Texila International Journal of Public Health
ISSN: 2520-3134
DOI: 10.21522/TIJPH.2013.10.03.Art024

Assessing Factors Contributing to Unsafe Abortion Practice among Women of Reproductive Age

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Abstract

The aim of the study was to investigate the factors contributing to unsafe abortion practices among women of reproductive age. Being a case study, this study used a mixed methodology approach which embraces the best of both qualitative and quantitative approaches, as this approach provides the researcher with both "breadth and depth in" obtaining a holistic understanding of social phenomena. The target population of this study comprised adolescent girls, that is, girls and women aged between 18 years and 25 years who are either in school or have dropped out after falling pregnant. This study used both qualitative and quantitative methods and relied on both quantitative and qualitative techniques of data analysis. The results indicate that reforming laws that regulate a highly stigmatized action takes time and may follow years of using multidisciplinary strategies to highlight the public health consequences and costs of unsafe abortion. Zambia is similar to other countries in the region with restrictive abortion laws in that many countries spell out the grounds for when abortion is not punishable in national penal codes. The recommendations are that the government should lift the most egregious barriers to legal services, such as requirements that multiple physicians authorize abortions and that only physicians can provide them. All healthcare professionals who provide abortion must be trained in WHO-recommended techniques, and the use of dilation and curettage must be discontinued. This invasive method should be completely replaced by either medication abortion or vacuum aspiration.

Keywords: *Abortion, Government, Health, Medical, NGOs.*

Introduction

An estimated five million women from less developed countries are hospitalised every year for unsafe abortion complications such as haemorrhage, infections, and perforations. The negative effects of unsafe abortions are disproportionately higher in Africa.

Early onset of motherhood in women foregrounds dismal consequences for the whole thread of human social development: social, economic, health, cultural, and demographic. Despite the consequences, abortion rates have been on the rise in low and middle-income nations [1]. This social problem is characterized by higher morbidity and mortality rates for both mothers and their offspring which are due to birth complications, especially among those in maturity years.

As pregnant adolescent mothers have to leave school in order to assume the role of motherhood, their socio-economic mobility is adversely affected due to limited educational opportunities and career prospects. These further compounds their impoverished status as they are led into marriage prematurely exacerbates their fertility rates and further affects the social status of their offspring who inherit their poverty [2].

Received: 27.04.2022 ***Accepted: 20.06.2022*** ***Published on: 30.09.2022***
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According to the [3] in the ZDHS for the period 2013-2014, 29 percent of women in the age group 15-19 years have either already given birth before or are pregnant with their first child. There also seems to be an upsurge in the percentage of women who have begun childbearing, from 5 percent to 59 percent among women aged 15 to 19 years. Compared to urban areas, adolescent pregnancy is much higher in rural areas, represented by 20 percent and 36 percent, respectively. The Copperbelt province has the lowest percentage of adolescent pregnancy at 16 percent while the highest proportion is seen in the Northwestern province at 41 percent. There is an inverse relationship between early childbearing and educational level with twice as many teenagers without secondary education have begun childbearing as those with secondary education (53 percent and 23 percent, respectively). For the past six years at the national level, however, no significant change in the proportion of teenage pregnancies has been noted.

The most severe consequence of unsafe abortion is death. The maternal mortality ratio in Zambia stands at 591 deaths per 100,000 live births as of 2007, and a significant proportion of these deaths are likely due to unsafe abortion 4]. According to (ZDHS) in 2015 data from four districts in Western Province suggest that in 2004–2005, about 120 deaths occurred as a result of induced abortion for every 100,000 live births.

More than half of these deaths were among schoolgirls. Another study estimated that in 2013, 15% of all maternal deaths in Lusaka were due to unsafe abortion [4]. For each woman who dies as a result of unsafe abortion, many more experience complications. In 2000–2008, some 66,579 women were admitted to five major Zambian hospitals for abortion-related complications, accounting for slightly more than one-third of all gynaecologic admissions [5].

However, seeking post-abortion care from Zambia's under-resourced health care system is not a simple matter as the problem of unsafe abortion has far-reaching consequences on women.

The study aimed to investigate the factors contributing to unsafe abortion practices, ascertain common unsafe abortion practices, assess the effectiveness of available sexual reproductive health education initiatives, and identify programs that are effective in discouraging unsafe abortion practices among women of reproductive age. Research in social sciences is segmented into two parts, viz., theory and facts. The former helps a researcher to identify relationships between phenomena, whereas the latter refers to the theory that has been proven beyond speculation—facts are verifiable empirical evidence [6]. This segment reviews two different theoretical perspectives which have been brought to bear on the study. These theories will be used to understand underlying factors in teenage pregnancy among schoolgirls. Furthermore, the researcher hopes these theories will help in the diagnosis and prescription of remedial measures to this social problem.

In stark opposition to operant condition as a feature of behavioural learning shaped by external stimuli championed by proponents such as B.F. Skinner, and Albert Bandura theorised those human beings, unlike animals, are rational and able to actively process information and learn appropriate behaviour through observation [7]. Bandura argues that vicarious learning takes place as a consequence of observing other people (models). The information acquired from models is stored in memory as a mental label. This implies that people are constantly learning both desirable and undesirable behaviours whose exhibition depends on the existence of reward or punishment for such behaviour [8].

The Social Learning theory postulates that human behaviour is a function of three (3) interacting elements: an active person (P), his behaviour (B), and the environment (E). This entails that human behaviour is as a result of a

bidirectional interaction between the person and his/her environment and implies that changes in each factor affect the other. This interaction Bandura termed as the concept of reciprocal determinism [7].

