FACTORS ASSOCIATED WITH INCREASED NUMBER OF ABORTIONS AMONG WOMEN AT KATIMA MULILO STATE HOSPITAL, ZAMBEZI REGION.

A THESIS SUBMITTED IN PARTIAL FULFILMENT OF THE

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Abstract

Background: In low- and middle-income countries, abortion is one of the leading causes of maternal mortality. According to reports, abortion is a common cause of maternal death in Namibia. This study described and probed factors associated with the high number of abortion cases and aimed to better understand, in an exploratory manner, the knowledge and awareness of abortion implications among women experiencing abortion at Katima Mulilo State Hospital.

Methodology: A qualitative approach with an exploratory, descriptive, and contextual design was used. The study's population consisted of women who underwent abortions at Katima Mulilo State Hospital. Purposive sampling was employed to select ten participants until data saturation was reached. A semi-structured interview guide was the sole means of data collection, and the collected data were analysed following the six steps proposed by Braun and Clarke (2013). Ethical considerations of institutional clearance, informed consent, the principle of justice, beneficence, privacy, and the principle of autonomy were adhered to.

Findings: Findings showed key reasons for abortion , including financial insecurity and dependence, being unprepared for pregnancy and motherhood, pregnancy-related mental and physical conditions, feelings of control over dismissal, influences on employment and education, personal assurance regarding termination, lack of partner support, lack of family support, risks of negative effects on family relationships, institutional and organizational support services, termination services available at private clinics, government clinics, and illegal termination services, as well as

societal norms and community socio-cultural beliefs surrounding termination and pregnancy.

Conclusions: There are factors associated with an increased number of abortions in women at Katima Mulilo State Hospital in the Zambezi region. Therefore, the study recommended that nurses offer comprehensive counselling to women on family planning, sexual health, and contraception options, promote better access to reproductive healthcare, and advocate for policy changes to ensure accessible contraception and supportive work environments.

Keywords: Abortion, factors, women, reproductive health, Katima Mulilo State Hospital.

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My deepest gratitude goes to everyone who provided me with data and information, especially women at Katima Mulilo State Hospital, Zambezi Region who shared details about the study.

Even with the help of many people, I am solely accountable for the information in this inquiry. The facts in this report and the content of this investigation are my personal responsibility, despite the assistance of many others.

Dedication

I dedicate this project to my Almighty Creator, my support, inspiration, wisdom, knowledge, and comprehension. You have given me strength through this program, and I have allowed myself to soar on your wings. My parents taught me that sometimes all it takes is one step to achieve something amazing, so I also dedicate this work to them. My child, thank you for allowing me to finish my thesis. It is for you.

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ABBRIVIATIONS AND ACRONYMS

ART	Antiretroviral Therapy
COVID-19	Coronavirus 2019
DHIS	District Health Information System
HBM	Health Belief Model
HIV	Human Immunodeficiency Virus
WHO	World Health Organization
UNAM	University of Namibia

DECLARATION

I, Lynn Monde Simasiku, hereby declare that this study is my own work and is a true reflection of my research, and that this work, or any part thereof has not been submitted for a degree at any other institution.

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LYNN MONDE SIMASIKU		October 2025
Name of Student	Signature	Date

CHAPTER 1

INTRODUCTION AND BACKGROUND

1.1 Introduction

The World Health Organization (WHO) [1] defines abortion as the termination of pregnancy prior to 20 weeks' gestation or the expulsion of a fetus weighing less than 500g, which is considered non- viable; this generally refers to the termination of a pregnancy, be it through medical intervention such as medications or surgical procedures, or whether it occurs spontaneously like a miscarriage. The development of successful interventions, policies, and strategies that can address the underlying causes of unsafe abortions, safeguard women's health, and advance comprehensive reproductive healthcare services depends on an understanding of the factors contributing to Namibia's rising abortion rate.[2] In recent years, the abortion rate in Namibia, a Southern African nation, has increased alarmingly. This trend has significant ramifications for women's reproductive rights and health, as well as for the overall health of individuals, families, and society. To better understand how these factors interact and what they might mean, this study investigates and analyzes the various aspects of Zambezi's rising abortion rate, as less is known about its context.

1.2Background of the study

Estimates from 2010 to 2014 show that 45% of women of reproductive abort worldwide and such abortions were carried out under the least safe circumstances.[1] this makes abortion a leading cause for maternal deaths.[3] Abortion is illegal in Namibia whereby it's only permitted under certain circumstances, which therefore

makes it challenging to get accurate statistics on the abortion cases. It's further indicated that, between 1990-1994 and 2015-2019; the unplanned pregnancy rate in Namibia grew by 17% while abortion rates rose 81% over the same time span, abortion rates resulting from unwanted pregnancies also increased from 18% to 28%.[4] Annually, there were 103,000 pregnancies between 2015 and 2019, of these, 66,300 were unplanned pregnancies, and 18,600 were aborted. In January 2023, the Namibian police revealed that about 179 babies were dumped in Namibia in the past three years, either through abortion or concealment of birth, the latest statistics provided by the police indicate that 63 illegal abortions were reported between 2019 and 2021 .[5]

In 2016 alone, Namibia had recorded 7033 illegal abortion cases with Katutura Intermediate Hospital being the highest and Okahao State Hospital being the lowest with 105 cases. Katima Mulilo had 201 cases of illegal abortions, however due to the illegality of abortion the country; abortions are more likely done in secret and therefore numbers could be more than these.[6]

Research indicates that reoccurring obstacles to access to safe and lawful termination services involve social stigma, adverse attitude of healthcare workers towards termination, conscientious objection by healthcare workers, human resource issues, disintegrated care delivery, and limited access to some facilities and services like post-termination counselling.[7] In addition, other studies indicate that women have given many reasons for ending pregnancies, from practical reasons (e.g., economic difficulties, educational opportunities), scheduling conflicts with pregnancy, and ontological reasons (e.g., unpreparedness for motherhood, stigmatization of

pregnancy, etc.).[7, 8,9,10] In addition, Baldwin-White and Gower indicate that social networks have a tremendous influence on the ending of a relationship, especially with the partner.[11]

A study in Kenya found that men made the majority of decisions regarding the termination of pregnancies[12], highlighting the importance of examining women's agency in making these choices. In Namibia, Shiningayamwe, Shalyefu and Kanyimba[13] found that young women practice abortion due to numerous social challenges they are faced with, such as economic hardships, family and social stressors, conflicts, environmental safety issues, and a high rate of gender-based violence, all of which are exacerbated by the country's on-going socioeconomic inequality. Therefore, it is vital if the research considers interpersonal factors (including family, peers, and partners), institutional factors, and public policy factors in isolation; our understanding of the reasons for termination (both legal and illegal) may remain incomplete in this particular setting. Therefore, this study described and probed into factors associated with the high number of abortion cases and better understand in an exploratory manner the knowledge and awareness on abortion implications among women experiencing abortion at Katima Mulilo state hospital.

1.3 Problem statement

The researcher noted that there has been a high number of abortion cases recorded at Katima Mulilo State Hospital between the years 2015 and 2021. According to the Zambezi area social worker, 1,681 illicit abortions have been recorded in the last six years, during which time only 10 legal abortions were documented, with the highest numbers reported among women aged 15 to 30 years.[6] The health information system (DHIS 2, which is an unpublished source) indicated that in 2015, 200 cases

were reported; in 2016, 201 cases were reported; in 2017, there were 219 cases; in 2018, there were 242 cases; while 2019 recorded 370 cases, and 2020 recorded 419 cases. In 2021, the number reduced to 41 cases. These numbers show a rising trend over the years; although the figures dropped in 2021, that year recorded one death among the reported cases. For interest's sake, the year 2022 recorded 129 cases, this again indicates a rise. According to a report in the New Era, [14] unsafe abortion cases reached 7,000 in 2017, and 14 women died due to abortive complications between April 1, 2018, and March 2021 nationwide. Genatra et al.[4] indicated that between 1990-1994 and 2015-2019, abortion rates rose by 81%. In 2016 alone, Namibia recorded 7,033 illegal abortion cases, with Katutura Intermediate Hospital having the highest number and Okahao State Hospital the lowest, with 105 cases, while Katima Mulilo had 201 cases of illegal abortions. Some implications, such as increased expenditure on medical bills by individuals and the health system at large, as well as disturbed mental well-being of affected individuals , could arise from the increase in cases that would not only impact individuals but also the economy and the health system as a whole . Factors attributed to abortion are not fully known; therefore, this study describes the factors associated with the high number of abortion cases among women experiencing abortion at Katima Mulilo State Hospital.

1.4 Purpose of the study.

The aim of the study is to describe factors associated with the high number of abortion cases among women experiencing abortion at Katima Mulilo state hospital.

1.5 Objective

1. Describe the factors associated with abortions among women seen at Katima Mulilo state hospital.
2. Explore the knowledge and awareness of women who experienced abortion at Katima Mulilo state hospital regarding implications of abortion.

1.6 Significance of the study

Firstly the study seeks to contribute to an understanding of the factors that lead to a rise in abortions. Secondly it might assist health workers to provide holistic care to these clients while understanding the experiences that these clients go through. In addition, some of these factors have been identified; and in turn it can further assist the ministry of health and social services and all its aligned ministries to close the gap on the causative factors. Furthermore, it can help the ministry of health to strengthen the provision of sexual reproductive health services in the school health programs with the help of the education ministry and lastly, future researchers can build further on the emotional implications that abortion has on these women.

1.7 Limitations of the study

The findings may be specific only to the studied population and may not be generalized to the entire Namibian context. It can also be difficult to get accurate information on abortion in a setting where abortion may be controversial. The study was further limited by the lack of Namibian literature on the factors linked to the rise in abortion rates among Namibian women. As far as the researcher was aware, no research had been conducted at the time of this study on the variables associated with a higher rate of abortions in Namibia. Therefore, studies carried out outside of

Namibia supported the study's findings. A portion of the participants from the institutions and organizations that were the focus of the study did not fully participate. Additionally, some participants repeatedly rescheduled appointments, which led to delays and, in certain cases, the abrupt collection of information.

