MIDWIVES EXPERIENCES OF WORKING WITH POST ABORTION FAMILY PLANNING

-A Minor Field Study in Zambia

Midwifery program, 90 university credits
Independent master thesis, 15 university credits
Advanced level
Date of examination: 19-10-04
Course: HT18

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SAMMANFATTNING

Användandet av preventivmedel efter abort är lägre i Zambia i jämförelse med andra afrikanska länder och behovet av familjeplanering är inte tillfredsställt i Zambia. Barnmorskeprofessionen har en viktig roll i familjeplanering. I samband med abort har barnmorskan ett utmärkt tillfälle att informera, diskutera, förskriva samt initiera familjeplanering med den berörda kvinnan. Det har visat sig att kvinnor som får information och kunskap om familjeplanering efter abort är mer benägna att använda sig av preventivmedel.

Syftet med denna studie var att beskriva barnmorskors erfarenheter av att arbeta med familjeplanering för kvinnor i Zambia som genomgått en abort.

En kvalitativ intervjustudie med semistrukturerade frågor användes. För att nå deltagare som uppfyllde studiens inklusionskriterier användes ett strategiskt urval. Tio barnmorskor i Zambia som arbetar med familjeplanering efter abort deltog i studien. En kvalitativ innehållsanalys utfördes för att analysera det insamlade materialet.


Barnmorskorna hade erfarenhet av att flera faktorer påverkade deras arbete med familjeplanering efter abort. Flera utmaningar med familjeplanering efter abort identifierades genom den här studien. Förbättringsområden involverar utbildning, fler verksamma barnmorskor och en bättre tillgänglighet till material och familjeplanering efter abort.

Nyckelord: Abort, Familjeplanering, Barnmorska, Zambia, Erfarenhet, Kunskap
ABSTRACT

The prevalence of post abortion contraception in Zambia is lower than in many other African countries, with unmet family planning needs. Midwives play an important professional role in family planning. In conjunction with an abortion the midwife is provided with an opportunity to inform, discuss, prescribe and initiate family planning with the woman concerned. It is shown that women receiving information and knowledge about post abortion contraception are more likely to use it.

The aim of the study was to describe midwives experiences of working with post abortion family planning in Zambia.

A qualitative interview study with semi-structured questions was used. To conduct the study and find participants with the right inclusion criteria a strategic sampling was used. Ten midwives working with post abortion family planning in Zambia were interviewed. Qualitative content analysis was performed to analyze the collected data from the interviews.

During the data-analysis two categories and eight subcategories were identified. The midwives had experiences of several challenges within post abortion family planning. These included lack of knowledge, supplies and health care staff as well as problem with stigma around family planning and lack of compliance. The midwives also described other factors influencing the work with post abortion family planning. These factors included changes in attitudes, the midwife's knowledge and the importance of information provided by the midwives.

The midwives experienced that there were several factors influencing their work with post abortion family planning. Several challenges within post abortion family planning were identified in this study. Areas of improvement involve education, more midwives working and a better availability to post abortion family planning equipment and services.

Keywords: Abortion, Family planning, Midwife, Zambia, Experiences, Knowledge
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INTRODUCTION

Every year there are approximately 210 million conceptions leading to pregnancy globally. Of these, 46 million result in abortion, also known as termination of pregnancy (Gemzell-Danielsson, 2016). One of the leading causes of abortion is unsuccessful family planning. Approximately 222 million women globally, who would like to delay or prevent their pregnancy, do not have access to contraception (Ministry of Health, 2017). Access to and consistent and correct use of contraception would reduce maternal deaths by an estimated 25-35 percent (Curtis, Huber, & Moss-Knight, 2017). Women who have had an abortion are more motivated to use contraception as a deterrent for future abortions (Maxwell, Voetagbe Paul & Mark, 2015). During the abortion procedure the woman comes in contact with a reproductive health care provider, for example the midwife. To reduce further unplanned pregnancy, leading to another and possibly unsafe abortion, post abortion family planning is the most effective method. Midwives have an opportunity to provide family planning, including information, discussion and prescription of contraception to the woman, in conjunction with the abortion (Curtis, Huber, Moss-Knight, 2017).

The authors’ of this study interest for family planning arouse during the lectures on sexual and reproductive health in the first semester of the midwifery program. Exploring this topic further it became clear how important post abortion family planning is for women and women's health and rights in the world. Post abortion family planning is a complex and challenging subject in Zambia with approximately 20 percent of women start using contraception in conjunction with an abortion (Marie Stopes International, n.d, c).

BACKGROUND

Zambia

Zambia is a country with 17 million citizens, in southern Africa (Landguiden, 2016). The World Bank has considered Zambia to be a middle income country since 2011, even though 58 percent of the population earn less than 1,90 US. dollars per day, which is regarded as the international poverty line (The World Bank, 2019). According to Trading economics (2019) Zambia is considered as one of the poorest countries in the world. The economy is though growing due to copper mining and agriculture. The main economic challenges are fast population growth and systemic youth unemployment (Trading economics, 2019). The capital city is Lusaka with about two million inhabitants. It is an old British colony that became independent in 1964 and is now a democracy. There are about 70 different ethnic groups living in the rural villages and the urbanized cities. Zambia consists of ten provinces. The official language is English and seven local languages known as Bantu has official status. The Bantu-languages are used more frequently and are understood to a higher extent. Most of the inhabitants are Christians, but there are also some traditional African religions in the country. Of the inhabitants 50,4 percent are women and the life expectancy is 64 years for women. Around 40 percent of the women are illiterate (Landguiden, 2016).

Fertility in Zambia

The total fertility rate in Zambia is five births per woman (The World Bank, 2016). Women in rural areas have almost three children more than women in urban areas. The median age at first sexual intercourse among women is 17.3 years. This is lower than the median age at first
Family planning

Family planning is defined as different actions to control the number of children born (Svenska akademiens ordböcker, 2015). It allows women to attain the desired number of children and to be able to space their pregnancies. This is possible with the help of contraceptive methods (World Health Organization, 2018). Contraception is one part of family planning, that can be used to control the number and time of childbirths (Karolinska Institutet, 2016). There are services and programs designed by the health care to assist women and men in the planning of family size (World Health Organization, 2018). There are both modern and traditional contraceptive methods within family planning. Traditional methods are coitus interruptus and calendar methods. Within modern methods there are several types of family planning; barrier methods, hormonal methods and the copper IUD. There is also a difference between short term and long term methods. Short term methods that are used for a limited period of time consists of the contraceptive pill, injectables, condoms, female condoms, birth control vaginal ring, birth control plaster and pessary. Long term methods includes transdermal implants and intrauterine devices (IUD’s) with copper or hormones. The long term methods are used for a longer period of time, between three years and up to ten years, but can be removed at any time the woman wish (Tydén, 2016). Family planning can be provided by a midwife or other healthcare professionals who are trained within the area (World Health Organization, 2018).

Post abortion family planning

Post abortion family planning is an integrated family planning service in conjunction with an abortion (Curtis, Huber, Moss-Knight, 2017). The recommendation is to provide post abortion family planning before the woman leaves the healthcare facility or within at least 48 hours of an abortion (Huber, Curtis, Irani, Pappa & Arrington, 2016). Providing post abortion family planning benefits not only the individual but in the long run also families, communities and countries (Curtis, Huber, Moss-Knight, 2017).

After an abortion, women can have ovulation again after eight days and 83 percent of the women ovulate at the first cycle following an abortion. This is the same for both medical and surgical abortion. A majority of women have sexual contact early on after abortion. It is of great importance to inform the women about the quick return of ovulation, and the risk of becoming pregnant before the first menstrual period after an abortion (Gemzell-Danielsson & Kopp-Kallner, 2015). To go through an abortion implicates a risk for future abortions and lack of post abortion family planning is the leading cause to this (Curtis, Huber, Moss-Knight, 2017). To reduce the risk of a further unplanned pregnancy, leading to another and possibly unsafe abortion, post abortion family planning is the most effective method. After an abortion women are motivated to start with contraceptives (Gemzell-Danielsson & Kopp-Kallner, 2015). The woman can often start with the contraception the same day as the abortion, or the following day. If the woman does not start using contraception there is a risk that she will get...
pregnant the next cycle (Gemzell-Danielsson, 2016). One of the goals of family planning is that the women is discharged from the facility after abortion with a contraception method and the method should not request frequent re-supplies. Family planning and contraceptive counseling before or after the abortion is thereby essential (International Federation of Gynecology and Obstetrics, n.d.).

