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Original article

FACTORS CONTRIBUTING TO SEPTIC ABORTION AMONG WOMEN AGED15-45YEARS ATTENDING POSTNATAL CLINIC AT IRAN-UGANDA HOSPITAL, KAMPALA DISTRICT. A CROSS-SECTIONAL STUDY.

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Abstract

Background:

Septic abortion is an infection of the placenta and fetus, products of conception, of a pre-viable pregnancy. The purpose of the study was to examine the Factors contributing to septic abortion among women aged 15-45 years attending at IRAN-Uganda Hospital, Kampala district.

Methodology:

A descriptive cross-sectional research design was used to describe factors contributing to septic abortion among women aged 15-45 years attending at IRAN-Uganda Hospital. A cross-sectional descriptive study design was adopted in this study that involved observation of a sample of a population or phenomena that are made at one point in time. 30 respondents were involved in the study who were selected using convenient random sampling procedures.

Results:

(43.3%) of the women were aged 20-30 years, the majority of them (83.3%) were Catholics, half of them (50.0%) had never been to school, Majority (46.7%) of them were single. The majority of the respondents (46.7%) were employed, (93.3%) of them reported that the distance from home to the nearest health facility contributed to septic abortion, the majority (66.7%) reported unavailability of healthcare services being part of the factors leading to septic abortion,(56.7%)reported high cost of safe abortion services, (70%) reported that Poor attitude of health workers whereas (86.7%) saidLong-waitingtime, majority (66.7%) reported that unnecessary requirement like parent's or spouse consent before providing abortion services led to septic abortion

Conclusion:

Personal factors, socio-economic factors, and health facility-related factors contributed to septic abortions among the respondents hence advocacy is needed to improve and prevent septic abortions among women.

Recommendation;

Septic abortion among women can be reduced and managed by considering and maintaining a balance between regular health education talks about the dangers of septic abortion and all categories of abortions, and mass sensitization of the community against practices of septic abortion.

Keywords: septic abortion, postnatal clinic, Iran-Uganda hospital, Submitted: 2023-04-07 Accepted: 2023-05-19

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1. Background

Septic abortion is an infection of the placenta and fetus, or products of conception, of a previable pregnancy (Tiffany Murano, 2016). Infection is primarily in the placenta; however, potential spread to the surrounding uterus, pelvis, and distant organs is possible with prolonged or potent toxin-producing bacteria (Tiffany Murano, 2016). Septic abortions, whether induced or spontaneous, occur because of improper, septic, or inadequate removal of products of conception (Tiffany Murano, 2016).

Septic abortion is an important problem in many resource-poor settings, with a prevalence as high as 86% (Ishoso et al., 2019). Apart from damage to the fallopian tubes with subsequent increases in the risk of ectopic pregnancy and infertility, it significantly contributes to maternal death (Ishoso et al., 2019). Any society with a high fertility rate, low contraceptive usage, and legal obstacles to the safe termination of pregnancy exposes women to an intricate web of factors with potentially adverse consequences (Michael Aziken, 2007). Clinically recognizable spontaneous abortion complicates about 15% of all pregnancies (Alemayehu et al., 2019), while induced abortion, which remains a method for fertility regulation, represents a staggering 30–60 million pregnancy losses annually (Alemayehu et al., 2019).

Septic abortion is a procedure of terminating an intended pregnancy either by individuals without the necessary skills or in an environment that does not conform to minimum medical standards, or both. The term spontaneous abortion means the loss of a fetus during pregnancy due.

In Africa, 56% of all abortions are septic, compared with just 6% in the developed world. The estimated annual number of deaths from septic abortion declined from 56,000 in 2003 to 47,000 in 2008. Complications from septic abortion accounted for an estimated 13% of all maternal deaths worldwide in both years). Most of the causes of maternal deaths can be prevented with the existing cost-effective interventions with PAC services inclusive). Each year approximately 210 million women throughout the world become pregnant, and as many as 80 million of these pregnancies are unplanned. Some unplanned pregnancies are carried to term, while others end in spontaneous or induced abortion). A hospital-based study in Ethiopia revealed that in 50% of unwanted pregnancies, 25.6% end up in induced abortion, and 58% of the women who induced abortion, terminated the current pregnancy either by seeking the help of untrained personnel or by themselves with no assistance resulting into septic abortion (Tekle-Ab et al., 2017).

In sub-Saharan Africa, nearly all septic abortion procedures occur in developing countries, with the highest rates occurring (36 per 1,000 women aged 15-44 annually in Eastern Africa, versus 1 per 1,000 women in developed countries annually). Likewise, estimated case-fatality rates per 100,000 abortions range from nearly in the United States to close to 100 in Eastern Africa (Finkielman et al., 2017). In East Africa, abortion complications are among the major reasons why women seek emergency PAC. In Uganda in the year 2013, an estimated 128,682 women were treated for abortion complications and an estimated 314,304 induced abortions occurred, both slightly up from 110,000 and 294,000 in 2003, respectively (Prada et al., 2016).

The national abortion rate was 39 abortions per 1,000 women aged 15–49, down from 51 in 2003 in Uganda (Prada et al., 2016). Regional variation in abortion rates is very large, from as high as an estimated 77 per 1,000 women 15–49 in the Kampala region, to as low as 18 per 1,000 women in the Western region (Prada et al., 2016). The overall pregnancy rate also declined from 326 to 288; however, the proportion of unintended pregnancies increased slightly, from 49% to 52% (Prada et al., 2016)

A study in Tanzania estimated the number of septic abortions to be 1.4 million in 2018 or 36 septic abortions per 1,000 women of reproductive age. Septic abortion represents one of the leading causes of maternal deaths in Tanzania

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(Guttmacher Institute,2016.) According to the Ministry of Health and Social Welfare, 16% of maternal deaths are due to complications from abortion (Center for Reproductive Rights, 2019).