1.8 Delimitation of the study

The study was strictly limited to women that have undergone abortion seen at Katima Mulilo state hospital that formed the population study. Clients seen at other unselected health facilities in the Zambezi were excluded from the study.

1.9 Definition of concepts

Abortions: This is defined as the medical or surgical ending of a pregnancy before the fetus is capable of living on its own outside the womb.[1] It can be generated in a number of ways or happen naturally (miscarriage).

Factors: Factors are the variables that manipulate to see how they affect the response variable.[12] In this study factors refers to what contributes to abortion among women of reproductive age at Katima Mulilo State Hospital.

Women: This is defined as adult female human.[13]In this study, a woman refers to those of reproductive age attending healthcare services at Katima Mulilo State Hospital.

1.10 Outline of the study

The study is composed of six chapters as follows.

Table 1.1: Outline of the study

Chapter Number	Chapter	Description
1	Introduction and background	This chapter provides an overview of the study, including the background, problem statement, goals, and research questions, as well as the outline and conclusion of the study.
2	Literature review	The theoretical and empirical foundations of the research study are supported by the relevant literature presented in this chapter.
3	Methodology	This chapter focuses on the researcher's efforts to address the research questions to achieve the goals and objectives of the study. It emphasizes data analysis, bias and ethics, validity and reliability, research design, research strategies, population and sampling, instruments, and pilot study.
4	Results	The results of data collection, using the research tools covered in Chapter 3, are presented in this chapter
5	Discussion	A discussion of findings related to the study's objectives was done in this chapter
6	Conclusions, recommendations	The concluding chapter summarizes everything and offers suggestions for the thesis's goals.

	and limitations	

1.11 Summary

This chapter presented the context and research problem of the study to the reader. The objectives, aims, and research questions of the study are also included. Chapter 2 has a chapter outline and study significance discussion. Chapter 2 presents the literature on the research topic.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

The study problem was identified, and its background was presented and discussed in the previous chapter. Additionally, it outlined the study's goals, importance, constraints, and boundaries. The definitions of key terms were also provided in the fifth chapter. The study's literature review is presented in this chapter. A literature review, according to McCombes[15] is an assessment of the body of existing knowledge on a given topic. Finding, evaluating, and integrating relevant information from books, scholarly journals, and other sources are all parts of it. The goals of a literature review are to provide a comprehensive overview of the current state of knowledge on a subject, identify gaps or inconsistencies in the body of existing research, and illustrate the need for further study. It demonstrates the researchers' command of the topic and helps situate research within the context of previously published works. Regarding childhood cancer, the literature is assessed in terms of its theoretical foundations, content, and concepts.[16]

2.2 Search strategy

The research's search strategy utilized a detailed method to locate relevant literature on factors associated with an increased number of abortions among women. Using a parallel search approach, the researcher applied specific search terms, including "factors," "abortions," and "women." These terms were consistently utilized across various data bases such as Sabinet African Journals, Scopus, PubMed Central, and

Google Scholar. To enhance the strategy and guarantee its strength, advice was obtained from the research librarian at the University of Namibia's main campus, including a session on efficient search techniques. The investigation covered articles written in English from January 2014 to August 2024, providing a modern viewpoint while taking into account the advancements of the past ten years. Local databases at the University of Namibia (UNAM) and Namibia University of Science and Technology (NUST) were accessed to identify possible studies specific to Namibia. The deliberate incorporation of Sabinet and Google Scholar enhanced the search by covering publications from Southern Africa and other countries. This extensive approach sought to encompass a wide yet specific array of literature on the topic, establishing the groundwork for later evaluations.

2.3 Overview of abortion

Abortion has been defined differently by different researchers and writers, example, the American College of Obstetricians and Gynecologists[17] defines abortion as the termination of a pregnancy when the embryo or fetus dies and is expelled spontaneously within the first 12 weeks of pregnancy. There are several methods of abortion, including surgical and medical abortion. A surgical abortion involves a minor operation with either curettage or suction, whereas a medical abortion uses medication that induces the abortion.[4] Women may choose to have an abortion for various known reasons, such as personal circumstances, a risk to the health of the mother or her unborn child, or a high likelihood that the unborn child will have severe physical or genetic defects.[18]

The most recent data available from the WHO and the Guttmacher Institute, covering the period from 2010 to 2014, indicates that 45% of all induced abortions were

unsafe.[1] This translates to approximately 25 million unsafe abortions annually during that period.[1] The majority of these unsafe abortions (97%) occurred in developing countries in Africa, Asia, and Latin America[1]

Unsafe abortion is most common in Africa. Up to 98% of abortions in Africa are unsafe[18]. The World Health Organization categorizes unsafe abortion into two types based on the individual who conducted it. These include abortions that a qualified practitioner conducted with an old or risky method or an inexperienced person with a safe method. Unsafe abortion can be carried out by inserting foreign materials and using herbal remedies in the vagina to end the pregnancy.[19,20]

Many women intentionally end their pregnancies through self-induced abortion, putting their health at risk and potentially facing immediate or long-term effects on their well-being. Women who have abortions may suffer from physical and psychological harm, and if all pregnancy tissue is not removed from the uterus, infections, vaginal issues, cervical complications, and haemorrhage may occur.[21]

The risks of performing an abortion, whether medically or surgically were identified by Mote, Otupiri and Hindin[22]. Internal organ damage, heavy bleeding, infection, incomplete abortion, cervical damage, uterine lining scarring, uterine perforation, and the potential for preterm birth in subsequent pregnancies are among the more serious physical effects, while minor ones include cramping, abdominal pain, nausea, vomiting, and diarrhea. Women who undergo abortions may experience psychological and emotional effects that can appear days or years later.[21] A variety of symptoms, including eating disorders, relationship problems, depression, suicidal thoughts, flashbacks, sexual dysfunction, and substance abuse, can manifest as a form of post-traumatic stress disorder or feelings of guilt.

According to research conducted in Namibia, there are numerous explanations for why African women continue to undergo unsafe abortions.[13] Additionally, the controversy surrounding the topic is linked to access to abortion services in Africa. This encompasses several elements, including political, practical, moral, ethical, and religious grounds. In some developing nations, where it was previously only accessible to the wealthiest, the number of people lacking access to safe abortion care is increasing. The medical community must understand the conditions under which safe abortion services in our public health facilities should be provided to comprehend the legal provisions for safe abortion.[23]

2.4 Factors associated with abortion among women

2.4.1 Socio-demographic Factors

Numerous studies have examined the socio-demographic characteristics of women who have carried out abortions. A study was conducted in sub-Saharan Africa that revealed that teenagers and young adults aged between 10-24 years are more likely to become pregnant unintentionally and have subsequent unsafe abortions.[23] Given a lack of information and less independent decision-making at younger ages, it might indicate that age is a factor in the risk of abortion. More studies also revealed that low levels of education, poverty, and unemployment have also been linked to higher abortion rates.[24,25]

Another socio-demographic factor for abortion rates is marital status. A study aimed at assessing pooled prevalence of abortions among youths in East African countries revealed that the tendency to abort was high in married women than unmarried

women. It is suggested that the reason for this trend is due to the stigma attached to modern contraception use or non-marital sexual activity, unmarried women may be reluctant to report pregnancy termination.[26]

2.4.2 Beliefs, Attitudes, and Knowledge

The beliefs, attitudes, and knowledge of individuals regarding contraception, reproductive health, and abortion play a crucial role in decision-making processes. Studies have shown how cultural and religious norms affect attitudes towards abortion, with conservative cultural norms and religious teachings influencing opinions and stigmatizing those who seek abortion services.[27, 28] In a recent Namibian study conducted among third year nursing students, 21% of the participants strongly agree with the fact that women have the rights to abort in case an unplanned pregnancy occurs. This mind-set is likely what causes women to go for clandestine abortion practices that lead to complications.[29]In addition, based to a study conducted in Ghana on nursing students, religious leaders, patients and medical officers, the participants cited financial constraints and unemployment to be the reason for practicing abortion.

2.4.3. Medical reasons

Preventing the transmission of infections to their children is one of the main worries for mothers who have Human Immunodeficiency Virus (HIV). The risk of HIV transmission from mother to child has dramatically decreased as a result of antiretroviral therapy (ART). However, in situations when a woman becomes pregnant and decides to end the pregnancy, abortion might be considered a means to stop the possibility of HIV spreading to the fetus. A research conducted in Romania

on the perception of their decision to practice abortion found that 13.3% of women choose to abort due to medical conditions.[30] This is supported by another study in America which found that 12% of women sought abortion due to theirs and the baby's health.[17] In 2022, Zambezi region had the highest prevalence rate of HIV in the country with 22.3%.[31]This makes it the best cohort to determine whether the HIV prevalence contributed to abortion rates.

2.4.4 Economic limitation

The primary cause of rising maternal mortality rate is the lack of funding allocated for maternal health services. Maternal mortality rate for women aged 15 to 49 is 350 deaths per 100,000.[32] Unsafe abortions account for the remaining 15%, with induced abortions representing only 15%.[33] Many lives are lost due to the inadequate resources of the current health structure. The system is overburdened by the increased demand for maternal services, which damages medical facilities and creates public health issues in society. Additionally, many of these facilities cannot manage the strain, leading to an increase in unsafe abortions.

2.4.5 Abortion law

Very few African countries allow uncontrolled abortion. Zambia allows abortion on grounds of social, a woman's health, and her physical and mental well-being. Abortion is prohibited in most states, such as Angola, Congo-Brazzaville, Congo-Kinshasa, Egypt, Gabon, Guinea-Bissau, Madagascar, Mauritania, São Tomé and Príncipe, and Senegal. These restrictions and limitations pressure and dehumanize women. Kenyan legislation allows abortion merely for the purposes of saving the life

and health of a woman.[28] Makleff et al.'s[34] research found a strong link between strict abortion laws and the stigma experienced by unmarried women, particularly related to adolescent and unintended pregnancies, as these situations are often associated with restrictive legal environments. Thus, unmarried women engaging in sex can neither receive sexual and reproductive healthcare nor quality-quality contraception. Instead, a great number of young females who become pregnant by accident turn to unsafe abortion. In Kenya, inappropriate access to reproductive health care results in low contraceptive method effectiveness utilization.[35] Most young women unwittingly expose themselves to further unintended pregnancy, which they might terminate through unsafe abortion. Unsafe abortion is now the major source of mortality; especially for women between the ages of 10 and 24 years.[21] repeated induced abortions are common in these circumstances, which enhance the risk of adverse health outcomes. To prevent the occurrence and recurrence of unwanted pregnancies, there is a need to emphasize the necessity of post-abortion care and ensure that young patients receive counselling in contraception and successful pregnancy prevention measures before they are released from the health facility

2.5 Theoretical framework

This research is founded on the Health Belief Model. The Health Belief Model (HBM) is a psychological model to explain and predict health-related behaviours and serves as a model for studying attitudes toward such behaviours.[36] Thus, the HBM was selected to be utilized as a basis for explaining the results of the research.