It is stated that any contraceptive method is better than none, but long term methods that includes implants and intrauterine contraception have been shown to be the most effective methods. If there is a risk of sexual transmitted disease (STD) there should also be a dual protection with condom or femidom (Gemzell-Danielsson & Kopp-Kallner, 2015). It is important to give information and counselling about different types of contraception to women. It helps them understand how the different contraceptive works, both advantages, disadvantages and possible side effects. Thereby the woman can make an informed choice. To provide a choice of methods to the women, so that she can choose her own method also increase the contraceptive uptake and compliance (Hancock, et al., 2016). A study has shown that women value post abortion family planning and that it can illuminate possible previous misunderstandings about contraception methods. It is important to talk about the woman’s contraceptive history. The woman should receive family planning in conjunction with the abortion, with a possible follow up, both for women that initiate a contraception method and for those who want family planning later (Penfold, Wendot, Nafula & Footman, 2018).

**Governmental health facilities providing post abortion family planning in Zambia**

Post abortion family planning is offered in governmental health facilities around Zambia. Women can find post abortion family planning in all District Hospitals. In addition, women can receive post abortion family planning in smaller clinics where midwives or doctors provide those services (Ministry of Health, 2017). During 2015 there were 33 percent of governmental facilities that provided post abortion family planning. Since Zambia has signed the Protocol to the African Charter on Human and Peoples Rights on the Rights of Women in Africa the government is obliged to provide family planning and a wide range of contraceptive methods. In 2005, the government launched a policy that guarantees free family planning methods in public health facilities (UNFPA, 2017).

**Non-profit organizations providing family planning in Zambia**

**Marie Stopes Zambia**

Marie Stopes Zambia is a part of Marie Stopes International (MSI), a global organization founded in 1976 in England, with a focus to provide family planning and safe abortion. To strengthen existing health care systems and transform political environment in the countries where MSI operates the organization often work together with governments (Marie Stopes International, n.d, b). Mary stopes Zambia has been operating since 2008 (Marie Stopes Zambia, 2018). It is a non-government and non-profit organization. The organization offer family planning and safe abortion in both urban and rural areas in Zambia (Marie Stopes International, n.d,a).

Marie Stopes Zambia offers four different types of services to reach clients; Mobile outreach clinics, Diva centers, MS Ladies and the family health center (Marie Stopes Zambia, 2018). The mobile outreach clinics operates in underserved communities where family planning services for different reasons can be out of reach. This service is found in seven different provinces; Central province, Copperbelt province, North Western province, Muchinga
province and Luapula province. The Diva centers provide family planning and reproductive health services to adolescents aged 15-19 and young women aged 20-24. There are totally three different Diva centers in Zambia, two in the capital city Lusaka and one in Ndola, a city in northern Zambia. At the centers, women get education about personal hygiene, sexual protection and reproductive health services. At the Diva centers women can also accomplish abortions. The MS Ladies operates in public areas by use of local mobilisers or tents where they provide family planning services as well as education in sexual health. MS Ladies do not though provide safe abortion services. The family health center is located at the Marie Stopes Zambia main office and here they offer a variety of sexual and reproductive health services, such as abortion and family planning as well as testing for sexual diseases and gynecological examinations (Marie Stopes Zambia, 2018).

Ipas
Ipas is a non-profit organization founded in the United States in 1973 with a commitment to expanding access to safe, legal abortions for women in the world. Ipas have been working in Zambia since 2006 with a main focus to reduce abortion-related deaths and injuries. They also provide contraceptive services, training for providers, equipment for providers and awareness about reproductive health. Ipas is collaborating with the government to extend safe abortion services in different parts of the country. The organization does not have any of their own clinics, instead they perform their services within the governmental facilities (IPAS, n.d).

Planned Parenthood Association of Zambia
Planned Parenthood Association of Zambia (PPAZ) is a member of a global non-governmental organization with a vision that all people are free to make choices about their sexuality and well-being, in a world free of discrimination. PPAZ was founded in 1972 and have since worked with family planning services, voluntary counselling and testing and treatment for sexually transmitted diseases, ante- and postnatal care, emergency contraceptive, provision of PAC, laboratory tests and screening (International planned parenthood federation, n.d), (Planned Parenthood Association of Zambia, n.d).

Laws and guidelines regarding abortion in Zambia

In Zambia, abortion has been legal since 1972 through the Termination of Pregnancy Act. According to the law, abortion is legal when the continuance of pregnancy involves; risk to the life of the pregnant woman, risk of injury to the physical or mental health of the pregnant woman or risk of injury to the physical or mental health of any existing children of the pregnant woman. Abortion is also legal if there is a great risk that the fetus suffers from physical or mental abnormalities and would risk being seriously disabled. Since 2005 pregnancy emerged by violation is another legal reason for abortion. To carry out an abortion in Zambia there is a need for three different physicians to approve, except in emergency cases, then approval from two physicians is required. The medical practitioner performing the abortion must also within seven days send in a form declaring the reason to abortion. Pregnancy termination can be performed in Zambia by any registered medical practitioners trained in abortion care. Abortion can though only be performed in approved registered medical institutions (National assembly of Zambia, 1972).

In the Termination of Pregnancy Act there is no formulation for when, meaning during which gestational weeks, abortion is permitted (National assembly of Zambia, 1972). The “Standards and Guidelines for Comprehensive Abortion Care in Zambia” published by the Ministry of Health is the only formal document where this is formulated. Both medical and
surgical abortion is available in Zambia. According to the “Standards and Guidelines for Comprehensive Abortion Care in Zambia” medical abortion can be conducted between gestational week five and nine and up to gestational week twelve under certain circumstances. Surgical abortion can be conducted between gestational week five and twelve and up to gestational week 15 under certain circumstances. After 15 gestational weeks abortion can be carried out, but only under very specific circumstances and in emergency cases. The definition of “certain circumstances” and “emergency” is though not defined within the “Standards and Guidelines for Comprehensive Abortion in Zambia” (Ministry of Health, 2017).

Abortion in Zambia

Knowledge about the Zambian abortion law is inadequate and many people in Zambia do not know that abortion is legal in above mentioned circumstances (Waszak Geary, Gebreselassie, Awah & Pearson, 2012). It is also shown that health care facilities sometimes ignore the law (Macha, Muyuni, Nkonde & Faúndes, 2014). Due to this, unsafe abortion is still a great problem in Zambia and the cause of 30 percent of maternal deaths every year (Open society initiative for southern Africa, 2018). Many women in Zambia do not have access to safe abortion services. Some women will instead go through an illegal and unsafe abortion. One study conducted in three provinces in Zambia showed that only 16 percent of women in reproductive age could identify the different grounds for which abortion is legal. Only 40 percent of women in reproductive age knew that the extreme situation where the pregnancy threatens the life of the woman is a reason for a legal abortion. The study also showed that the attitudes towards abortion were generally very conservative, and the majority of women disagreed with the statements that women should have access to safe abortion services (Cresswell et al., 2016).

Another study performed in Lusaka, Zambia, identified that before 2007, abortion was rarely performed. Both information about post abortion and family planning was rarely given to the women. In this intervention study, which focused on post abortion family planning, the women received information about different family planning methods from the midwife. The women got information about both short term and long term methods. Through this study, the percentage of women who received or got a prescription for a contraceptive method increased from 25 percent to almost 70 percent (Macha, Muyuni, Nkonde & Faúndes, 2014).

Midwives professional responsibilities

According to the World Health Organization, a core competency in midwifery is family planning and counselling about family planning in post abortion care (World Health Organization, 2015). One of the sustainable development goals of United Nations for 2030 is to ensure good health and wellbeing. The goals include universal access to sexual and reproductive health, family planning, information, education and that reproductive health gets integrated in national strategies and programs (United Nations, 2016).