The Social Learning Theory's important contribution to human behaviour is in its variables, viz., modelling, and self-efficacy. The former refers to how people learn from others through observation (imitation), while the latter refers to a person's self-confidence in his aptitude to execute an act which is a salient feature of behaviour change) [6].

The literature reviewed various factors which contribute to a pregnancy which include early engagement in sexual activities, abuse of alcohol and drugs, inadequate sexual and reproductive health education, lack of effective programmes aimed at preventing pregnancies, peer pressure, sexual molestation, rape, incorrect use of contraception, familial problems, low self-esteem, and low educational ambitions and goals [9].

Abortions are deemed unsafe when it does not meet the regulatory standards and are not performed by a trained health professional in a sterile environment. This places women in danger when seeking termination services, and subsequently face the highest risk of death during pregnancy termination in the world. Sub-Saharan Africa's maternal mortality is estimated at 200 000 deaths a year, approximately 68% of all maternal deaths per year worldwide [9].

In Africa, 93 % of women of reproductive age (15-44) live in countries with restrictive termination laws. Countries like Angola, Egypt, and Senegal prohibit abortions all together. Here, no explicit legal exception is allowed, and abortions are prohibited under any circumstances.

Many countries allow for abortions under special medical conditions, such as to save a mother's life or preserve her physical or mental health. The prevalence of unsafe abortions is associated with restrictive abortion laws, poor quality health services, and low community awareness.

While assessing factors associated with teen pregnancy among low-income communities in Brazilian from a sample of 452 teenagers, 10] used a multivariate analysis which demonstrated that teen pregnancy was associated with: living with a partner; use of oral contraception; lower age of the first sexual intercourse; use of alcohol; and less division of home. Additionally, teen pregnancy tends to appear when a conjugation of developmental risk variables exists. These results could be helpful to those who work with adolescents as well as to teen pregnancy prevention campaigns.

[11], conducted a study of teenage pregnancies in rural areas, which focused on the socio-demographic characteristics and complications of teenage pregnancies. A cross-sectional study design was adopted in the service area under the PHC, having an approximate population of 45,000 within a duration of 6 months, and a total of 412 registered pregnancies were studied. The prevalence of adolescent pregnancy in the study was found to be 19.9%, with the majority belonging to lower socio-economic status. The prevalence of anaemia was found to be 52.44%, and pre-eclampsia 17.07%. 34.14% delivered a LBW baby. The study concluded that nearly one-fifth of pregnancies occur in teenage girls with significantly higher rates of complication.

A study by Nguyen [12] on the prevalence and factors associated with teen pregnancy in Vietnam used two broad questions: (1) What was the prevalence of teen pregnancy in contemporary Vietnam; and (2) What selected social, family, and individual factors were associated with teen pregnancy in Vietnam? The study utilized the Vietnam Survey Assessment of Vietnamese Youth surveys conducted in 2003 and 2008 to answer the two research questions within the context of fast political, economic, and social change in Vietnam over the past two decades. Results of

this study show that the prevalence of pregnancy among Vietnamese teenagers in the surveys was stable at 4%, or 40 pregnancies per 1,000 adolescent girls aged 14 to 19. Age, the experience of domestic violence, and early sexual debut were positively correlated with higher odds of teenage pregnancy for both survey cohorts; however, being an ethnic minority, educational attainment, sexual education at school, Internet use, and depressive symptoms were significantly related to teenage pregnancy only in the 2008 cohort.

A study aimed at investigating the factors contributing to teenage pregnancies in a rural community of Zimbabwe was done by [13]. To this end, the researchers recommended the empowerment of teenagers in the rural community and sexual health reproductive education among teenagers in rural communities of Zimbabwe.

[14] conducted a study to ascertain the determinants of teenage pregnancy in Lusaka district whose research design was a case-control study.

The study consisted of female teenagers between the ages of 13 and 19 years selected from antenatal clinics at health centres. The sample populations were split in two groups: One group constituted cases comprising pregnant teenagers attending antenatal clinic while the other constituted controls comprising female non-pregnant teenagers, who have never reported pregnancy nor abortion, attending the same clinics for some other ailments.

A study conducted in the Chawama compound involving youngsters aged 8 – 17 years old found that their main sources of information on reproductive functions and sexual practices were grandparents, friends, and pornographic videos. Boys in school also got information from their textbooks and teachers. For 13 – 15-year-olds pornographic books and films acted as the highest source of information. The videos were shown at a local restaurant three times a week and were accessible to all without any age or other restrictions and with flexible payments such as soft drinks and beer bottles. For girls, the main source of information was the grandmother, followed by aunts, female neighbours, friends as well as school textbooks, and teachers. For some, it was also during the initiation ceremony that female relatives imparted sexual knowledge and taught the ‘‘sex dance’’. Some older girls also mentioned that they hesitated to visit the clinic just for the sake of information because when older people saw them go to the clinic, they suspected that they might be carrying an STI [15].

[16] analysed the significance of sexuality education in schools and its effects on sexual behaviour among Portuguese university students for the academic year 2009/2010. Their sample size was 3,278 which included 70% and 30% women and men, respectively. The findings of the study indicate that students who had received sex education in school before their sex debut mentioned more often having had fewer sexual risk behaviours, less occasional partners (30%), less sex associated to alcohol (33.2%) and drugs (4.8%), less STIs (3.2%), less unwanted pregnancies (3.4%) and abortions (2.1%)) than those who had not (35.8%, 38.6%, 6.5%, 3.3%, 4.7% and 4.2%, respectively). Furthermore, the study reveals that there is a positive correlation between receiving sex education and subsequent protective sexual behaviours, knowledge, motivation, and skills.