The HBM deconstructs health decisions into a series of steps and presents a checklist of factors that affect health behaviour. The determinants of a higher number of

abortions among the research participants will be attributed to the constructs of the HBM in the research environment to further understand and explain the determinants of the higher prevalence of abortions among women attending Katima Mulilo state hospital, especially women's perceptions of the seriousness of getting an abortion, perceived severity of the condition (abortion), perceived benefits of action, perceived barriers to action, and cues to action.[33] This theory is most critical in supporting the discussion, findings, and conclusion of the study as a foundation of providing recommendations based on the outcome.

2.6 Summary

The chapter presented the reviewed literature. This was done in sections, including an overview of abortion and factors associated with abortion among women, which include socio-demographic factors, beliefs, attitudes and knowledge, medical reasons, economic limitations, abortion law, and finally, theoretical framework. The next chapter presents the research methodology used.

CHAPTER 3

RESEARCH METHODS

3.1 Introduction

This chapter outlines and examines the research methods employed in the study. It covers aspects such as research philosophy, design and approach, the study population, sampling, and the procedures involved. Additionally, the chapter delves into the research instruments utilized, the processes for data collection, and the analysis of the data. It also addresses the concept of trustworthiness and concludes with a discussion on ethical considerations.

3.2 Research design

A research design, according to Creswell and Creswell[37], is a process for conducting a study that includes participant treatment and data collection techniques. A research design is also a plan that establishes what, when, where, how much, and how the research study is carried out. It is therefore called a study blueprint.[38] According to Creswell and Guetterman[39], a suitable framework for a study that concentrates on the final results is sometimes referred to as a framework selected by researchers when conducting research. Research data can be broadly categorized as either qualitative or quantitative textual data. There are, however, other distinct sections in the qualitative textual material, as shown on the next page, and the current study takes significance of only qualitative approach into account. Additionally, the sources for the specific information needed for the current study are provided. The study used a qualitative design that is explorative and descriptive in nature

Exploratory design: A study of a condition or problem that provides the researcher with new information is referred to as an exploratory design.[40] It is used as an early stage of problem research when there are few or no prior studies to refer to or rely on for predicting an outcome.[41] To gather preliminary information that will help define issues, exploratory research is conducted.[42] To prepare for additional research, the exploratory design concentrated on gaining knowledge and understanding. It can be conducted when research challenges are still in the early stages of analysis.[43]

An exploratory approach is advantageous because it establishes the best methodologies to employ in a follow-up study or assesses the viability of a larger study.[44] Because of its foundational nature, exploratory research in this study relied on techniques such as formal qualitative research through in-depth interviews. In accordance with the qualitative method of data collection and analysis, an exploratory research design was employed to ensure a more thorough understanding of the factors associated with increased number of abortions in women at Katima Mulilo State Hospital, Zambezi Region.

Descriptive design: This involves observing and documenting subjects' behaviour using scientific research techniques while preventing them from influencing the investigation's findings.[45] Its primary objective is to accurately depict participants. According to Saunders, Lewis, and Thornhill[45] descriptive research design promotes observing the subjects under study by monitoring and recording the participants. Descriptive research aims to answer specific questions by analyzing the relationships between variables, such as which factors appear to be consistently linked to

particular conditions, events, or behavioural patterns.[46] Descriptive studies employing this type of survey design can reveal the specific characteristics of a sampled population or group.[47]

Qualitative design: Addo- Atuah[48] asserts that qualitative research is particularly well-suited for explaining and understanding issues and processes. From the perspective of an informant, the qualitative method aims to comprehend human behaviour inductively and holistically. Therefore, a qualitative approach dedicated to viewing the phenomenon from an individual's viewpoint that was necessary to understand the factors associated with increased number of abortions in women at Katima Mulilo state hospital, Zambezi region. According to Creswell[49], it presents an opportunity to research and generate meaning that enhances and contextualizes human existence.

The selected designs enabled the researcher to draw the conditions relating to the factors linked to the rising number of abortions among the females observed in the setting.[49] Particularly, it facilitated responding to the what, when, where, and how questions related to the research issue instead of the why.[50] This was a suitable design for the research because the researcher wished to examine and expound on the variables that are linked with the rising rate of abortions among women at Katima Mulilo State Hospital.

3.3. Study setting

Research setting is the location where data are gathered.[51] Data will be gathered in Katima Mulilo. Katima Mulilo, or simply Katima, is the capital of Namibia's Zambezi Region. It was inhabited by 28,362 people in 2010 and consists of two electoral constituencies. The urban component of Katima Mulilo consists of a

population of 14,359, of whom 22% are childbearing-aged females.[52] Katima Mulilo state hospital is the sole district hospital within the region.

3.4 Target population

Study population is defined as individuals or items sampled from the population in general, who possess a common feature of interest to the researcher.[52] The focus group consisted of women who underwent abortion at Katima Mulilo State Hospital and fulfilled the sampling criteria, to whom the researcher was exposed during study period.

3.5 Sample and sampling

Sampling is the process of picking relevant people from the population to be included in the research. The process of selecting units such as individuals and organizations from the population being studied is called sampling.[53] A sample is a representative portion of a population, and even a small sample will be representative of the entire population, according to Garg and Kothari.[54] Data can be collected from a finite sample by researchers and projected to the entire population based on the representative sample.[55] The subjects in this research were women who underwent abortions at Katima Mulilo State Hospital. On the other hand, a sample refers to a subset of the population selected to participate in the study, whereas sampling is referred to as selecting a part to represent the whole population.[56]

In accordance with qualitative research design, a non-probability inform of purposive sampling was used to select the research participants for the study. In purposive sampling, participants are selected because they possess the characteristics that make them the appropriate people to provide information to answer the research question.[57] The researcher purposefully selected participants from women who had undergone abortions at Katima Mulilo State Hospital by reviewing hospital ward records. These participants could either still be receiving care or have been discharged at the time the data was being collected and with the will to be interviewed for this study.

To obtain an increased number of interviews and the maximum number of interviews depends on whether data saturation is reached.[58] Data saturation is defined as the point where additional participants provide no new information and the emerging themes become repetitive[58]. In this study, a total of 10 participants participated in the study until data saturation was reached. Thus, the sample size for the study was 10 participants.

3.6 Research instrument

In qualitative research, the researcher obtains information by conducting interviews with the participants[59]. A research instrument is a device that will be utilized to collect data in the data collection phase of thestudy[59]. Individual semi-structured interviews with an interview guide and open-ended questions were employed in this research. Individual semi-structured interviews were employed since they provided participants with adequate time to give their own personal detailed and in-depth opinions on matters regarding the topic being addressed. The researcher created the

interview guide suitable for the study's purposes using equipment such as a notebook and a voice recorder.

3.6.1 Face to face interview

The researcher collected data by personally conducting study interviews and observing participants ' behaviour and responses, both verbal and non-verbal. The interviews were structured, utilizing an interview guide comprised of semi - structured questions to maximize the quality of information. Additionally, the questions in the interviews were open - ended, taking a time frame of between 30 minutes to an hour for completion. Some interviews were targeted to be conducted in the local language of the participant (Lozi/Subia/Sifwe, etc.) for those who did not speak English. Nonetheless, all participants understood English, and thus the entire exercise was conducted in English. With this type of interview, the researcher was able to collect and explore the information needed to comprehend and describe the participants' knowledge of the possible implications that abortion had or caused for the affected women and the people around them, as well as to explore different causative and associative factors related to current abortions.

The interview guide included open - ended questions, which comprised seven questions classified into two main domains. The third domain was for probing questions if needed, based on participants' responses to the main questions. Further probing questions asked are not currently listed in the data collection tool, as the responses may influence the direction of the questioning. There are two main questions to the topic under study which are:

1. What do you think are the factors associated with your current abortion?

2. What is your the knowledge and awareness on abortion at Katima Mulilo state hospital?

Some probing questions that are not indicated on the study tool were followed based on clients' responses to the main question to ensure that more information is obtained.

3.6.2 The audio-recorder

This was used to capture all detailed responses of participants from the face - to - face in-depth interview. The audio recorders made it easy for the researcher to record, review, and analyze data during the data analysis process[60]. This was another way for the researcher to keep accurate information as per participants' responses. The researcher asked for permission before recording any of the interviews.

3.7 Procedure

Semi-structured individual interviews was chosen as a flexible method of attaining a wide range of detailed information when seeking to learn about factors associated with increased number of abortions in women seen at Katima Mulilo State Hospital. Due to the sensitivity of the study, a social worker was involved in the setting (with the participant's permission) to ease the situation, as some individuals needed further counselling and psychosocial support. Duration of 30 minutes to 50 minutes was spent with each individual during the interview, which took place in the hospital setting, where a separate room (filing room) was used in the gynae ward, away from other clients and staff, to avoid clients having to walk long distances to other hospital blocks. Those who preferred to be interviewed in the comfort of their homes were accommodated. Only two participants were interviewed in their homes, which were closer to the researcher's residence. Data was collected over one month in September/October 2024. Data analysis was conducted immediately after data

collection in October/ November 2024. Project management involved three members: the patient as a study subject, a social worker for counselling if there was an identified need for some participants, and lastly, the researcher to carry out the study, including data collection, analysis, and reporting. The results obtained from this study will be disseminated as an academic paper in both published soft and hard copy versions after adherence to publication policy.