According to International Confederation for Midwives (ICM) the midwife has the competence to insert and remove intrauterine device and insertion and removal of subdermal implants. Midwives also handle initiation and continuation of injectable contraceptives. Also, a part of the midwives professional role is to provide family planning and offer different methods of contraception. During this process, the midwife is an advocate for the woman, so the woman can be central in the decision making. The midwife assists the woman in meeting
her needs, knowledge, feelings and preferences. The midwife also provides information and
guidance about sexual and reproductive health and can assist the woman’s decision making
(International confederation for midwives, 2018). According to the International Code of
Ethics for Midwives (2014) the midwife should develop a partnership with the individual
woman and share relevant information regarding family planning that leads to informed
decision-making. This is important for the achievement of successful family planning since it
is shown that women who are more satisfied with their contraceptive counseling are more
likely to use contraception (Kilander, Salomonsson, Thor, Brynhildsen & Alehagen, 2017).
Midwives should also, together with women, work with policy and funding agencies to define
women’s needs for health services (International Code confederation for midwives, 2014).

A global study about the midwife’s role in abortion-related care showed that except for
providing comprehensive abortion care, post abortion family planning is central for the
midwife when giving abortion-related care (Fullerton, Butler, Aman, Reid & Dowler, 2018).
The type of health care provider that are giving family planning within abortion is important.
It is shown that women who receive post abortion family planning services from a midwife
are more likely to start with a contraceptive method (81 percent) than women who receive
post abortion family planning by a physician’s (53 percent) (Maxwell, Voetagbe Paul &
Mark, 2015). Many women are influenced by the midwife during family planning, something
that shows the importance of the professional role of the midwife in family planning decision-
making. Family planning in conjunction with abortion is for the midwife more complex
compared to family planning not related to abortion. This since the family planning covers
both the future contraception method and the abortion that also can be emotional for the
woman (Kilander, Salomonsson, Thor, Brynhildsen & Alehagen, 2017).

Midwifery in Zambia

To become a midwife in Zambia there is an education of at least one year depending on the
qualifications of the applicant. If the applicant is a registered nurse it takes one year to
become a midwife and hold the Zambia Enrolled Nurses Certificate. For other applicants,
without a nurse certificate there is an education consisting of two years and after this one
becomes an Enrolled Midwife. The education consists of both theoretical and practical
education. The midwife student has to attend lectures, conduct examinations on antenatal
women, witness and attend births, perform vaginal examinations, nurse puerperal women and
infants. The student also has to attend infant welfare clinics which may include postnatal
examination and attend lectures on mother craft and health education. The syllabus does not
include sexual health, family planning or practical education about contraception. In Zambia,
one can also become a Registered Midwife and for this one has to complete an education of at
least one year in a registered midwifery school. To have admission to undergo the education
the student shall be in possession of the Zambia Registered Nurses' Certificate or a certificate
recognized by the Council as being equivalent to the Zambia Registered Nurses. This training
also consists of both practical and theoretical knowledge (The laws of Zambia, 2019).

Zambia has approximately 2700 midwives and is a member of International Confederation for
Midwives (International confederation for midwives, n.d). The midwifery education, training
and practice are regulated by the General nursing council of Zambia to ensure that the public
receives the best possible midwifery care and contribute to quality health care in Zambia
(General nursing council of Zambia, 2019). The work of midwives are regulated through the
Nurses and Midwives Act. To be able to carry on the practice of a midwife the council grant a
certificate of competence, “the Zambia enrolled Midwives certificate”, or for the registered
midwives “the Zambia Registered Midwives' Certificate”. In the registered midwives education abortion and allied subjects are included in the syllabus, but not family planning. One must have attained the age of 19 years to get this certificate (The laws of Zambia, 2019).

**Family planning in Zambia**

In Zambia twenty-one percent of married women have an unmet need for family planning services for spacing births or an unmet need for limiting them (DHS program, 2015). There seem to be a problem with limited supplies or what is known as stock-outs in some family planning clinics from time to time. There are clinics that does not provide intrauterine devices (IUD) and subdermal implants due to lack of available midwives and equipment and postcoital pills are not available at all clinics (Hancock et al., 2015).

In Zambia 45 percent of married women use a family planning method. The most popular modern methods used are injectables, pill and implants. The knowledge about different family planning methods differ in Zambia. Family planning methods that are commonly known are male condoms (97 percent), the pill (96 percent), injectables (95 percent), female condoms (90 percent) and implants (87 percent). Other methods that are less known are female sterilization (70 percent), IUD (60 percent), male sterilization (23 percent), lactation and emergency pill (21 percent). Overall, women are said to be aware of eight family methods on average (DHS program, 2015). According to the Standards and Guidelines for Comprehensive Abortion Care in Zambia (Ministry of Health, 2017) family planning services should be based on informed consent without the service provider’s personal opinion or conceived prejudice. Institutions should also ensure that there is a broad offer of family planning methods to choose from. Capability to reproduce and the freedom to decide when and how often to reproduce is one of the factors of a good reproductive health. All women should have the right to make their own choice about their reproductive health. Women need to have access to information, and safe effective and affordable contraception methods (UNFPA, n.d.).

**Research area**

In Zambia abortion is legal, but the knowledge about legal abortion and the abortion law is inadequate among women. One of the leading causes of abortion is unsuccessful family planning. Access to and consistent and correct use of contraception would reduce maternal deaths by an estimated 25-35 percent. The prevalence of post abortion family planning in Zambia is lower than in many other African countries and there is an unmet need of family planning among Zambian women. Midwives have an important professional role in family planning and working with women's health. In conjunction with an abortion the midwife has a great opportunity to inform, discuss, prescribe and initiate contraception with the woman concerned. It is shown that women receiving information and knowledge about post abortion family planning are more likely to use it. As prospective midwifery graduates, the authors would like to learn more about the post abortion care midwives perform in Zambia.

**AIM**

The aim of the study was to describe midwives experiences of working with post abortion family planning in Zambia.
METHODS

Approach

An inductive approach was used, meaning the data was collected without a predetermined theory about the result (Danielson, 2012). The collected data, containing narrative descriptions, does not give explanations and to make sense it needs to be processed by the authors giving the content a new meaning. An inductive approach is useful when little is known about the studied topic and it is the most common approach within qualitative research (Burnard, Gill, Stewart, Treasure & Chadwick, 2008). The aim of the study was to describe midwives experiences of post abortion family planning in Zambia. The term “experience” refers to; “regular activity or sensory observation building knowledge or skill”. Experience is a process where knowledge or skill is gained or the result of this process (Nationalencyklopedin, n.d.). This is the definition that will be used in this study.

Design

To answer the aim of the study an inductive qualitative interview study with semi structured questions was used (Polit & Beck, 2017). In accordance to Burnard, Morrison and Gluyas (2011) qualitative research is suitable when the researchers want to get a deeper understanding of the subject and understand the individual experience. In qualitative research interviews or observations are often used as data collection method to be able to study experiences and people's understandings within a certain topic (Burnard et al., 2011).

Minor field study

This study is a Minor Field Study, sponsored by the Swedish International Development Cooperation Agency (SIDA). SIDA is a governmental authority working with reducing the poverty globally (SIDA, 2017a). A Minor Field Study is a SIDA-sponsored program resulting in a thesis (SIDA, 2017b). The aim is to give students knowledge about developing countries and development issues. The study is sponsored by SIDA, the authors have not though received any other funding’s from implementing organisations in Zambia. The authors have no conflict of interest.

Sample selection

Inclusion criteria
Inclusion criteria for participation in this study was that the participant was an enrolled or registered midwife with at least one-year experience of working with post abortion family planning in Zambia. The midwife should have experience of working with post abortion family planning within the last ten years (2009-2019). Further inclusion criteria were participants who understood the English language, in both oral and written form, to minimize misunderstandings as no translator was used during the interviews.

Recruitment of participants
To recruit participants strategic sampling was used. Strategic sampling is when recruiting participants who can give a representative aspect of the studied phenomena (Jakobsson, 2011). Midwives working with or who had been working with post abortion family planning were invited to participate in this study. The midwives were recruited from different
reproductive health facilities that the authors’ were in contact with. The participants were asked to participate in person by the authors’ and they also received written information (Appendix B) about the study to read through before deciding whether to participate or not. The written information included the aim of the study, that the interviews would be audio-recorded, and the expected time of the interviews. The written information also included a written consent where both the participant and author signed with names, date and place. The participants were also informed, both oral and written, that participation in the study was voluntary. The number of participants was decided by saturation, as usually in qualitative research, derby saturation is what will decide how many participants the study will include (Polit & Beck, 2017). Saturation was reached by eight interviews and after this two more were done for assurance.

