FACTORS INFLUENCING UNSAFE ABORTION PRACTICES AMONG TEENAGERS IN POST ABORTION CARE WARD AT JINJA HOSPITAL

BY

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A RESEARCH REPORT SUBMITTED TO KAMPALA INTERNATIONAL UNIVERSITY FACULTY OF CLINICAL MEDICINE AND DENTISTRY AS A REQUIREMENT FOR PARTIAL FULFILLMENT FOR THE BACHELOR OF MEDICINE AND BACHELOR OF SURGERY

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DECLARATION

I **KIMERA MANISUULI**, hereby declare that the research is my original work and has never been submitted to any institution of higher learning for any academic award.

NANE: KIMERA MANISUULI (STUDENT)

SIGNATURE:……..

DATE:……

APPROVAL

This research has been done under my supervision and submitted with my approval

NAME OF SUPERVISOR: DR MIREMBE STEPHEN KIZITO
(DERMATOLOGIST)

SIGNATURE: …….

DATE:…….

DEDICATION

This research is especially dedicated to my Guardian DOCTOR Mudiope Peter, my good friends especially Martin Bampaire,Herman Beingana, joanitah Twanza and Gift Amumpaire,my mother Mutesi Halima and other friends at large for their efforts in sustaining me during my academic years and their closeness towards me all through.

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LIST OF ACRONYMS

FCM:	Faculty of Clinical Medicine and Dentistry
FP:	Family planning
JRH:	Jinja Regional Referral Hospital
MOH:	Ministry of Health
SSA:	Sub Saharan Africa
STDs:	Sexually transmitted diseases
WHO:	World Health Organisation

DEFINITION OF TERMS

Maternal Mortality: Death of pregnant woman or within 42 days of termination of pregnancy, irrespective of duration and site of pregnancy from any cause related to or aggravated by the pregnancy or its management.

Maternal Morbidity: Any health condition attributed to or aggravated by pregnancy and child birth that has a negative impact on the woman`s wellbeing.

Sepsis: Is an immune response.

Knowledge: Information or awareness gained through experience or education or total of what is known.

Attitude: A way of thinking or feeling about something.

Practice: This is the action rather than the theory of doing something

Unsafe abortions: Termination of pregnancy by people lacking the necessary skill or in an environment with minimal medical standards or both.

Abortionist: A person who carries out abortions.

Contraceptive: Variety of methods used to prevent pregnancy.

ABSTRACT

Unsafe abortion is a public health concern because of its direct reproductive consequences and impact on maternal mobility and mortality. Handling this problem will go a long way towards achieving one of the millennium developmental goals, which aim to reduce overall maternal mortality.

The main aim of this study research was to determine the knowledge, attitudes, practices of unsafe abortion and factors associated with it among teenagers around Jinja and the surrounding areas. s

Materials and Methods

This was designed as a cross- sectional descriptive study. The multistage sampling method was used to select 30 respondents. The first day I captured 9 respondents, the second day 10 and the third day they were 11 respondents.

Data were collected with self-administered questionnaires and analyzed.

The questionnaire was divided into four sections: the socio demographic characteristics of the respondents, knowledge about unsafe abortion, attitudes towards unsafe abortion, and the practice of unsafe abortion.

The responses towards knowledge and attitude questions were scored and graded as good (>50%] and poor [<50%].

Results:

The response rate was 100%. The majority of age in years affected was 15-18 on average.

Almost 100% of respondents demonstrated poor attitude towards unsafe abortion.

There was a statistically significant association between the age, their practice, knowledge of sex and unsafe abortion.

Conclusion

The respondents showed a poor knowledge about unsafe abortion, poor attitudes towards unsafe abortion, and a higher practice of unsafe abortion among teenagers around Jinja and surrounding areas.

CHAPTER ONE
INTRODUCTION

This chapter presents the introduction of the topic, problem statement and purpose of the study, specific objectives, research questions and justification of the study.

1.1 Back ground

World health organization (WHO, 2011) defines unsafe abortions as termination of pregnancy by people lacking the necessary skill or in an environment with minimal medical standards or both. Globally abortions have been practiced in almost all societies to regulate population size and maintain stable social and economic conditions. The proportions of teenage pregnancies that end up in abortions vary widely across countries with complete estimation of 17% in Slovakia and 69% in Sweden. (Ds Correia, 2011)

The United Nations (UN) indicates that up to 3.2 million unsafe abortions involving teenagers take place in developing countries every year. However, if compared to adult women, teenagers are more prone to complications such as severe bleeding, septicemia, and death because of the use of dangerous methods. Teenagers may also postpone the search for medical help when complications arise. The same study showed that at the end of the reproductive life, approximately one in every five women had a miscarriage and more than half of abortions (50%) occurred when the participants were teenagers. (Thatiana, 2016).

Sub Saharan Africa has the highest rate of hospitalization due to unsafe abortions worldwide with 31 per 1000 pregnancies. (World health Organisation, 2007).Unsafe abortions in Africa were highest in ages between 15-19 years than any other region in the world (Pathfinder*et al*, 2008).