3.8 Pilot study

Brink, Van de Walt and Van Rensburg[61] describe a pilot study as a preliminary, small-scale investigation carried out before the main research, involving a limited number of participants who meet the study's criteria. For this pilot study, two participants who qualified were chosen for interviews. This process helped refine the interview guide, of which some questions were altered slightly to bring a clear understanding to the participants but not besides the study purpose. The interviews were recorded to verify the proper functioning of the tape recorder, assess the environmental conditions, and identify any weaknesses in the researcher's approach. This included paying attention to both verbal and non-verbal cues, the way questions were posed and allowing opportunities to explore relevant responses from the participants.

3.9 Data analysis

The researcher applied a manual data analysis approach using thematic evaluation. Braun and Clarke[61]defined thematic analysis as the process of identifying recurring patterns in the data by thematizing them. The researcher conducted all the interviews verbatim. The interviews were analyzed using coding and theme identification. For this research, the researcher applied a thematic analysis approach that centered on

individuals' experiences, opinions, perceptions, and descriptions of a specific phenomenon.[61]

The six stages of Braun and Clarke's thematic analysis were used, which in order of sequence are: familiarization, coding, theme development, reviewing themes, theme definition and naming, and finally, writing up.

Data familiarization: After transcribing the data, the researcher read the transcripts several times to obtain a comprehensive understanding of the data.

Creating the first codes: By looking for similar responses, the researcher utilized Microsoft Word's highlight feature to colour - code the data.

Searching for themes: The researcher identified themes by organizing the codes into groups, which resulted in the formation of themes.

Reviewing the themes: After evaluating the emergent themes, four main themes were discovered.

Defining and naming themes: The overarching themes that emerged included individual level factors, interpersonal factors, institutional and organizational factors, and community factors (refer to Chapter 4).

Writing up: The final report was compiled by the researcher. It is challenging, if not impossible, for those evaluating the data to maintain total objectivity due to the nature of qualitative research. By using two individuals to code the data, bias was reduced in this study to prevent discrepancies between the findings of one researcher and another, thus preserving the study's objectivity. To facilitate interpretation, triangulation was also employed to examine additional data sources. Additionally, this study performed extra checks to validate interpretations and rule out bias.

3.10 Trustworthiness of the study

Trustworthiness of the whole study will be guaranteed by using the model of Lincoln and Guba (1985), consisting of the criteria to ensure credibility, dependability, conformability and transferability of the study. [63]

3.10.1 Credibility

Credibility is the reliability and trustworthiness of the data gathered and analyzed during the research. The researcher established credibility through member checks, which were required in verifying the participants.[64] The researcher cross-checked results deliberately through follow-up interviewing two participants with the aim of confirming their earlier findings. As the researcher administered the interviews, she asked follow-up questions for clarification to participants on the topic during the time of interviewing so as to verify the accuracy of their answers. Field notes and reflective notes facilitated the verification of the correctness and accuracy of information obtained.

3.10.2 Conformability

Conformability is responsible for ensuring that conclusions and findings of the researcher are based on the data, and therefore the researcher should prove how conclusions and interpretations were drawn.[64] All original data, interview field notes, data analyzed, and recordings were kept by the researcher until the research process was finished.

3.10.3 Transferability

Transferability refers to the applicability of the study findings, in terms of the context of intended aim and actual research performed.[65]An exhaustive account of the research context is done, of which the procedure started with the aim, details on data gathering, and criteria for inclusion were presented to assess whether the research was intended to be shifted to different research environments.

3.11 Research ethics

The researcher obtained ethical clearance from the University of Namibia (UNAM) ethical committee (See appendix C). Approval sought from the Ministry of Health and Social Services (See appendix D). The researcher also obtained consent from the regional director, the nursing manager and the unit in-charge of the hospital under study as well as obtain informed consent from the individual participant. Different ethical principles were applied to the study as explained further bellow.

3.11.1 Principle of Autonomy

The idea of autonomy in academic study refers to participant's ability to make educated, independent decisions about their wiliness to participate in the study. This principle highlights the significance of respecting participants' and researchers' rights to self-determination, allowing them to choose to partake in the study with free of coercion or undue influence.[65] Participants were provided with comprehensive information about the study's purpose, procedures, risks, benefits, and their right to

withdraw at any time without penalty. This ensured that individuals could make knowledgeable decisions about their participation

The researcher ensured that an informed signed consent form was obtained from all study participants before participation in the study. Participants were informed that the interview would be audio recorded and written notes taken. Moreover, the participants were informed that they could withdraw from the study at any given time with no penalty.[66]

3.11.2 Beneficence

Beneficence refers to the moral obligation to act for, or maximize, the benefit of others and non-maleficence means to not inflict harm on others.[67] Beneficence was ensured in this study by exploring certain risks of the study such as a participant may face embarrassment or social ostracism if their involvement in this study became known as they had practiced abortion, and /or if a participant reveals illegal behaviour during a study (e.g., illegal abortion), researchers was legally obligated to report this information. The researcher explained it to the participates in order to ensure no harm comes to the participants, and that the study will be conducted in an ethical manner. The researcher avoided harm by being culture and religious sensitive.

3.11.3 Privacy

Ensuring privacy in research is crucial for protecting participants' personal information and maintaining ethical standards. The privacy of the research

participants and confidentiality is strictly observed during the in-depth individual interviews. Each participant is interviewed individually and not in a group. Obtaining explicit consent from participants regarding how their data is used is essential. This ensures that participants are fully aware of the nature of the research and the potential risks involved. Without informed consent, participants' privacy rights may be violated, leading to ethical breaches. Collected data will be stored for five years for auditing and verification purposes.

3.11.4 Principle of confidentiality

The only person who knows the research participants is the researcher. The attendees were provided with guarantees that no private information will be shared without their knowledge or consent. The researcher kept the participants' data safe, even in cases where anonymous information collection was not possible. The dissertation, to be retained in the university library, was composed of the utilizing of the collected information. Besides, the information was collected in a professional manner, such that the Data was collected through codes not connecting participants' answers. Data gathered like physical copies of the consent forms, field notes, and reflection notes were placed out of the sight of unauthorised people. The disclosure or use by placing it within a locked cupboard, while all electronic files with data are saved in documents on a computer that is password-protected.

3.11.5 Principle of justice

This principle obliges researchers to act always in ways that are reasonable, non-exploitative, and well thought through and with fair sharing of costs and benefits.[68]

For this research, the participation was a free will. Everyone who wanted was offered an equal opportunity to participate based on the research design's eligibility criteria. There were no rewards for failing to participate in this study, nor were there any payments offered for participating either.

3.12 Summary

This chapter introduced the research methods employed in the study. This chapter, which also discusses the methodological approach and conceptualizes the research philosophy, research method, research approach, data collection approaches, and data analysis methods, emphasizes specifically the research project. The overall credibility of the study can be assessed by the reader even from this chapter. The main subject of the subsequent chapter was the statement of results and its interpretation.

CHAPTER 4

RESULTS

4.1 Introduction

The previous chapter discussed the research method employed in gathering and processing data. This chapter summarizes the findings of the research collected from ten (10) research participants. The aim of the research was to describe and explore issues around high numbers of cases of abortion, and more define, in exploratory mode, awareness and perception of abortion outcomes by women presenting at Katima Mulilo State Hospital for abortion.

As discussed earlier, ten participants participated in the research until saturation of data was achieved. Data was gathered by conducting in-depth interviews that were audio-recorded. The collected data were analyzed through Braun and Clarke's thematic analysis, suggested to be done in this study. The verbatim transcriptions of the audio-recorded interviews were used to extract important study-related statements and clauses. These statements were carefully reviewed to ensure they supported the study's objectives. Following the assignment of meanings to the significant statements, theme clusters were developed. These theme clusters were eventually analyzed into emergent themes, which provided the essential structure for creating a comprehensive account of the phenomenon under investigation.

4.2 FINDINGS FROM THE STUDY

The study findings are presented in two sections, namely; demographic information of the participants and factors associated with current abortion.

4.2.1 Demographic information of the participants

The demographic information of the participants includes age, marital status, employment, reason for coming to the hospital, and previous experience of abortion. The demographic information of the participants is presented in Table 4.1 that follows.

Table 4.1: Demographic information of the participants

Participants	**Age (years)**	**Marital status**	**Employment**	**Reason for coming to the hospital**	**Previous experience of abortion**
P1	26	Single	Unemployed	Vaginal bleeding in pregnancy	0
P2	34	Married	Unemployed	Passage of blood clots	1
P3	22	Single	Student	Vaginal bleeding in pregnancy	0
P4	38	Single	Employed	Fever and chills	2
P5	41	Married	Employed	Severe pelvic cramps	2
P6	23	Single	Student	Vaginal bleeding in pregnancy	0
P7	33	Single	Employed	Severe back pain	1
P8	37	Single	Unemployed	Vaginal bleeding	1
P9	35	Single	Self employed	Passage of blood clots	1
P10	29	Single	Unemployed	Vaginal bleeding	1

Table 4.1 above shows that only ten (10) participants took part in the study, with ages ranging from 22 to 41 years. Findings indicate that five (5) of the participants were in their 30s, followed by four (4) in their twenties, while the remaining one was 41 years old. Further findings reveal that eight (8) of the participants were single, whereas only two (2) were married. Additionally, four (4) of the participants were unemployed, followed by three (3) who were employed; two (2) who were students, and the remaining one (1) was self-employed. All (10) participants visited the hospital due to the signs they were experiencing. Regarding previous abortion experiences, five (5) of the participants had undergone one abortion, followed by three (3) who had not experienced abortion, while the remaining two (2) had aborted two times prior to the study.

4.2.2 Factors associated with current abortion

The study aimed to describe and probe factors associated with the high number of abortion cases and to better understand, in an exploratory manner, the knowledge and awareness of abortion implications among women experiencing abortion at Katima Mulilo State Hospital. The participants' recorded interviews were transcribed verbatim. Each statement was then assigned a meaning, and only four themes emerged from multiple readings of the transcriptions, which were grouped into thirteen subthemes. The main themes that emerged are individual - level factors, interpersonal factors, institutional and organizational factors, and community factors. The subthemes representing the findings include insecurity in finance and dependence, being unprepared for pregnancy and motherhood, pregnancy related

mental and physical conditions, feeling of control over dismissal, influence on employment and education, personal assurance regarding termination, lack of partner support, lack of family support, risk of negative effects on family relationships, institutional and organizational that offer support, termination services available at private clinics, government clinics, and illegal termination services, pregnancy termination norms, community socio-cultural beliefs and norms around termination and pregnancy. Each theme and its corresponding subthemes are presented. At the end of each participant's quote, there are numerical suffixes for the reader to reference the data distribution. Themes and subthemes are presented in table 4.2 below.

