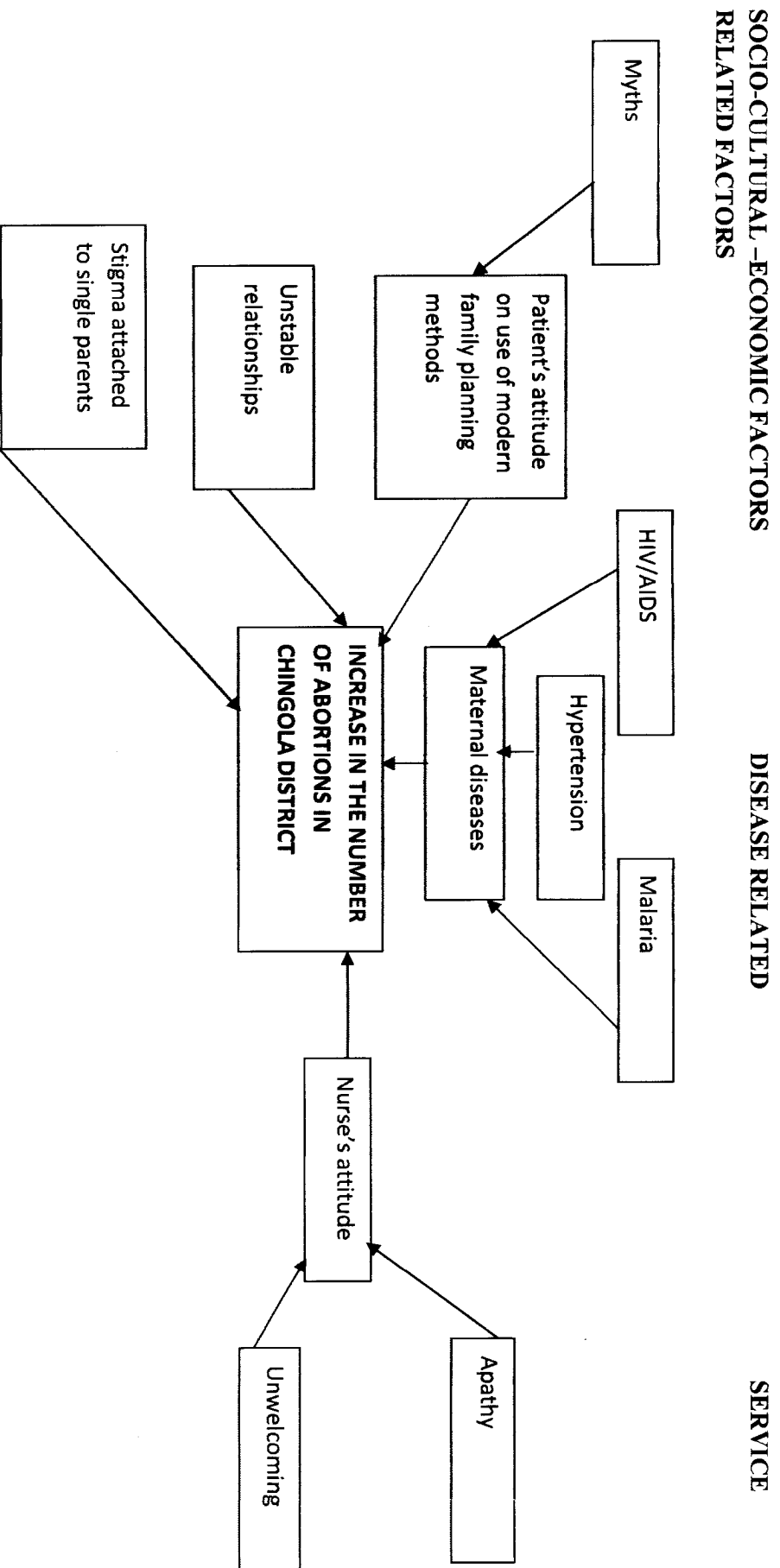
### **1.3.7 Service Related Factors**

#### **1.3.7.1 Poor attitude from health care providers**

Women complain that when they attend family planning clinics they do not receive the necessary attention and the welcome that will motivate them to continue accessing the services. They avoid attending the clinics and so may end up with unplanned pregnancy which may lead to abortion. Others are sent away and told to come at other days preferred by the health care provider and in the process of waiting they may fall pregnant (Ipas, 2010). Sometimes health facility however may have inconsistent supplies and these lead to non compliance and put the women at risk of unplanned pregnancies which they fail to keep as they are not ready.

Most of our health centres do not pay attention to the youth. The little services that are provided lack the privacy and right attitude from the providers as a result a lot of youths avoid or stop utilizing these centres and at the end of the day they are left uninformed leading to increased number of unplanned pregnancy among the youth. This may lead to increased number of abortions.

**1.3.8 DIAGRAM OF FACTORS INFLUENCING INCREASING NUMBERS OF ABORTIONS AMONG THE REPRODUCTIVE AGE GROUP**



## **1.4 Justification of the problem**

Abortions are a serious problem world wide and Zambia has not been spared form this problem despite being a Christian nation.

The studies conducted at The University Teaching Hospital have shown that abortions, both safe and unsafe are still being conducted as some women come to the gynecological ward with complications of unsafe abortions. Chingola district on the Copperbelt has also recorded a number of abortions both safe and unsafe abortions. However a number of studies have been conducted at the University Teaching Hospital (UTH) but none have been conducted in Chingola as a district concerning abortions. This study therefore will be conducted to explore the abortions taking place in Chingola. The result of the study will be used to sensitize the general public on abortions and also to make recommendations to health institutions on ways to reduce on the number of abortions as well as prevent unsafe abortions among the women of the reproductive age group in Chingola.

### **1.4.1.0 OBJECTIVES**

#### **1.4.1.1 General Objective**

The General Objective for this study is to:-

Determine the factors leading to increase in abortions among the reproductive age group in Chingola district.

#### **1.4.1.2 Specific objectives**

The specific objectives for this study are to:-

Identify maternal diseases which contribute to increased abortions in Chingola.

Establish the influence of unstable relationship on the number of abortion

Determine whether the nurses negative attitude contribute to increase in abortions

Identify the relationship between patient's attitude on use of modern family planning methods and increase in abortion.

Determine whether stigma attached to single who get pregnant contribute to increase in the number of abortions

Having stated the specific objectives and the general objective the definition of the hypothesis as well as the null hypothesis and the statement of the hypothesis and null hypothesis for this particular study will follow.

#### **1.4.2.0 Hypothesis**

- There is an association between stigma related to single women who get pregnant and the increase in abortions.

There is a relationship between maternal diseases and increase in the number of abortions

- There is a relationship between unstable or broken relationships and increase in abortions
- There is an association between nurses attitude and increase in abortion
- There is a relationship between patient's attitude on use of modern family planning methods and abortions

#### **1.4.3.0 Variables**

##### **1.4.3.1 Dependent variables**

**Abortions**

##### **1.4.3.2 Independent variable**

Treatment, intervention, or experimental activity that is manipulated or varied by the researcher to create an effect on the dependent variable (Grove and Burns, 2009).

## **The following are the independent variables in this study**

1. Unstable relationships
2. Patient's attitudes towards family planning
3. Attitude of health workers
4. Stigma associated with single women who get pregnant
5. Maternal diseases

Having stated the hypothesis the researcher will go on to define the operational definitions and conceptual definitions.

### **1.4.3.3 Conceptual definitions**

#### **Attitude**

A settled way of thinking or feeling (Pearsal, 2002)

#### **Stigma**

Stigma is a mark or sign of shame, disgrace or disapproval, of being shunned or rejected by others. Stigma can often lead to discrimination (Wikipedia, 2010).

#### **Unstable**

It means something that is alternating, borderline, changeable, or disorderly

#### **Maternal diseases**

Any departure, subjective or objective, from a state of physiological or psychological well-being (Boulvian, 1995)

### 1.4.3.5 VARIABLES AND THEIR CUT OFF POINTS

| VARIABLES   | CONCEPTUAL DEFINITION  | OPERATIONAL DEFINITIONS  | CUT-OFF POINTS                                      | QUESTIONS |
|---|--|--|---|-----------|
| 1. Patient's attitudes towards use of family planning methods | Attitude is a settled way of thinking or feeling (Pearsal, 2002) | <p>Patients able to use the modern family planning methods.</p> <p>Patient's spouse able to support use of modern contraceptives</p> <p>Religion being in favour of use of modern contraceptives</p> | <p>Yes=good</p> <p>No=bad</p>                       | 20-22     |
| 2. Nurses attitude  | Attitude is a settled way of thinking or feeling (Pearsal, 2002) | <p>Nurses very welcoming</p> <p>Nurses ensuring that contraceptives are accessed at every Visit</p> <p>Nurses able to treat client for post abortal care with love and</p>                           | <p>Yes=good</p> <p>Sometimes=fair</p> <p>No=bad</p> | 23-33     |

|  |  |  |  |       |
|--|--|--|--|-------|
|  |  | <p>sympathy</p> <p>mother is satisfied with the services provided by health workers and feels that women are well treated at the health facility</p> <p>satisfied with the services</p>  |  |       |
| Unstable relationships                     | Unstable means something that is alternating, borderline, changeable, or disorderly. | <p>Unstable relationship is when the woman not married to her partner</p> <p>The woman does not get any support from the partner (can be both financial and emotional support).</p> <p>Partner has a wife and other children at his home</p> <p>The woman and her partner are on separation.</p> | <p>Yes= unstable relationship</p> <p>No= stable relationship</p> | 9-12  |
| 3. Stigma associated with single women who | Stigma is a mark or sign of shame, disgrace or disapproval,                          | The community does not supports nor accepts single women   | <p>Yes= stigma</p> <p>No= no stigma</p>                          | 10-11 |

|                   |  |  |   |       |
|-------------------|--|--|---|-------|
| get pregnant      | of being shunned or rejected by others. Stigma can often lead to discrimination (Wikipedia, 2010). It means something that is alternating, borderline, changeable, or disorderly | who get pregnant Religion does not allow single women who get pregnant to take up church responsibility  |   |       |
| Maternal diseases | Maternal disease involves any departure, subjective or objective, from a state of physiological or psychological well-being (Boulvian, 1995                                      | Patient suffered from chronic conditions prior to pregnancy. Abortion due to any of the following; HIV, malaria, hypertension and diabetes mellitus. | Yes=high probability<br>No=low or no relationship | 35-38 |

## **CHAPTER TWO**

### **2.0 LITERATURE REVIEW**

#### **2.1 Introduction**

According to Basavanthappa (2006) literature review is an extensive exhaustive and systematic examination of publications relevant to a specific research project. It is discussed and presented from works of previous studies around the world. Literature review is important because it provides a guide and an idea on the different aspects involved in the research. The literature in this study's literature review will be looked at from different perspective including the religious view on abortions.