In Ghana unsafe abortions among teenagers is on the rise and the practice is among the girls between the ages of 13 and 15 years. Early and forced marriages were the major contributory factor to the unsafe abortion rates in the community. There was need to prevent unsafe abortions among teenagers in Ghana. It was no secret that teenagers were engaging in unprotected sex

which could end up in unwanted pregnancies and unsafe abortions which usually led to death. (Asiedu *et al* 2016)

In Lusaka, Zambia most girls between 13 to 19 years had very low knowledge about contraceptive use and therefore ended up performing clandestine abortions. Reasons for the unsafe abortion practice were; fear of facing personal shame and social stigma following premarital pregnancies such as parental disapproval, abandonment by the partner and expulsion from school. Limited access to contraception and the stigma attached to abortions are likely to continue to compel girls to rely on unsafe abortions if comprehensive adolescent reproductive health services are not reached. Abortion is procured in unsafe and unsanitary conditions that put the lives of pregnant teenage girls at risk. Teenagers engage in sexual behaviors that put them at risk of unwanted pregnancies. The necessity to give adolescent girls more attention and advocacy is obvious. (Dahl. Back *et al*, 2007)

In Kenya , abortion is perceived as a practical solution to unwanted pregnancy that is compounded by social stigma. (Reproductive Health and Rights Alliance, 2016). In Kenya, about 21,000 women annually are admitted to public hospitals with abortion complications. 41% of pregnancies are unintended and they end up in abortions (Shukri *et al*, 2011).

According to a demographic survey which was carried out in Kenya 2008-2009, maternal mortality to which unsafe abortion is a major contributor was unacceptably high with about 488 maternal deaths per 100,000 live births. The fear of parental reaction, age, lack of support from the partner and pregnancy rejection were the explanations to stimulate abortions. (Pathfinder 2008).

In Rwanda, despite legal restrictions and strong stigma around abortion, 22% of unintended pregnancies in Rwanda end in induced abortions, this is because women who want to postpone or stop child bearing, 19% do not use contraceptives. Most of abortions are common in Kigali. The likelihood of complication is directly linked to who performs the abortion. 34% of unsafe abortions are performed by untrained individuals like traditional healers and 17% are self-induced by women (Basingaetal, 2013)

In Uganda, abortion is permitted only when the life of the mother is in danger (Uganda penal code of 1950). This restriction compels perpetualization of the practice in secrecy and often under unsafe methods. Uganda has a high maternal mortality rate with unsafe abortions being one of the major cause especially among young people. (Byamugisha *et al*, 2007). One in every 4 teenage girls between 15-19 yeas are found pregnant and this contributes to the bulk of unwanted abortions and births (Uganda Bureau of statistics, 2013).

In Eastern Uganda where Jinja Referral Hospital is, the cases of unsafe abortions among teenagers are still high irrespective of contraceptives being available. In 2016; there were 160 cases of unsafe abortions. In 2017 they were 150 cases of unsafe abortions and almost 30% of them were among teenagers (JRH records, 2016-2017).

Ministry of Health (MOH) has tried to slash teenage pregnancies through provision of free contraceptives in almost all public health facilities, expanding sex education but the fall in unintended pregnancies has failed to meet the government target(Steve *et al*, 2007)

Ending the silent pandemic of unsafe abortions among teenagers is an urgent public health and human rights concern.

Taking a look at Jinja District where Jinja Referral Hospital is located, there is no evidence of any study done on the factors influencing teenagers to practice unsafe abortions.

1.2 Problem Statement

Worldwide, complications due to unsafe abortion procedures account for an estimated 47,000 maternal deaths per year (Singh *et al*; 2009).

Additional consequences of unsafe abortions include loss of productivity, economic burden on public health systems, stigma and long term health problems such as infertility (WHO, 2007.)

In Africa it`s estimated that 8.3 million induced abortions occurred each year, with these abortion ranging from 23% in West Africa, 28% in North Africa, 24% in South Africa, and 13% and 14% in Middle and Eastern Africa respectively. (Guttmacher *et al*; 2014).

Almost all abortion-related death worldwide occurs in developing countries, with the highest number in Africa. The most common complications from unsafe abortions are incomplete abortions, excessive blood loss and infections. Less common but very serious complications include septic shock, perforation of abdominal visceral organs and inflammation of peritoneum. (Guttmacher *et al*, 2014).

In Uganda about 8% of maternal deaths are due to unsafe abortions (Ministry of Health, 2010-2015). Every year in Uganda about 1500 teenagers die from complications resulting from unsafe abortions and this contributes to the slow progress in reducing number of women who die due to pregnancy related complications (Mugerwa *et al* ; 2013).

According to the study area, irrespective of all that has been put in place, the level of unsafe abortions is still high, especially among the teenagers. (JRH records, 2016). Therefore, there is need to understand the factors associated with unsafe abortions to end the silent pandemic which is an urgent public health concern.

1.3 Study objective

1.3.1 General Objective

To determine the factors influencing unsafe abortions among teenagers in the post abortion ward of Jinja Referral Hospital.

1.3.2 Specific Objectives

To determine knowledge of teenagers attitudes.

Determine the practices which influence teenagers to practice unsafe abortions amongst those attending the postal abortion care ward of JRRH.

1.4 Research Question

How much do teenagers attending the post abortion care ward of Jinja Referral Hospital know about unsafe abortion?

What are the attitudes of teenagers attending post abortion ward of Jinja Referral Hospital towards unsafe abortions?

What are the practices that influence teenagers to practice unsafe abortions amongst those attending the post-abortion ward of Jinja Referral Hospital?

1.5 Justification of the study

Despite the fact that very many actions have been put in place by the World Health Organization (WHO),and the Ministry of Health, (MOH), to reduce on the cases of unsafe abortions which include improving teenagers access to contraceptives , making most contraceptives free in public health facilities, laws relating to abortions and programs that provide detailed right sex education, the number of abortion cases is still high and there is need to understand the factors influencing teenagers to practice un safe abortions.

Addressing the actors influencing teenagers to practice unsafe abortions in a more effective way will give strong ground for effective intervention to reduce maternal mortality and morbidity.

It will empower the teenagers with knowledge to change unhealthy attitudes and practices and embrace those recommended for the prevention of unsafe abortions.

It will help in knowledge enrichment and as a yard stick of reference and comparison of data obtained elsewhere in Uganda.