Table 4.2: Thematic table

Themes	**Subthemes**
Theme 4.2.1: Individual level factors	**Subtheme 4.2.1.1:** Insecurity in finance and dependence
	Subtheme 4.2.1.2: Being unprepared for pregnancy and motherhood
	Subtheme 4.2.1.3: Pregnancy related mental and physical conditions
	Subtheme 4.2.1.4: Feeling of control over their own
	Subtheme 4.2.1.5: Influence on employment and education
	Subtheme 4.2.1.6: Personal assurance regarding termination
Theme 4.2.2: Interpersonal factors	**Subtheme 4.2.2.1:** Lack of partner support
	Subtheme 4.2.2.2: Lack of family support
	Subtheme 4.2.2.3: Risk of negative effects on family relationships
Theme 4.2.3: Institutional and organizational factors	**Subtheme 4.2.3.1:** Institutional and organizational that offer support
	Subtheme 4.2.3.2: Termination services available at private

	clinics, government clinics, and illegal termination services
Theme 4.2.4: Community factors	**Subtheme 4.2.4:1** Pregnancy termination norms
	Subtheme 4.2.4:2 Community socio-cultural beliefs and norms around termination and pregnancy

4.2.1Theme 1: Individual level factors

Individual level factors emerged as those main factors associated with the high number of abortion cases at Katima Mulilo State Hospital. These factors include insecurity in finance and dependence, being unprepared for pregnancy and motherhood, pregnancy related mental and physical conditions, feeling of control over dismissal, influence on employment and education and personal assurance regarding termination.

4.2.1.1 Subtheme 1: Insecurity in finance and dependence

Participants indicated that financial insecurity and dependence, along with the belief that they would not be able to support a child adequately, were significant factors in their decision to terminate their pregnancy. This is evidenced as follows.

> *"Due to our reliance on others (parents and family members), we were unable to have a baby because we sometimes go without food. I had no desire to bring a child into this world."* P3

> *"What was I supposed to give the child? Although I know that the child's father will help me, I believe that at this point in my life-I am*

in my late 20s-I need to be independent. What will I do, then, if he decides not to contribute this month?" P10

"I rely on my mother, I don't have a matric, and I don't work." P6

Some of these participants mentioned feeling unable to support another child because they already had one or more children to care for, which suggests that the financial strain was greater for women who were already mothers.

"*My first two children are having a difficult time... With three children, the burden will be too much, especially if you are unemployed*." P5

Finally, while most participants did not directly attribute their decision to terminate to COVID-19, many did report changes in their employment and socioeconomic circumstances, suggesting that this may have played a role.

"Human beings have lost jobs due to COVID starting. Initially, they were losing jobs, but now it is worse because the organization is putting some regulations and has to take some actions which discourage them from hiring people. If I don't have a job, then I won't work, and if I won't work, then what will I feed my kids with? Thus, that came into play also." P7

"So, then I thought, 'Well, if I've got a baby and my mum isn't working, I am not working, and the father's family don't want the baby, then things weren't going to go well. I wasn't working properly, and my mum also lost her job due to the lockdown rules of COVID-19.'" P10

Participants indicated that financial insecurity and dependence, along with the belief that they would not be able to support a child adequately, were significant factors in their decision to terminate their pregnancy. This is evidenced as follows.

> *"Due to our reliance on others (parents and family members), we were unable to have a baby because we sometimes go without food. I had no desire to bring a child into that world."* P3

> *"What was I supposed to give the child? Although I know that the child's father will help me, I believe that at this point in my life-I am in my late 20s-I need to be independent. What will I do, then, if he decides not to contribute this month?"* P10

> *"I rely on my mother, I don't have a matric, and I don't work."* P6

The extracts above show that financial insecurity, dependence, and belief in inadequate child support as significant factors in women's decision to terminate their pregnancy. The COVID-19 pandemic also impacted on these decisions, with job opportunities and family support being the primary reasons.

4.2.1.2 Subtheme 2: Being unprepared for pregnancy and motherhood

Many participants said they did not want any more children.

> "*They [children] are not what I want in the future. The problem is that when I was younger, I took on the role of mother to my siblings, so I don't think I want to return*." P4

> "*No, I was not ready to have a child. I would not cope with it with all these financial problems I have*" P3

Furthermore, a few participants explained that they wanted children in the future but decided to end their pregnancies because they did not feel psychologically ready to become mothers or have another child while pregnant.

> "*Because I wasn't ready for that child wasn't ready for me... My baby is only a year old, so I believe she requires more care. I also believe I won't be able to manage the demands of both a baby and a young child*." P9

The unplanned nature of the pregnancy, which was caused in part by unsuccessful contraception or a failure to use birth control methods, was one aspect of this lack of preparedness. Participants expressed that learning they were pregnant made them feel shocked, unhappy, and disappointed.

> *"I told myself after this first pregnancy that I would not become pregnant again anytime soon, so I was really disappointed. I had conflicting feelings and was devastated to learn that I was pregnant. I've just concluded that it's best for me to end things until I am emotionally, financially, and psychologically prepared for a second child*." P10

The above extracts confirm that participants ended pregnancies due to psychological unpreparedness, unplanned pregnancy, unsuccessful contraception, distance to clinics, judgment, and negative beliefs, resulting in shock, disappointment, and eventual termination.

4.2.1.3 Subtheme 3: Pregnancy related mental and physical conditions

According to two interviewees, their decision to end the pregnancy was influenced by their physical and mental health issues during the pregnancy. In particular, one participant reported self-reported depressive symptoms that she recognized from prior pregnancies, which were exacerbated by her partner's lack of support.

> *"After that, I began to feel ill due to the pregnancy. I've never been good with pregnancy. I started to lose weight. After contemplating ending things, I had a depressing weekend and didn't want my children or anyone else around me. I wanted to be alone and wished to disappear. I went three days without food or water because I had lost my appetite. I felt depressed and cursed, and I didn't want anyone near me. When my partner returned from his recent outing, he argued with me and asked why I hadn't cleaned the house. I told him that I was constantly sleeping and acting like I was pregnant for the first time. I then decided that Monday morning, I would terminate the pregnancy".* P2

> *"I was ill. I couldn't stand for more than two minutes because I wasn't feeling well. I felt lightheaded unless I sat down. I couldn't go without food for more than two hours."*P4

The narratives above show that two interviewees experienced physical and mental health issues during pregnancy, including self-reported depressive symptoms, weight loss, depression, and loneliness. One experienced three days without food or water, feeling cursed leading to pregnancy termination.

4.2.1.4 Subtheme 4: Feeling of control over their own

In face-to-face interviews, participants conveyed a sense of autonomy, expressing that they believed the decision to terminate their pregnancy was entirely their own.

> *"I was not under any pressure to terminate; the decision to do so or not was completely up to me."*P4

> *"Since the baby is in my body and will ultimately affect me more than you, if I say I don't want a baby, then I don't want it."* P1

Even participants who decided to terminate due to circumstances that left them with few options, such as financial strains, appeared to use language that affirmed their own authority.

> "*I didn't want to care what other people thought because I had my own reasons for doing it."* P9

> "*I simply made the decision to act in my own best interests at that specific time*." P1

One participant stated that she did not think she had any control over her sexual life. Interestingly, despite feeling fully in control of her decision to end her pregnancy, her sexual self-efficacy and ability to negotiate sex with her partner were impeded.

> *"Sometimes you don't want to have sex, but you find that your partner wants it, so you just do it to get him to stop bothering you. Therefore, I don't believe I have any influence over that."* P8

The extracts above show that interviews reveal that participants felt autonomy in terminating their pregnancy, even with financial strains. However, one participant's sexual self-efficacy and negotiation ability were impacted, emphasizing the importance of personal autonomy.

4.2.1.5 Subtheme 5: Influence on employment and education

The detrimental effects of pregnancy and the ensuing childcare responsibilities on work and educational opportunities were another clear factor in two participants' decisions to end their pregnancies.

> *"I told him [partner] that I wanted to go to school and that pregnancy would delay me, so I wasn't ready."* P3

> *"What will I do if I accept a job offer?"* P8

The above narratives show that two participants decided to end their pregnancies due to the negative impact of pregnancy on work and educational opportunities.

4.2.1.6 Subtheme 6: Personal assurance regarding termination

Most participants shared their personal opinions that termination was sinful or wrong to some extent, and several expressed fear of the physical or spiritual repercussions of the termination. There was some religious or cultural reason for most of them (e.g., traditional cultural beliefs or Christianity).

> "I *think it would haunt you later in life or perhaps limit future childbirth possibilities." P5*

"Although I'm not very religious, I believe abortion is wrong because you are killing a soul. I don't believe in it, but I didn't really have another option." P4

While some individuals had some concerns regarding aborting their pregnancies, others spoke of disregarding such doubts as they made the choice because it was the best choice to make at that time.

"I had to put my beliefs aside, what other people told me, and what the Bible said for the first time.". I told myself, Fine, if it was a sin, we all commit sins; it's just that they are varied, and I will deal with that later. I pretended to myself that I was making the choice. Even though I wanted to break up, I did know that the fact that there was a child was a gift. I do not say that it is bad or good; everyone has his or her why." P7

"No, [beliefs were not involved in the decision]. It just sorts of felt like something I wanted to do" P10

"Breaking up is a sin. I never really believed that [these beliefs] were applicable. Church is church, anyway, and only God can judge you." P6

Yet, some of the participants held beliefs about trusting and respecting personal decision-making instead of believing termination was wrong.

"*Everyone does have their reasons, which is good. My reasons for aborting were different. For example, I did not want to think about it a lot because I wanted to do it, so yes." P9*

"I was told to follow what I believe in, I just have to rely on myself. I just have to keep with it if I am okay with it if I decide." P3

The extracts above show that most participants view termination as sinful due to religious or cultural beliefs, fearing physical or spiritual repercussions. Despite uncertainty, many believe in the right choice, acknowledging individual motivations and God's authority. They respect individual decision-making and stick with it if comfortable.