**Data collection**

Semi structured interviews with midwives working with post abortion family planning in Zambia were held. The aim of semi structured interviews is that the authors have a number of specific questions about the research area determined earlier (Burnard et al., 2011). The order of the questions can vary depending on the process of the interview and the answers from the individual participant (Holloway & Galvin, 2017). The authors can also ask supplementary questions to fulfill the aim of the study (Burnard et al., 2011). An interview guide (Appendix A) was written and discussed by both authors and then revised before starting the data collection. The motive of the interview guide was that all the essential substances would be covered but still allow the participants to speak freely about all the questions and sharing their work experiences in their own way. The questions were written with a transparency to allow the participant to give detailed answers. It was important that the authors had the aim of the study in the back of their mind to be able to concentrate on the aim during the interviews (Polit & Beck, 2017).

Only the authors and the participant were present during the interviews. All the interviews were held in English. Interviews were conducted, using the guide in Appendix A. The interviews were audio-recorded by two electronic devices for further analysis. Two devices were used to minimize the risk of any possible loss of recorded data material. All of the participants approved that a recorder was used. Both authors participated during the interviews to be able to analyze the material equal (Trost, 2010). One of the authors asked the questions, and one author wrote notes and asked supplementary questions, when needed. The notes could be different themes, words or further questions. The author asking the questions and the author making notes differed between different interviews, so that both authors were in both positions. The first interview was a pilot interview to test the interview guide and the recording devices. Irrelevant parts of the interviews such as interruptions, someone coughing or sneezing during the interview were not transcribed, because it does not contribute value to the context. Pauses or laughter that occurred were though transcribed (Polit & Beck, 2017). The interviews lasted between seventeen and thirty-five minutes. The interviews were listened through repeated times during the transcription to get all the word right. Words that were unknown to the authors were looked up using a lexicon. In the transcription, there was marking for what the participant said and what the authors said, to make the transcription easy and analyze advantageous (Danielsson, 2017).

**Data analysis**
In this study a qualitative content analysis was used. A content analysis is suitable when the researcher is addressing a bigger quantity of data and can be used for different types of texts (Elo & Kyngäs, 2008). The processing of data begun during the interviews (Trost, 2010). To enable deeper analysis of data the interviews were recorded and transcribed. To manage the material and break down the data into smaller pieces the transcriptions were analyzed with a qualitative content analysis (Graneheim & Lundman, 2012). To perform this the transcribed interviews were read through by both authors with focus on the aim of the study and notes were written on the side while reading. The interviews were read through several times (Elo & Kyngäs, 2008). By marking important sentences, words or paragraphs, meaning units were formed. As Graneheim and Lundman (2012) describe, a meaning unit is the smallest segment of a text that contains significant information answering the aim. The meaning units were condensed, still taking consideration to the whole context so that the significance of the sentence was not dissolved (Graneheim & Lundman, 2012). From the condensed meaning units subcategories and categories took form. The categories were named from content-characteristic words. Subcategories that were similar were grouped together to categories and similar categories were grouped as main categories. The aim of the categories were to describe and give meaning to the subject, to increase knowledge and comprehension. To structure the meaning units, the codes and the condensed meanings a coding scheme was formed (Elo & Kyngäs, 2008).

Table 1. Examples of analyze process

<table>
<thead>
<tr>
<th>Transcription</th>
<th>Meaning Unit</th>
<th>Condensed meaning Unit</th>
<th>Code</th>
<th>Subcategory</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>“They don’t access family planning cause they are scared, it’s like; ohh, my mum will see me, my aunt will see me, my neighbour will see me, they say; you too young, you are too young to do family planning and stuff like that, so the girl would not do family planning because of that...”</td>
<td>They don’t access family planning because they are scared that someone will see them and say that they are too young to do family planning and therefore girls will not do family planning.</td>
<td>Fear of being noticed hinder adolescent women from having post abortion family planning</td>
<td>Attitudes towards post abortion family planning</td>
<td>Stigma within post abortion family planning</td>
<td>Challenges of working with post abortion family planning</td>
</tr>
</tbody>
</table>
"If you don’t give them the information there about family planning you find them having another abortion in maybe just six months, when they abort again..."

If you don’t give them the information about family planning, you will find them having an abortion again.

If you don’t give information about family planning women will abort again.

Prevention of further abortions

Importance of information

Factors influencing post abortion family planning

Ethical considerations

All participants received oral and written information (Appendix B) about the study and its voluntary nature of participation before giving their approval of taking part in the study. Making sure that the participants did not have to give an answer about participation right away the authors left their contact information and asked the participants to contact the authors when they had read the information and thought it through. This was done to make sure participation was free from pressure and giving the participants a chance to make an informed choice (Webster, Lewis & Brown, 2014). The participants also signed an informed consent prior data collection with information the participants had the right to withdraw from the study at any time, without consequences. The authors also told all participants that all questions were voluntary (Kjellström, 2017).

The data was stored confidentially in electronical devices with passwords protection. No private data such as names or birth data was stored in the devices. When taking notes during the interviews no names or personal information was written down and this kind of information was also not recorded. To protect and organize the interviews the participants were named after numbers. This was done not being able to identify the participants (Kjellström, 2017).

For all researchers it can be difficult to be objective when assessing their own study and this is why a study should be assessed by an external group or committee (Polit & Beck, 2017). This study has undergone an ethical review by the Swedish ethical review board at Sophiahemmet University College in Stockholm (Appendix C). An ethical approval was also applied for through an ethics board committee in Zambia called ERES Converge and approved before collecting data to the study (Appendix D).

FINDINGS

The findings of this study are based on the experiences of ten midwives in Zambia. The findings will be presented in two main categories and eight subcategories (Table 2).
Table 2. Categories and subcategories from the analysis process.

<table>
<thead>
<tr>
<th>Challenges in working with post abortion family planning</th>
<th>Lack of knowledge</th>
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<tbody>
<tr>
<td></td>
<td>Stigma within post abortion family planning</td>
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<tr>
<td></td>
<td>Shortage of healthcare staff</td>
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<td></td>
<td>Lack of supplies</td>
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<tr>
<td></td>
<td>Compliance</td>
</tr>
<tr>
<td>Factors influencing post abortion family planning</td>
<td>Change in attitudes</td>
</tr>
<tr>
<td></td>
<td>Midwife’s knowledge</td>
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<tr>
<td></td>
<td>Providing information</td>
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Challenges in working with post abortion family planning

Lack of knowledge
All midwives that were interviewed in this study mentioned how women, as well as other health care professionals had a lack of knowledge concerning post abortion family planning. This was considered a challenge by the midwives in the study. The midwives described that lack of knowledge, misconceptions and myths were common among women. The misconceptions and the myths were mainly about how family planning methods would interfere with the women's health. One midwife had the experience of women believing that family planning would affect their fertility so that one become infertile. Another misconception was that use of family planning would lead to cancer. Some women thought that family planning methods like implants and IUD’s could harm their bodies. The midwives expressed that it was a great need to clear those misconceptions and educate women.

“They will say when you insert the implant it moves around in your body. Yes. So some will say if you presses where the implant is, it will break. And that it will cause problems, and you can’t...you know the ones that are in the farming area, they can’t do their normal routines, like caring and everything because it will start moving to your head, and then it will prick you and you will die!”

The midwives described lack of knowledge as one of the main reasons for women not to receive family planning after abortion. Lack of knowledge about the return to fertility after abortion was also an issue and according to the midwives they had experienced that some women believed fertility returned first after six months after an abortion. The lack of knowledge could thereby also lead to further unplanned pregnancies.
“You will find, maybe someone that had an abortion and then maybe six to eight weeks later they are pregnant again. Because they don’t know that they need to use contraceptives.”

Of the midwives interviewed in this study, most had an additional education in family planning and all of them provided post abortion family planning services. However, they had experience of other healthcare professionals having a lack of knowledge and training in post abortion family planning and being unable to advice on the methods. This was described as one of the difficulties within lack of knowledge.