1.6 Study Scope

This will involve the study of the geographical scope, content scope and time scope.

1.6.1. Geographical Scope

The study will be conducted from the post abortion care ward of Jinja Referral Hospital (JRH) in Jinja Municipality, Jinja District in Eastern part of Uganda. The area is found around 70km from Kampala (capital city of Uganda). JRH is a Government hospital with many services offered including comprehensive abortion care services. It consists of Obstetrician/ Gynecologists, Medical Officers, Clinical Officers, Nurses and Midwives who all have knowledge in gynecology and reproductive health. Therefore many women including teenagers attend to it, whose knowledge, attitude and practices towards the factors influencing them to practice unsafe abortions can be assessed.

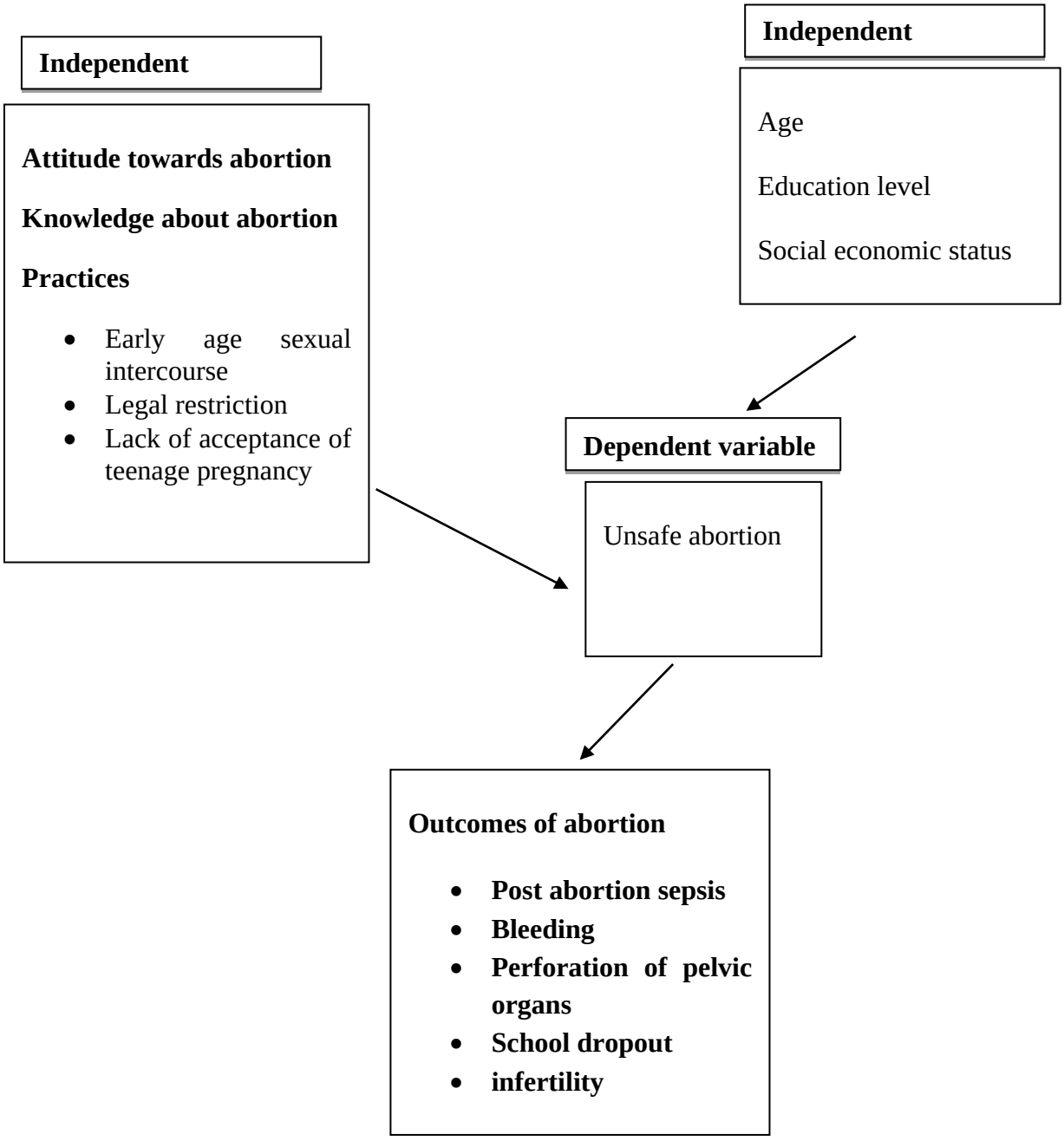
1.6.2. Content scope

1. The dependent valuable is abortion.
2. Independent variables are
    a) Knowledge.
    b) Attitude.
    c) Practice.

1.6.3. Time Scope.

The study will be carried out in Jinja Referral Hospital at the post abortion care ward for a period of (2017-2019).

1.7 Conceptual frame work



CHAPTER TWO
LITERATURE REVIEW

2.0 INTRODUCTION

This chapter deals with reviewing literature relevant to the study and it is obtained from various sources that include medical, nursing journals, text books and the internet.