4.2.2 Theme 2: Interpersonal factors

Interpersonal factors emerged as a theme in this study, with three subthemes: lack of partner support, lack of family support, and the risk of negative effects on family relationships. These factors are associated with abortion among women of reproductive age at Katima Mulilo State Hospital in the Zambezi region.

4.2.2.1 Subtheme 1: Lack of partner support

A couple of women mentioned that the abortion was done with support of their partners beforehand and afterward, but other women had unstable relationships, partners that would not own up to fatherhood, or broke up upon informing their partners that they were pregnant. Decision making on performing an abortion seemed to result from not being able to trust one's partner or embrace one's pregnancy due to insufficient support.

"*My partner and I don't have a very good relationship. It wouldn't have been wise to have another child."*P4

'When I told him that I was pregnant, he started ignoring my calls and gave excuses for not visiting me. He told me that he did not want to be a father. I told him how the state of the house is, what happens to me in case I abort the baby, and the rest, but he informed me that he never wanted all those things. First, he was okay; see the kind of boys - promising you heaven and earth - and then you see it is not okay, and then I'm a student." P6

"*It was fine before I got pregnant, but after I became pregnant, he became indifferent and preoccupied with other girls. We would talk about other things when I mentioned the pregnancy, so I decided to end it since I could see that it was pointless to keep bringing it up*." P7

One participant found it unacceptable that their partner wanted to raise their child in secret while also being in a serious relationship with another woman.

"You see, I came to the realization that this is not the type of partner I want to have. And it's obvious that my child will remain a secret; otherwise, he might suddenly stop talking to me, as you know. After that, I decided to let him go."P8

On the other hand, one participant stated that her partner was unable to provide for the child financially, despite his willingness and support.

"*He stated that he is not ready. In addition to being young, he lacks financial stability. I won't be able to fully support the child, he said. He must take care of his siblings, manage his household, and send money to his family because he is still a young man*." P6

The extracts show that participants' decisions to end pregnancies were influenced by inability to trust and accept their partners, exacerbated by lack of support. Some had committed relationships, others were unreliable, and some partners refused to accept responsibility or provided financial support.

4.2.2.2 Subtheme 2: Lack of family support

Participants cited a lack of emotional or practical support from their families as a reason for deciding to abort their pregnancies. They described having strained social relationships, living in hostile family environments, fearing judgment, and experiencing poor communication with minimal emotional backing. Because of these circumstances, many participants opted not to inform their family members about their pregnancies, which made them feel even more isolated in their decision.

> *"There is absolutely no bond between my mom and me. That's why I didn't want to have any more children. I would never have had an abortion (termination) if my mother and I were close. You see, she would have said, "The second one now," and then she would have become irate because she is a parent if we had that relationship. My mother and I are not friends, so I would have said, "I have my mom," and she would have responded, "We'll see what we can do." Therefore, I don't have that connection with my mother; I can't rely on her to support me."*P8

> *"I have a good relationship with my family, but I keep some things from them. I feel this way, especially about my sister, which is why I*

have been unable to approach her and let her know that I am this way and that I intend to do this. She seems too critical, in my opinion. The moment you tell her something, she is the kind of person who will fight against it." P9

On the other hand, one participant reported that family members' pressure to end their marriage was influenced by their families' living conditions and financial hardships.

"My decision to terminate was influenced by my mother. Mothers tend to ask questions like, 'Where will your child stay?' and 'You see that we are in a small house, among other things. She revealed her financial circumstances to me, as well as the fact that I already had two other kids." P10

The above extracts show that family members' lack of emotional or practical support, poor social relationships, hostile environments, fear of judgment, and poor communication led to pregnancy termination. The study also revealed that living conditions and financial hardships also influenced the decision.

4.2.2.3 Subtheme 3: Risk of negative effects on family relationships

As some of the participants described, one of the reasons they had ended their pregnancies was to prevent a negative response from their families, ranging from rejection to abuse. One of the participants' stories demonstrated how the family response to the disclosure of a second undesired pregnancy was hostility and, eventually, a broken relationship, with little contact with the family and no discussion on the abortion of the pregnancy.

> *"They recognized my error the first time, so I'm being careless with the second child. They rejected me, and I'm not serious about the future." P2*

In certain instances, this threat stemmed from traumatic events related to prior unwanted pregnancies, which had been met with animosity and stress from relatives. Negative consequences, such as being denied food or being evicted from the family home, had resulted from this. In these situations, the participants chose to terminate their pregnancies to prevent similar circumstances in their families.

> "*My family was upset with me because I was pregnant while still in school. After they learned that I was pregnant, they stopped talking to me and stopped feeding me. My older sister chased me out of my mother's bedroom, locked it, and told me to sleep in the dining room, even though I was already sleeping there. I was terrified when I learned about the most recent pregnancy and began thinking about my first pregnancy and how things had changed at home during that time."* P3

> "*There will be issues if I bring another child because my oldest sister always says she doesn't want one. During my first pregnancy, they drove me away*."P6

The narratives above show that participants ended their pregnancies to avoid negative reactions from relatives, including rejection or mistreatment. Traumatic events and lack of contact led to negative consequences, prompting them to choose termination.

4.2.3 Theme: Institutional and organisational factors

Only two subthemes emerged from this main theme: institutional and organizational, which offer support and termination services available at private clinics, government clinics, and illegal termination services.

4.2.3.1 Subtheme1: Institutions and organizations that offer support

Participants indicated the presence of organizations and institutions supporting their decisions to stop, even though many participants stated they received little mental health support from facilities like clinics. One participant, for instance, reported receiving assistance from clinic staff, which differed from some other participants.

> *"At the neighborhood clinic, they did not pass judgment on me. The nurse I saw there was elderly, so she spoke to me kindly and advised me not to feel bad during our conversation. Knowing that I wasn't alone was very helpful to me*." P7

Two participants received assistance from a church and a youth organization.

> "*It was [organization], and it doesn't generate any revenue. It is a children's organization with various categories. I joined the decision category, which includes individuals who have had abortions or terminations in the past and those who wish to do so. Do you understand? Yes, they were helpful to me."* P8

"*I might mention the church. They oppose firing, but they do support adhering to your decision as long as you comprehend it. It doesn't matter what decision you make."* P2

The extracts above show that while some organizations and institutions support participants' decision-making, many lack mental health support from facilities like clinics.

4.2.3.2 Subtheme 2: Termination services available at private clinics, government clinics, and illegal termination services

Participants were discharged at government facilities, private clinics, or illegal termination services. Many participants stated that using private clinics was too costly. Participants' experiences with accessibility at government clinics differed, particularly regarding the availability and attitudes of the staff. While some participants had a positive experience with clinic staff, others reported feeling mistreated or judged.

"*They were okay... the way they spoke to me*." P10

"People have complained that the nurses are unkind and harsh in front of onlookers, so they do not understand why you want to fire them." P7

"She [the nurse] was very cocky. However, I told myself that I wanted to do it, as if I had decided that I wanted this to happen." P9

The narratives above show that participants discharged at government facilities, private clinics, or illegal termination services, with varied accessibility and staff

attitudes. Some felt mistreated, while others desired termination despite perceived harshness.

4.2.4 Theme: Community factors

Socio-Cultural factors were identified to be associated with a greater prevalence of abortions among women at the Katima Mulilo State Hospital in the Zambezi region. This subject was brought up with two subtopics: i.e., pregnancy termination norms and socio-cultural community norms and beliefs regarding termination and pregnancy.

4.2.4:1 Subtheme 1: Pregnancy termination norms

Despite the stigma and beliefs mentioned experienced by participants, most participants said they felt that termination was common in their communities.

> *"It is common, but if you're doing it alone, you're the only one who knows because other people do it that way, just like I did mine. Thus, I will state that it is typical."* P2

> *"I believe it's common because we hear rumors and some people see for themselves, but we don't know if they ended the pregnancy or if it was a miscarriage. We simply don't know, but that happens to many girls"* P5

While acknowledging the confidentiality of pregnancy terminations, some participants found solace in the notion that these procedures are routine, either

because it lessened the perceived stigma attached to the choice or because it provided them the opportunity to gain knowledge from community members who had already experienced it.

> *"Because they [her community members] accept the situation as it is and do not pass judgment. Yes, I wanted to know more, so I asked those I know who were fired before me for information."* P10

The above extracts show that participants reported common termination in their communities, despite stigma and beliefs. They believed it was typical, as others did it alone, making it difficult to determine if it was a miscarriage or not.

4.2.4:2 Subtheme 2: Community socio-cultural beliefs and norms around termination and pregnancy

According to the participants, there are cultural norms and beliefs surrounding pregnancy and termination in their families, churches, and larger communities. Many participants stated that pregnancy termination is frowned upon in their communities, which view children as blessings.

> "*They think that having a child is a blessing and that I am a girl."* P9.

> *"You must not terminate at all in my church. It would not have been permitted by my mother. ' I bring the child into the world, and we would rather suffer with the child than kill an innocent soul, ' she would have said*." P10

The majority of participants believed that these widely held beliefs did not affect or discourage their decision to end their pregnancy, even though they seemed to impact

their own views regarding termination. However, participants acknowledged that termination is stigmatized and judged in their community, and that these judgments are often based on the aforementioned views that termination is unacceptable.

> "*Their sole belief is that termination is bad; you don't kill. You can't do something and then decide to stop when the results are in. Termination is not well - received in the community. It is subject to judgment."* P3

Through direct remarks they received or through alleged gossip, participants reported feeling stigmatized and judged by their community.

> *"They [people in their community] will view you differently once they find out that you were fired. You see, this person was fired, and there will always be comments about your termination, even if they downplay it. However, we always encounter people who are judgmental."*P1

> "*People would actually come and make judgments like, you were fired; you are a terrible person! How could you do that?"*

The above narratives show that cultural norms and beliefs in families, churches, and communities often discourage pregnancy termination, as children are seen as blessings. Despite this, participants do not discourage their decision, but feel stigmatized and judged, leading to negative comments.