Interventions to combat the problem of adolescent pregnancy are divided into two broad categories: viz., preventive and support interventions. The former is a class of programmes that are designed to avert adolescent pregnancy, whereas the latter are remedial support interventions offered to pregnant and parenting adolescents in order to mediate the effects of pregnancy. Furthermore, this classification is made based on primary and secondary programmes. Primary programmes refer to interventions aimed at preventing first time pregnancy, while secondary interventions

are aimed at preventing the occurrence of second or subsequent pregnancies in adolescents.

This research will concern itself with the preventive programme interventions. And as opposed to popular views, comprehensive sexuality education programs do not increase sexual activity in teenagers. It should be noted that CSE programmes aimed at preventing teen pregnancy must have the support of parents as well as involve community participation in order to be successful [17].

[18] Studied the factors that contribute to teenage pregnancy in the Capricon district of the Limpopo province in South Africa. The study was quantitative descriptive research, which involved a simple random sample of 100 pregnant teenagers who attended antenatal care at a local clinic between June and August of 2007. In this study, demographic classification of sex debut was in three cohorts, viz., between 10-12 years (4% of the respondents), 13-15 years (62%), and 16-19 years (54%). The study revealed that among other factors, the age of the male partners had a significant role in adolescent pregnancy.

The sample indicated that 91% had their partners who were aged 19 and above, and "that the pressure by older boys and their refusal to use condoms during sexual intercourse were the main reasons for teenage pregnancies" [18]. Furthermore, they recommended that, based on the results, pregnancy prevention programmes with a focus on reproductive health services, male involvement, and adult-teenager communication be instituted.

And as available literature suggests that adolescent pregnancy is a complex problem, a multifaceted intervention strategy is called for. Some of the available strategies aimed at preventing pregnancy in adolescents include education programmes, family planning services, school-based health centres, youth-friendly clinics, and youth development programmes.

Methods and Materials

Materials

The study used a selected sample of 50 *Adolescent girls*: These are directly affected by the problem of teenage pregnancy and the most reliable primary source of data.

They were selected from schools within Lusaka district.

Research Design

A descriptive survey using a mixed type of approach

Sampling Technique(s)

A non-probability sampling method which is known as the purposive sampling technique, was used for this study, besides others.

Research Instruments and Data Collection

Participants were asked to respond to a self-administered structured questionnaire and an audio recording device on information concerning abortion practices, sexual health reproduction education, and programs.

Data Analysis

Descriptive statistics was used to analyse quantitative data [23].

Study Location

This study was carried out at different schools within Lusaka district.

Data processing, Analysis, and interpretation

The Statistical Package for Social Sciences (SPSS) such as Microsoft Excel (MS Excel) and STATA was used.

Presentation Of Results

The Figure 2 shows findings on educational background of respondents that participated in the study.

The majority of participants indicated attaining secondary education (58%), those who

indicated attaining primary accounted for 28% while those who indicated tertiary were represented by 14% respectively.