2.1 Knowledge on unsafe abortions by teenagers.

Teenagers should have adequate education about safe sex rather than imposing moral lessons most likely given by the parents or at school, joining and participating in religious clubs (Masthoff *et al,* 2017)

In Brazil, abortion is routinely condemned in public discourse yet practiced privately on a large scale. Teenagers especially those between 13-17 years in such an environment are likely to hear conflicting information regarding the safety, efficiency and acceptability of induced abortions. (Mitchell*et al,* 2013)

The teenagers may prefer unsafe induced abortions rather than contraception because they perceive the effects of contraceptives to be prolonged yet then abortion is an immediate solution to unplanned pregnancy. This has been seen in the Nigeria population. (Otoide *et al*; 2010)

Some studies done in Lusaka have it that most girls between 13-19 years had very low knowledge about contraceptives use and they ended up getting pregnant and performing unsafe abortion because of fear of facing personal shame and social stigma following premarital pregnancies such as parent disapproval, abandonment by partner and expulsion from school.(Dalback *et al*; 2007)

Teenage girls between the ages of 13 and 15 years of age in Ghana, were lacking sex education and that could partly be a factor to the alarming rate of teenage pregnancies and unsafe abortions. Unsafe abortions in Ghana were on the rise and the practice was very common between the ages of 13-15 years and it is related to the lack of sex education. (Mohammed *et al*, 2017)

In Democratic Republic of Congo, the knowledge level about abortions and its associated complications among girls increased with age. It was as follows: 28% among the 16 years

180.8% among the 17 years and 87.7% among the 18 years old and 90.10 among the 19 years old. (Paluk *et al*; 2010)

2.2 Teenagers attitudes towards unsafe abortions

Teenagers may choose to have abortions because they have concerns of how having a baby would derail important personal goals for example completing their education; Worrying about financial responsibilities associated with parenthood or they feel they are not ready to become parents. (World Bank indicator *et al*; 2015)

The staff of health workers at health centers have attitudes that generally inhibit teenagers to seek safe abortion services. This is because teenage abortion seekers are verbally abused and humiliated by staff and find it hard to get services. The community members acknowledge the deep stigma surrounding abortion and expressed that some health providers mistreat women seeking post abortion care and as a result they do it in secrecy with unsafe methods. (Hendel *et al*; 2007)

Abortion in most African countries is a sin and it is highly condemned by both christians and moslems and because of the religions views, it is difficult for teenagers to procure safe abortions freely. One of the reasons teenagers for not using contraceptives is their religion, and this is common among moslems and roman catholics, their religious leaders have been vocal in opposing the use of contraceptives. When religious leaders were asked if they would encourage their peers to take contraceptives, most of them replied in a negative way. The most common reasons was that contraceptives encouraged sexual immorality and that young people should be encouraged to abstain from sex. (Thatiana *et al*; 2016)

Most teenagers no longer look at sex as a taboo. About 28.7% teenagers have sexual intercourse at an early age and 24.7% become pregnant and most of such pregnancies end up in abortions which is usually unsafe. Teenagers become sexually active at an early age; the number of such incidences. According to the feminist Women`s Health Center, a sexually active teenager who does not use contraceptives has 90% chance of conceiving in the first year. It is true that abstinence is the best way to avoid a teenage pregnancy but in all reality that is not a practical solution in today`s times. (Mascothiff *et al*; 2017)

Similarly the illegal status of abortion in most African countries makes teenagers opt for illegal means that results into cases of unsafe abortion causing several health hazards to the girls. Unsafe abortions are performed in the most outrageous ways such as inserting foreign objects in the vagina that can harm the body and the uterus. (Mascthiff *et al*; 2017)

A child `s birth is a life altering decision because it will define the way the teenage girl`s life will be. When the teenager sees no support coming from her family, particularly parents, she may feel stressed and under pressure to choose not to continue with pregnancy.

2.3 Practices that influence teenagers to practice unsafe abortions

Abortion is the oldest known cure of unwanted pregnancies and has been practiced in almost all races through using various traditional methods. (Mpangile *et al*, 2007).Some of the practices which influence teenagers to practice unsafe abortions include;

About 28.7 % of the teenagers have sexual intercourse at an early age and 24.7% become pregnant with 93.3% of such pregnancies ending up in unsafe abortions. The National Abortion Federation states that four out of five Americans have experienced sex before the age of 20 and the average age at which Americans loose virginity is 17, this means that there is a staggering number of youth, teenagers and young adults who are at a growing risk of contracting STDs, unintended pregnancies and abortions. (Masthoff, 2017 and Thatiana 2016).

The legal restriction in most African countries has led to services by skilled providers to be expensive and therefore not that available for most women who need them. This means that teenagers who need to carry out abortions have to rely on the services of unskilled providers in all settings.

Our society passes pressure which has come a long way from its tradition, on teenage pregnancies, particularly when the teenager is not married and becomes pregnant due to a passing affair. Though our society has accepted the fact most teenagers today are sexually active there is still lack of acceptance of teenage pregnancy. Teenagers who decide to keep their babies become a subject of constant gossip and pity. To avoid this social pressure, many teenagers choose to abort their babies (Masthoff, 2012)

In South Africa, abortion was legalized according to the Pregnancy Act of 1997. The overall women under 18 constitute only 11% of those using the services. This is because the teenagers who seek for safe abortion services are verbally abused and humiliated by health workers and as a result, when girls get pregnant, they visit street abortionists where unsterile knitting needles are inserted into their vaginas and days later, they are hospitalized for severe sepsis of the uterus. (Wendell, 2007).

There is inequality in provision of safe abortion services between higher income and low income women. This avails safe abortions for the indications in private clinics while the later adolescents and teenagers who cannot afford tend to resort to unsafe abortion methods in less sanitary conditions. Death due to unsafe abortions is the third leading cause of maternal mortality in Rio de Janeiro concentrated in the poorest sectors of the city. (Guttmacher, 2008)

Many teenage girls also opt for unsafe abortions in secrecy of incest and rape. It's traumatic for a teenage girl to be sexually molested by a family member or trusted friend and then to find out that the unwanted liaison resulted in pregnancy. Rape and incest cause a feeling of shame and this multiplies when the teenage girl find out she is pregnant. She wants to wipe out the memory of the incident and the best way to do so is usually done in secrecy (Guttmacher Institute, 2017).