In Uganda, more than 80% of the population lives within a 5 km radius of a healthcare facility. Still, healthcare utilization is poor (Uganda Ministry of Health, 2018). This is attributed to poor infrastructure, lack of supplies including essential medicines, a shortage of health workers, low pay, unofficial patient fees, long waiting times, and poor interpersonal skills among some Health Care Professionals (HCPs) contributes to septic abortion leading to septic abortion (Uganda Ministry of Health, 2018). Therefore, this study seeks to investigate the factors contributing to septic abortion among women aged 15-45 attending a postnatal clinic at IRAN-Uganda Hospital.

1.1. Purpose of the Study.

The purpose of this study was to investigate the factors contributing to septic abortion among women aged 15-45 attending at IRAN-Uganda Hospital, Kampala district.

1.2. Specific Objectives.

The study was guided by the following objectives;

- To assess personal factors contributing to septic abortion among women aged 15-45 attending a postnatal clinic at IRAN-Uganda Hospital, Kampala district.
- To find out socio-economic factors contributing to septic abortion among women aged 15-45 years attending at IRAN-Uganda Hospital, Kampala district.
- To identify health facility factors contributing to septic abortion among women aged.

2. RESEARCH METHODOLOGY.

2.1. Study Design.

The study used a cross-sectional research design and a quantitative approach to data collection. The cross-sectional design was used because the study was carried out within a short period. A quantitative approach was used because it was time-saving and could be used to collect data from a big number of participants.

2.2. Study Settings and Rationale.

This study was carried out in IRAN-Uganda Hospital. The hospital is on NAGGULU Road, on NAGGULU Hill, Nakawa Division, Kampala District, in Kampala, the capital of Uganda, and the largest city in that country. This location lies approximately 4 kilometers (2 mil), by road, east of the central business district of Kampala. It was easily accessible for the same IRAN-Uganda Hospital near her place of residence. The hospital offers postnatal and postnatal clinics. General HIV clinic catering to reproductive health services, surgeries, delivery services, and other medical conditions. This study was carried from the post-natal ward, post-abortion ward, and postnatal care clinic among mothers since its where they were majorly found.

2.3. Study Population.

The study population included all women who are receiving health services in the gynecological ward, family planning clinic, and maternity ward in IRAN-Uganda Hospital. Those who were present during the time of data collection and had consented to participate in the study were study respondents.

2.4. Sample Size Determination.

According to Roscoe (1985), a sample size of 30 was appropriate for most research for populations larger than 30 and less than 500. Therefore, the research utilized a sample size of 30 respondents. The researcher sampled a size of thirty (30) respondents which was obtained from the study population in IRAN-Uganda Hospital on the days and dates of data collection. This size was adequate to generate the required information. This sample size was also chosen because the UNMEB guide, 2009 permits a sample size of not fewer than 30 respondents.

2.5. Sampling Procedure.

A convenient random sampling method was used in the study. This was because, by this method of sampling, the researcher got a good representation without any biases. As the patients settle waiting to be attended to, the researcher wrote numbers from one to sixty (1-60) on white small pieces of paper of the same size, thirty (30) who picked even numbers were considered eligible for participation in the study while those who picked odd numbers were not be allowed to participate in the study. The pieces of paper were folded uniformly into tiny pieces, and mixed, and people were made to pick one.

2.6. Inclusion criteria.

All women aged 15-45 years that were available and voluntarily consented to take part in the study were eligible for the study.

2.7. Definition of Variables.

Variables referred to the characteristics that can exist in different values or amounts. These included;

2.7.1. Dependent Variable.

Septic abortion among women aged 15-45 years attending a postnatal clinic at IRAN -Uganda Hospital.

2.7.2. Independent Variables.

In this study, independent factors were; Personal factors, Socioeconomic factors, and Health facility factors contributing to septic abortion among women aged 15-45 years attending a postnatal clinic at IRAN-Uganda Hospital.

2.8. Research Instrument.

The researcher used a questionnaire to collect data. This tool was most appropriate because most of the women were assumed to have attained some level of education that enabled them to be able to read and write. Those who weren't able to read and write answered the questionnaire with the help of the researcher who translated the questions into the local language. The questionnaire contained 4 sections; section A consisted of the demographic characteristics of the respondents, section B consisted of personal factors, section C consisted of socioeconomic factors, and Section D consisted of health facility-related factors.

2.9. Data Collection Procedure.

The researcher presented a letter of introduction that was gotten from the Principal, of Mildmay School of Nursing and Midwifery to the Hospital Administrator who then introduced herself to the respective respondents (women age aged 15-45 years) attending the postnatal clinic atIRAN -Uganda Hospital, who also then introduced themselves to her. The respondents were informed about the general objectives of the study to ensure the confidentiality of the information provided. Each respondent was contacted on her own time. This prevented sharing of information among themselves. was Data collected within 5 days, dealing with 6 women per day? Questionnaires were administered to respondents who knew how to write and read. For those who didn't know how to read and write, the researcher translated for them questions in the local language (Luganda) such that they can be able to complete the questionnaire.

2.10. Data Management.

The researcher compiled and managed data to ensure that all questions were retrieved or collected and answered well. Data management involved data editing before leaving the area of study to ensure that all questions were properly answered before leaving the area of study.