4.3 Summary

The chapter presented the findings of the study collected from 10 participants who took part in the research. The findings were organized into themes and subthemes for better comprehension. Four major themes emerged from the study: Individual- level factors, Interpersonal factors, Institutional and Organizational factors, and Community factors. These themes encompassed thirteen subthemes, namely: financial insecurity and dependence, being unprepared for pregnancy and motherhood, pregnancy - related mental and physical conditions, feelings of control over dismissal, influences on employment and education, personal assurance regarding termination, lack of partner support, lack of family support, risks of negative effects on family relationships, institutional and organizational support services , termination services available at private clinics, government clinics, and illegal termination services, as well as societal norms and community socio-cultural beliefs around termination and pregnancy. The next chapter presents the discussion of findings.

CHAPTER 5

DISCUSSION

5.1 Introduction

The previous chapter presented the findings of the study in themes and subthemes. This chapter provides a literature review of the findings. The literature review is conducted by comparing the findings with the literature discussed in Chapter Two, the problem statement, and the background information of this study.

5.2 Factors associated with increased number of abortions among women at Katima Mulilo state hospital; Zambezi region

Determinants of having high rates of abortions in women at Katima Mulilo state hospital, Zambezi region, were translated to the interpersonal and individual levels of the socio-ecological model. The most common reasons were not being ready for children (again), financial instability and dependence, and poor support from families and partners. Also, the study revealed spaces within every framework category that, rather than being open grounds for abortion, contextualised the participants' decision and decision-making process. Indirectly influencing the participants' abortion decisions through negative economic shifts and accessibility of health care, the COVID-19 pandemic and the subsequent lockdown regulations did so as well. The overall conclusion drawn from the findings of this study is that people live in a multi-layered and multifaceted world.

By including cross-cutting issues for investigation, i.e., the (lack of) sources of support, decision-making under social norms influence, structural socioeconomic and

healthcare obstacles, and pregnancy-related emotions and experiences, this complexity may be more fully appreciated. Table 2 in Chapter four shows themes and subthemes which are associated with a high rate of abortions among women at Katima Mulilo state hospital, Zambezi region. The findings of this study were that rather than a single factor, the women's reasons for ending their pregnancies tended to interact in a complex manner. This subtle and introspective aspect of reproductive choice-making is supported by other evidence from the literature, e.g., a study among Australian women.[69].

Single status is one of the socio-demographic features of pregnancy abortion in the study area, based on existing evidence from research.

From the demographic statistics presented in Table 4.1, most of the unmarried women of reproductive age have undergone an abortion. This result is consistent with results obtained in previous studies.[70, 71, 72] Single women and older women are more likely to obtain high-risk pregnancy outcomes of ill effects, including maternal morbidity and pregnancy conditions like ectopic diabetes, ectopic pregnancy, and pre-eclampsia, resulting in miscarriages or stillbirths.[73, 74] Failure of use or non-use may be the cause of the positive correlation of single women with high frequencies of pregnancy abortion.[72]. Low socioeconomic status among unmarried women may not be able to purchase contraception, leading to elevated levels of unwanted pregnancy and increased maternal mortality caused by unsafe abortion. Financial issues, lack of preparedness for motherhood, reluctance (to bear more) children, fear of losing education and employment opportunities, and relationship problems with partners were also some of the most significant causes of abortion in previous quantitative and qualitative research,[73,75,76,77] as well as other research in other African contexts.[69,76,77]

Although earlier research on family dynamics[69, 78] has existed, this has only been written about the influence of partners on pregnancy abortion decision-making and not on other family members. As most of the participants in this study were not married, resided with their family, and were economically dependent on them, the remaining relatives other than the partner-siblings, parents, grandparents, and cousins might have had a greater influence on the choice of aborting the pregnancy. In a surprising twist, the majority of the respondents in this research indicated having decided to have an abortion all by themselves in line with societal expectations.

Alternatively, one Kenyan study reported that men were the only decision-makers if pregnancy was to be terminated [79]. Notwithstanding the existence of multi-level socio-ecological determinants, respondents in the current study accepted and took ownership and responsibility of the decision of abortion. This is also closer to the conclusions of a US study that, while among study participants who had ever experienced inter-partner violence, women's decisions were shaped by the quality of their intimate partner relationships, and this was not typically accomplished through coercion.[18] Partners in the current study indicated taking themselves out of the decision or being sometimes not informed about the pregnancy or abortion. Women's decisional autonomy may also reflect a possible need for more social-emotional support since among the prolific reasons for ending a relationship with a partner was the lack of social-emotional support from partners and families.

Several unmet needs concerning women’s access to reproductive health care in our setting were also identified in our study.

The study found that health literacy regarding contraception and contraceptive services is low, and this could be the cause of unwanted pregnancy in our society.

Also, some of the participants had accessed unsafe (illegal) abortion services. The justification of this judgment is consistent with how women in our environment still do not have access to legal abortion services. Elimination of access barriers at government clinics included, for instance, not pursuing and visiting the clinics that provide abortion services, delays caused by clinic staff, and evaluations from personnel. Although Namibia does not offer legal abortion services, access to the services of safe abortion of pregnancy is established by stigma related to seeking and obtaining a pregnancy abortion.

The Namibian media is currently actively highlighting the long-term effect that it has on women's reproductive well-being. The research findings in the current setting indicate the effect of the structural and social determinants on, firstly, the use of unsafe abortion services, and secondly, pregnancy abortion decision and failure in the provision of healthcare.

These include, for instance, society and health professionals' stigmatization, health literacy deficiencies, and (intergenerational) poverty. This highlights the need to involve various sectors in responding to unwanted pregnancies and barriers to safe abortion. Although all the women in our study indicated that they believed abortion of pregnancy was common in their communities, they also indicated experiencing various forms of stigma from the communities, including poverty, unmarried person pregnancy, and abortion of pregnancy. To address the stigma of pregnancy abortion and gain access to safe pregnancy abortion services, clearly an intersectional response is required,[1] as the following overlapping levels of stigma indicate with their impact on the lives of women and their reproductive autonomy.

5.3 Summary

The chapter made literature control by comparing the findings presented in chapter 4 with the reviewed literature. The next chapter presents the conclusions, recommendations and limitations of the study.

CHAPTER 6

CONCLUSIONS AND RECOMMENDATIONS

6.1 Introduction

This is the last chapter of the study that presents the conclusions and recommendations of the study.

6.2 Conclusions

The study explores factors contributing to high abortion cases and women's awareness of abortion implications at Katima Mulilo state hospital. It uses the Health Belief Model to understand perceptions of abortion risk, effectiveness of measures, benefits of family planning, contraception, and reproductive health education, and potential obstacles to implementation.

The study reveals that financial insecurity, dependence, and mental and physical conditions, along with child support issues, influence women's abortion decisions at Katima Mulilo state hospital in Zambezi region.

Furthermore, in the current study interpersonal factors were found to be associated with increased number of abortions in women. These factors include lack of partner support, lack of family support and risk of negative effects on family relationships. The study reveals that factors such as trust issues, lack of support, poor social relationships, and financial hardships influence participants' decisions to end pregnancies.

The study found that institutional and organizational factors, including support and termination services at private, government, and illegal clinics, contribute to increased abortions among women at Katima Mulilo state hospital.

The study finally concludes that community factors including pregnancy termination norms and community socio-cultural briefs and norms around termination and pregnancy lead to increased number of abortions among women at Katima Mulilo state hospital, Zambezi region. Cultural norms discourage pregnancy termination, but participants still feel stigmatized and judged. They report common termination in their communities, believing it is typical and difficult to determine if it is a miscarriage.

6.3 Recommendations

The recommendations of this study are based on the finding and discussion made in the previous chapter

6.3.1 Recommendations for nursing practices

To address the factors linked to higher rates of abortion among women, nurses are essential. The following are some suggestions for nursing practices:

Comprehensive Counseling: To help prevent unwanted pregnancies, the nurses should offer women comprehensive counseling on family planning, sexual health, and contraception options. This can be done at the clinics and during primary healthcare visits. They (nurses) have to offer comprehensive abortion counseling, understanding the patient's needs, providing accurate information, discussing

alternatives, offering emotional support, and discussing legal and ethical considerations. They should respect autonomy and provide follow-up care.

Access to reproductive healthcare: To ensure that women have the means to make informed decisions, nurses should promote better access to reproductive healthcare services, such as contraception and prenatal care. To guarantee that all women have access to the care they require, barriers must be removed and supporting policies implemented. Women's health and well-being depend on providing them with access to comprehensive reproductive care.

Education and Awareness: There is a need for the nurses to implement and community education and awareness programs to raise knowledge of safe sex practices, sexual health, and the importance of making informed decisions about pregnancy. In some communities, a few of these may already be in place and need to be more enhanced and inclusive for all age and socio-economic groups.

Support Services: The nurses should provide women facing unwanted pregnancies with nonjudgmental support services, such as emotional support, information about their options, and connections to relevant resources.

Advocacy for policy change: Nurses should promote laws that uphold women's reproductive rights, ensure access to contraception, and provide comprehensive sex education to tackle the root causes of increasing abortion rates.

6.3.2 Organizational recommendations

Comprehensive Sexual Education: The MoHSS through Katima Mulilo State Hospital should implement programs that educate women about family planning, reproductive health, and contraception.

Accessible Contraception: Katima Mulilo State Hospital should ensure that a variety of contraceptive methods, such as long-acting reversible contraceptives (LARCs), are readily accessible to prevent unwanted pregnancies

Supportive work environments: The MoHSS should encourage companies to provide supportive work environments, such as paid maternity leave and flexible work hours to alleviate the financial burdens that may lead to abortion.

Community support programs: The MoHSS needs to develop community support initiatives offering resources, financial assistance, and counseling to women facing unintended pregnancies.

6.3.3 Recommendations for future researcher

The present study was purely qualitative in nature. It is recommended that the mixed method approach using both qualitative and quantitative approach be used to study the same problem at the same setting.

Another recommendation is to conduct a study focusing on the prevalence and factors contributing to abortion and unsafe abortion among women of reproductive age at Katima Mulilo State Hospital.