CHAPTER THREE:
METHODOLOGY

3.0 Introduction

The chapter explains the various methods and procedures that were used and followed while conducting the study. It includes the study design, study setting, study population, sample size determination, sampling procedure, data analysis, ethical considerations, study limitations and dissemination of results.

3.1 Study design and rationale

The study was conducted through cross-sectional study of qualitative nature. The study design was used to determine the factors influencing teenagers to practice unsafe abortions in the post abortion ward of JRH. The cross-sectional research design was used because it aids in rapid data collection and allows a snap shot interaction with a small number of respondents at a point in life. I considered both qualitative and quantitative method s of data collection. Under quantitative, the findings were presented in numeral forms such as percentages, using frequency tables, bar graphs and pie charts, under qualitative approach, narration and explanation findings were done. To gather qualitative data, a questionnaire were designed and be administered to the respondents. This type of study design helped the researcher to identify teenager`s knowledge, attitudes and practices influencing them to practice unsafe abortions.

3.2 Study population

The study population consisted of teenagers who attend post abortion ward of Jinja Referral Hospital during the time of data collection.

3.2.1. Inclusion Criteria

All teenagers who undertook post abortion care in Jinja Regional Referral hospital on research days and who would have consented to participate in the study were included.

3.2.2 Exclusion criteria

Not consented.

3.2.3 Sample size determination

The sample size were determined by using krejcie and Morgan sample size formula for finite population.

$$S = \frac{x2\ NP\ (1-P)}{d2(N-1) + X2P(1-P)}$$

Where S=estimated sample size

P=proportion of the population.

X=the z value on the table for 1 degree of freedom at tge desired confidence level 1.96 for a 95% confidence level.

d=margin of error of set at 5%.

N= the population size (35-40 patients in a week)

Therefor, krejcie and Morgan simplified the process of determining the sample size by coming up with a table developed basing on the formula.

3.2.4. Sampling procedure

Consecutive recruitment of the first 30 respondents who would have consented to participate in the research project during the data collection period were considered.

3.2.5 Data collection methods

The researcher used a structured interview to determine the factors affecting teenagers towards practicing unsafe abortion in JRH at the post abortion ward. And involved qualitative and quantitative methods of data collection.

3.2.6 Data collection tools

A structured questionnaire with both open and closed ended questions were used as a tool for gathering information. It were designed and administered to the selected respondents where they were requested to fill them in their own responses with the help of an interpreter for those who

were not able to read and write. This design were opted for this method because the teenagers may need a lot of privacy and comfort if they are to provide factual and detailed information about themselves and more so concerning them with their reproductive sexual ways.

3.2.7 Data Collection Procedures

On each research day, teenagers in the post abortion ward were addressed, the researcher introduced himself to the prospective participants and read to the individual participant the consent form that detailed the title and the purpose of the study as well as the rights of the participant. Whenever a participant agreed to be interviewed, she was asked to provide written consent by signing or finger printing and those who refused were not forced or affected in any way. The researcher entered the questionnaire serial number and date of the interview and proceeded from the first up to the last question using the language understood by the participants with the help of the questionnaire. The researcher entered the responses that were given by the participants by ticking the appropriate response and entering the same number in the same coding box. This were done to ensure data quality as the question number ticked were supposed to be the same as the one entered in the coding box. The researcher reviewed the questionnaires on a daily basis to ensure they are being completed correctly and any errors corrected to avoid being repeated. The process of data collection continued for until every study participant in the sample size is exhausted.

3.2.8 Quality Control

The filled questionnaires were checked for validity before leaving the data collection site for accuracy, missing data and completeness of the questionnaires on a daily basis. This were followed by coding and entry data using Epi info 3.4.1 software for Windows and double entry into Statistical Package for Social Scientists (SPSS) version 16.0 software for analysis , data were coded manually then entered correctly in the computer, this were done to avoid access to those who are not authorized and prevent losses.

3.2.9 Data analysis

The collected data were analyzed by descriptive statistics using SPSS version 16.0 software and presented in frequency tables, pie-charts in order to make interpretation and analysis easier.

The most frequent response were used as a measure of truth about an event and this helped in drawing conclusions.

3.2.10 Ethical Considerations

An introductory letter was obtained from the research committee of KIUTH through the FCM&D. With the introductory letter, permission was obtained from the hospital director of JRH and the ward manager in charge.

All participating teenagers were selected on the basis of informed consent and they were informed of their right to withdraw from the study at any time without any penalty if they feel not comfortable to go on with the research study. The study was on voluntary basis and information was kept private and confidential. Participants` anonymity was kept. It were conducted while upholding the professional code of conduct in a manner that would not compromise the scientific intentions of research.

3.3 Limitations of the study

Inadequate funds

Language use.

1.4 Dissemination of Results

Information obtained were discussed with the research supervisor for guidance and corrections, then after approval and the study has been done, the final report were printed and distributed as follows:

A copy to KIU-TH library

A copy to the Faculty of Clinical Medicine and Dentistry

A copy for the researcher

CHARPTER FOUR:

RESULTS

4.1 INTRODUCTION:

This chapter is addressing the demographic factors of participants, attitudes, practices , knowledge towards unsafe abortion among teenagers at post abortion care ward of Jinja regional referral hospital.

Table 1: Summary of patients' social demographic factors.