#### **2.2 Abortions**

Abortion is the interruption of pregnancy before 22 weeks of gestation (Ngoma, 2002). There are two main types of abortions namely spontaneous and induced abortions. Spontaneous abortion, also known as miscarriage is the expulsion of an embryo or fetus due to accidental trauma or natural causes before the 22nd week of gestation (Stoppler, 2010). The definition by gestational age varies by country. For instance, any pregnancy loss before 24 weeks of gestation is regarded as an abortion or miscarriage in the United Kingdom. Spontaneous abortions are usually referred to as miscarriage while induced abortions are referred to as abortion in the lay man's language and perspective (Wikipedia, 2010). Spontaneous abortions are said to occur naturally and may become threatened or inevitable.

Threatened abortion is when a pregnant woman experiences vaginal bleeding but with an ongoing pregnancy. It may either go to term or may become missed abortion. Missed abortion (silent) is when the fetus has died in utero before 20 weeks of gestation but has not been expelled. On the other hand, a situation where there is passage of some but not all products of conception from the uterus is called incomplete abortion while complete abortion is where all the products of conception are expelled from the uterus (Magowan et al, 2009). Inevitable abortion may be complete or incomplete.

Induced abortion however can be therapeutic or criminal. An abortion is medically referred to as therapeutic when it is performed to save the life of the pregnant woman or preserve the woman's physical or mental health among others.

Criminal abortion as the name implies is performed by unauthorized persons in unacceptable standards of operations (WHO, 2003). Induced abortions are typically characterized as either therapeutic or elective or even criminal. An abortion is referred to as elective when it is performed at the request of the woman "for reasons other than maternal health or fetal disease" (Wikipedia, 2010).

Abortion is a sensitive and contentious issue debated with religious, moral, cultural, and political dimensions. It is also a public health concern in many parts of the world. Most of the world's people live in countries where the procedure is prohibited or permitted only to save the woman's life. Yet, regardless of legal status, abortions are still conducted and nearly half of them are performed by an unskilled practitioner (Wikipedia, 2010).

Abortions performed under unsafe conditions claim the lives of tens of thousands of women around the world every year. A large number is therefore left with chronic and often irreversible health problems, and drain the resources of public health systems. Often, however, controversy overshadows the public health impact (WHO, 2005).

Worldwide, one in five pregnancies (22 %) end in abortion, and one in 10 pregnancies end in unsafe abortion. An estimated 46 million abortions are performed each year, and 19 million of them are considered unsafe because they are performed by unskilled providers and/or in unsanitary conditions (WHO, 2005). The reasons for these abortions differ from place to place.

#### Personal ambitions/ attitudes

A 1998 aggregated study, from 27 countries, on the reasons why women seek to terminate their pregnancies found several common factors as influencing the decision to have an abortion. These included the desire to delay or end childbearing, concern over the interruption of work or education and issues of financial or relationship instability among others (Wikipedia, 2009). However, most of the pregnancies that lead to abortions could

have been prevented way back with the use of modern methods of contraception. The use of modern methods of contraception may be hindered by the myths that are carried on from one cultural group to another.

There are a lot of myths in the African culture associated with the use of modern contraceptives. This has led to a number of unmet family planning needs amongst the women in the public.

In developing countries, about one in six married women faces an “unmet need” for family planning they prefer not to become pregnant but are not using any form of contraception (Mesce, 2005). In such cases women end up pregnant because they did not use any form of protection or resorted to traditional ones which have a high failure rate.

### **2.3 Unstable relationships**

Unstable relationships may contribute to the desire to have an abortion because the women in such situations fear to face the responsibility of parenthood all by themselves. Others are faced with financial instability and feel that they are not ready and well able to support and care for the child (Mesce, 2005).

### **2.4 Legal issues**

The Abortion Act 1967 allowed abortion for limited reasons in the United Kingdom (except Northern Ireland). In the United States, some States impose a 24-hour waiting period before the procedure, prescribe the distribution of information on fetal development, or require that parents be contacted if their minor daughter requests an abortion (Wikipedia, 2009). On the other hand, Zambia has one of the most liberal abortion laws in sub-Saharan Africa, yet the epidemic of illegal abortion continues. It is important to note that not only is abortion allowed to safe guard the life of the woman but also for social and economic reasons. Several factors, however, explain the limited access to legal abortion. The Abortion Act specifies that abortion must be performed in a hospital and that three physicians, including a specialist, must sign the consent form. These conditions render hospital abortion services inaccessible to the majority of women who live far from them.

It is possible to obtain an abortion in the hospital but only about 1000 is conducted annually, when a conservative estimate would argue that a service should be providing 3000 terminations annually (Sims, 2010)

Despite Zambia having the most liberal abortion laws in sub-Saharan region, an unknown number of women each year resort to illegal abortions, many of which are performed under unsanitary and unsafe conditions. The death toll from these procedures is likely to be high, and almost all such deaths could be avoided if access to safe abortion was improved and unintended pregnancies were prevented. However few women who need an abortion can meet requirements that it be performed by a physician, in a hospital and with the consent of three registered medical practitioners, one of whom must be a specialist with expertise relating to the case.

The fact that there are fewer than two physicians for every 10,000 people in Zambia forms one of the obstacles that women face when seeking a legal abortion. The cost of the procedure and the strong social and religious sanctions against abortion may also prevent women who cannot overcome the considerable logistical, financial or social obstacles to obtaining a legal procedure may resort to illegal abortion, risking their well-being and seven years' imprisonment (Sims, 2010). Abortion in Zambia is legal on social and medical grounds under the 1972 Termination of Pregnancy Act. However, the high number of hospital admissions due to abortion complications and the many school drop-outs attributed to pregnancy suggested that unwanted pregnancies and illegally-induced abortions might be an issue of concern in the nations.

A safely-induced, legal abortion does not carry much risk for a woman's health compared to illegal and unsafe abortions. Unsafe abortions may lead to complications such as severe hemorrhage, sepsis, chronic pelvic inflammatory diseases and death.

## **2.5 Religion**

The debate concerning abortion laws usually takes two sides. In the United States those in favor of legal restriction or even complete prohibition of abortion describe themselves as pro-life while those against legal restrictions are called pro-choice. The former argues that a

fetus is a human being with a right to live while the latter argues that a woman has a choice and reproductive rights whether to carry a pregnancy to term or not. Pro-life activists represent one extreme of opinion. They believe life begins at the instant of conception.

On the other hand Pro-choice activists represent the other extreme of opinion. They believe that abortion does not differ fundamentally from other forms of birth control, and they strongly support the right of a woman to make her own choice about abortion, free of any legal constraints. They point out that legalized abortion does not force anyone to have an abortion against her will, and they say that laws against abortion amount to forcing a religious doctrine onto people of other faiths (Wikipedia, 2009). However, it is argued that the pro-choice position ignores the fact that many widely accepted laws are the result of moral concerns and that there is a long history of moral opposition to abortion and legal regulation of its practice.

Further, The Muslims have their own views concerning abortion. Muslim theologians supported contraception as long as both partners consent. Most scholars agreed that abortions were allowed if pregnancies ended before ensoulment of the fetus. Ensoulment was said to occur between 40, 90 or 120 days after conception, depending on the school of thought. Usually, a justifiable reason is needed for terminating a pregnancy, for instance to protect a breastfeeding child, or socio-economic concerns or health reasons (Wikipedia, 2010)

Christians in general, the Roman Catholic in particular have a different perspective. They argue that abortion at every stage is not permissible. The belief that life begins at conception apparently has its origins in an 1869 decree by Pope Pius IX which states that abortion at any point in pregnancy was cause for excommunication (Wikipedia, 2010). Pope Sixtus V (1585–90) is noted as the first Pope to declare that abortion is homicide regardless of the stage of pregnancy (Wikipedia, 2010). Other churches, including Roman Catholic and Southern Baptist, oppose all abortions and favor making abortion illegal (Dumbleday, 1990).

Many churches in the world including have adopted the same view of the Pope and preach the same to their members as part of the church doctrine. They do not approve of abortion as

a means of birth control but they support the right of a woman to obtain legal abortion if she deems that is the best choice in her circumstances.

## **2.6 Stigma**

Women's reasons for terminating a pregnancy vary widely, but small-scale studies of patients seeking post abortion care reveal certain patterns. Adolescent's primary motivations include feeling ashamed because of the stigma attached to early motherhood and wanting to continue with school. Other reasons for all ages may include wanting to avoid being expelled from school, and void revealing a secret relationship.

## **2.7 Attitude of health workers on abortion**

Ministry of Health guidelines stipulate that health workers treat women who have undergone induced abortion in a sensitive and human manner and inform women about the possibility of legal abortion. Some health care providers are uncomfortable with the issue of abortion or hold judgmental attitudes toward abortion patients. Interviews with providers revealed that those with negative and discriminatory attitudes about women trying to terminate their pregnancies gave those women lower quality care. Providers' negative attitudes toward abortion and other types of sexual and reproductive health care may affect women in the reproductive age group wishing to access abortion services.

Yet a recent study found that many health care providers (including doctors) were not aware of the requirements for legal abortion. When the law was explained, many thought that requiring three doctors' consent was unacceptable because of the shortage of doctors in most parts of the country; some expressed interest in being trained to provide legal abortions (Masce, 2010)

## **2.8 Diseases**

Abortions may result from untreated or poorly managed medical conditions. Therefore there may be need to emphasize the importance of good antenatal services in the health set up. These medical conditions may include maternal illnesses like syphilis, HIV/AIDS, severe malaria and also chronic conditions such as Tuberculosis, diabetes mellitus and hypertension.

Literature reveals that the major cause of abortion in the developing world is malaria. In areas of epidemic, adult women without a significant level of immunity against malaria usually become ill once infected with *Plasmodium falciparum*, the primary infective agent. Pregnant women living in endemic areas have greater risk of having abortion due to severe malaria when compared to the risk of pregnant women living in the non endemic area (Curtis, 2010).

## **2.9 Attitude of women towards the use of modern family planning methods**

There are a lot of myths in the African culture associated with the use of modern contraceptives. This has led to a number of unmet family planning needs amongst the women in the public.