**Stigma within post abortion family planning**

Stigma was a recurring topic in midwives experience of post abortion family planning. The stigma was both about the abortion itself and family planning. Midwives experienced that people and even healthcare professionals in Zambia judged women that have gone through an abortion and therefore the women tend to not seek post abortion family planning service. Midwives described that people in Zambia had the opinion that a woman that had gone through an abortion was considered to be unclean and should be treated differently. For example, one midwife described that in some families a woman who had aborted was not allowed to cook or prepare meals. This was because she was seen to be unclean due to the abortion.

“It is the attitudes, and also the culture, the norms and beliefs. Because the other thing is, if you are accessing family planning and you are not married you are seen as a prostitute. Yeah. So most of them, they do not access family planning because they fear to be judged”

The decision of having post abortion family planning was also stigmatized according to the midwives. Some women kept the family planning method hidden from their family such as partner or parents, whilst other women felt the need of ask their partner for permission of using family planning before starting a method. According to one of the midwives women wanted long term family planning but resulted having short term family planning such as injection or contraceptive pill because it was considered easier to hide from their partner. Other stigmas surrounding post abortion family planning was religion and believes. The midwives described that women of certain religions were not willing to start family planning.

“In some areas you find that most women are not willing to start family planning. And this again because of the religion and beliefs. So most of them, citizens in Zambia, they are Christians. And it’s about one third of the population that are Catholic, and most Catholics don’t promote family planning. “

The midwives also described that they experienced that there was a stigma around post abortion family planning within the governmental facilities. They described that even if abortion is legal in Zambia this is something that the government don’t want to go public with, making it even more difficult to fight the problem with the stigma within post abortion family planning.

**Shortage of healthcare staff**

According to midwives shortage of staff was also a challenge when working with post abortion family planning in Zambia. The midwives described that this was one reason why it could be difficult for women to access post abortion family planning. The shortage of midwives and other healthcare staff was described making it difficult for the midwives to give the care they wanted because they did not have time. Instead, the midwives described they
were only able to perform the most important tasks and not more than what was expected of them. This was to be able to provide the service to all women needing the service. One midwife especially said that she felt she could not give the psychological care that she wanted, as a result of staff shortage

“Sometimes you don’t give the psychological care as much as we would because maybe there is just one person working... you don’t really have the time to like sit down and say; ok, so how has this affected you?”

When describing the challenge with shortage of staff within post abortion family planning one main reason was the lack of staff with the right knowledge to provide the service. Some midwives described that this was a problem especially for the long term methods due to lack of trained providers. The midwives experienced that this differed between rural and urban areas. They described that lack of trained staff was a bigger challenge in rural areas where a lot of nurses and midwives were not trained in post abortion family planning.

“Staffing levels are bad, like in the government facilities, yeah, in post abortion family planning, the staffing is bad. Yeah so staffing has been our biggest challenge...And then it also break the contributes to clients not really access the services because providers are not available all the time”

Lack of supplies
Another challenge described by the majority of the midwives was lack of supplies within governmental facilities. Since most of the midwives had worked both in private and governmental facilities with post abortion family planning they were able to compare their experiences between the different clinics. The experiences were that both family planning methods and the equipment needed to provide the service to the client was lacking, making it difficult to give the service that the client asked for in governmental facilities. When comparing the different family planning methods midwives mainly experienced a lack of long term family planning methods. Again, this was both because of stock outs of the method itself but also because the equipment needed was not available for long term methods. This made it difficult for the midwives to offer long term methods and at times they had to offer short term family planning method to the woman instead.

“My experience with the government, yeah, from times, you only have maybe just short term methods, sometimes you could have long term, but then you need equipment and then you don’t have sterilizer to sterilize, yeah so it becomes tricky with long term, and then instead you go for short term....“

Compliance
Women’s compliance was also something that the midwives experienced as a challenge when working with post abortion family planning. They described that compliance differed between short term and long term family planning methods. Midwives experienced that there was a lack of compliance mainly regarding short term methods, like the contraceptive pill and injectables. At the same time, the majority of midwives described short term family planning methods being the most common method chosen by women.

“Short term for example pills, if the women after accesses the pill, the chances of them forgetting to take a pill are high, so they might get an unwanted
pregnancy again, so their compliance are really, is doubtable, and the same with the injectables,”

The midwives described that there was several reasons to the lack of compliance. One reason described was women forgetting about their family planning. Another reason was women not coming back to the clinic to extend their family planning. Many midwives experienced that women had long distances to the healthcare facilities and that women struggled to get transport to the clinic, also making compliance difficult.

“Short term family planning and compliance is very compromised and most of them they come from...quite some distance, so normally when you talk to them and you tell them to come, they tell you they will not be able to reach you.”

Factors influencing post abortion family planning

Change in attitudes
Many midwives experienced that post abortion family planning and similar topics in reproductive health are controversial and stigmatized, but that there has been slight change in attitudes surrounding these topics the last years both in the society and among women. Women that earlier would have rejected post abortion family planning services are today accepting it.

“It has been a very big change, acceptance is going up and up and it is improving every day, yeah. It's not like seven years ago...there is a big change and women are now accepting the methods.”

The midwives also described that they could see a change in attitude within the healthcare system. For example one midwife described that for adolescents there are now more information available in reproductive health and the health information system have now included sexual health info for adolescents. She described that a few years back there was no information or clinic for adolescents seeking post abortion family planning services.

“We tremendously seeing a great improvement. Before you couldn’t even just talk to an adolescent about reproductive health but now, even adolescents are free to talk about reproductive health”

Midwife’s knowledge
All midwives experienced that one essential component when providing post abortion family planning was having the right knowledge. To be able to provide post abortion family planning the midwife had to inform and consult the woman about post abortion family planning and they all expressed the importance of having the right knowledge to be able to do this.

“That what we need is to, as midwives, is just to have more knowledge of post abortion family planning, so that when we go out there, we are able to give the right information to the client.”

All midwives expressed that they experienced an opportunity to help women and give them a chance, to give the women a better future when working with post abortion family planning. They described that through post abortion family planning they could give the preconditions
for the women to pursue their dreams. To enable this the midwives described knowledge as a necessary factor.

“I was trained and I know that I should put myself to the level of the client, I should understand what the client want, but our friends at the government facilities, they have never done this training, so it is a bit of a difference”

Providing information
All midwives talked about their counselling role within post abortion family planning and the importance of informing women. They expressed that, as midwives, they had a key role in post abortion family planning in the woman’s process to start with post abortion family planning. One factor that could influence the women’s the interest in post abortion family planning services was to inform about it through the different parts of the abortion, even before the abortion.

“Counselling starts during, before we even send the client for termination of pregnancy. Even during termination of pregnancy, even after termination of pregnancy, we keep on talking about the birth control methods that are available for them to easily access”.

The midwives described that since abortion is a controversial topic in Zambia they experienced a need of them bringing up the subject when working with post abortion family planning. They explained that for many women it is difficult to come out and tell about having an abortion. One reason that made it difficult for the women to talk about was the fear of being looked down on for having post abortion family planning, and that women therefore were shy about their need of post abortion family planning services. The experience was also that if the midwife did not bring up the subject and inform the client the women would sometimes leave without a family planning method when seeking for post abortion family planning. One midwife expressed that if she didn’t bring up the subject of post abortion family planning, the woman would not be interested or ask about it. The midwives experienced that lack of information about post abortion family planning because of this sometimes would then end up in another abortion for the woman.

“Cause if you haven’t said anything to them, they just go, they won’t even have any family planning and when they come back, maybe pregnant again, maybe they abort again”

Midwives who provide family planning counselling in post abortion family planning, midwives experienced that they had to be subtle and sense the client when talking about this topic. One midwife expressed that the information also had to be direct and clear, nuanced to give the woman all the information needed to make an informed choice. A majority of midwives also expressed that there was a great need for information about post abortion family planning general in Zambia. When interviewing the midwives, majority of them stated that they were driven by this and enjoyed doing it. One midwife meant that when spreading information about post abortion family planning you are able to not only strengthening the woman but in the long run the whole country.