6.4 Summary of the study

The study's background, problem statement, purpose, and objectives have all been tackled in this research report. This was done in chapter one. The report has also reviewed relevant aspects of the topic under research. This was accomplished in the literature review chapter. A clear explanation of how the research planning and conducting were done was then provided. Data collected was reported textually in Chapter 4 following introduction and thematic analysis. Conclusions have been drawn in this chapter (chapter 6) of the report based on findings and discussion as reported in Chapter 5. This chapter summarizes the research report. The purpose is to respond to articles and research questions that the researcher believes will be beneficial to Katima Mulilo State Hospital.

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APPENDICES

Appendix A: Ethical clerence certificate

UNAM
UNIVERSITY OF NAMIBIA

ETHICAL CLEARANCE CERTIFICATE

Ethical Clearance Reference Number: DEC OSH 0122 **Date:** 09/07/ 2024

This Ethical Clearance Certificate is issued by the University of Namibia Ethics Committee (REC) in accordance with the University of Namibia's Research Ethics Policy and Guidelines. Ethical approval is given in respect of undertakings contained in the Research Project outlined below. This Certificate is issued on the recommendations of the ethical evaluation done by the ethics committee.

Title of Project: FACTORS ASSOCIATED WITH INCREASED NUMBER OF ABORTIONS IN WOMEN AT KATIMA MULILO STATE HOSPITAL, ZAMBEZI REGION

Principal researcher: LYNN MONDE SIMASIKU

Staff Number/ Student number: 201403364

Remarks: Low Risk and Approved with minor corrections

Centre for Research Services

Take note of the following:

1. Any significant changes in the conditions or undertakings outlined in the approved Proposal must be communicated to the ethics committee. An application to make amendments may be necessary.
2. Any breaches of ethical undertakings or practices that have an impact on ethical conduct of the research must be reported to the ethics committee.
3. The Principal Researcher must report issues of ethical compliance to the ethics committee (through the Chairperson) at the end of the Project or as may be requested by the ethics committee.
4. The ethics committee retains the right to:
   i) Withdraw or amend this Ethical Clearance if any unethical practices (as outlined in the Research Ethics Policy) have been detected or suspected,
   ii) Request for an ethical compliance report at any point during the course of the research.

The ethics committee wishes you the best in your research.

Prof Hans J Amukugo (Oshakati Campus Chairperson Decentralized Ethics Committee)

Prof. Davis Mumbengegwi (Head, Multidisciplinary Research)

Appendix B: Permission letter from the MOHSS

REPUBLIC OF NAMIBIA

MINISTRY OF HEALTH AND SOCIAL SERVICES

Ministerial Building
Harvey Street
Private Bag 13198, Windhoek

OFFICE OF THE EXECUTIVE DIRECTOR

Tel: No: 061 -203 2507
Fax No: 061-222 558
Andreas.Shipanga@mhss.gov.na

Ref: 22/4/2/3
Enquiries: Ms. C. Narib

Date: 06 August 2024

Ms. Lynn M. Simasiku
PO Box 1331
Ngweze
Katima Mulilo

Dear Ms. Simasiku

Re: Factors associated with increased number of abortions in women at Katima Mulilo State Hospital, Zambezi Region.

1. Reference is made to your application to conduct the above-mentioned study.
2. The proposal has been evaluated and found to have merit.
3. **Kindly be informed that permission to conduct the study has been granted under the following conditions:**
   - 3.1 The data to be collected must only be used for academic purpose;
   - 3.2 No other data should be collected other than the data stated in the proposal;
   - 3.3 Stipulated ethical considerations in the protocol related to the protection of Human Subjects should be observed and adhered to, any violation thereof will lead to termination of the study at any stage;
   - 3.4 A quarterly report to be submitted to the Ministry's Research Unit;
   - 3.5 Preliminary findings to be submitted upon completion of the study;
   - 3.6 Final report to be submitted upon completion of the study;
   - 3.7 Separate permission should be sought from the Ministry for the publication of the findings.
4. All the cost implications that will result from this study will be the responsibility of the applicant and **not** of the MoHSS.

Yours sincerely,

BEN NANGOMBE
EXECUTIVE DIRECTOR

All official correspondence must be addressed to the Executive Director

Appendix C: Permission letter from the setting

REPUBLIC OF NAMIBIA
MINISTRY OF HEALTH AND SOCIAL SERVICES
ZAMBEZI REGIONAL HEALTH DIRECTORATE

Private Bag 1081 | RMT Building | Tel: 066-251400
Katima Mulilo | Katima Mulilo Hospital | Fax: 066-253283
Namibia | Fax to email: 0886561768 | Email: zambezi.pa@mhss.gov.na

Enquiries: Mr. W. Kapumburu

Date: 13/09/2024

OFFICE OF THE REGIONAL DIRECTOR

Ms. Lynn Monde Simasiku
Private Bag 1081
Katima Mulilo
Namibia

Dear Ms. Simasiku

RE: APPROVAL TO CONDUCT RESEARCH AT KATIMA MULILO STATE HOSPITAL.

As per your request to conduct a research study on ***"Factors associated with increased number of abortions in women at Katima mulilo state hospital,"*** the region has no objection to your request. All information collected should be used as per the initial approvals from your institution of high leaning as well as the office of the Executive Director, Ministry of Health and Social Services.

Since the information will be collected at Katima Mulilo state hospital, please present yourself to the Senior Medical Officer's office when you start with your research in order that she is made aware of all the approvals granted to you.

Wishing you all the best in your academic endeavours.

Yours Health,

MR. WOITA KAPUMBURU
REGIONAL DIRECTOR

Ministry of Health and Social Services
DIRECTORATE: ZAMBEZI REGION
2024 -09- 13
Private Bag 1081. Katima Mulilo
OFFICE OF THE DIRECTOR
REGIONAL MANAGEMENT TEAM
Republic of Namibia

Appendix D: Research tool/instrument- Interview guide

Names: Lynn. M. Simasiku

Student number: 201403364

Resolution number: SoNPHHDBSP/24/18/20

Program: Master of Public Health.

Topic: Factors associated with increased number of abortions in women at Katima Mulilo state hospital; Zambezi region.

Interview guide

DOMAIN	**QUESTIONS**
A. Introductory questions	Age
	Marital status
	Employment
	Reason for coming to the hospital
	Previous experience of abortion and cause/s
B. Interview question	What do you think is a factor/factors that is /are associated with your current abortion? What could be the possible implications that abortion may have or cause to you?
C. Probing questions	Other question will be used to probe depending on the participant's answer on the above questions.

Appendix E: Informed consent

TITLE: FACTORS ASSOCIATED WITH INCREASED NUMBER OF ABORTIONS IN WOMENAT KATIMA MULILO STATE HOSPITAL,.ZAMBEZI REGION.

Researcher: Lynn Monde Simasiku

Resolution number: SoNPHHDBSP/24/18/20

Dear participant

I am Lynn Monde Simasiku registered with University of Namibia, doing a master of public health degree. I wish to conduct a research project entitled: 'Factors associated with increased number of abortions in women at Katima Mulilo State Hospital,.Zambezi Region.'The study will be conducted under the supervision and guidance of Dr Anna Shilunga of the School of Nursing and Public Health, University of Namibia.

The objectives of this study are to probe factors associated with abortions among women seen at Katima Mulilo state hospital and to explore the knowledge and awareness of women seen at Katima Mulilo state hospital regarding implications of abortion.

Your participation will provide information that might enable decision makers to assist in this regard. Participation in this study will take approximately 30 minutes to 1 hour. The procedure includes responding to questions from an interview guide with regard to the topic under study which will be done on an audio recording and use of written notes if permission is granted.

Your participation in this study is voluntary and you have the right to withdraw at any time should you feel so. You should feel free to ask the researcher to clarify the question where you don't understand and you will be expected to answer all questions. The study data will be coded so they will not be linked to your name. Your identity will not be revealed during the study or when the study is being reported or published with the permission granted by the Ministry of Health and Social Services for the benefit of understanding factors associated with abortions and exploration of the knowledge and awareness regarding its implications at the hospital under study. The researcher and the supervisor are the only people that will have access to the data collected.

You are among the study population of the women that underwent abortion seen at Katima Mulilo State Hospital.

Should you agree to participate, please sign your consent with full knowledge of the nature and purpose of the study.

If you have any questions or concerns about the research, please feel free to contact Ms. Lynn Monde Simasiku at cell 0816385115 or E-mail ***lynnsimasiku@gmail.com*** .The Main Supervisor Dr. A. Shilunga at E-mail:

ashilunga@unam.na,Faculty of Health Science, School of Nursing and Public Health, at the University of Namibia.

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims or rights because of your participation in this research study.

Should you agree to participate, please sign the consent provided. If you have any question that needs clarification you are welcome to contact me.

I……

Agree to participate in this research project on my own will.

Signed at ……..

……. …….

Participant signature Date

Appendix F: Interview consent form

Interview consent form

TITLE: FACTORS ASSOCIATED WITH INCREASED NUMBER OF ABORTIONS IN WOMEN AT KATIMA MULILO STATE HOSPITAL,.ZAMBEZI REGION.

I…….(name), being over the age of 18 years, hereby consent to participate as requested in the interview for the research project held on…….(date).

1. Details of the interview have been explained to my satisfaction.
2. I agree to audio recording and note taking of my information and participation.
3. I understand that:

- I may not directly benefit from taking part in this research.
- I am free to withdraw from the project at any time and I am free to decline to answer particular questions.
- While the information gained in this study will be published as explained, I will not be identified and individual information will remain confidential.

- Whether I participate or not, or withdraw after participation, I will have no effect on my treatment or service that is being provided to me.
- I may ask that the recording/ observation be stopped at any time and that I may withdraw at any time from session or the research without disadvantage.

4. I understand that I can contact either the researcher or the University of Namibia with questions about this research via the contacts below:

Lynn. M. Simasiku, researcher –University of Namibia

At email; lynnsimasiku@gmail.com and +264816385115

OR

Dr Anna Shilunga, research supervisor-University of Namibia

At email; ashilunga@unam.na and +26465 223 2257

Participant's signature: …….

Date: ……/……/……

Name of researcher: ……. Signature: ……

Date: …./..../….