2.11. Data Analysis.

Data was analyzed manually and using a Microsoft Excel computer program. Then it was converted into frequencies and percentages and presented in tables, graphs, narratives, and charts.

2.12. Ethical Consideration.

An introductory letter was obtained from the Mildmay School of Nursing and Midwifery that introduced the researcher to the Hospital Administrator of IRAN-Uganda Hospital from whom

consent was sought. The study only commenced after the purpose of the study was well explained to the respondents. The respondents were assured that all information given was treated with the utmost confidentiality.

3. RESULTS PRESENTATION.

3.1. Socio-demographic characteristics.

Table 1: distribution of Socio-demographic characteristics respondents

n=30

Variables	Frequency(f)	Percentage (%)
Age		
Below 15-20	0	0
20-30	13	43.3
21-40	11	36.7
41-45	6	20.0
Religion		
Roman Catholic	25	83.3
Protestant	3	10
Islamic faith	2	2.7
Education level		
Never been to school	15	50
Primary	10	33.3
Secondary	5	16.7
Tertiary/University	0	0
Marital status		
Single	14	46.7
Married	9	30.0
Separate/divorced	6	20.0
Window	1	3.3
Format of the work		
Self-employed	14	46.7
Employed by others	10	33.3
Unemployed	6	20
Others	0	0

The majority of the respondents 13(43.3%) were in the age group of 20-30 years old while the minority 6(20.0%) were in the age group of 41-45years old.

According to religion majority of the respondents 25 (83.3%) were Catholics, followed by 3(10%) were protestants, while minority 2(6.7%) were moslems.

Half of the respondents 15(50.0%) had never been to school, 10(33.3%) had attained primary level while a minority 5(16.7%) had attained a secondary level. None of them had gone up to tertiary/university level.

The majority of the respondents 14(46.7%) were single, 9(33.0%) were married, 6(20%) were separate/divorced and the minority 1(3.3%) were widowed.

The majority of the respondents 14(46.7%) were employed whereas the minority were 6(20%) unemployed.

3.2. Responses of the participants on Personal factors contributing to septic abortion among women aged 15-45 attending the postnatal clinic.

Results Figure (1) above shows that the majority of the respondents 17(56.7%) had ever done an abortion while the minority13(43.3%) had never done it.

Figure 2 shows that the majority 24(80%) of the respondents believed that unintended pregnancy was a major driving force for septic abortion while the minority 6(20%) didn't believe that unintended pregnancy is a major driving force for septic abortion.

Table 2: Shows the participants' responses on the high-risk practice that could expose women to abortion which is commonly unsafe.

(n=30)

High-risk practices	Frequency (f)	Percentage (%)
Multiple sexual partners	20	66.7
Relying on traditional herbalist		
Negative attitude medical services	2	6.7
Aborting many times	4	13.3
	4	13.3

The majority 20 (66.7%)of the respondents mentioned multiple sexual partners as high-risk practice that can expose women to abortion which is commonly unsafe while the minority 2(6.7%)of the respondents mentioned Relying on traditional herbalists.

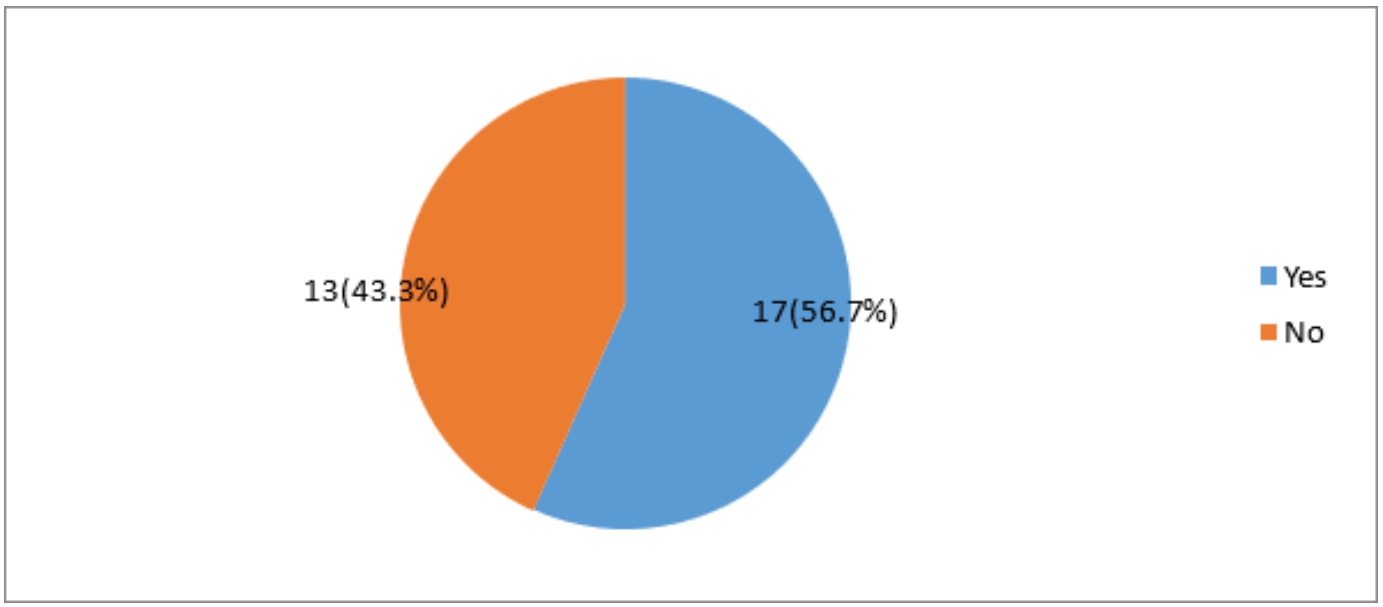

Figure 1: **Shows whether respondents had ever done an abortion. n=30 The primary source of data**