“Let's say I am dealing with a girl, once I empower a girl, then I empower a house, I empower the country, I empower the whole nation! Because a girl or a women is very crucial and once a women is empowered she will do greater things.”
DISCUSSION

Discussion of findings

The result of this thesis showed that a majority of midwives experience that both women and midwives have a lack of knowledge about post abortion family planning. Lack of knowledge was according to the midwives one of the main reasons for women not receiving family planning after abortion. According to UNFPA (n.d), women need to have access to information to be able to start a family planning method. The lack of knowledge about the return to fertility among women lead to further unplanned pregnancies (Gemzell-Danielsson & Kopp-Kallner, 2015). This was something that the midwives in this study had experienced as well. Thereby there is a great need of getting women back for a revisit soon after the abortion if they leave the facility without a family planning method. Some of the women they have met thought the fertility wouldn’t come back until after six months. This even though fertility can return already after eight days and a majority of women ovulate already the first cycle after an abortion (Gemzell-Danielsson & Kopp-Kallner, 2015). The fact that a majority of women have sexual contact early on after abortion (Gemzell-Danielsson & Kopp-Kallner, 2015) makes it even more important to inform the women and give them knowledge.

The midwives described that they experience a stigma towards both abortion and family planning and that this is something making it difficult to work with post abortion family planning. This goes in line with the study conducted by Cresswell et al. (2016) stating that attitudes towards abortion generally is very conservative in Zambia. In the study it was shown that women considered that women should not have access to safe abortion in Zambia. That midwives in this study described many women felt that they had to hide their family planning from their husbands and families, which can be explained by the attitudes towards abortion. Another factor might be the Christian culture of Zambia (Landguiden, 2016), that might lead to stigma surrounding post abortion family planning. Some midwives that we interviewed even blamed religion for the stigma.

Furthermore the result from this study shows that the midwives experience a negative attitude towards abortion and family planning coming also from health care staff. This is confirmed by the fact that it is shown that some health care facilities sometimes ignore the abortion law in Zambia and does not provide abortion, even though it is legal (Macha, Muyuni, Nkonde & Faúndes, 2014). As the midwives experienced, this can be one reason why women don’t get the post abortion family planning service they should be offered.

The result also showed that midwives experience it difficult to provide post abortion family planning due to a shortage of healthcare staff. According to the World Health Organization (2018) family planning can be provided by a midwife or other healthcare professionals with the right training. On the other hand, women who receive post abortion family planning services from a midwife are more likely to start a family planning method, compared to other health care professionals. The authors states that this indicates that to improve the post abortion family planning service, there is a need of a larger number of midwives working within the area. With a larger number of midwives there is also a better chance to reach the development goal of United nations for 2030 (United Nations, 2016), there every woman would be ensured to get universal access to family planning.
According to UNFPA, institutions should ensure that there is a broad offer of family planning methods to choose from and all women should have the right to make their own choice when it comes to family planning (UNFPA, n.d.). In this study the midwives described the lack of supplies as one main challenge and especially with long term methods. The midwives experiences are verified with the study written by Hancock et al. (2015) describing a problem with limited supplies and stock-outs from time to time in the clinics in Zambia and especially with implants and IUD’s. With this in mind it is clear that what the midwives experience is that they cannot offer the women to make their own choice because of the lack of supplies. There is a recommendation that post abortion family planning should be provided within 48 hours of an abortion (Huber, Curtis, Irani, Pappa & Arrington, 2016), something that can be hard to achieve when there are lack of supplies and there are no delivery of supplies. The midwives experiences of stock outs were mostly about long term methods and sterile equipment to insert these. Long term methods is proven to be the most effective family planning method. On the other hand it is shown that any method is better than none (Gemzell-Danielsson and Kopp-Kallner 2015). With this in mind, there is a big challenge with lack of supplies, but maybe there is most essential that midwives can provide a method.

The midwives described a problem of compliance within post abortion family planning. The result shows that midwives mainly experience a lack of compliance with short term family planning methods and that one reason to this was that women could not get transport to the facility or the pharmacy to prolong their family planning method. More than half of the Zambian people live under the international line for poverty (The World Bank, 2019). This might be a reason why compliance of short term methods are lacking, that women don’t have money to transport or to prolong their family planning method at the pharmacy. One of the goals with post abortion family planning is that women receive a method that doesn’t require prolonging (International Federation of Gynecology and Obstetrics, n.d.), but there is also women’s right to make their own decision about their reproductive health (UNFPA, n.d.). This means that even if the midwife recommend a long term family planning method that does not require prolonging in the near future, the women is the one making the decision, something that might affect the compliance in the long run. On the other hand it is shown that women making their own choice of family planning have a better compliance than others (Hancock et al., 2016).

Long term methods is shown to be the most effective family planning methods (Gemzell-Danielsson & Kopp-Kallner 2015). There are many Zambian women in reproductive age that does not want more children (DHS program, 2015), and for them there is a great need of a reliable family planning method. Long term methods are not well known in Zambia, and that could be the reason to why they are less popular. In Zambia, the condom, the pill and injectables are the most well-known family planning methods (DHS program, 2015). The midwives in this study described that women use the family planning methods injectables or the pill to be able to hide that they use family planning. Another reason why many women choose a short term family planning method might though be that they are well known. The authors to this study also claim the reason to this can be explained by the methods being considered to be confidential, since there seem to be a stigma around family planning. It is essential that the midwife inform the woman about different family planning methods, so that she can make an informed choice (Hancock et al., 2016). The midwives that were interviewed in this study pointed out information as one of the key factors influencing post abortion family planning. They experience that they as professional midwives have an essential role in providing information to the women. This experience is along the same line as the result from a study showing that women receiving information about family planning from a midwife are more likely to start with a family planning method (Macha et al., 2014).
In Zambia, post abortion family planning is a controversial topic. Midwives in this study experienced that women often do not bring it up or talk about it. Instead the midwife has to bring up the topic. This demands the midwife to be responsive and keen, to be able to give post abortion family planning services. On the other hand post abortion family planning is one of the midwife’s core competencies (World Health Organization, 2015) and a part of the midwife’s professional role (International confederation for midwives, 2018). Thereby the midwife should be able to bring up the topic and handle it so that the women get the right service, even though it can be seen as a great demand for the midwife. Providing post abortion family planning benefits not only the individual but in the long run also families, communities and countries (Curtis, Huber, Moss-Knight, 2017).

According to the midwives there were several misconception and myths surrounding post abortion family planning but the midwives also described that they are experiencing a change in attitudes. The fact that Zambia since 2012 have a goal to increase the use of modern family planning methods among married women to 58 percent by year 2020 demonstrates that there is actually an ongoing change in the country (Family Planning 2020, 2019). There is also more non-profit organizations providing post abortion family planning services that have started their work in Zambia during the last decades (Marie Stopes Zambia, 2018), (IPAS, n.d). This might be one reason why services has become more available, as well as change in attitudes. Another factor to add is the “Standards and Guidelines for Comprehensive Abortion in Zambia” (Ministry of Health, 2017), that can make the abortion law easier to understand.

Post abortion family planning is a core competency in midwives work (World Health Organization, 2015). In the Zambian midwifery education, family planning is though not included in the syllabus (The laws of Zambia, 2019). The interviews it was showed that midwives experience a lack of knowledge within health care staff and colleagues which made it difficult for women to receive post abortion family planning. From the author’s perspective, it seems like post abortion family planning is an important part that the education does not contain. To provide a good education, the authors think family planning should be included in the education. The midwives that were interviewed in this study explained that they only had the knowledge because they had received additional training within the area and a majority said that they were unaware of the importance of post abortion family planning before working in the area. It was though shown that all interviewed midwives were proud of their knowledge. The authors claim that this result shows that midwives need additional education within family planning to be able provide a good service. This is strengthening by the international confederation for midwives (ICM), that claims that family planning is a part of the midwives professional role (International confederation for midwives, 2018). According to ICM (2018) the midwife should assist the woman and talk to the woman at the same level as her. The midwife should advocate the woman and be on her side in the decision making of post abortion family planning. The midwives in this study also talked about the importance of putting themselves to the level of the woman to be able to provide both autonomy and knowledge. The midwives in this study mean that through this, the information and post abortion family planning, women can get a brighter future.
Discussion of method

Approach
The chosen objective of this study was to describe midwives experiences. According to Henricsson & Billhult (2017) it is important that the method is suitable for the objective. Since the aim of the study was to explore midwives experiences a qualitative study was chosen. The authors wanted to explain the topic as it is and not with preconceptions. Therefore an inductive approach was chosen. An inductive approach is integrating information and processing observations to more general rules (Polit & Beck, 2017).