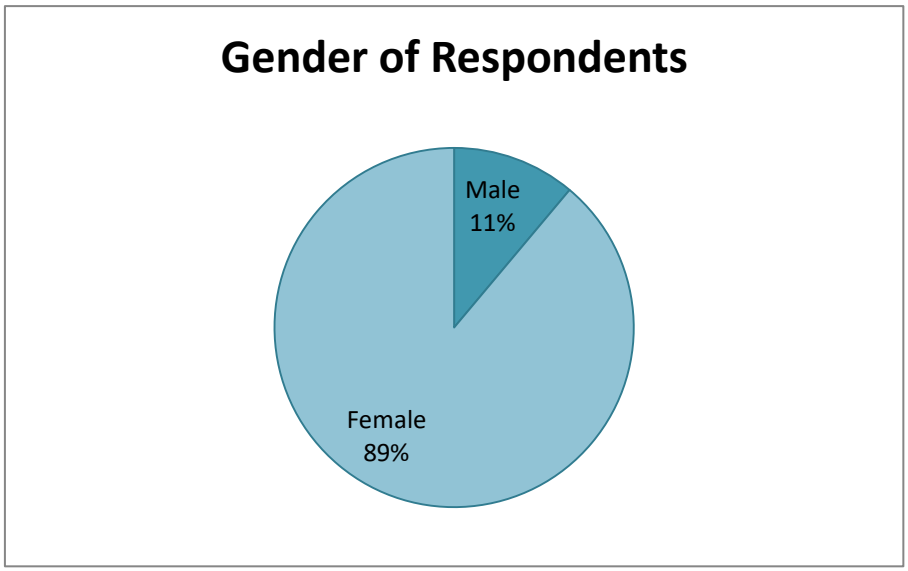

Figure 1. Gender

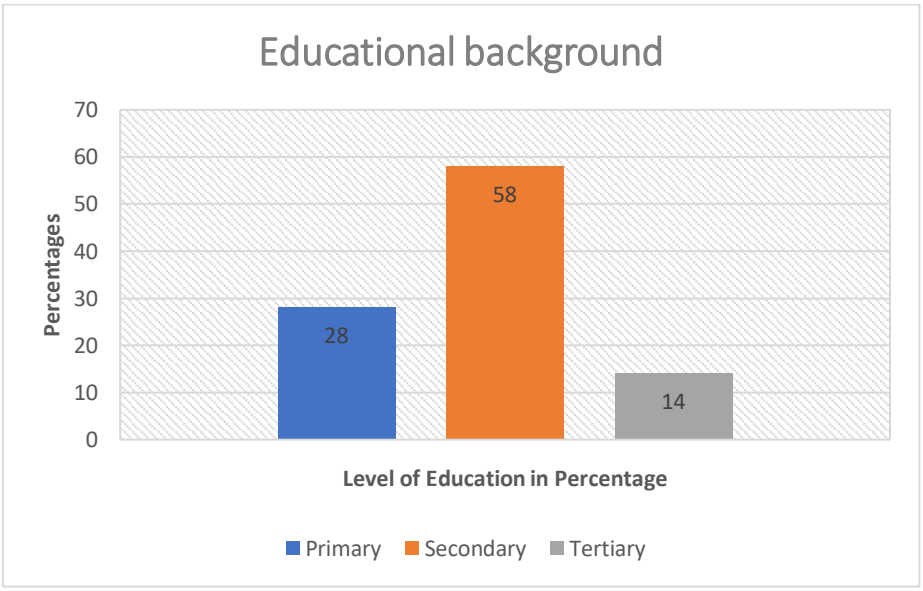

Figure 2. Education Background

Table 1. Names of Primary and Secondary Schools

School Type	***Frequency***	***Percentage***
Primary Schools		
Chainda Primary	4	9.3%
Ngómbe Primary	2	4.7%
Kanyama Primary	8	18.6%
Secondary Schools		
Munali Secondary	9	20.9%
Kamwala Secondary	6	13.9%
Olympia Secondary	14	32.6%

Total	*(43)*	*(100)*

Figure 3 shows findings on the ethnicity of girls that participated in the study. Chewa indicated 9 (25%), Tumbuka indicated 12 (33.3%), Luvale indicated 2 (5.6%), Kaonde indicated 4 (11.1%), Lozi indicated 1 (2.8%), Goba indicated 3 (8.3%) and Bemba indicated 5 (13.9%) respectively.

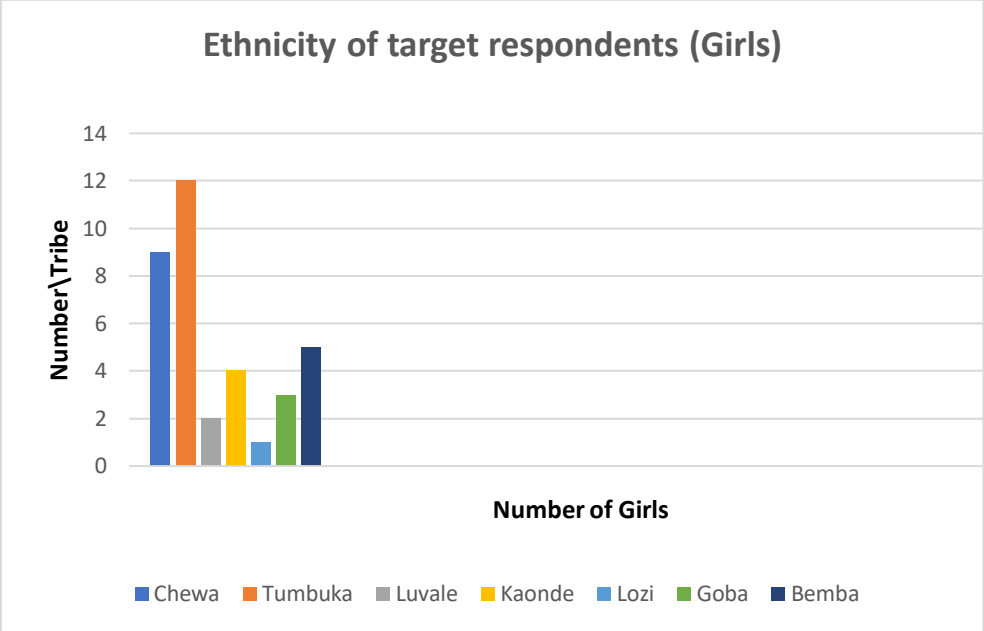

Figure 3. Ethnicity

Figure 4 shows findings on knowledge of unsafe abortions from the girls that participated in the study. The majority of participants indicated having knowledge 86% (yes), and those who indicated no knowledge accounted for 14% respectively.

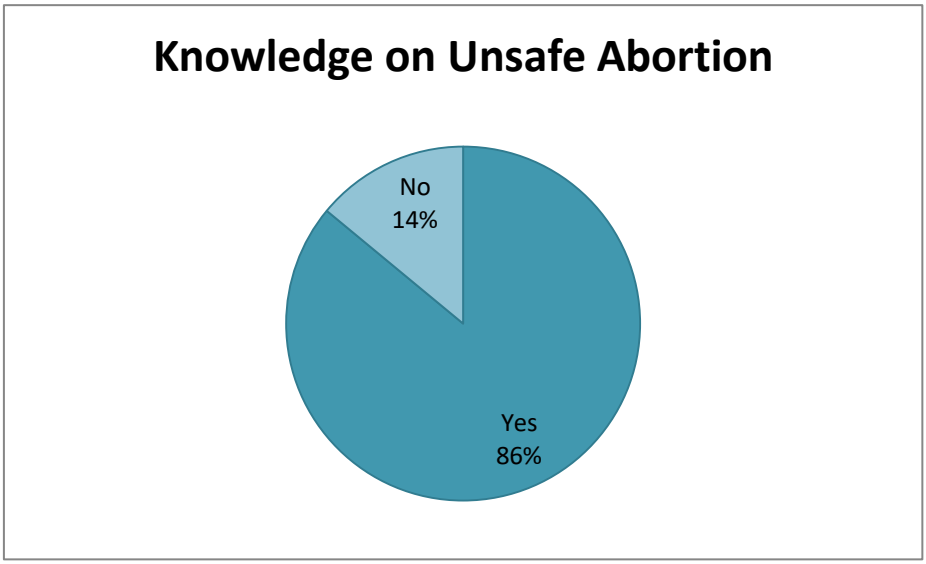

Figure 4. Knowledge on Unsafe Abortion

Figure 5 shows findings on the source of knowledge on unsafe abortion from girls that participated in the study. The majority of participants indicated acquiring the knowledge from friends (40%), and those who indicated acquiring it from Radio/television accounted for 28%. Those who acquire knowledge through

reading were 12%, while those who acquired through parents represented 20% respectively.