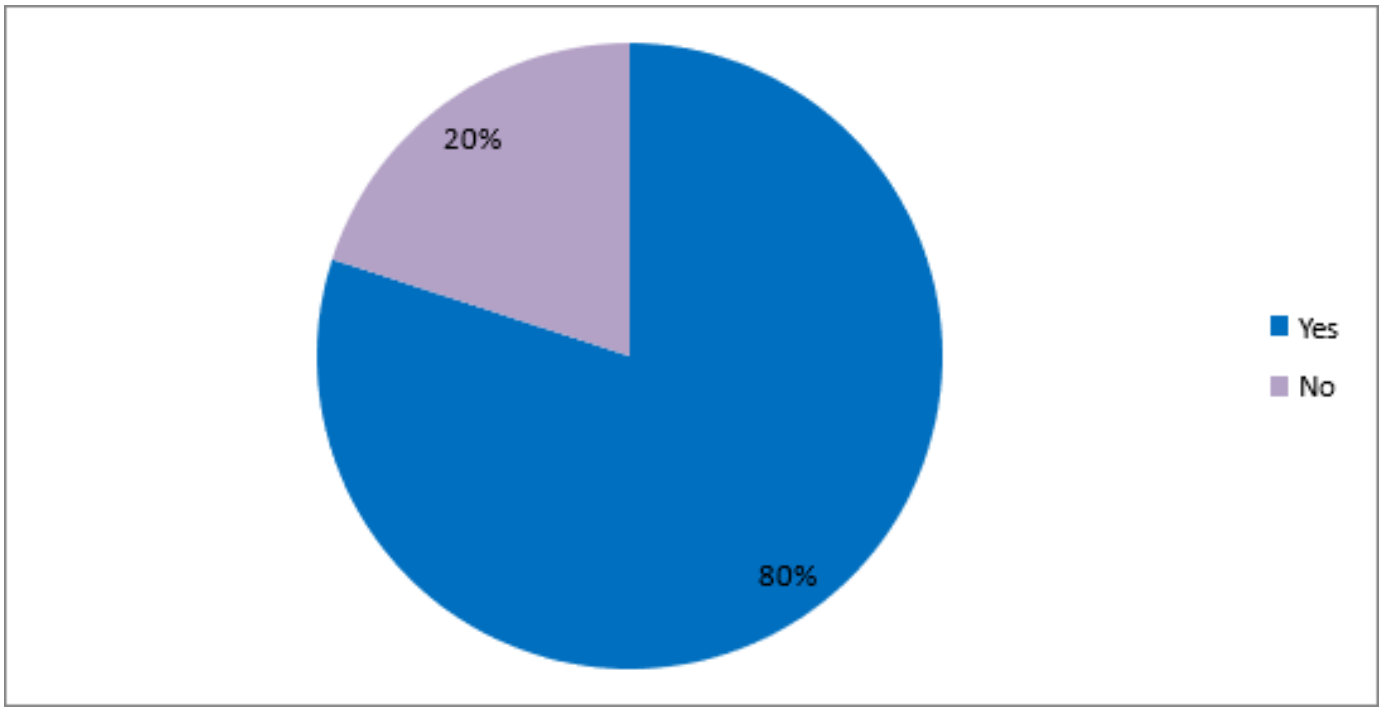

Figure 2: **Shows whether respondents believed that unintended pregnancy was a major driving force for septic abortion (n=30)**
Data source: Primary

Table 3: Shows responses on whether these Personal factors contributed to septic abortion (n=30)

Variable	Responses	Frequency	Percentage(%)
Avoidance of health worker's fee exposes women to ineffective abortion methods	Yes No	24 6	80 20
Women are at a risk of unwanted pregnancies and septic abortion if their family planningneeds are not met.	Yes No Not sure	15 14 1	50 46.7 3.3
Desire for a specific sex makes some women toresort to abortion by assistance of herbalists	Yes No Not Sure	4 6 20	13.3 20 66.7
Well-educated women are more likely to havemore abortion than poor and illiterate women	Yes No Not sure	2 27 1	6.7 90 3.3
Adolescents mostly resort to unskilled persons	Yes	27	90
to perform abortion.	No	3	10
TOTAL		30	100

As shown in table 3, The majority 24(80%) of the women reported that avoidance of health worker's fees exposes women to ineffective abortion methods while a minority 6 (20%) said it did not.

The majority 15(50%) of the participants said that women were at risk of unwanted pregnancies and septic abortion if their family planning needs are not met whereas the minority 1(3.3%) was not sure.

When asked whether the desire for a specific sex makes some women resort to abortion assistance of herbalists, the majority 20(66.7%) of the women were not sure about this whereas a minority4(13.3%) of them said yes it did so.

The majority 27(90%) of the women said that well-educated women were less likely to have more abortions than poor and illiterate women whereas the minority1 (3.3%) were not sure about it.

Last but not least, the Majority 27(90%) of the women reported that adolescents mostly resorted to skilled persons to perform an abortion while the minority3(10%) said no.

3.3. Socioeconomic factors contributing to septic abortion among women aged 15-45 attending postnatal the clinic.

Figure (3), it was shown that the majority of the respondents 19(63.3%) had never been forced into a sexual relationship that led to pregnancy while the minority 11(36.7%) had ever forced.