Design
An interview study with semi structured questions was used (Polit & Beck, 2017). An interview study gives the participants the opportunity to describe and talk freely about their experiences (Danielsson, 2017). According to Burnard, Morrison and Gluyas (2011) both interviews and observations are suitable data collection methods when performing qualitative studies and wanting to experience people’s understandings and experiences. Observations requires a larger sample size than interviews. It is also a time-consuming method, and this master thesis has a time limitation. The authors of this study argue that it would have been difficult to do observations since there was not enough time.

Another data collection method is survey questionnaires. With survey questionnaires the authors does not get the opportunity to clarify the questions or ask supplementary questions and there is a risk that the participant does not speak as freely as in an interview. When conducting a qualitative study it is important to enable the participant to explain her or his own experiences (Danielson, 2017). On the other hand, a survey can let the participant be more autonomy and to be able to fill in the questionnaires in solitude. Another benefit with survey questionnaires is that is it time and cost efficient and it is a good method when wanting to reach a larger number of participants in a short period of time. This could give a larger quantity of data but in qualitative studies, a large quantity is not the main objective (Polit & Beck, 2017). A survey questionnaire is therefore more suitable when having a quantitative approach and the aim is to measure and generalize data (Billhult, 2017). Since this was not the aim in this study the authors did not find survey questionnaires as a suitable data collecting method.

Sample selection
There are several inclusion criterias for participation in this study. The authors agreed on them together. One of the inclusion criterias was that the participant had worked with post abortion family planning for at least one year. Even though all of the participants had been working with post abortion family planning for at least one year, some of them only work with it sporadically. This study does not have an inclusion criteria for how often or much the participant works with post abortion family planning. This could be considered as a limitation of the study. Since it was difficult for the authors to find participants who had experience with post abortion family planning the midwives that only had sporadically experiences were included in the study. All of the participants did though contribute to the study and all of them had experiences of working with post abortion family planning. It is important to have enough participants and a good range of participants (Henricson & Billhult, 2017). This would have been difficult with more inclusion criterias.
There was a strategic recruitment of participants to get participants within the inclusion criterias. This enabled the authors to find participants with the certain inclusion criterias. All of the participants completed the interview and no participant withdrew from the study. This can be considered as a strength as canceling of participation can be seen as weakness of the study (Danielsson, 2017). Another strength is the fact that the participants had worked both within non-profit organizations and governmental post abortion family planning services. This can be seen as a type of person-triangulation (Polit & Beck, 2017) since the authors have included participants from different levels within the health care area.

Ten midwives were interviewed for the study, something that can be seen as a limitation. There is a risk that a small amount of participant can result in a material that is not deep enough (Polit & Beck, 2017). Holloway and Galvin (2017) states that this is not always the case since the interviews in a qualitative interview study means interviewing the participants on a deeper level. According to Danielsson (2017) the sample should be somewhere between ten and twenty. In contrast Holloway and Galvin (2017) states that six to eight participants is enough when the participants are homogenous. The authors can according to this state that there is not a consensus on how many participants should be include in a study. In this study the number of participants was decided by data saturation (Polit & Beck, 2017). This meant that when the authors perceived that similar stories and experiences were told by the participants and the authors could see patterns in the data, data collection was considered sufficient. The ambition was to accomplish between eight and twelve interviews but when data saturation was considered to be reached by eight interviews the authors decided to only complete two more. This argument is confirmed by Holloway and Galvin (2017) who means that data collection should proceeded until no additional data can be found, and then the authors have reached data saturation.

Data collection
Eight of the interviews took place at the participants workplace and the other two took place in a hotel room. The interviews taking place at the hotel rooms were without disturbance but for the interviews taking place at the participants workplace, there was sometimes disturbance from colleges or others. The main importance according to the authors was though that the participants would feel safe and convenient where the interview took place and therefore the place was always chosen by the participant. Holloway and Galvin (2017) highlights the importance of choosing a place where the participants feel comfortable and where they are in control when interviewing, they mean that this can lead to a richer material. When the physical environment is chosen by the participant it can also increase the participants feeling of confidentiality (Polit & Beck, 2017).

The authors did not have much experience of interviewing, something that can be seen as a potential weakness. The authors experienced that more supplementary question was asked in the later interviews than in the first ones and the authors felt more comfortable in the interviewing role during the later interviews. Although one pilot interview was held, it might have been positive to have additional pilot interviews to be more experienced interviewer at the time when the interview with the participants started. Pilot interviews is according to Holloway & Galvin (2017) a good way to guidance the authors for upcoming interviews. The interview guide though was a support instrument for the authors when the participants did not have more to contribute to the interview. It enabled the authors to stick to the topic and to get a deeper understanding of the participants experiences. The interview guide was also a
strength of this study because it enabled the authors to collect similar data from all interviews (Holloway & Galvin, 2017).

All of the interviews were held in the English language. English is not the native language for any of the authors and neither for the majority of the participants. Because of this there was sometimes shown to be language barriers during the interviews when a word or a phrase was not understood by the authors or the participants. When this occurred the authors made sure to clarify this during the interview. Holloway & Galvin (2017) states that it is important to have an allowing atmosphere when interviewing. The authors encouraged the participants before starting the interviews to tell if there was something that they did not understand. Both the authors and the participant spoke English fluently though and could understand each other. If there was any mishearing or misconception it was talk through immediately so that both parts understood. According to Trost (2010) it is requirement that the authors have adequate knowledge in the language to manage a rich interview.

There are several risks associated with data collection and papers, recordings and files that needs to be confidential and protected. One of the most common risks is that confidential data gets revealed (Kjellström, 2017). It was therefore important for the authors to treat the data correct and to keep the material safe. The authors to this study had passwords for both files and recordings and the papers were been stored in a safe place. The material was also destroyed after it had been used for transcription. The authors have also tried to make sure that no participant can be revealed through personal details such as names or where the participants work. This in accordance to Kjellström (2017) who describes the importance of insuring confidentiality. The confidential handling of the data material did not affect the findings.

To be able to transcribe the material the authors had to record the interviews (Danielson, 2017). The authors made sure that this was approved by all the participants in the study before the interviews begun. It is useful to test the recorder before starting the conducting of material. This was done before every interview the authors performed. Because of the importance of being able to transcribe the material the authors always recorded on two devices.

Data analysis
The data analysis was performed with a qualitative content analysis. Both the authors were active in the analysis process. Graneheim and Lundman (2017) states that the reliability increases if both of the authors are participating, reflect and discuss during the process of analyzing. The codes and categories can then be more specific and correct. This is confirmed by Danielson (2017) who means that credibility increases when both authors are involved when develop the analytical coding scheme.

Holloway and Galvin (2017) explains that it is important to be able to follow the analysis process. By using a coding scheme and presenting how the analysis was performed and give examples how it was done, credibility can be met. Holloway and Galvin (2017) also mean that it is important to be able to track the data. To enable this and to strengthen the presented result the authors used quotes when presenting the collected data. By doing this the readers can easily follow the reasoning. This is confirmed by Polit and Beck (2017) who means that quotes can be used to strengthen and make the collected data more concrete.

Validity is a quality criterion, that claiming to measures that the study is really examining the aim of the study (Polit & Beck, 2017). To reach validity in a study, it is
important that the authors put their own opinions aside so that it will not affect the outcome of the study (Holloway and Galvin, 2017). To achieve validity the authors have, during the whole process, been having in mind that their own opinions should be put aside, as a manifest analysis was performed. The authors had also gone through the material carefully several times, both separately and together and excluded all material that does not answer the aim of the study.

The authors of the study have tried to write the method as detailed as possible to ease replicability. It can be difficult to redo a qualitative study the exact same way (Danielsson, 2012). One thing that could make the replicability in this study difficult is confidentiality. In this study the specific clinics where the midwives work are not revealed. The authors claim that since most of the clinics are small and only have a few midwives working there this could cause the participants to be revealed.