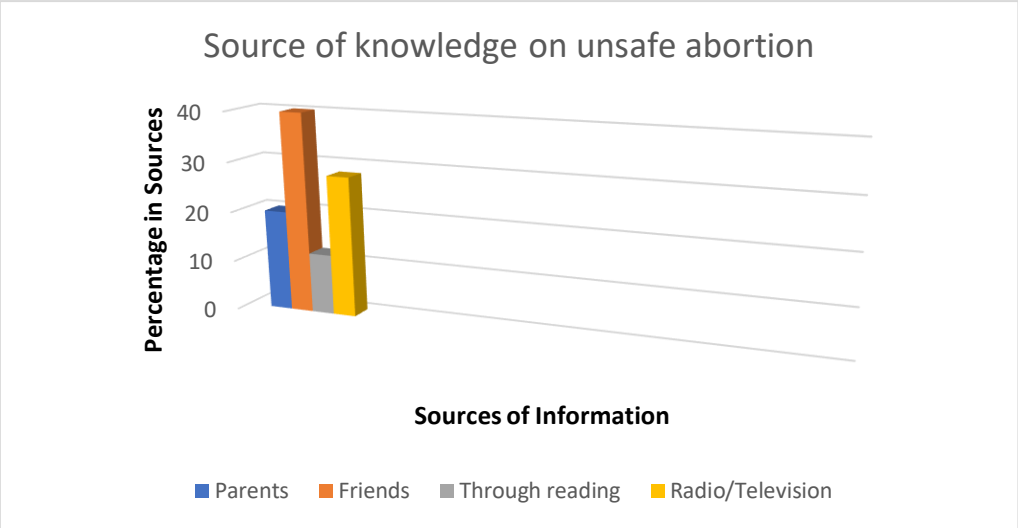

Figure 5. Sources of Knowledge on Unsafe Abortion

Figure 6 shows findings on the unsafe abortion practices known by the girls that participated in the study. The majority of participants indicated all of the above (38%), and those who indicated ingestion of caustic substances accounted for 32%. Those who indicated the use of traditional concoctions were 22%, while those who indicated terminating using a person not skilled were represented by 8% respectively.

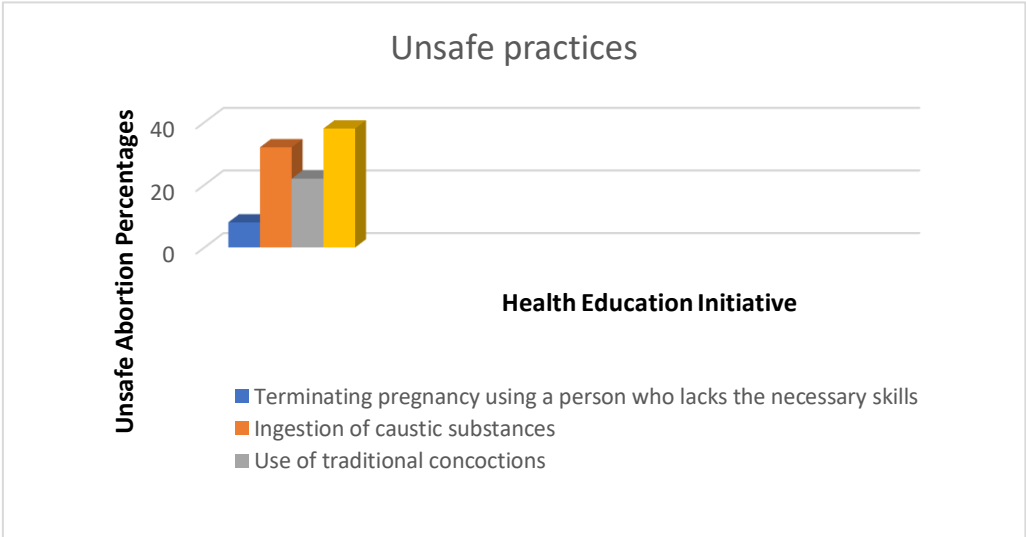

Figure 6. Unsafe Practices

Figure 7 shows findings on whether the sexual reproductive health education initiative is effective by the girls that participated in the study. The majority of participants indicated not effective (42%), and those who indicated not sure accounted for 34%. Those who indicated effective were 18% while those who indicated very effective were represented by 6% respectively.