TEXT 1: Responses on what happened after being forced into sexual relationship (n=11)

According to text one, the Majority of 8(72.7%) of the women aborted when after being forced into a sexual relationship while minority1(0.9%) produced following a forced sexual relationship.

Table 4: The monthly income of the house hold.

n=30

Item	Variable	Frequency (f)	Percentage (%)
Monthly income level of your household	Very high	2	6.7
	Neither low nor high	5	16.7
	High	8	26.6
	Low	11	36.7
	Very low	4	13.3

According to table 4, the majority of the respondents 11(36.7%) mentioned Monthly income level of your household was low while minority 2(6.7%) mentioned that it was high.

Figure 4 shows that the majority of the respondents 26(86.7%) affirmed that household monthly income level could lead to septic abortion among women of child bearing age attending postnatal clinic while minority 4(13.3%) reported that it could not.

Text 2: Reasons that respondents gave as to why said household monthly income level could lead to septic abortion among women(n=30)

According to text 2, all 26(100%) who reported that it could lead to septic abortion said so because they could not afford proper treatment of post-abortive care since they were to be charged money to access those services.

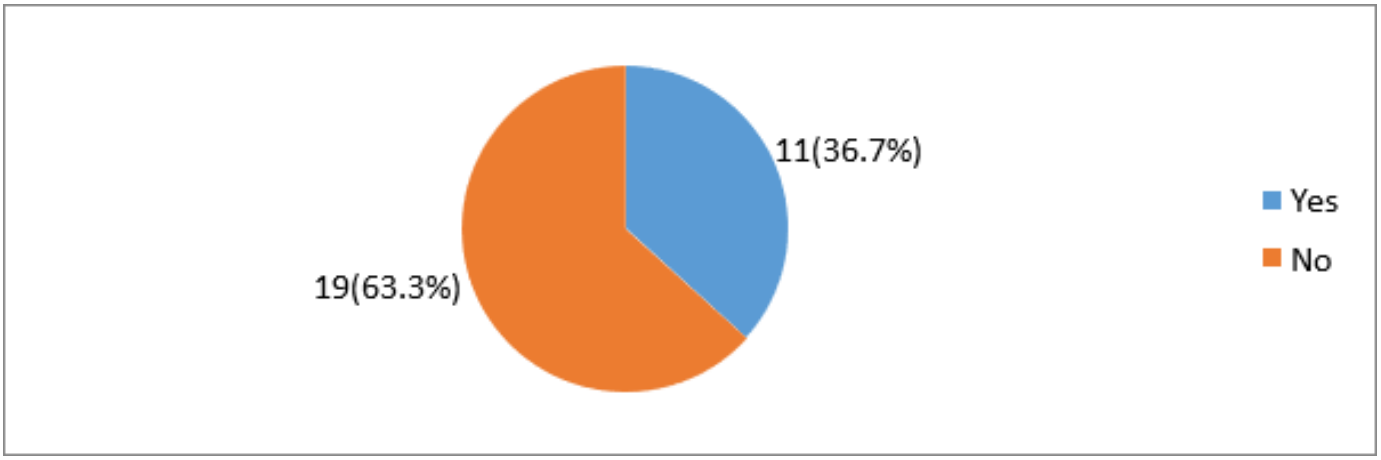

Figure 3: **Shows whether respondents had ever been forced into a sexual relationship that led to pregnancy n=30**
The primary source of data