Socio-demographic factors	Frequency n=30	Percentage (%)
Age of the participants		
13-14	04	13.3
15-16	14	46.7
17-19	12	40.0
Marital status		
Single	20	66.7
Married	07	23.3
Divorced	03	10.0
Religion of the participants		
Moslem	08	26.7
Catholic	10	33.3
Anglican	04	13.3
Others	08	26.7
Level of education		
Primary	10	33.3
Secondary	07	23.3
Tertiary	04	13.3
None	09	30.0
Occupation		
Student	03	10.0
House wife	02	6.7
Peasant	13	43.3
Business	06	20.0
Others	06	20.0

Table 2: Summary of assessed patient's knowledge about unsafe abortion

Knowledge	Frequency n=30	Percentage (%)
Knowledge about unsafe abortion		
Use of sticks.	03	10
Over the counter medication.	17	56.7
Street abortionist.	07	23.3
Traditional healers.	03	10
Knowledge on complication of unsafe abortion		
Bleeding	10	33.3
Anemia	03	10.0
Sepsis	09	30.0
Perforation of visceral organs.	04	13.3
Death	04	13.3
Source of knowledge about abortion		
Peers		
Parents	12	40.0
Church	03	10.0
Media	02	6.7
School	10	33.3

	03	10.0
Knowledge of where to get safe abortion.		
Health facilities	10	33.3
Self medication	04	13.3
Traditional healers	03	10.0
Abortionist	13	43.3
Knowledge about contraception.		
Use of condoms	15	50.0
Hormonal	07	23.3
Abstinence	08	26.7

Table 3: Showing attitude of teenagers about unsafe abortions.

The attitude of teenagers	**Frequency n=30**	**Percentage (%)**
Can abortions be legalized in Uganda		
Yes	17	56.7
No	13	43.3

Reasons Safe abortion Avoid social stigma Easy access to post abortion care Allow funding to post abortion care	10 04 02 01	33.4 13.3 6.67 3.3
Do you think unsafe abortion can be stopped Yes No How ? Health education Extending safe abortion Improving health workers relationship with teenagers Skilled health workers.	 11 19 04 03 03 01	 36.7 63.3 13.3 10.0 10.0 3.4
Would like to access safe abortion services Yes No	 30 00	 100 Oo
Do religious beliefs have impact in accessing safe abortion practices Yes No	 24 06	 80.0 20.0

Table 4: Showing the practices which influence the teenagers to practice unsafe abortions.

Teenagers practices	Frequency n=30	Percentage (%)
At what age did you start sex		
13- 14	04	13.3
15- 16	16	53.3
17- 19	10	33.3
Barriers found in accessing safe abortion care		
Poor health workers attitude	04	13.3
Poverty	08	26.7
Fear to be ashamed	18	60.0
Can you afford abortion care services		
Yes	03	10.0
No	22	73.3
Free	05	16.7

Summary of the results.

From the results above it was seen that more teenagers started sex at an age between 15-16 years with 46.7%, peasants had more prevalence with 43.3% while the house wife had a prevalence of

6.7%. 56.7% had more knowledge about unsafe abortion as it is over the counter medication, patients reported bleeding as a more complication of abortion with 33.3%.

The peers were seen as the trusted source of information more than parents, media, school with 40%. It was seen that 50% of the teenagers use condoms. More patients reported that unsafe abortion can be stopped through health education with 13.3% and more of them said abortions can be legalized in Uganda because they will be able to access safe abortion services 33.4%. while fear to be ashamed and societal pressure constituited a greater percentage with 60.0% among the barriers found in accessing safe abortion care.

CHAPTER FIVE
Discussion and Conclusion

5.1. Introduction:

The research was set to conduct on knowledge, attitudes, and practices around unsafe abortions amongst the teenagers which was carried out at post abortion care ward Jinja regional referral hospital.

Knowledge towards unsafe abortions practices among teenagers

Teenagers had limited knowledge about unsafe abortion with 43.3%. This was understood that more teenagers had knowledge about unsafe abortion as the use of over the counter medication with a percentage of 56.7%, followed by the use of street abortionist with 23.3%,use of sticks 10% and those who use traditional healers also 10%. The lack of unreliable sources was consistent with the findings of the results gotten; that they could not adopt effectively safer pregnancy prevention strategies and other good reproductive health practices due to low knowledge.(paluk et.al; 2010).

The study revealed that the majority 46.7% of the patients were in the age group of 15-16 years. This was similar to the studies done Goma (Democratic Republic of Congo) and in Brazil in which the majority 15-19 and 16-19 respectively. It was also noted that the peers were the most source of information with 40%, media, parents and church with 33.3%, 10%,10% respectively this was corresponding with the study done in Nigeria and Brazil.(Mitchellet et al, 2013) .This could be one fundamental reason why the parents did not provide their teenagers with sufficient information, even though the teenagers wanted to receive trusted information from them.

Teenagers found themselves receiving more information from their peers, media followed by the parents and church/mosque.

There was a strong indication that teenagers received less of the accurate, trusted information because it was more readily available. These findings were consistent with other studies in

Nigeria and Goma(Democratic Republic of Congo) , It was understood that low knowledge has a direct impact on behaviors, as it is actualized by wrong or incomplete information and that strong parental relationships coupled with information sharing about risky behavior have shown a decrease pregnancy risk among teenagers.

The importance of involving parents in teenagers sexual and reproductive health issues should not be underrated , as this is a critical strategies must also be mindful of the cultural discomfort that arises when parents when parents talk about contraception and abortion with their children.

Attitude towards unsafe abortion practices among teenagers

In this study research, it was discovered that abortion was more acceptable among the single teenagers 66.7%, compared to the married ones with 23.3% and this was more influenced by their male partner and the religious influence with catholics who had more percentage of 33.3% over unsafe abortion practices, moslems had similar values with other religions and this was 26.7%. this was corresponding with other studies done in lusaka.(Mascothiff et al; 2017).