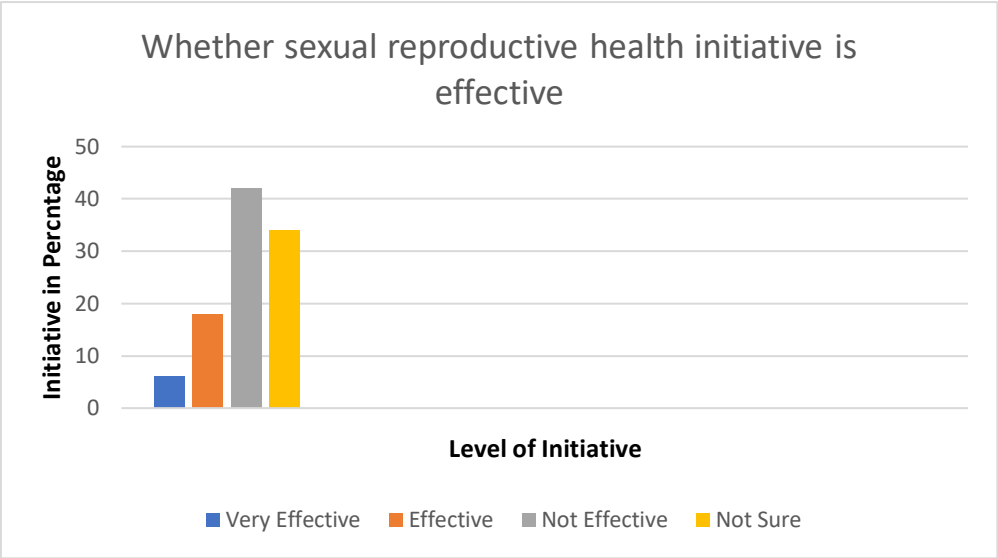

Figure 7. Whether Sexual Production Education is Effective

Figure 8 shows findings on whether the girls felt the sexual reproductive initiative is necessary during the study. The majority of participants indicated Yes (92%), and those who indicated No accounted for 8% respectively.

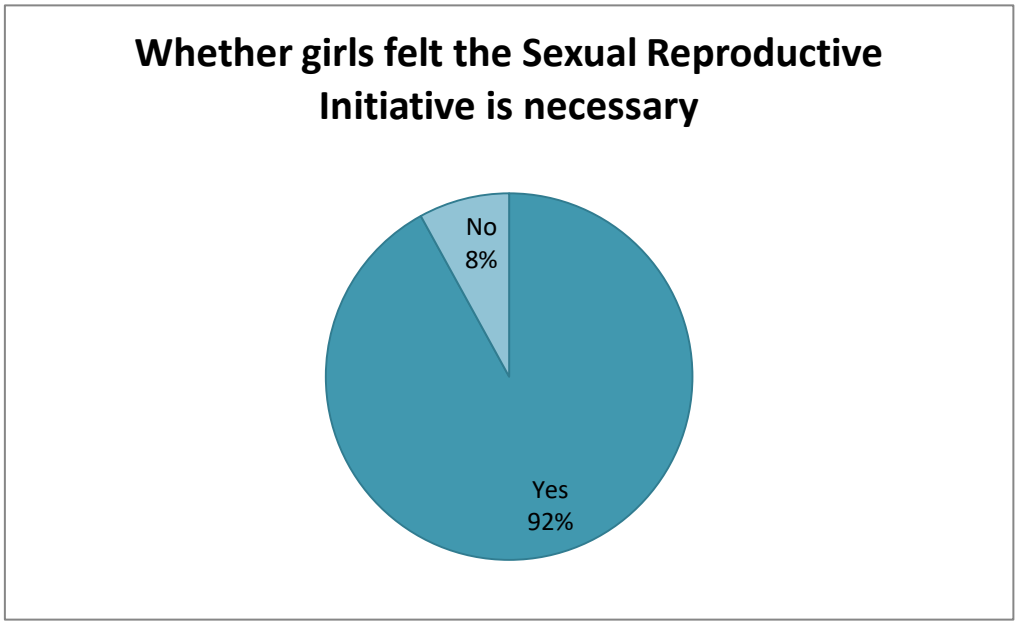

Figure 8. Whether Girls Felt Sexual Reproductive Initiative is Necessary

Figure 9 shows findings on whether the girls are aware of any program discouraging unsafe abortion during the study. The majority participants indicated Yes (76%), those who indicated No accounted for 24% respectively.