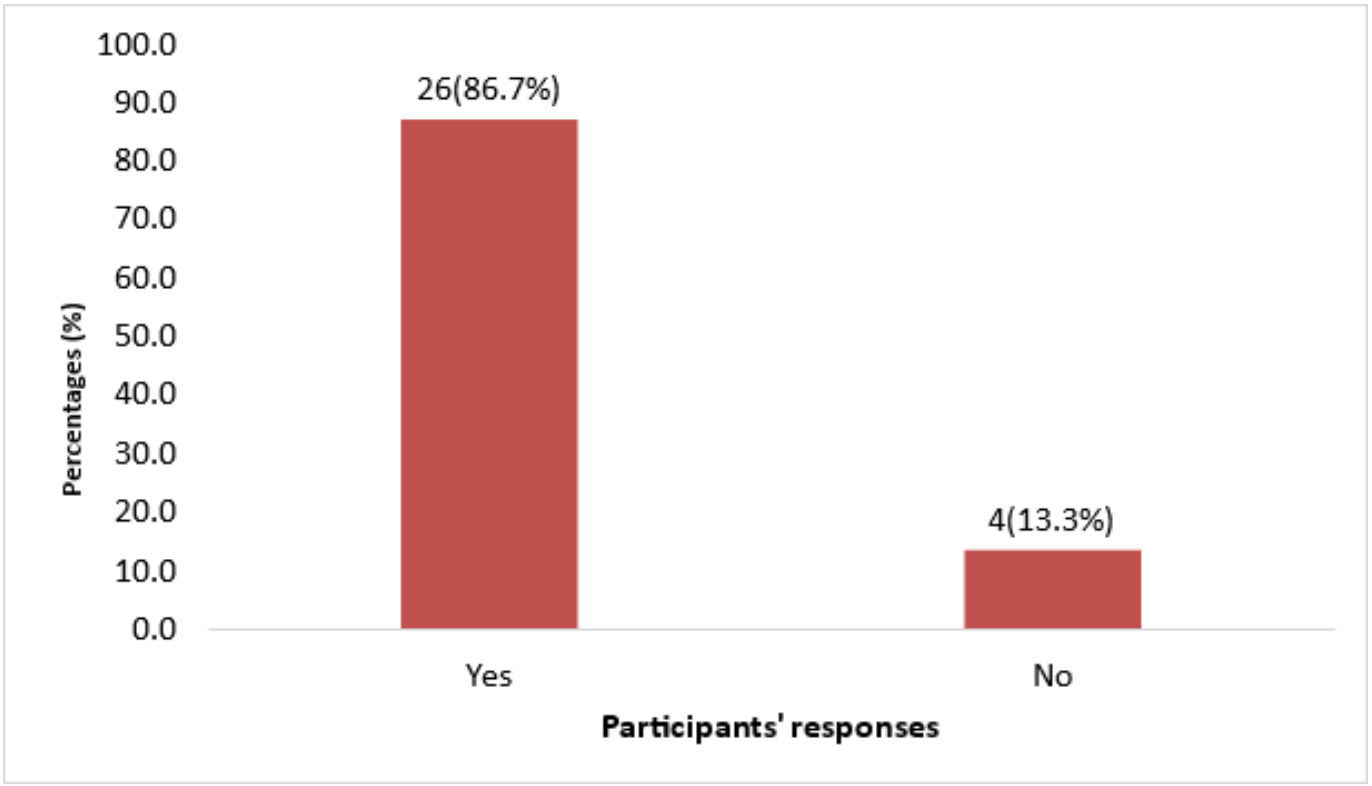

Figure 4: **Respondents' responses on whether household monthly income level could lead to septic abortion among women of childbearing age attending the postnatal clinic. n=30**

Table 5: Shows the responses link between septic abortion and social support as well as community reaction towards a girl when found pregnant. (n=30)

Variable	frequency(f)	(%)
Whether There is a link between septic abortion and lack of social support		
a) Agree		
b) Disagree	5	16.7
c) I don't know	15	50
	10	33.3
How does your community react when a girl is found pregnant?		
a) Beat her		
b) Force her to get married	18	60
c) Discriminate her	2	6.7
d) Encourage her to produce from home	6	20
	4	13.3

Table 6: Showing Responses on whether these Socio-economic factors contributed to septic abortion (n=30)

Variable	Response	Frequency(n)	Percentage (%)
Lack of money to pay for a qualified health provider	Yes	30	100
	No	0	0
Fear of rejection by family members	Yes	15	50
	No	13	43.3
	Not sure	2	6.7
Fear of sanction by church	Yes	30	100
	No	0	0
Restrictive law	Yes	16	53.3
	No	12	40
	Not sure	2	6.7
Fear of not getting a husband	Yes	15	30
	No	15	30
Fear of stigmatization	Yes	22	73.3
	No	8	26.7
Fear of expulsion from school/institution	Yes	30	100
	No	0	0
TOTAL		**30**	**100**

Most 15(50%) of the participants disagreed that there is a link between septic abortion and lack of social support while the least 5(16.7%) of them agreed that there is a link betweensepticabortion and lack of social support.

The majority 18(60%) of the respondents reported that the community beats a girl when she is found pregnant while minority2(6.7%) of them said that she is forced to get married.

According to table 6, All 30(100%) affirmed that lack of money to pay for a qualified health provider led to septic abortion.

The majority 15(50%) of them said that fear of rejection by family members led to septic abortion while the minority 2(6.7%) were not sure. In addition, all 30(100%) of them reported that fear of sanction by church led to septic abortion where as none of them said it was not.

Concerning whether restrictive law led to septic abortion, the majority 16(53.3%) said yes while minority2(6.7%) of them weren't sure.

Half 15(30%) of the respondents reported that fear of not getting a husband led to septic abortion whereas half said didn't.

The majority 22(73.3%) reported fear of stigmatization led to septic abortion while the minority8(26.7%) said it didn't lead to septic abortion.

Lastly, all 30(100%) of the respondents reported that fear of expulsion from school/institution led to septic abortion.

About Figure 5, the majority 24(80%) of the respondents reported that Poor health education sensitization was not among the factors which led to septic abortion whereas theminority6(20%) said it led to septic abortion.

3.4. Health facility factors contributing to septic abortion among women aged 15-45 attending postnatal clinic.

Table 7: Distance from participants' homes to the nearest health facility

(n=30)

Variable	Frequency (f)	Percentage (%)
Less than 1Km	4	13.3
1-5Km	10	33.3
More than 5km	16	53.3

Primary data Source

According to Table 7, the majority 16(53.3%) of the respondents reported that the distance from