In developing countries, about one in six married women faces an “unmet need” for family planning; they prefer not to become pregnant but are not using any form of contraception (Mesce, 2005). This leads to most women ending up with unplanned conception.

Abortion may be said to be what most women resort to when they are faced with unintended pregnancies. Some of the native methods that they use include;- Swallowing large doses of drugs, such as antimalarials or oral contraceptives, Inserting a sharp object into the uterus, drinking or flushing the vagina with caustic liquids such as bleach (Sims 2010). Contraceptive use is also an issue of concern as some conceive whilst on contraceptive due to incorrect or inconsistent use. However some nations such as China have policies such as one child policy in order to control population in their nation and these lead to abortions.

This chapter gives an impression that abortion is a major concern in all parts of the world. It affects women of all age groups in the reproductive age group. The reasons for abortions are almost similar in every part of the world except for a few minor differences. Different nations have had hot debates concerning the legalization of abortions. As a result each nation has some legal guide on the performance of abortions in order to safe guard the woman’s life as well as that of her baby. However a lot of measures have been put in place to try helping the women prevent pregnancy in the first place through provision of contraceptives and reproductive health care needs. Despite the efforts however the number

of abortions seems to be increasing and this becomes a serious concern even in our *Zambian* set up. Despite the abortion act passed in 1972 in Zambia which renders abortion legal under certain criterion most women both the literate and illiterate seek abortion services outside the hospitals by unskilled personnel for several reasons and end up with major complications

There has never been a study conducted on abortions in Chingola district and hence the reason I have decided to conduct a research on abortion there for Chingola too is not spare from the problems brought about as a result of unsafe abortions.

## **CHAPTER THREE**

### **3.0 METHODOLOGY**

#### **3.1 Introduction**

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 discusses the design that was employed. The study population was identified and sample selection done. The first step in research methodology is to come up with a research design.

#### **3.2 Research design**

According to Basavanthappa (2007) a research design involves the formulation of a plan, structure and strategy of investigations for obtaining answers to the research question. It has basically two purposes; the first one is to provide answers to research questions and to control variations. In this study, a descriptive, cross sectional design will be used. A descriptive study involves systematic collection and presentation of data to give a clear picture of a situation under study. Cross sectional design aims at quantifying the distribution of certain variables in a study population at a special point of time (Basavanthappa, 2007).

On the other hand, according to Basavanthappa (2007), quantitative research is a formal, objective and systematic process to describe, test relationships, and examine cause and effect interaction among variables. It is based on the measurement of quantity or amount and it is applicable to phenomenon that can be exposed in terms of quantity.

This descriptive study described the factors which may influence abortions in Chingola while the quantitative design facilitated quantifying and objective measurement of subject's responses. The cross sectional design was used because data from subjects was collected at one point in time with no need to go back to the same subjects or study setting to get the same data.

In this study therefore one had to describe how the different variables contribute to abortions in Chingola.

### **3.3 Research setting**

Research setting is a place or area where the research study will be conducted (Basavanthappa, 2007). This study was conducted at Nchanga North General Hospital in Chingola. It is situated near Konkola Copper Mines (KCM) and has a bed capacity of 500. It receives referrals from nine clinics in Chingola urban and two clinics in Chililabombwe. It also receives referrals from a number of clinics along Solwezi road such as Kalilo rural health centre.

This district was chosen because during the time of working in that hospital the number of abortion cases appeared to be on the increase despite availability of family planning and reproductive health services.

### **3.4 Study population**

The study population is the total group of people or things meeting the designated interest to the researcher (Basavanthappa, 2007). The study population includes the target population and the accessible population. The target population is the entire population in which the researcher is interested and to which the study result will be generalized.

In this study the target population consisted of all women in the reproductive age group. The study population comprises patients admitted with incomplete abortion in Nchanga North General Hospital's gynecological ward.

### **3.5 Sample selection**

Sample selection is the process of selecting a portion of the designated population to represent the entire population (Uys and Basson, 2000). Participants were selected using convenience sampling technique which is a method in which study units available at the time of data collection are selected in the sample. Convenience sampling was appropriate for the present study because of the limited number of patients admitted with a diagnosis of abortion. Therefore in order to meet the required number for the sample which was in this case the sample size every patient admitted with this diagnosis was be included in the sample.

### **3.6 Sample size**

Sample size is a small part of the population selected in such a way that the individuals in the sample represent as near as possible the characteristics of the population (Dempsey and Dempsey, 2001). In this study, a sample size of 50 respondents was chosen. This was convenient looking at the limited time that was available and also taking into consideration the flow of patients. All the women with history of abortion in the gynecological ward were interviewed.

A sampling method may either use an inclusion or exclusion criteria.

- I. Inclusion sampling criteria- are those characteristics that a subject or element must possess in order to be part of the target population (Burns and Grove, 2009). In this study, the subject must have had an abortion and belong to the reproductive age group.
- II. Exclusion sampling criteria- are those characteristics that can cause a person to be excluded from the target population (Burns and Grove, 2009). In this study, the exclusion sampling criteria were the women outside the reproductive age group and those with no history of abortion.

### **3.7 Operational definitions**

#### **Patient's attitudes towards use of family planning methods**

Patient's able to use the modern family planning methods.

Patient's spouse able to support use of modern contraceptives

Religion being in favour of use of modern contraceptives

#### **Nurse's attitude**

Nurses very welcoming

Nurses ensuring that contraceptives are accessed at every Visit

Nurses able to treat client for post abortal care with love and sympathy

When mother is satisfied with the services provided by health workers and feels that women are well treated at the health facility

### **Unstable relationships**

Unstable relationship is when the woman is not married to her partner

The woman does not get any support from the partner (can be both financial and emotional support).

Partner has a wife and other children at his home

The woman and her partner are on separation.

### **Maternal diseases**

Patient suffered from chronic conditions prior to pregnancy

Abortion due to any of the following; HIV, malaria, hypertension and diabetes mellitus.

### **Stigma associated with single women who get pregnant.**

The community does not supports nor accept single women who get pregnant

Religion does not allow single women who get pregnant to take up church responsibility

## **3.8 Data Collection Tool**

Data collection is one of the most exciting parts of research. According to Burns and Grove (2009), data collection is the process of selecting subjects and gathering data from these subjects. The actual steps of collecting the data are specific to the study design and measurement method. To successfully collect data collection tools are used.

A data collection tool is a device used to collect data (Polit and Hungler, 1999). In this study, data were collected by the investigator using a structured interview schedule. A structured interview schedule is an approach to collecting information from participants, either through self-report or observation, in which the researcher determines response categories in advance (Polit and Beck, 2006). This was the tool used as it was appropriate

for this study because it is applicable to both the literate and illiterate care takers in the district. According to Basavanhappa (2007), the advantages of using this tool include that data from one interview to the next one are easily comparable, recording and coding data does not pose a problem and attention is not diverted to extraneous, irrelevant and time consuming conversation. The disadvantages include that the research assistance may not fully understand the need for consistency in the interviews and definitely the researcher and the assistant can not be able to use the same tone or gestures as they are different individuals thus chances for some biasness.

### **3.9 Validity**

Validity refers to the ability of data gathering instrument to measure what it is intended to measure (Dempsey and Dempsey, 2001).

There was need to measure the validity and reliability of the data collection tools employed which was the interview in this case to ensure true results. There are different types of validity to consider when gathering data.

Internal validity is the extent to which the effects detected in the area are a true reflection of reality rather than the result of extraneous variables (Burns and Grove, 2005). It is achieved through preparing the same questions to be asked to every participant. Content validity was ensured by covering all the variables under study in the interview schedule. To ensure face validity a pilot study was conducted. This tested the interview schedule.

### **3.10 Reliability**

According to Basavanhappa, (2006) reliability refers to the stability of a measuring instrument over a period of time. This implies that the instrument used should be able to bring out accurate information even when it is used after some time. It is used to standardize the instrument. Reliability of the study was ensured by testing research tools before the main study through a pilot study, which was undertaken in an environment with similar characteristics to those in the study.

### **3.11 Data Collection Technique**

Data collection technique is a process used to gather information to be used in addressing the problem under study (Polit and Beck, 2006). It consists of systematically collecting information from respondents to address the objectives of the study. Data were collected through face-to-face or one- to- one interview, which was an interaction between the interviewer and the informant. Data collection was done in the care takers' home and under five clinic sessions. The interview involved the researcher explaining to the respondent the research project, the purpose, what kind of questions would be asked, assurance of confidentiality and consent was asked for and signed. Each interview lasted between 30 to 45 minutes. At the end of the interview, the researcher thanked the informants for their corporation during the interview.

### **3.12 Pilot study**

A pilot study refers to a smaller version of a proposed study conducted to develop or refine the methodology, such as the instrument or data collection technique (Burns and Groves, 2005). The primary objective of the pilot study is to test as many elements of the research proposal as possible in order to correct any part that would not work properly. It is also meant to test validity and reliability of the instrument in order to detect and solve any detected problem. The pilot study was conducted at Kitwe Central Hospital. A sample of 5 clients in the gynecological ward was chosen as pilot study. The interviews were carried out on five (5) conveniently selected respondents (10% of 50 actual respondents) from Nchanga North Hospital. These were under women with history of abortion in the reproductive age group. The reason for using the non-probability convenient sampling is because it was difficult to get an adequate number of clients without using this method. No major modifications were made to the research instrument except the adjustment of a few questions in the way they were phrased. This was done to make them easier for clients to understand what the interviewer is putting across.

### **3.13 Ethical and cultural considerations**

Ethics are a system of moral values that is concerned with the degree to which research procedures adhere to professional, legal and social obligations to the study participants. Permission was sought from supervisor to get ethical clearance. Once granted permission was also sought from each participants by means of verbal consent. The completed interview schedule was also kept under strict security to avoid unauthorized access to the information gathered. To ensure anonymity and confidentiality during the interview codes were used instead of names and each respondent was interviewed separately from others in a private room. Participants were informed of their right to withdraw from the study without any prejudices

## **CHAPTER FOUR**

### **4.0 DATA ANALYSIS AND PRESENTATION OF FINDINGS**

#### **4.1 Data Analysis**

According to Basavanthappa 2009, data analysis is the process of categorizing, scrutinizing, synthesis of research data and the testing of research hypothesis using those data. The purpose of this study was to determine the factors that influence an increase in abortions among women in Chingola District. Before the analysis of data, the questionnaires were checked for accuracy, completeness, uniformity and consistency. Then data was entered on data master sheet and it was analyzed manually using a calculator..