Similarly, health facility abortions but with untrained abortion practitioners and traditional healers were reported as the common source with easier accessibility. Health facilities had a value of 33.3%, self-medication 13.3%, abortionist with 43.3% and traditional healers with least of 10%

It was noted from the results that teenagers faced more stigma when pregnant or if they terminated a pregnancy 41.2%.

The fear of shame due to abortion was far much higher than stigma due to pregnancy the reason why teenagers potentially did not opt for safe abortions when they fell pregnant.

It was noted that abortion stigma as a challenge for teenagers because of the negative label that they are given by the community around them and by themselves too. Stigma was noted as a significant reason for clandestine abortions to maintain secrecy.

The attitude of health workers also affected teenager’s unsafe abortions as were helpful and unbiased in their service provision was different among different teenagers. Some expressed

positive attitudes, others were treated in a cold, arrogant and judgmental manner through these were seen as trusted sources.

Practices towards unsafe abortion practices among teenagers

From the results , it was noted that teenagers contraceptive use was typically low, but they practiced the most common known methods of contraception such as the use of condoms and these ones were the mostly accessed to as was found in other studies too.

It was also noted that teenagers with age between 15-16years, were more prone to unsafe abortions compared to 17-19 and 13-14 prevalence respectively.

The poverty was the leading barriers to access standardized health care services towards safe abortions 73.3% who said abortion care services were expensive as this was found the other studies done in Nigeria. Though many had fear to be ashamed and societal pressures influencing among teenagers in accessing safe abortions. From the results obtained, the issue of health care services being expensive was undertaken, as many teenagers opted for unsafe cheap methods of abortions.

5.2. Conclusion.

In conclusion teenagers face a lack of access to useful information about contraception and abortion as observed in the studies reviewed in this study. Lack of access was propagated mainly by the information sharing norms and exist around sexual and reproductive health .This suggests severe limitations in prior interventional approaches.

Without knowledge , many of them still resort to dangerous solutions when most of these services are accessible , another signal of both system and structural failures inherent in existing strategies but also on who are the other key stake holders who must take much more critical roles also keeping in mind the significant different categories of teenagers.

This further suggests a need for an urgent response in addressing the unmet need for unsafe abortion with contraception and services at the moral and public good for teenagers. In doing so , it can be urged that holistic approaches and interventions which target broader stake holder

involvement are also critically needed but must be evidenced based on taking into account differential context and contrast while remaining with one wholesome consistent and appropriate message that promote the total wellbeing of the teenagers.

5.3. Recommendation

The recommendation of this study is to encourage the people who provides information about unsafe abortion in Jinja and the surrounding regions to package a right full information to the teenagers. And to add on this teenager should obtain extensive knowledge about contraception methods and safe methods of abortion.

Parents are recommended to practice family planning methods around the people living in Jinja as it would increase the care of parents to their girl child and this will decrease on the number of un wanted teenage pregnancies thus prevention of un safe abortion.

To the ministry of health so that can avail qualified skilled health workers with right information about unsafe and safe abortion and the services to perform safe abortion.

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APPENDIX

CONSENT FORM

My names are KIMERA MANISUULI, a medical student undertaking a bachelor of medicine and surgery at Kampala International University Western Campus. I am conducting a study on the factors influencing teenager abortions in the post abortion ward of Jinja Referral Hospital. Please you are kindly requested to participate in this study. All information provided will be treated with maximum confidentiality and there is no need for writing your name on the questionnaire provided, only respond to questions asked, participation in the study is purely voluntary and you are free to withdraw from the study if at any point you feel uncomfortable to continue the study, no penalty will be given to you.

There are no individual benefits and incentives for the study participant's .The wider community and health sector stand to benefit from this study if the findings are adapted

Respondent

I have read the information stated and understand the significance of the study and am ready to participate

Respondents signature:……Date:……..

Researcher

I have explained the topic and its objectives to the participants and they have understood the topic and its objectives and voluntary consented to participate in the study.

Researcher`s signature:…….. Date:……

APPENDIX II:

QUESTIONNAIRE

INTRODUCTION

Kindly respond to all questions by ticking the appropriate response I a box against the objectives given or fill in the blank space provide where applicable.

Do not indicate your name anywhere on the questionnaire, only write your response.

For those who do not understand English and cannot read or write, the interpreter shall help you to read, write your views and responses.

SECTION A

1. Age in years of the participant
   a) 13 ☐ b) 15-16 ☐ c) 17-19 ☐
2. Marital status
   a) Single ☐ b) married ☐ c) divorced
3. Religion
   a) Muslim ☐ b) catholic c) Anglican ☐ d) others
4. Level of education
   a) Primary ☐ b) secondary ☐ c) tertiary ☐ non ☐
5. Occupation
   a) Student ☐ b) house wife ☐ c) peasant ☐ d)business ☐ e) non ☐

SECTION B

The knowledge of teenagers attending the port abortion care ward at Jinja regional referral hospital about the factors influencing teenagers to practice unsafe abortion

6. what do you know about unsafe abortion
   a) use of sticks ( )
   b) Over the counter medication.( )
   c) Street abortionist( ) ☐
   d) Traditional healers( )

7. Do you know any complication of unsafe abortion?
   a) yes ☐

b) no ☐

8. if yes ☐
   a) bleeding
   b) Anemia
   c) Sepsis
   d) Perforation of visceral organs.
   e) Death
9. Where did you get to know about abortion?
   a) peers ☐ b) parents ☐ c) church/mosque ☐ d) media ☐
   e) School ☐
10. What is safe sex?
   a) Use of protection like condom during sexual intercourse ☐
   b) Abstinence ☐
   c) Having sex with some one of the same age ☐
11. Do you know contraception/ family planning
   a) Yes ☐
   b) no ☐

SECTION C

The attitude of teenagers towards unsafe abortion

12. Should abortion be legalized in Uganda
   a) Yes ☐
   b) No ☐
13. If yes why ……
14. If no why …….
15. Why did you decide to carry out unsafe abortion?
   ……..
16. Do you think unsafe abortion can be stoped?
   a) Yes ☐
   b) No ☐
17. If yes, what can be done to stop it
18. Would you like to access safe abortion services?
   a) Yes ☐
   b) No ☐
19. If yes, why?.....
20. If no, why? ……..