**Conclusion**

The main objective of this study was to describe midwives experience of working with post abortion family planning in Zambia. The midwives experienced that there were several factors influencing their work with post abortion family planning. Some of these factors made their work challenging and some factors were essential to be able to provide a good post abortion family planning. Essential factors identified were good knowledge, good information and a neutral attitude towards post abortion family planning. The midwives in this study experienced they were able to provide all these essential factors. To improve the post abortion family planning there is though a need of working with challenges, such as lack of staff and equipment, the stigma around post abortion family planning and the general lack of knowledge within the area. To do that education, more midwives working and a better availability to post abortion family planning equipment and services is needed.

**Clinical implications**

Because of the low prevalence of post abortion family planning in Zambia (Marie Stopes International, n.d, c), and the risks with additional unplanned pregnancies (Open society initiative for southern Africa, 2018), there is of great importance to explore this topic. Also, no research has to the authors knowledge yet been published within this area of midwives experiences about post abortion family planning in Zambia. Through this study the authors have received an additional knowledge of the process of research. The result shows that midwives experience several challenges in post abortion family planning. The authors claim that there is need to explore this topic further and especially to do research in how to handle these challenges.
REFERENCES


IPAS. (n.d.) Where we work. Retrieved April 15th, 2019, from https://www.ipas.org/where-we-work


Appendix A

Interview guide

“The aim of the study is to describe midwives experiences of working with post abortion family planning in Zambia”

Demographical information before starting the recording:
- Gender?
- Age?
- Country and place of birth
- How many years of experience do you have working as a midwife?
- How many years of experience do you have working with post abortion contraception?
- Do you have any additional education within the area of midwifery?

Questions asked when recording:
- Can you tell us about your experience of working with post abortion family planning?
  - What are the greatest challenges when working with post abortion family planning?
  - What are the greatest opportunities when working with post abortion family planning?
  - What are your experiences of stock/supplies in clinic when working with post abortion family planning?
  - What are your experiences of staffing levels in your clinic when working with post abortion family planning?
  - How do you follow-up women that have received post abortion family planning?

- Can you tell us about your experience of informing women about family planning methods after abortion?
  - Based on your experiences, can you give the information needed about post abortion family planning?
  - Based on your experience, are women interested about information about post abortion family planning?
  - Based on your experience, do women understand the information you give about post abortion family planning?
  - What are your experiences in regard to women’s compliance in post-abortion family planning?

- How have you experienced this interview?
Appendix B

Informed Consent Form for participation in a post abortion family planning master’s thesis study in Zambia

Anna Wramsby and Linnéa Wallén are our names and we are Swedish midwife students from Sophiahemmet University College in Stockholm, Sweden. We are writing our master’s thesis here in Zambia, which is a Minor Field Study, sponsored by SIDA. SIDA is a governmental authority working with reducing the poverty globally. The subject of our thesis is to explore how midwifes in Zambia are working with post abortion family planning. As a midwife working with post abortion family planning in Zambia we would like to invite you to participate in this study. In order to participate in this study, you should have at least one year’s experience of working in this area in Zambia. Further information about the study follows.

Background
In Zambia the prevalence of post abortion contraception is lower than in many other African countries. Midwives have an important professional role in family planning and in women's health services. In conjunction with an abortion the midwife has an opportunity to inform, discuss and even prescribe contraception. Previous research has shown that women receiving information and knowledge about post abortion contraception are more likely to use it. By exploring midwives experiences of working with post abortion family planning in Zambia the authors would like to identify opportunities and challenges in practices surrounding post abortion contraception.

Aim
The aim of the study is to describe midwives experience of working with post abortion family planning in Zambia.

Study design
In order to collect data for this study, we will hold interviews with semi-structured questions. This entails that the interviews will be supported by a prewritten interview guide with semi-structured questions, but the order of the questions will be decided by the situation and how the conversation is proceeded. This is an oral interview where each participant will be interviewed individually face to face. The interview will take around 60 minutes. As a participant you are free to choose the place for the interview. The interviews will be recorded by an electronic device and transcribed for further analysis. Both of the authors of this study will participate during the interviews. After the interviews have been transcribed the audio-recordings will be stored confidential in locked devices, in line with the guidelines of Sophiahemmet University College.
These interviews will result in a qualitative master thesis that will be in open access for students at Sophiahemmet University College in Stockholm, Sweden and for other Minor Field Study students at SIDA, Sweden.

Voluntary participation
Participation in this study is voluntary and as a participant you can at any time choose to terminate your participation in the study. All collected material will be anonymous and the information will be kept confidential.

Authors contact information
Anna Wramsby annawramsby@gmail.com +260 76 198 96 57
Linnéa Wallén linnea.wallen@hotmail.se +260 76 199 02 41
I have taken part of the information above and I hereby approve that Linnéa Wallén and Anna Wramsby have permission to interview me with the aim of collecting data for their master thesis “Post abortion family planning in Zambia”.

Place and date

..............................................................

Signature Participant

..............................................................

Clarification of signature participant

..............................................................

Place and date

..............................................................

Signature Author

..............................................................

Clarification of signature author

..............................................................
Etikrådets bedömning om projektet behöver etikprüvas

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**Forskningsetiska rådets anteckningar**

Tillståndspliktigt Ja ☐ Nej ☒

Comments:

Since the data collection will be undertaken in a country outside Sweden, The Swedish Ethical Review Board cannot examine and approved the project. The author and supervisor have to make sure that the project is performed in accordance with ethical guidelines and/or with ethical clearance from Zambia. Sophiahemmet University cannot be responsible for ethical issues that may occur in Uganda but only for the part that is done in Sweden. It is recommended to think about the ascendancy the interviewers have in the interview situation, which is further enhanced by the fact that it is one respondent and two interviewers. Information is missing about what the intended respondents are informed about? Who informs them (parent?)? How should collected data be handled, during the data collection and afterwards? How should data be identified? Provided that these points are described in accordance with good research practice and that ethical considerations are made in all parts of the project, in accordance with ethical guidelines at Sophiahemmet University the Ethical Review Board at Sophiahemmet University approve the performance of the project.

**Ledamot av forskningsetiska rådet**

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20\textsuperscript{th} May, 2019

Ref. No. 2019-Apr-007

The Principal Investigators
Ms. Linnea Wallen and Ms Anna Wramsby
Marie Stopes Zambia
Plot 120 Kudu Road Kabulonga,
LUSAKA.

Dear Ms Wallen and Ms Wramsby,

RE: POST ABORTION CONTRACEPTION IN ZAMBIA.

Reference is made to your corrections dated 2\textsuperscript{nd} May, 2019. The IRB resolved to approve this study and your participation as Principal Investigator for a period of one year.

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Specific conditions will apply to this approval. As Principal Investigator it is your responsibility to ensure that the contents of this letter are adhered to. If these are not adhered to, the approval may be suspended. Should the study be suspended, study sponsors and other regulatory authorities will be informed.

Conditions of Approval

- No participant may be involved in any study procedure prior to the study approval or after the expiration date.
- All unanticipated or Serious Adverse Events (SAEs) must be reported to the IRB within 5 days.
- All protocol modifications must be IRB approved prior to implementation unless they are intended to reduce risk (but must still be reported for approval). Modifications will include any change of investigator/s or site address.
- All protocol deviations must be reported to the IRB within 5 working days.
- All recruitment materials must be approved by the IRB prior to being used.
- Principal investigators are responsible for initiating Continuing Review proceedings. Documents must be received by the IRB at least 30 days before the expiry date. This is for the purpose of facilitating the review process. Any documents received less than 30 days before expiry will be labelled “late submissions” and will incur a penalty.
- Every 6 (six) months a progress report form supplied by ERES IRB must be filled in and submitted to us.
- A reprint of this letter shall be done at a fee.

Should you have any questions regarding anything indicated in this letter, please do not hesitate to get in touch with us at the above indicated address.

On behalf of ERES Converge IRB, we would like to wish you all the success as you carry out your study.

Yours faithfully,

ERES CONVERGE IRB

Dr. Jason Mwanza
CHAIRPERSON