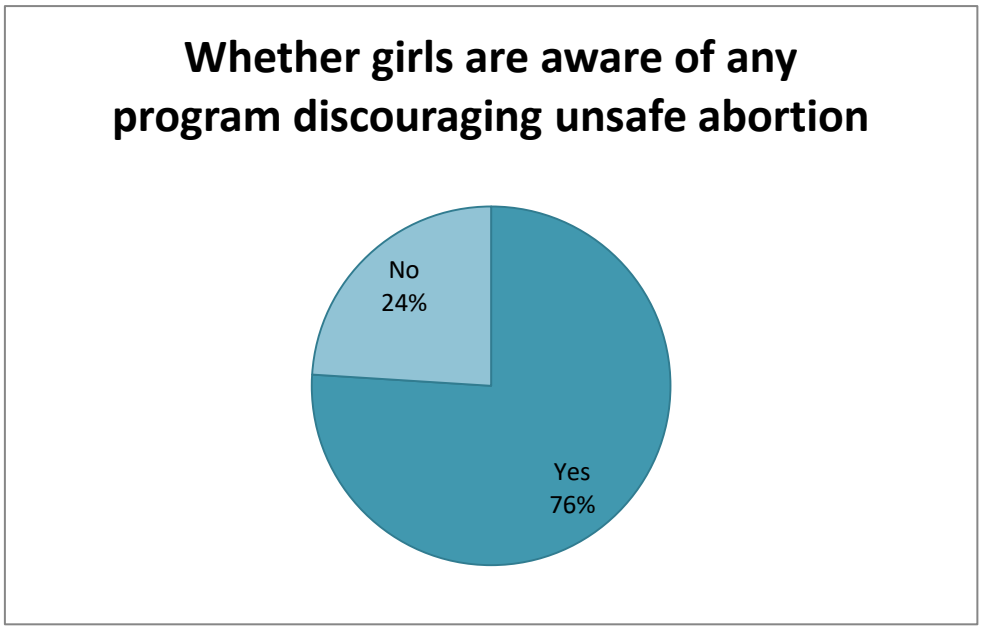

Figure 9. Whether Girls are Aware of Programs Discouraging Unsafe Abortions

Figure 10 below shows findings on the effective programs for unsafe abortion by participants in the study. The majority of participants indicated magazines from AFYA MZURI (38%), those who sensitised programs from clinics/hospitals accounted for 32%. Those who indicated sensitising programs by DREAMS were 24%, while those who indicated seminars by YWCA were represented by 6%, respectively.

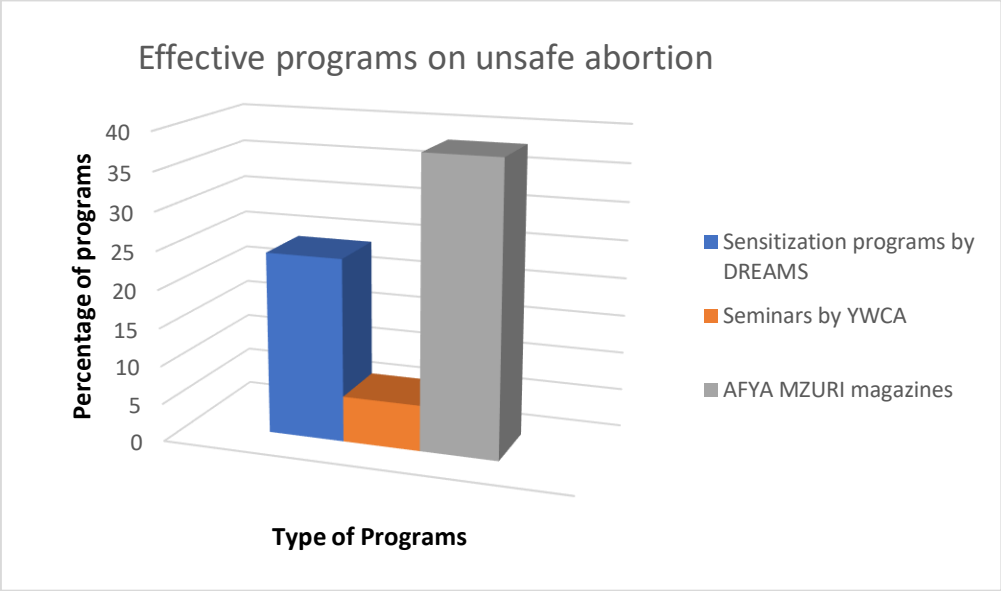

Figure 10. Effective Programs on Unsafe Abortion

Discussions

The research shows the age range of the respondents that participated in the study. Out of all the respondents, 82% represented those aged between 18 and 25, while 18% represented those aged between 28 and 52, respectively. Out of all the respondents, 89% represented female participants, while 11% represented male participants respectively. The majority of participants indicated attaining secondary education (58%), those who indicated attaining primary accounted for 28%,

while those who indicated tertiary were represented by 14% respectively. The study shows findings on the ethnicity of girls that participated in the study. Chewa indicated 9 (25%), Tumbuka indicated 12 (33.3%), Luvale indicated 2 (5.6%), Kaonde indicated 4 (11.1%), Lozi indicated 1 (2.8%), Goba indicated 3 (8.3%) and Bemba indicated 5 (13.9%) respectively.

The study shows findings on knowledge of unsafe abortions from the girls that participated in the study. The majority of participants indicated having knowledge 86% (yes), and those who indicated no knowledge accounted for 14%, respectively.

On findings on whether the sexual reproductive health education initiative is effective, the girls that participated indicated not effective were (42%), and those who indicated not sure accounted for 34%. Those who indicated effectiveness were 18% while those who indicated very effective were represented by 6% respectively. Many of the 48 nations of Sub-Saharan Africa are undergoing broad societal transformation. Progress is being made on many fronts, including improvements in the standard of living, political stability, Internet connectivity, and educational attainment. As the economies of the subcontinent continue to grow, so do expectations for parallel positive developments in women's health. However, one of the major contributors to poor health among women is the continuing high prevalence of unsafe abortion in the region. Of all world regions, Sub-Saharan Africa has the highest estimated proportion of abortions classified as least safe (i.e., done by an untrained provider using a no recommended method). Such abortions have the highest likelihood of being incomplete or leading to medical complications, either of which can result in the need for immediate medical treatment. Yet this risk to the health and survival of women of all ages is largely preventable.

Indeed, when abortions are done following internationally accepted standards, they very rarely result in complications. They only become unsafe when the lack of access to safe services—often, though not always, determined by legal restrictions—leads women to end a pregnancy under conditions that pose a risk to their health. Most Sub-Saharan countries that highly restrict abortion have penal codes dating from the colonial era. But even in the few countries in the region that allow abortion on broad grounds, access to safe and legal services is often limited for a range of reasons. Foremost among these reasons are poor implementation of the law, religious and social stigma, and lack of health care resources and of trained personnel.