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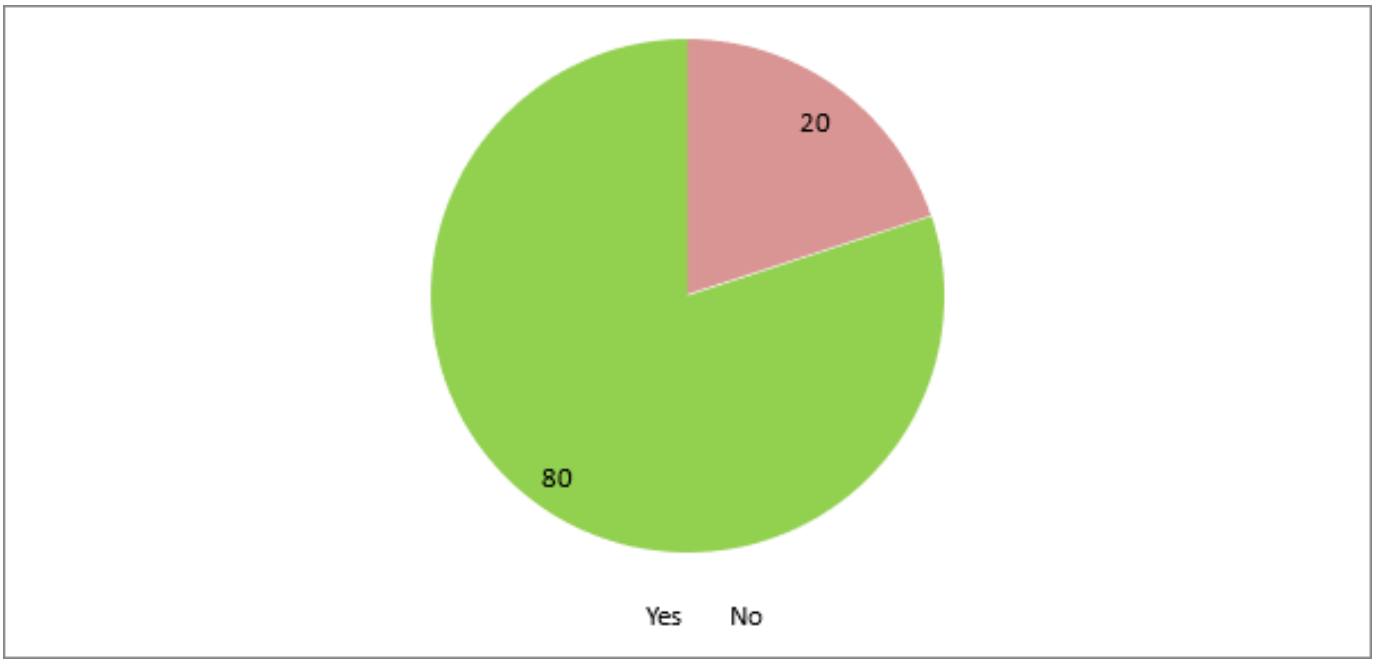

Figure 5: **Shows whether Poor health education sensitization contributed to septic abortion (n=30) Datasource: Primary**

their home to the nearest health facility was more than 5 km while the minority 4(13.3%) reported less than 1 km.

According to the respondents, the highest number 28(93.3%) of them reported that the distance from home to the nearest health facility contributed to septic abortion whereas lowest of them 2(6.7%) reported that the distance from home to the nearest health facility didn't contribute to septic In abortion.

Table 8: Health Facility related factors contributing to septic abortion

Variable		Frequency	Percentage
Unavailability of health-care services	Yes	20	66.7%
	No	10	33.3%
High cost of safe abortion services in the hospital	Yes	17	56.7%
	No	13	43.3%
Poor attitude of health workers	Yes	21	70%
	No	9	30%
Long waiting time before accessing services in the healthcare facilities	Yes	26	86.7%
	No	4	13.3%
Unnecessary requirement like parent's or spouse consent before providing abortion services	Yes	20	66.7%
	No	10	33.3%

From Table 8, the majority of respondents 20(66.7%) reported the Unavailability of health-care services being part of the factors leading to septic abortion, while the minority 10(33.3%) re-

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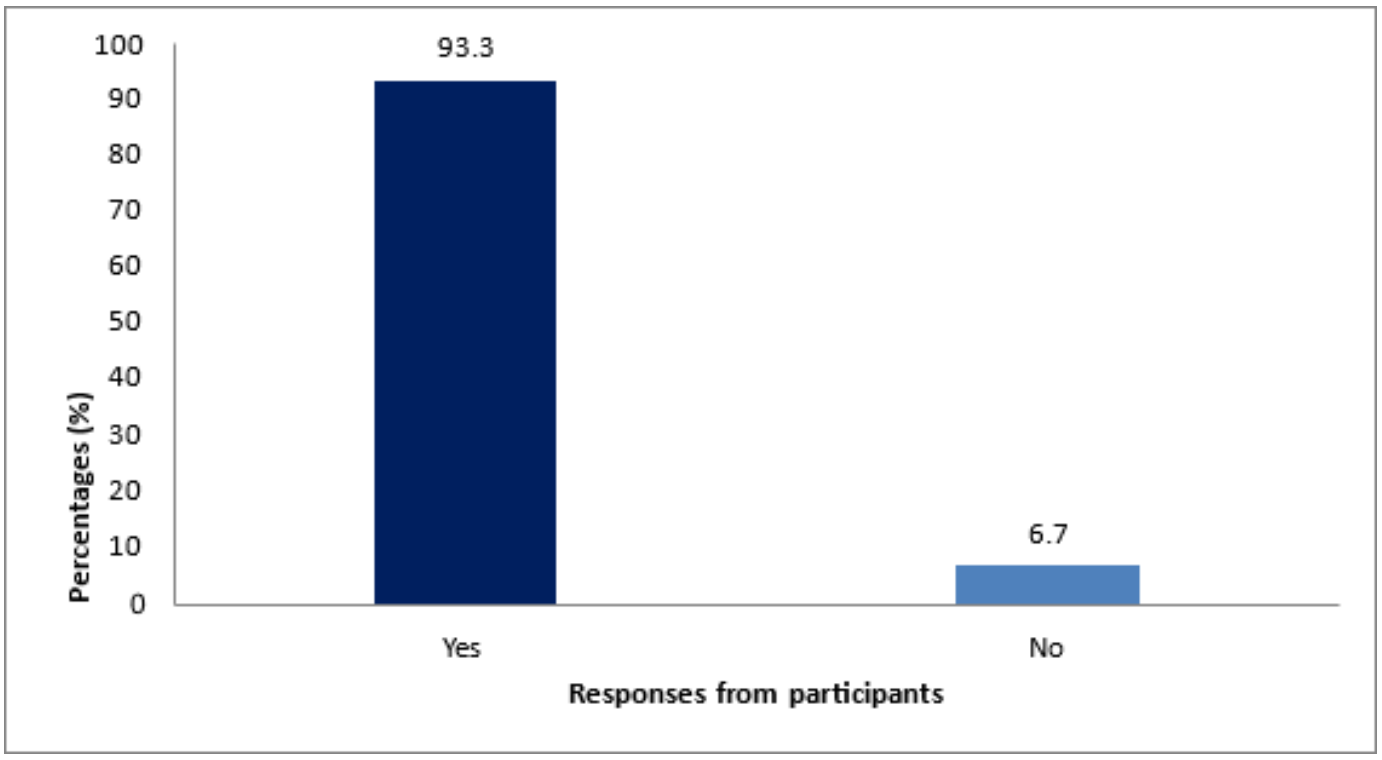