#### **4.2 Presentation of Findings**

Presentation of findings was according to the sequence in the questionnaire; starting with section A; demographic, section B; Social cultural factors, Section C; attitude of women on the use of modern family planning methods, Section D; attitude of Nurses and Section E; Diseases. Data was presented in frequency tables which summarized the results of the findings of the research study. Cross tabulation of variables helped to show clearly the relation between the variables and made it possible to draw meaningful inferences from the study.

## Section A : Demographic Characteristics of respondents

**Table 4.1 Age of the respondents**

| Age category | Frequency | Percentage |
|--------------|-----------|------------|
| 15-24        | 23        | 46         |
| 25-34        | 19        | 38         |
| 35-44        | 7         | 14         |
| 45-49        | 1         | 2          |
| Total        | 50        | 100        |

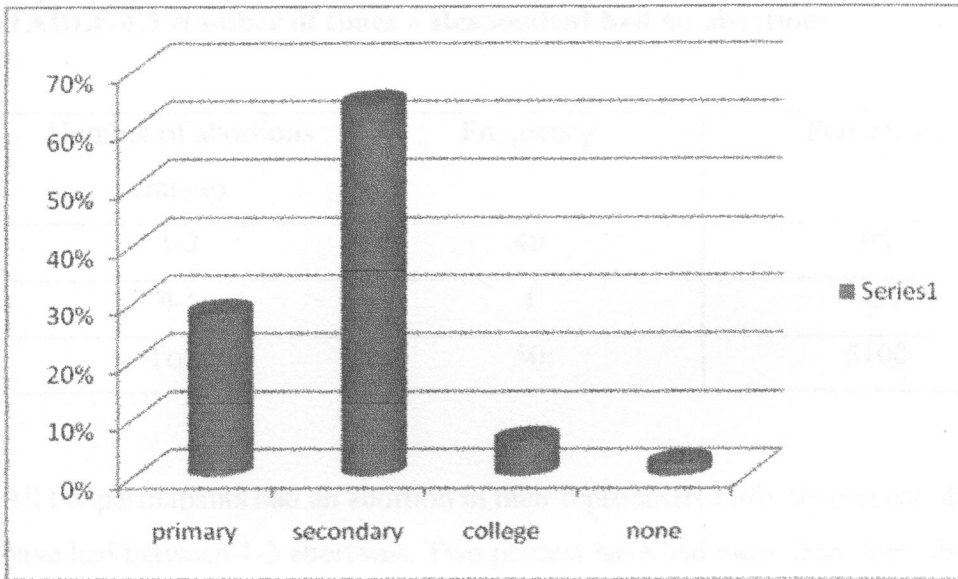
Most of the respondents were aged between 15-24 years (46%), followed by 25-34 (38%) while the least ranged from 45-49 years (2%).

**Table 4.2 Respondent's marital status**

| Marital status | Frequency | Percent |
|----------------|-----------|---------|
| Single         | 15        | 30      |
| Married        | 32        | 64      |
| Divorced       | 3         | 6       |
| Total          | 50        | 100     |

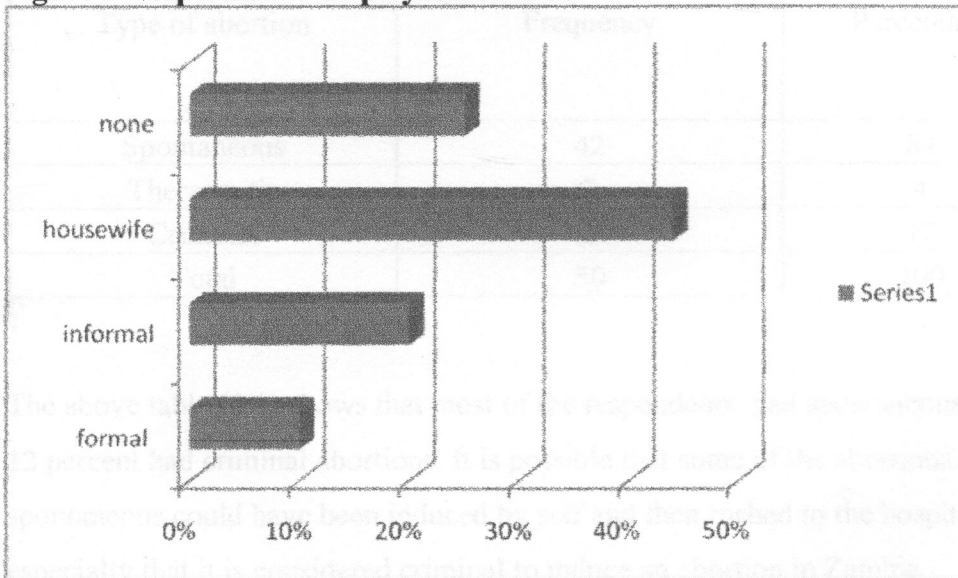
Table 4.2 Most of the respondents were married (64%) while 30 percent were singles. The minority (6%) were in the divorced category.

**Figure 1 Respondent's level of education**



Most of the respondents (64%) interviewed attained secondary level of education while a good number (28%) primary level of education. Only six percent attained college level and two percent had not been to school respectively.

**Figure 2 Respondent's employment status**



Majority of the respondents were housewives (44%) and the minority were in formal employment. Twenty five percent were not employed.

**TABLE 4.3 Number of times a Respondent had an abortions**

| Number of abortions<br>(range) | Frequency | Percentage |
|--------------------------------|-----------|------------|
| 1-3                            | 49        | 98         |
| 4-6                            | 1         | 2          |
| Total                          | 50        | 5100       |

All the participants had an abortion in their reproductive life. 98 percent of the respondents have had between 1-3 abortions. Two percent have had more than three abortions.

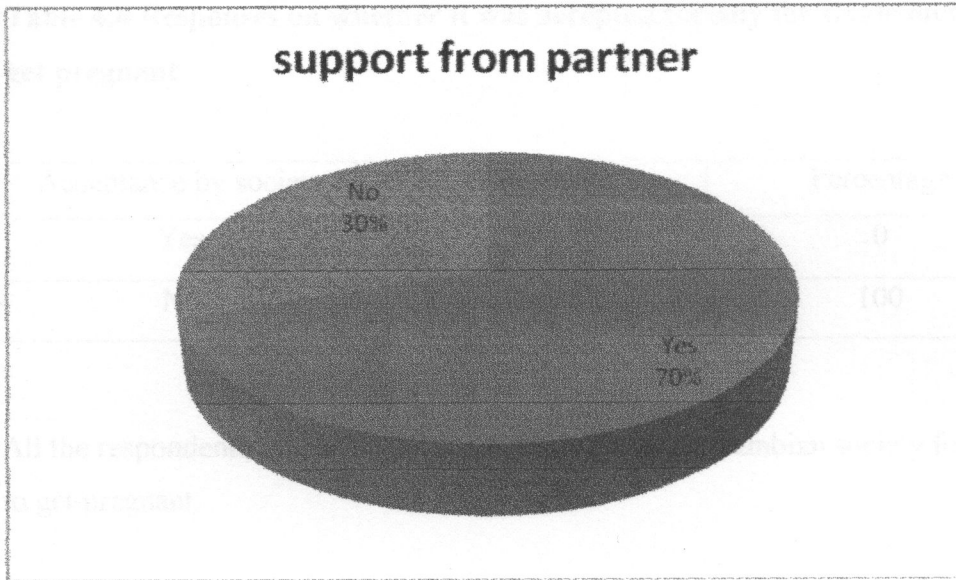
**Table 4.4 Type of Abortion experienced by the Respondent**

| Type of abortion | Frequency | Percentage |
|------------------|-----------|------------|
| Spontaneous      | 42        | 84         |
| Therapeutic      | 2         | 4          |
| Criminal         | 6         | 12         |
| Total            | 50        | 100        |

The above table (4.6) shows that most of the respondents had spontaneous abortions (84%). 12 percent had criminal abortions. It is possible that some of the abortions recorded as spontaneous could have been induced by self and then rushed to the hospital. This is especially that it is considered criminal to induce an abortion in Zambia.

## Section B: Social cultural factors

Figure 3



Majority of the respondents received support from their partner (70%) during their relationship. However the percentage could be higher as most of the women fear to disclose for fear of embarrassing their partner.

Table 4.5 Respondent's with a partner married elsewhere

| Respondent's partner married elsewhere | Frequency | Percentage |
|--|-----------|------------|
| Yes                                    | 14        | 28         |
| No                                     | 36        | 72         |
| Total                                  | 50        | 100        |

Most of the respondents (72%) had partners who were not married somewhere else while 28 percent had partners who were married somewhere else.

## **STIGMA ASSOCIATED WITH SINGLE WOMEN WHO GET PREGNANT**

**Table 4.6 Responses on whether it was accepted socially for single mothers to get pregnant**

| Acceptance by society | Frequency | Percentage |
|-----------------------|-----------|------------|
| Yes                   | 0         | 0          |
| No                    | 50        | 100        |

All the respondents said that it was unacceptable in the Zambian society for a single mother to get pregnant.

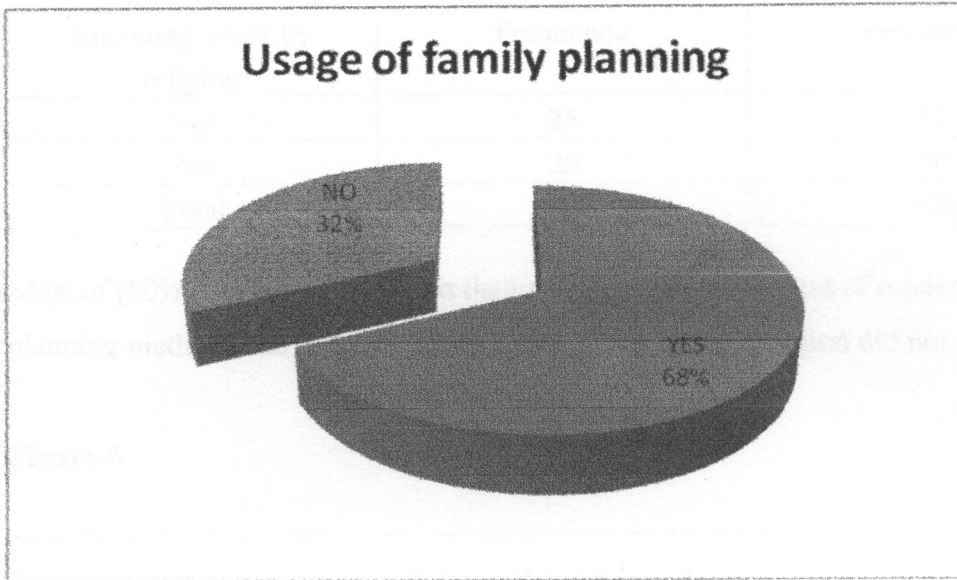
**Table 4.7 Responses on whether it was acceptable within Christian religion for a Single Mother to get pregnant**

| Acceptance of single mothers by religion | frequency | Percentage |
|--|-----------|------------|
| Yes                                      | 0         | 0          |
| No                                       | 50        | 100        |

All respondents said that it was unacceptable within the Christian religion for a single mother to get pregnant.