21. Do you think religious belief have an impact in accessing safe abortion practices?
    a) Yes ☐
    b) No ☐

SECTION D

The practices which influence the teenagers to practice unsafe abortions

22. At what age did u start sex?
    a) 13-14 ☐
    b) 15-16 ☐
    c) 17-19 ☐
23. Why did you start at that age?.....
    ……..
24. Which barriers did you find to access safe abortion care?
    a) Poor health workers attitude ☐
    b) Poverty ☐
    c) Fear to be ashamed ☐
    d) Social pressure ☐
25. Comment on the charges of abortion care services in health facilities around your area.
    a) Cheap ☐
    b) Expensive ☐
    c) Abortion services not practiced ☐

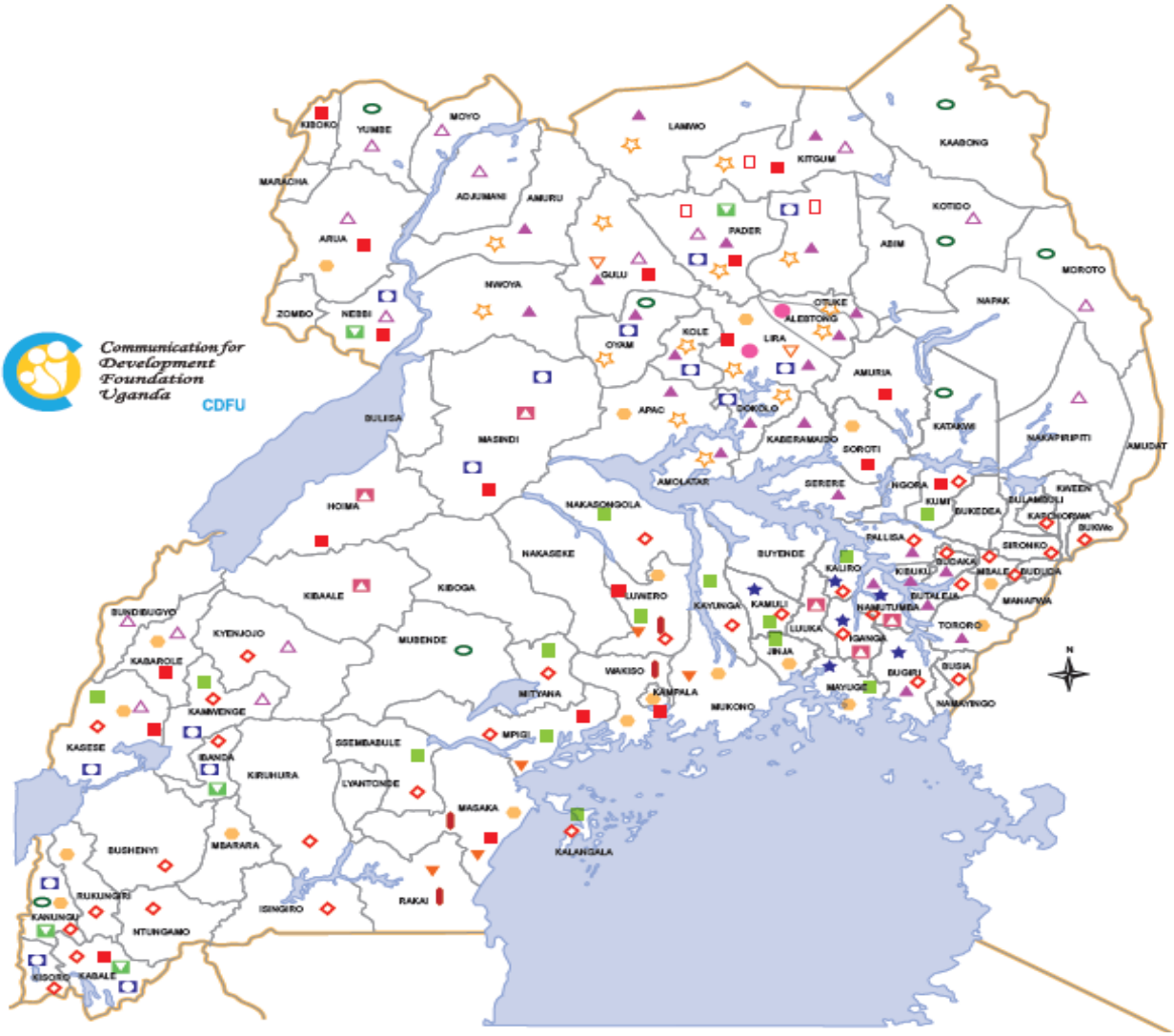
Appendix III

Tentative program for research

Date	Activity
Day 1	Preliminaries Presentation of letters of introduction to hospital administration Visit to research area
Day 2-day 6	Establishing of contact with research assistants Civil education of research assistants Testing of sample questionnaires with research assistants.
Day 7-14	Data collection
Day 15-30	Data processing Data analysis Writing of research report.
Day 30-37	Printing and handing in of the report.

Appendix IV

A map of Uganda showing all districts



Appendix V

A map of Jinja showing neighboring districts