The safety of abortion is closely related to its legal status. Abortion incidence, however, is not related to legality. For example, the global abortion rate is identical—at 40 abortions each year per 1,000 women aged 15–49—where abortion is broadly legal and where it is prohibited. By comparison, the prevalence of the least-safe abortions increases dramatically with legal restrictiveness: Fewer than 1% of abortions are classified as least-safe in countries with the least-restrictive laws, compared with 31% of those in countries with the most restrictive laws. Because many Sub-Saharan African countries have restrictive abortion laws, the region bears a disproportionate burden of unsafe abortion: Whereas 45% of the world's abortions in 2010–2014 were estimated to be unsafe, that proportion reached 77% in Sub-Saharan Africa.

The study shows findings on whether the girls felt the sexual reproductive initiative is necessary during the study. The majority of participants indicated yes (92%), and those who indicated No accounted for 8%, respectively. It is possible to accelerate progress toward ensuring that all women in Sub-Saharan Africa have access to the sexual and reproductive health services they need. Doing so will require scaling up the provision of contraceptive care,

safe abortion care, and postabortion care. Sustained collaboration from all stakeholders will be needed to expand legal criteria to at least the grounds in the African Union's Maputo Protocol. As the African Union's General Comment on Article 14 asserts, "the Maputo Protocol is the very first treaty to recognize abortion, under certain conditions, as women's human right which they should enjoy without restriction or fear of being prosecuted." Expanding legal criteria to align with this protocol demands input from all sectors of society.

Sub-Saharan Africa has made substantial progress toward talking openly about unsafe abortion, a subject that two decades ago was rarely broached in public discourse. Local and international actors have introduced safer and more effective methods of abortion; trained a wide range of providers in safer methods of abortion and postabortion care; enhanced the quality and coverage of postabortion care; and expanded the legal criteria for abortion to improve safety, thus reducing the numbers of women needing postabortion care. The incipient trend toward wanting smaller families and better control over healthy birth spacing is likely to continue. But without meaningful access to the means to have fewer children and more time between them, recourse to abortion is likely to increase in the short term.

The study shows findings on whether the girls are aware of any program discouraging unsafe abortion during the study. The majority participants indicated Yes (76%), and those who indicated No accounted for 24% respectively. Law reform means little unless new criteria for legal abortion are widely communicated to the general public, medical professionals, legal professionals, and law enforcement officials. Abortion is such a stigmatized subject that reluctance to talk about it publicly is at least part of the reason why women remain largely uninformed about legal criteria. Better public information campaigns are needed to inform all parties of their rights and responsibilities more widely. Abortion-related stigma compels many women to risk their health by seeking abortion outside of formal medical channels. This stigma touches both women who have abortions and those who seek postabortion care, as well as the medical professionals involved. Providing these professionals with values clarification and sensitivity training is an important start to their treating all patients without judgment and with dignity. Such training also helps medical professionals defend themselves from stigmatization for providing abortion-related services.

The findings on the effective programs on unsafe abortion by participants in the study. The majority of participants indicated magazines from AFYA MZURI (38%), and those who sensitising programs from clinics/hospitals accounted for 32%. Those who indicated sensitising programs by DREAMS were 24%, while those who indicated seminars by YWCA were represented by 6%, respectively. In Zambia, 41% of births are unplanned, and the average woman gives birth to about one child more than she wants, indicating that unintended pregnancy is very common.16 Many women and couples are at risk for unintended pregnancy because they have an unmet need for contraception; that is, they want to delay or stop childbearing, but they are not practicing contraception. About one in four married women have an unmet need for contraception, and while this proportion decreases as education and economic status rise, nearly one in five women in the highest wealth quintile have an unmet need.

Conclusion

Zambia has made great strides in addressing unsafe abortion since 2000. As of 2019, deaths related to unsafe abortion account for 7% of maternal mortality in Sub-Saharan Africa, and Sub-Saharan Africa's overall maternal mortality ratio is the highest of any world region, at 542 maternal deaths per 100,000 live

births. Nearly all the harm caused by unsafe abortion is preventable. Eliminating unsafe abortion starts by expanding the availability of contraceptives, and thus their use, to prevent the unintended pregnancies that underlie most abortions. The most direct way to continue the decline in unintended pregnancy, which would lead to a concomitant decline in unsafe abortion, is to increase modern contraceptive use among women who say they do not want a pregnancy any time soon. Currently, a little more than one-quarter of married women say they want to avoid pregnancy but are not using a modern method.

Recommendations

1. Quality abortion services should be made available and accessible wherever they are allowed by law. It is also essential that governments enact accompanying policies and guidelines that fully implement the law with minimal administrative barriers.
2. The government should lift the most egregious barriers to legal services, such as requirements that multiple physicians authorize abortions and that only physicians can provide them. A commonsense solution to the scarcity and expense of high-level physicians is to rewrite laws to permit the full range of health professionals to provide abortions. Providers who claim conscientious objection without offering the legally required referral to a willing provider can also affect availability; these abuses need to be prevented so women always have access to a legal service.
3. Zambia is similar to other countries in the region with restrictive abortion laws in that many countries spell out the grounds for when abortion is not punishable in national penal codes. But it is unique in belonging to a regional body, the African Union, which issued a women's rights protocol with legal grounds for abortion. Being fully compliant with the Maputo Protocol is a minimum international standard that all countries in the region should meet—and the nine countries that have still not ratified the protocol need to do so.

Acknowledgements

Thanks to my supervisor Kelvin Chibomba (PhD), for his guidance in the process. I also thank the Texilla university staff for their support in the process.

Declaration of Conflicts of Interest

This research project was not funded by any sponsors; I, therefore, declare that they will be no conflict of interest.

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