## Section C: Attitude of women towards use of modern family planning methods

Figure 4



Most of the respondents had used modern family planning methods before while 32 percent had not used any modern family planning methods.

Table 4.8 responses on whether the respondent's partner was in favor of family Planning

| Favor of family planning use by partner | Frequency | Percentage |
|---|-----------|------------|
| Yes                                     | 34        | 68         |
| No                                      | 16        | 32         |
| Total                                   | 50        | 100        |

Majority (68%) percent of the respondents had partners who favored use of modern family planning methods while (32%) percent had partners who were not in favour of the use of modern family planning methods.

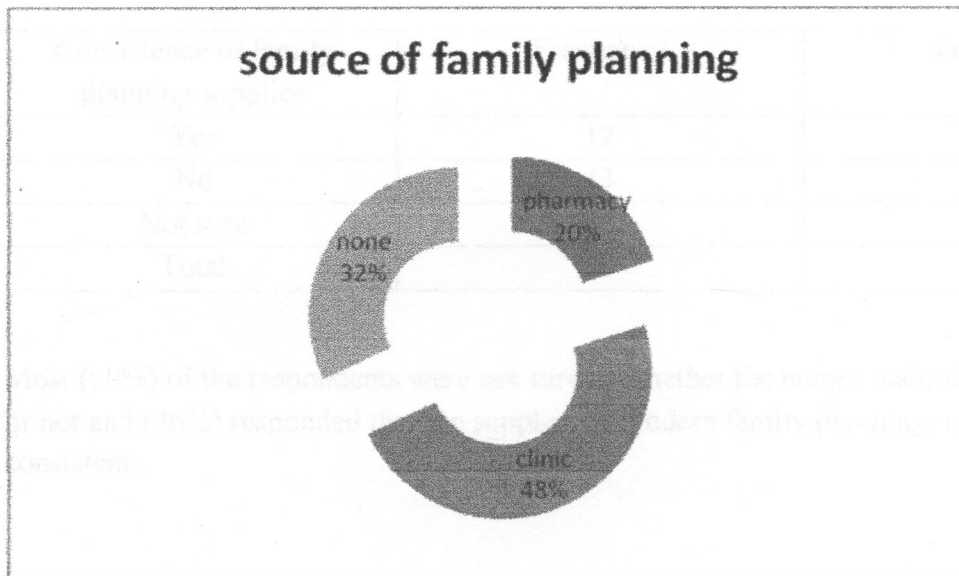
**Table 4.9 Favour of Use of Modern Family Planning Methods by Religion**

| Encouragement by religion | Frequency | Percentage |
|---------------------------|-----------|------------|
| Yes                       | 25        | 50         |
| No                        | 25        | 50         |
| Total                     | 50        | 100        |

Most of (50%) of the responds that their religion encouraged use of modern family planning methods and another (50%) responded that their religion did not.

**Figure 5**

Table 4.11 Consistency of Family Planning Supplies



Most of the respondents (48%) obtained their supplies of modern family planning from the clinic while (20%) bought from the pharmacy and (32%) neither obtained them from the pharmacy or the clinic.

**Table 4.10 Attitude of Nurses**

| Welcome of nurses | Frequency | Percentage |
|-------------------|-----------|------------|
| Good              | 26        | 52         |
| Not certain       | 24        | 48         |
| Total             | 50        | 100        |

Most (52%) of the respondents revealed that the nurses at the clinic had good attitude towards clients while (48%) indicated that they were not sure of what so say.

**Table 4.11 Consistence of Family Planning Supplies**

| Consistence of family planning supplies | Frequency | Percentage |
|---|-----------|------------|
| Yes                                     | 12        | 24         |
| No                                      | 13        | 26         |
| Not sure                                | 25        | 50         |
| Total                                   | 50        | 100        |

Most (50%) of the respondents were not sure of whether the nurses maintained the supplies or not and (26%) responded that the supplies of modern family planning methods were not consistent.

**Table 4.12 Responses on whether respondents were satisfaction with the services**

| Satisfaction of respondents | Frequency | Percentage |
|-----------------------------|-----------|------------|
| Yes                         | 26        | 52         |
| Not sure                    | 24        | 48         |
| Total                       | 50        | 100        |

Most (52%) of respondents were satisfied with the services provided at MCH while 24 percent were not sure.

## CROSS TABULATIONS

**Table 4.13 Relationship between Age of the respondents and Number of Abortions**

| Number of the respondents who aborted | Age      |          |         |         | Total    |
|---------------------------------------|----------|----------|---------|---------|----------|
|                                       | 15-24    | 25-34    | 35-44   | 45-49   |          |
| 1-3                                   | 23(100%) | 18(95%)  | 7(100%) | 1(100%) | 49(98%)  |
| 4-6                                   | 0        | 1(5%)    | 0       | 0       | 1(2%)    |
| TOTAL                                 | 23(100%) | 19(100%) | 7(100%) | 1(100%) | 50(100%) |

Most of the respondents (100%) aged between 15-24 years had aborted 1-3 times while those aged between 25-34 years had aborted 4-6 times.

**Table 4.14 Number of Abortions of Respondents in Relation to Marital Status of Respondents**

| Number of abortions of respondent | Marital Status |          |          | Total    |
|-----------------------------------|----------------|----------|----------|----------|
|                                   | Single         | Married  | Divorced |          |
| 1-3                               | 15(100%)       | 31(97%)  | 3(100%)  | 49(98%)  |
| 4-6                               | 0              | 1(3%)    | 0        | 1(2%)    |
| Total                             | 15(100%)       | 32(100%) | 3(100%)  | 50(100%) |

All (100%) of the single respondents had had between 1-3 abortions and 3% of the married respondents had had 4-6 abortions.

**Table 4.15 Number of Abortions of Respondent in Relation to Education of Respondent**

| Number of abortions of respondent | Education of respondent |           |                    |         | Total    |
|-----------------------------------|-------------------------|-----------|--------------------|---------|----------|
|                                   | Primary                 | Secondary | College/University | None    |          |
| 1-3                               | 13(93%)                 | 32(100%)  | 3(100%)            | 1(100%) | 49(98%)  |
| 4-6                               | 1(7%)                   | 0         | 0                  | 0       | 1(2%)    |
| Total                             | 14(100%)                | 32(100%)  | 3(100%)            | 1(100%) | 50(100%) |

Most of the respondents (100%) had attained secondary school education and had aborted 1-3 times. 75% who had attained primary level of education had about 4-6 times.

**Table 4.16 Relationship Between Number of Abortions and Employment of Respondent**

| Number of abortions of respondent | Employment of status |          |           |          | Total    |
|-----------------------------------|----------------------|----------|-----------|----------|----------|
|                                   | Formal               | Informal | housewife | None     |          |
| 1-3                               | 5(100%)              | 10(100%) | 21(95%)   | 13(100%) | 49(98%)  |
| 4-6                               | 0                    | 0        | 1(5%)     | 0        | 1(2%)    |
| Total                             | 5(100%)              | 10(100%) | 22(100%)  | 13(100%) | 50(100%) |

All the respondents (100%) who had no formal employment had aborted between 1-3 times and 5% Housewives had aborted between 4-6 times.

**Table 4.17 Number of Abortions in Relation to Support from Partner during the relationship**

| Number of abortions of respondent | No support from partner |          | Total    |
|-----------------------------------|-------------------------|----------|----------|
|                                   | Yes                     | No       |          |
| 1-3                               | 15(100%)                | 34(97%)  | 49(98%)  |
| 4-6                               | 0                       | 1(3%)    | 1(2%)    |
| Total                             | 15(100%)                | 35(100%) | 50(100%) |

All (100%) the abortions occurred in respondents without partner support.

**Table 4.18 Relationship Between Number of Abortions and Acceptance of Single Mother by Society (stigma)**

| Number of abortions | acceptance of single mother by society |          | Total    |
|---------------------|--|----------|----------|
|                     | Yes                                    | No       |          |
| 1-3                 | 0                                      | 49(98%)  | 49(98%)  |
| 4-6                 | 0                                      | 1(2%)    | 1(2%)    |
| Total               | 0                                      | 50(100%) | 50(100%) |

The above table (4.23) shows that all the participants responded that it was not acceptable for a single woman to get pregnant in the Zambian society. This means that the fact that society did not favor single women to get pregnant could be a contributing factor to the increase in the number of abortions especially among the single women.

Therefore there is a relationship between number of abortions and acceptance of single women who get pregnant by society (stigma).

**Table 4.19 Relationship Between Number of Abortions and Acceptance of Single Mother by Religion (stigma)**

| Number of abortions | Acceptance of single mothers by religion |          | Total    |
|---------------------|--|----------|----------|
|                     | Yes                                      | No       |          |
| 1-3                 | 0  | 49(98%)  | 49(98%)  |
| 4-9                 | 0  | 1(2%)    | 1(2%)    |
| Total               | 0  | 50(100%) | 50(100%) |

Majority (98%) of respondents said that it was not acceptable for a single woman to get pregnant in the Zambian society.

**Table 4.20 Number of Abortions of Respondent in Relation to Usage of Modern Family Planning Methods**

| Number of abortions of respondents | Usage of family planning |          | Total    |
|------------------------------------|--------------------------|----------|----------|
|                                    | Yes                      | No       |          |
| 1-3                                | 33(97%)                  | 16(100%) | 49(98%)  |
| 4-6                                | 1(3%)                    | 0        | 1(2%)    |
| Total                              | 34(100%)                 | 16(100%) | 50(100%) |

Table 4.25 shows that abortions were higher among the women using modern family planning methods than those who were not. It could be possible that they were not using them correctly. However the number of women who had not used any methods at all though

lower than the ones who had used the methods before was equally high (38%). This shows that there is a relationship between number of abortions and use of modern family planning methods.

**Table 4.21 Relationship of number of abortions and source of Family Planning method**

| Number of abortions | Source of family planning |          |          | Total    |
|---------------------|---------------------------|----------|----------|----------|
|                     | Pharmacy                  | Clinic   | None     |          |
| 1-3                 | 10(100%)                  | 23(96%)  | 16(100%) | 49(98%)  |
| 4-6                 | 0                         | 1(4%)    | 0        | 1(2%)    |
| Total               | 10(100%)                  | 24(100%) | 16(100%) | 50(100%) |

Table 4.26 shows that the women who obtained the family planning supplies from the clinic recorded the highest number of abortions. It could be that probably the methods were not correctly used. The relationship between the number of abortions and the source of family planning method is not so certain. It can be concluded that there is no relationship between the number of abortions and the source of family planning method

**Table 4.22 Relationship between number of abortions and attitude of nurses**

| Number of abortions | Attitude of nurses |          | Total    |
|---------------------|--------------------|----------|----------|
|                     | Good               | Not good |          |
| 1-3                 | 25(96%)            | 24(100%) | 49(98%)  |
| 4-6                 | 1(4%)              | 0        | 1(2%)    |
| Total               | 26(100%)           | 24(100%) | 50(100%) |

The above table shows that the number of abortions among the women who responded that the attitude of nurses at the clinic was not good was equally high which could somehow contribute to the increase in the number of abortions. There is therefore a relationship between the number of abortions and attitude of nurses in the MCH department.

**Table 4.23 Relationship between number of abortions and continuity of family planning**

| Number of abortions | Continuity of family planning |          |          | Total    |
|---------------------|-------------------------------|----------|----------|----------|
|                     | Yes                           | No       | Not sure |          |
| 1-3                 | 11(92%)                       | 13(100%) | 25(100%) | 49(98%)  |
| 1-4                 | 1(8%)                         | 0        | 0        | 1(2%)    |
| Total               | 12(100%)                      | 13(100%) | 25(100%) | 50(100%) |

The table above shows that the number of abortions were higher among the women who said that they was no continuity of the family planning supplies though the difference is small we can still conclude that there is some relationship between the number of abortions and the continuity in the supplies.

## **CHAPTER FIVE**

### **5.0 DISCUSSION ON FINDINGS AND IMPLICATIONS FOR THE HEALTH CARE SYSTEM**

#### **5.1 INTRODUCTION**

The purpose of the study was to explore the factors contributing to increase in abortions in Chingola district. The discussion is based on the findings of the study from fifty women participants in the reproductive age group.

##### **5.1.1 Characteristics of the Sample**

The study sample consisted of 50 women respondents who were in the reproductive age group (15 to 49 years). All the respondents had an abortion. Some of the abortions were induced while others were spontaneous. The reasons for inducing abortions varied from one respondent to another.

Most of the respondents in this study were aged between 15-24 years (Table 4.1). This indicates that Zambia has youthful population and it is in line with the Zambia Demographic Survey (CSO 2002).

The educational level of the clients was found to be low (below college level), with only six percent going up to college/University level (figure 1). This shows that abortion prevalence is lower when women are more educated as they are able to know more about their rights including their reproductive rights. It is recognized that education also raises women's self esteem giving them the ability to make informed decisions concerning their reproductive health and even able to acquire better negotiating skills (Ipas, 2010). The low education level among participants may be attributed to the fact that women and girl children are commonly discriminated against in terms of access to education and employment (WHO, 2000).

### **5.1.1.1 Occupation**

Few women (5%) in the present study were in formal employment. This implies that the women are not economically strong and when one has no means of finances, they have less independence and could be a contributing factor to why most unemployed women have abortions when faced with unwanted pregnancy (Wikipedia, 2010).

### **5.1.1.2 Marital Status**

Most of the respondents in the study were married (Table 4.2). The high number of married respondents could be attributed to the strong belief that marriage is an important social cultural activity in the society. If one is not married, he or she is not given respect in society especially the rural areas. This is according to CSO (2007) who reveal how treasured marriage is in Zambia.

## **5.2 Discussion of Variables**

### **5.2.1 Age**

In this study, most of the respondents were aged between 15 and 24 years, showing that Zambia has a youthful problem (Table 4.13). This may be influenced by the fact that there are a lot of early marriages in the study setting and also girls indulge in sexual intercourse earlier in life (CSO 2009). Therefore many adolescents end up with unwanted pregnancies which result in unsafe abortions. The (CSO 2009) also asserts that teenage pregnancies are likely to be precipitated by influences of premarital sexual practices and early marriage practices which are still commonly practiced in Zambia. In addition Likwa (2009) asserts that the prevalence of unwanted pregnancy culminating into increased incidence of unsafe abortions has resulted in severe consequences of maternal morbidity and mortality. Unwanted pregnancy is therefore one of the aspects that prompt women to abort and access unsafe abortions as they are not ready for the pregnancy and would want to terminate it at all costs.

According to CSO (2009), unplanned pregnancy is common in Zambia. Recent studies have shown that about three in ten young women aged 19-15 has experienced childbearing. The Office for National Statistics (1996) reveals abortions statistics for 1994 by age group which reveal that the highest number of abortions were recorded among the ages 20-24 and the least number of abortions were recorded between the ages 40 to 44.

This is similar to this current study for the highest number of abortions was adolescents and the least among the women over forty years. There is therefore a relationship between age and the number of abortions. The early marriages, early sexual indulgence and many drop outs from school mentioned above could contribute to this. Further studies need to be conducted to find the reasons most women who abort are those who have dropped out of school so as to establish them and work at helping people involved.

### **5.2.2 Stigma**

Stigma may be described as the discrimination that is associated with a particular type of issue or condition which causes separation and loneliness. In this study, stigma was

measured in terms of acceptance of single women who get pregnant. However, all the participants responded that it was unacceptable in the Zambian society for a single woman to get pregnant (Table 4.18). The response from the respondents concerning stigma attached to single mothers in our Zambian society demonstrates that it contributes to the increase in the number of abortions especially among the single women. When single women get pregnant they worry about how society will regard them. This study also shows that it is unacceptable within the Christian religion for a single woman to get pregnant (Table 4.19). While this may perpetuate abortion, it is regarded as murder and is prohibited by the Christian doctrine (Wikipedia, 2009).

As a result, many women in this situation may fear to be excommunicated from the congregation especially if they were known. This stigma associated with the women under these circumstances may make them desperate to terminate the pregnancy. Mostly such women end up seeking abortion services from unskilled practitioners who subject them to unsafe conditions which may even result in maternal death and other complications.

Ministry of Health and Ipas (2008) state that factors that attribute to unsafe abortions are related to stigma associated with unwanted pregnancy, cultural values and religion. Naturally, in their respective churches people present themselves as holy beings and pregnancy before marriage is seen to expose the single woman of their conduct in secret.

Therefore stigma associated with unwanted pregnancy with respect to cultural values of society and religion; contribute to increase in the number of abortions. The victims fear to be discriminated in society as well as in their respective churches.

The present study suggest further study which will explore how women faced with the challenge of stigma resulting from having a child as a single parent can cope, and so avoid abortion.

#### **5.2.4 Attitude of Women towards Use of Modern Family Planning Methods**

Family planning methods offer cheap means of spacing children and preventing unwanted pregnancies which otherwise may lead to unsafe abortions. This study discussed attitude of

women towards use of modern family planning methods. It looked at usage any modern family planning method before, source, support by partner of respondent and support by respondent's religion. It was found that 32 percentage of women had not used any modern family planning methods before (figure 4). The reasons for not using modern methods despite them being offered freely are many. However there are a lot of myths concerning these methods, which can be misleading to some women and may discourage from using them. Given that some women obtained their supplies from the pharmacy, compliance remains unclear for such women as there is no room for follow up. When they have side effects they may easily stop.

This poor usage the family planning method may contribute to the increase in abortions. The study also revealed that other women did not obtain any family planning method at all. This was as a result of long distance and apathy towards the service.

The present study results therefore support Mesce (2005) study which revealed that there are a lot of myths in the African culture associated with the use of modern contraceptives. This has led to a number of unmet family planning needs amongst the women. In developing countries, about one in six married women faces an "unmet need" for family planning. They may prefer not to become pregnant but may not access any form of contraception. These lead to most women ending up with unplanned conception which later end in unsafe abortions.

In addition CSO (2009) reveals that despite the overall knowledge of family planning being adequately high and nearly universal since 1996, utilization of the services is still low. Seventy percent of women have used family planning methods before of which the most commonly used is the pill. Therefore unmet needs for family planning still remain problematic in this country.

Therefore further research is required which should address usage of modern family planning methods as it contributes to increased number of abortions.

### **5.2.5 Attitude of Nurses**

The attitude of nurses was assessed by looking at whether the nurses welcomed the clients at the clinic, ensured the availability of family planning supplies at all times and whether or not the clients were satisfied with the services provided at the clinics. The attitude of nurses is important because it may serve as a motivating factor for women to attend family planning clinic and access the services. From this study most of the participants were satisfied with the services provided to them (Table 4.12). However, the majority of the respondents also reported that the supplies at the clinic were inconsistent. This may pose a risk to women because as clients wait for the supplies they may get pregnant. Others may get discouraged and turn to obtaining supplies from unreliable sources which may put them at further risk.

This study results are in line with Ipas (2008) which revealed that the biggest challenge in Africa is the fact that unsafe abortion is a societal problem and affects entire communities. In addition to providing family planning measures to prevent unplanned pregnancy which is seen to lead to unsafe abortions, the policy emphasizes the importance of making abortions safe so as to reduce the maternal mortality rate believed to be resulting from unsafe abortions resulting from unplanned pregnancy. Abortion has always occurred and will continue to occur in all cultures and societies. The challenge is to make it safe so that women and girls do not die unnecessarily (Ipas, 2008).

Ipas (2008) also pointed out that despite Zambia, Ghana, Botswana and Zimbabwe having favorable laws on abortion, women continue to die in great numbers from unsafe abortions because they cannot either get to the legal services or they do not know legal services exist. In addition to reproductive health services such as provision of family planning counseling and methods, Ipas in conjunction with MOH has introduced the service of provision of safe abortion to women by health workers. Doctors, Nurses and other practitioners have been trained to facilitate this. However, some nurses do not attend to clients fully because of religious beliefs. This is acceptable but the right of the patient should still be respected.

Ministry of Health respects medical providers to conscientious objection with regards to participation in the termination of pregnancy. However the client's right to information and

access to health care services including termination of pregnancy must also be respected. With the current policies attitude of the nurses is not only talked about in terms of provision of reproductive health services, but also provision of safe abortion services. This is enhanced by the stigma which surrounds abortions in our society as well as the religious forum (Ipas 2008).

From the results obtained from this current study there might have been women who may not have been satisfied with the services but could not have the courage to say it especially that they were interviewed within the hospital premises by a health personnel. Others may not show it for fear of being labeled or just not wanting to offend the interviewer. Therefore I feel that the study should be conducted by a neutral person who is not in the medical profession so that the clients could be free to put their views forward concerning the quality of services received.

## **5.3 Implications to the Health Care System**

### **5.3.1 Implications for Nursing Practice**

The study shows that the highest number of abortion is among the adolescents. This may be attributed to early indulgence into sexual practices and early marriages. Once faced with unwanted pregnancy, they may resort to abortion which is in most cases unsafe and performed by unskilled practitioners. There is need for the nurses and midwives to be equipped with knowledge and skills needed to provide reproductive health services including family planning education and services to the adolescents. Youth friendly corner should be established and strategies to attract youths to family planning services. There is need to reach out to these young women and equip them with negotiating skills to help them escape unwanted pregnancies.

The Ministry of Health has trained nurses to conduct counseling and safe abortion services to women who feel they need to abort. This is with a view to reduce maternal mortality due to unsafe abortions. The purpose of this program is to lessen limitations of the abortion law in Zambia as this service can be accessed with only two witnesses. These witnesses should be medical personnel who have been trained in providing safe abortion services and should not necessarily be doctors. They could be nurses, midwives, doctors, or clinical officers. However there is need for more nurses to be trained in this programme so as to reach women on time. Nurses and midwives need to be trained in empowering with knowledge on their rights as well as help them to improve their self esteem so that even when they are faced with stigma like the one associated with single parenthood, they will still be able to stand their ground and make informed decisions which will not endanger their lives. Therefore more sensitization among the nurses and midwives concerning the provision of safe abortion services should be done. Family planning is one of the methods of reducing unwanted pregnancies hence the need to have more nurses in the family planning clinic so as to attend to the clients efficiently.

### **5.3.2 Implication for Nursing Administration**

Nursing administration should make available family planning services so that women do not turn to wrong sources or fail to access the service. Supervision of provision of family planning services should be reinforced and staffing of health providers increased to ensure adequate provision of the service. There is need to train nurses in order to equip them with knowledge and skills necessary for provision of family planning and safe abortion services to women in society. This can be done through refresher courses or in-service training. Management therefore needs to reinforce supervision and also help develop strategies on how best to sensitize the women in the communities.

### **5.3.3 Implication for Nursing Education**

According to the study findings there are several programmes and policies that have been formulated and passed in the recent few years, for example; the provision of safe abortion services, comprehensive abortion care, reproductive health and many more. Most of the nurses and midwives trained before these were implemented and hence the need for in-service training so as to achieve the intended goal. There is need to conduct actual training of nurses and midwives in safe abortion services. Health education programs should be provided in order to sensitize women in society about the abortion law.

The General Nursing Council too may be requested to include these new trends into the new curriculums so that graduating nurses attain the necessary skills needed by the clients. This will improve their usefulness.

### **5.3.4 Implications for Nursing Research**

This is the first study done on abortions in Chingola district. There is therefore need for many other studies to be done on abortions in Chingola district so as to broaden understanding factors associated with abortions. Exploring the subject of abortions further can help to develop new strategies and approaches in the prevention and reduction of unsafe abortions.

## **5.4. Factors contributing to the increase in abortions among the reproductive age group in Chingola district**

This study was done to determine factors that contribute to increase in the number of abortions among the reproductive age group.

It has revealed that sigma is a major factor contributing to increase in the number of unsafe abortions. This is common among the adolescents as well as the older women. It is not acceptable in our Zambian culture for a single woman to become pregnant. This was also true of all the religious groups. A single woman who falls pregnant is excommunicated and regarded as a sinful person.

Age is also an important factor in this respect. The study also reveals that there is a relationship between age and the number of abortions. This implies that the adolescents are the victims of unsafe abortions resulting from unwanted pregnancies because they become sexually active at an early age and early marriages are still common in Zambia. Teenage pregnancy is precipitated by influences of premarital sexual practices and early marriage practices which are still a social norm of the Zambian societies. Unwanted pregnancies which later lead to increase in abortions have related to gender sexual violence, rape, defilement, gender and women empowerment.

Unstable relationships between the man and the woman have also shown some relationship. This may be attributed to the fact that a lot of women could not really open up concerning their spouses as they feared embarrassment.

## **5.5 Recommendations**

Having completed the study, the following are the recommendations;

### **5.5.1 To the Ministry of Health**

- ❖ The ministry of health should train more nurses and midwives in the provision of reproductive health services, family planning services, counseling as well as provision of safe abortion services.
- ❖ The public should be educated and sensitized on the availability of safe abortion services and enlightened on their right to access the service. A lot of resources are

being spent to train health workers but most of the public members are unaware of such a service and so continue seeking services from unskilled practitioners illegally.

- ❖ The ministry of health should ensure adequate, continuous and sustainable supplies of modern family planning methods to reduce the frequency of unwanted pregnancies.

#### **5.5.2 To Nchanga North General Hospital and Chingola District Office**

- ❖ The two facilities should ensure proper functioning youth friendly services with well equipped personnel behind them so as to help young women prevent unwanted pregnancies.
- ❖ The Nchanga north hospital should train more health personnel in the provision of reproductive health services, family planning and safe abortion services to reduce the number of unsafe abortions.
- ❖ The two facilities should work hand in hand and sensitize the public on the provision of, and access to safe abortion services including safe abortion as most of the people are having their abortions outside the hospital. It is possible that most of the abortions recorded as spontaneous are induced and then rushed to the hospital for Manual Vacuum Aspiration (MVA).

#### **5.6 Dissemination of findings**

Dissemination of findings involves the spread of information and knowledge so that it reaches many people. In this case many copies will be made and given to the following;

- ❖ The University of Zambia (UNZA) School of Medicine Library
- ❖ Department of Nursing Sciences
- ❖ Ministry of Health
- ❖ General Nursing Council
- ❖ Nchanga North General Hospital
- ❖ Chingola District Hospital

This information will also be disseminated to workshops and seminars whenever an opportunity arises.

### **5.7 Limitations of the study**

- ❖ There was limited time in which to conduct the study, therefore it was not possible to recruit a large sample to participate in this study.
- ❖ The funding allocated to this research was not enough and this limited the study in a way for the budget was adjusted to suit the income and this was quit stressful to the researcher.
- ❖ It is not possible to generalize the results of this research to the rest of the population in Zambia as the sample was small even though generalization is a characteristic of the scientific method in which information from a sample of a population can be said to be representative of the entire population (Basavanthappa, 2007).
- ❖ This topic is very sensitive and so to collective truthful data from clients is not as certain as some hide or feel embarrassed to give the true picture about their situation. Therefore extreme privacy and confidentiality is demanded by the participants

### **5.7 Conclusion**

This study sought to determine the factors contributing to increase in abortions in Chingola District. It yielded a lot of valuable information and it is hoped that this information will be utilized by the relevant authority to in the formulation of strategies to reduce and prevent unsafe abortions in the district.

The study reviewed that the major cause of abortions is the stigma associated with single women who get pregnant. These are discriminated against in their religion as well as in their societies and they abort in fear of the stigma. There is however other factors such as poor family planning service delivery and low education levels due to early marriages among the girl children. There is need to sensitize the women on the importance of educating the girl child and also the delaying marriage to ensure full maturity among the adolescents. Concerning the newly launched programme for safe abortion service provision which is not so rigid to the abortion law, a lot of sensitization has to be done so that more women can access the services and be saved from the consequences of unsafe abortions

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## **Appendix i**

**THE UNIVERSITY OF ZAMBIA**  
**SCHOOL OF MEDICINE**  
**DEPARTMENT OF NURSING SCIENCES**

### **INTERVIEW SCHEDULE**

**TOPIC: FACTORS CONTRIBUTING TO AN INCREASE IN ABORTIONS  
AMONG WOMEN IN CHINGOLA**

Date of Interview: \_\_\_\_\_

Place of Interview: \_\_\_\_\_

Name of Interviewer: \_\_\_\_\_

Serial Number of Respondent: \_\_\_\_\_

### **INSTRUCTIONS TO THE INTERVIEWER**

1. Introduce yourself to the respondent
2. Explain the purpose of the interview
3. Tell the respondent how she was selected and obtain verbal consent to interview her
4. Assure respondent of confidentiality and anonymity
5. Do not write name of respondent on interview schedule
6. Tick in the box corresponding to the correct answer or write responses in spaces provided.

**SECTION A: DEMOGRAPHIC DATA**

**FOR  
OFFICIAL**

1. Age USE ONLY

- (a) 15 – 24 years
- (b) 25 – 34 years
- (c) 35 -44 years
- (d) 45 – 49 years

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2. Marital status

- (a) Single
- (b) Married
- (c) Divorced
- (d) Widowed

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3. Educational level

- (a) Primary
- (b) Secondary
- (c) College
- (d) University
- (e) Never been to school

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4. Employment status

- (a) formal
  - (b) Informal employment
  - (c) Full time Housewife
  - (d) Other, (specify)-----
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5. How many pregnancies have you had?

- (a) 1
- (b) 2-5
- (c) 6 and above

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6. How many children do you have?

- (a) 1-3

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- (b) 4- 6
- (c) 7 and above
- (d) None

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7. Any difference between the number of pregnancies and the number of children

- (a) Yes
- (b) No

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8. If yes give details -----

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**SECTION B: SOCIAL CULTURAL**

9. Why did you abort?

- (a) want to continue school
- (b) fear parents
- (c) not ready to have a baby
- (d) no support from partner

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10. how does the community perceive pregnancy

Outside wedlock (from single women)

- (a) taboo
- (b) sin
- (c) disgraceful
- (d) prostitution

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11. how does your religion perceive single pregnant women

- (a) sinful
- (b) excommunicated
- (c) prostitutes
- (d) unfit to partake in church responsibilities

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12. How does the community perceive abortion?

(a) It is murder

(b) It is sin

(c) It is evil

(d) It is illegal

(e) Other (specify)-----

13. How is your relationship with your partner?

(a) Good

(b) Bad

14. If the answer to question 12 is no give reasons-----

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15. Was the pregnancy planned?

(c) Yes

(d) No

16. why did you not want to get pregnant?

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17. What type of abortion did you have?

(a) therapeutic

(b) criminal

(c) spontaneous

(d) Threatened

18. Did you induce it?

a. Yes

b. No

19. If the answers to question 11 is no, give reason

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**SECTION C: ATTITUDE OF WOMEN TOWARDS  
FAMILY PLANNING**

20 Have you ever been on modern family planning methods?

(a) Yes

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(b) No

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21 If the answer is no give reasons-----

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22 What does the community say about modern family  
Planning methods?

(a) it gives cancer

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(b) leads to infertility

(c) leads to fibroids

(d) Promotes weight gain

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23 Does your religion encourage use of contraceptives?

(c) Yes

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(d) No

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24 Does your partner favour the use of contraceptives?

(a) Yes

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(b) No

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25 If the answer is no what alternative are you using-----

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SECTION D: ATTITUDE OF NURSES IN MCH/FAMILY

PLANNING CLINIC

26 Who prescribed the method of family planning for you?

(c) nurses

(d) self

(e) Any other

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27 What type of family planning method were you on?

(e) oral

(f) Injectable

(g) condom

(h) Norplant

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28 What was the source of contraceptives?

(e) nearby clinic

(f) private clinic

(g) pharmacy

(h) Contraceptive based distributors

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29 Were the contraceptives available?

(a) always

(b) sometimes

(c) never

(d) Does not know

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30 Were you able to access the contraceptives at the clinic?

a. always

b. sometimes

c. Never

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31 What was the attitude of nurses at the family planning

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clinic?

a. good (welcoming)

b. Bad (not welcoming)

32 Are you satisfied with the services provided by the health workers at your health facility?

a. Yes

b. No

SECTION E: DISEASES

33 Have you ever had an abortion before?

a. Yes

b. No

34 If yes, what was the cause?

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35 Did you have any of the following illnesses prior to abortion?

(a) malaria

(b) HIV

(c) hypertension

(d) Diabetes mellitus

36 What do you think could have contributed to abortion in your case?

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37 Have you ever attended a health discussion on unsafe abortion?

(a) Yes

(b) No

38 Have you ever attended a health discussion on dangers of unsafe

abortions?

(a) Yes

(b) No

39 What do you think can be done to discourage women from having unsafe abortions?

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END OF INTERVIEW

THANK YOU FOR YOUR CO-OPERATION

**APPENDIX II**

**INFORMED CONSENT**

Dear participant,

My name is Georgina Chipowe; I am a student at the University of Zambia, School of Medicine. I am pursuing a Bachelor of Science degree in Nursing in the Department of Nursing Sciences. I'm required to undertake a study on abortion among the reproductive age group in Chingola district. This is in partial fulfillment of my degree.

The information that you give will give me will help in developing better understanding of the problem of the factors that influence abortion increase in Chingola and such information will be used by health planners and other organizations in finding ways of helping these women not to suffer from complications that may arise as a result unsafe abortions.

You have been selected to participate in this study and wish to inform you that participation in this study is voluntary. You are free to withdraw at any stage of the study if you so wish without any prejudice you will be asked some questions about abortion. Any information you will give me will be kept in confidence and no name will be written on the interview schedule.

I ..... hereby called the participant understands the guidelines of this study and I am willing to participate in the study.

Dated this .....day of .....2010

Signature/ thumb print of respondent.....

Signature of interviewer.....

**APPENDIX III****WORK SCHEDULE**

| <b>APPENDIX III<br/>WORK SCHEDULE<br/>ACTIVITY</b> | <b>TIME</b>        | <b>FRAME</b>    | <b>RESPONSIBLE<br/>PERSON</b> |
|--|--------------------|-----------------|-------------------------------|
|  | <b>DATES</b>       | <b>DURATION</b> |                               |
| Research Proposal development                      | 15/06/10-15/09/10  | 90 days         | Researcher                    |
| Finalize Research Proposal                         | 20/09/10- 30/10/10 | 15 days         | Researcher                    |
| Formulation of data collection tools               | 01/10/10- 05/10/10 | 5 days          | Researcher                    |
| Pilot study  | 18/10/10- 22/10/10 | 5 days          | Researcher                    |
| Clearance From Authority                           | 25/10/10- 28/10/10 | 3 days          | Researcher                    |
| Collection Tool Amendments                         | 25/10/10-28/10/10  | 3 days          | Researcher                    |
| Training Research Assistant                        | 25/10/10-28/10/10  | 3days           | Researcher                    |
| Data Collection                                    | 28/10/10-11/11/10  | 21 days         | Researcher                    |
| Data Analysis                                      | 15/11/10- 10/01/11 | 45 days         | Researcher                    |
| Report Writing                                     | 20/01/11-20/02/11  | 30 days         | Researcher                    |
| Submission of Draft Report to Supervisor           | 22/02/10- 25/02/11 | 3 days          | Researcher                    |
| Finalize Report                                    | 01/03/11-31/03/11  | 30 days         | Researcher                    |

**APPENDIX IV**

**GANTT CHART**

| TASK PERFORMED                      | RESPONSIBLE PERSON | JUN | JUL | AUG | SEP | OCT | NOV | DEC | JAN | FEB | MAR | APR |
|-------------------------------------|--------------------|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|
| Literature review                   | Researcher         |     |     |     |     |     |     |     |     | →   |     |     |
| Finalizing research proposal        | Researcher         |     |     |     | →   | →   |     |     |     |     |     |     |
| Clearance from authority            | Researcher         |     |     |     |     | →   |     |     |     |     |     |     |
| Pilot study                         | Researcher         |     |     |     |     | →   |     |     |     |     |     |     |
| Data collection (actual study)      | Researcher         |     |     | →   | →   | →   | →   |     |     |     |     |     |
| Data analysis                       | Researcher         |     |     |     |     |     | →   | →   | →   |     |     |     |
| Report writing                      | Researcher         |     |     |     |     |     |     | →   | →   | →   |     |     |
| Submission of research draft to DNS | Researcher         |     |     |     |     |     |     |     |     | →   |     |     |
| Finalizing the report               | Researcher         |     |     |     |     |     |     |     |     |     | →   |     |
| Dissemination of results            | Researcher         |     |     |     |     |     |     |     |     |     |     | →   |
| Monitoring and evaluation           | Researcher         |     |     |     |     |     |     |     |     | →   |     |     |

## **BUDGET JUSTIFICATION**

In order to conduct this study effectively and professionally, funds for operational, administrative and secretarial services will be required as outlined above.

## **STATIONERY**

Stationery will be required for typing the research proposal, writing the final research report as well as typing and printing the report. Interview schedules will be produced using the same stationary. The notebooks will be needed for record keeping during data collection and analysis. The scientific calculator will be required for data analysis. Tippex will be used to erase errors. A bag will be used for carrying and storing data and other stationery.

## **SECRETARIAL SERVICES**

Funds for typing work will be required to pay a hired secretary. Photocopies will also be required at times to reduce costs on printing the questionnaires. The research proposal and report will need binding and hence money will be needed.

## **PERSONNEL**

The researcher will need money for Lunch and any other unforeseen circumstances during the study.

## **CONTINGENCY**

Contingency fund will be required in case of any unforeseen circumstances like inflation and unstable currency. The contingency fund is 10% of the total budget.

Georgina Chipowe  
University of Zambia  
School of Medicine  
P.o. Box 50110  
LUSAKA.  
8<sup>th</sup> October 2010

The Executive Director,  
Kitwe Central Hospital,  
PO Box 21994,  
Kitwe.  
UFS: The Head, Department of Nursing Sciences

*Chipowe*

Dear Sir /Madam,

**RE: REQUEST FOR PERMISSION TO UNDERTAKE A PILOT STUDY  
AT KITWE CENTRAL HOSPITAL**

I am a fourth year student pursuing a Bachelor of Science degree in nursing at the University of Zambia.

In partial fulfillment of this programme, I am required to carry out a study. My study topic is abortions in Chingola District. The purpose of this research is to explore abortions and the factors that influence increase in abortions among the reproductive age group in the district. It is hoped that the results of this study will help health care providers institute measures that will educate women on the dangers of unsafe abortions and prevent complications that may arise as a result of these unsafe abortions.

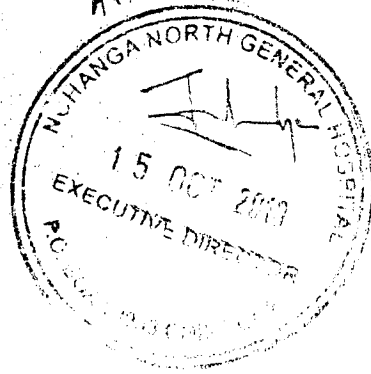
I am therefore requesting for permission to conduct the pilot study at Kitwe Hospital Central Gynecological ward. I hope to conduct my data collection between 18<sup>th</sup> October and 22<sup>nd</sup> October, 2010.

Your favorable consideration of this request will be highly appreciated.  
Thanking you in advance.

Yours faithfully,

*Chipowe*  
Georgina Chipowe  
4<sup>th</sup> year BSc Nursing Student

*S. Hazinyu*  
*tend to her please*



Georgina Chipowe  
University of Zambia  
School of Medicine  
P.o. Box 50110  
LUSAKA.  
8<sup>th</sup> October 2010

The Executive Director,  
Nchanga North General Hospital,  
PO Box 10063,  
Chingola.  
UFS: The Head, Department of Nursing Sciences

*Chipowe*

Dear Sir /Madam,

**RE: REQUEST FOR PERMISSION TO UNDERTAKE A RESEARCH STUDY  
AT NCHANGA NORTH GENERAL HOSPITAL**

I am a fourth year student pursuing a Bachelor of Science degree in nursing at the University of Zambia.

In partial fulfillment of this programme, I am required to carry out a study. My study topic is abortions in Chingola District. The purpose of this research is to explore abortions and the factors that influence increase in abortions among the reproductive age group in the district. It is hoped that the results of this study will help health care providers institute measures that will educate women on the dangers of unsafe abortions and prevent complications that may arise as a result of these unsafe abortions.

I am therefore requesting for permission to conduct the pilot study at Nchanga North General Hospital Gynecological ward. I hope to conduct my data collection between 25<sup>th</sup> October and 8<sup>th</sup> November, 2010.

Your favorable consideration of this request will be highly appreciated.  
Thanking you in advance.

Yours faithfully,

*Georgina Chipowe*  
Georgina Chipowe  
4<sup>th</sup> year BSc Nursing Student