Figure 6: **Shows whether home to the nearest health facility contribute to septic abortion Datasource: Primary**

ported that it didn't lead to septic abortion. With regard High cost of safe abortion services in the hospital leading to septic abortion, the majority 17(56.7%) said yes, while the minority13(43.3%) said no.

According to the respondents, the majority 21(70%) reported that the Poor attitude of health workers led to septic abortion while the minority 9(30%) did not. Furthermore, when it came to a Long waiting time before accessing services in the health care facilities majority 26(86.7%) reported that it affected septic abortion, while a minority 4(13.3%) said that it didn't.

In addition, the majority 20(66.7%) reported that unnecessary requirements like parent's or spouse consent before providing abortion services led to septic abortion while the minority 10(33.3%) said unnecessary requirements like parent's or spouse consent before providing abortion services didn't led to a septic abortion.

TEXT 3: Whether Negative attitudes against women in adolescents in the hospital ground that they are underage to receive abortion services.

According to text 3, the majority 25(83.3%) of the respondents reported that negative attitudes against women in adolescents in the hospital ground that they are underage to receive abortion services led to septic abortion while the minority 5(16.7%) of them said it didn't lead to septic abortion.

4. Discussion

4.1. The demographic factors influencing septic abortion among women.

According to age, (43.3%) were aged 20-30 years. This showed that respondents who were in the youthful age bracket were more prone to septic abortion compared to their counterparts who were between 41-45 years and were not exposed to septic abortions since they were sexually active and nearing their menopause which reduces the chances of becoming pregnant zero. In agreement with the study findings, Lete et al., (2017)also reported that an upward trend in rates of septic

abortion was observed in young girls as compared to aged women because young girls are more sexually active than mature women. On the Contrary, Appiah-Agyekum et al., (2015) established that septic abortions are on high increasingly in areas with high fertility, as older women want smaller families and greater control over the timing of their births. These women are at risk of unwanted pregnancies and septic abortions.

The majority of the respondents (46.7%) were single. This is because most of them were still young women in terms of age and they weren't married. Secondly, incidences of septic abortion could be more common in singles who normally engage in sexual intercourse with men who are not their husbands as compared to the married who normally conceive when prepared.

The majority of the health workers were married (63.3%). This implied that marriage could also be a stressing factor which stress can as well be transferred to the workplace hence exacerbating the situation.

Regarding religion, the Catholics were dominant (83.3%) while those who belonged to Islamic regions were the least (6.7%). This indicates that the catholic region may be positively correlated to septic abortion since it prohibits the use of some family planning methods like contraceptive pills which make the women susceptible to unintended pregnancies which can result in septic abortion.

Regarding education, most of the women (50%) had never been to a school where none of them had reached university. This implied that most of the women lacked enough information about the causes of septic abortion and its preventive measures hence being at high risk of septic abortion as compared to those that had attained some level of education. This disagrees with another study done by Gao et al (2015) in IRAN which reported that well-educated women are more likely to have septic abortion than illiterate women.

Concerning the employment status respondents did earn a living Majority of the respondents (46.7%) were employed whereas the minority were unemployed. This showed that women who were employed had high rates of septic abortion since they could persuade men and seduce them using their money as compared to those who were unemployed. In agreement, Gao et al., (2015) reported that rich women are more likely to have a septic abortion than poor and illiterate women. However, there is no clear and established evidence on this issue, especially in low-and middle-income countries according to the study results.

4.2. Personal Factors Influencing Septic abortions among women.

The majority of the respondents (56.7%) had ever done an abortion while the minority (43.3%) had never aborted before. In addition, the majority (80%) of the respondents believed that unintended pregnancy was a major driving force for septic abortion. This could be because of the positive history of abortion reported by the majority of the women which would be due to the negative attitude that they had towards unwanted pregnancy.

The majority (66.7%) of the respondents mentioned multiple sexual partners as a high-risk practice that can expose women to abortion which is commonly unsafe while the minority 2(6.7%) of the respondents mentioned Relying on traditional herbalists. On the contrary, the African Population and Health Research Centre (APHRC), (2017) equally observed that adolescents are more likely than adults to delay an abortion.

The majority (80%) of the women reported that avoidance of health workers' fees exposes women to ineffective abortion methods. This is so perhaps due to no support from the partner or other family members which leaves the woman desperate hence leading septic abortion. This agrees with a study done by Adjei et al., (2015) which revealed that partner opposition to pregnancy, instability, and other household and community circumstances often influence the decision to terminate an unintended pregnancy which in most cases is done in a septic way.

The majority (50%) of the participants said that women were at risk of unwanted pregnancies and septic abortion if their family planning needs are not met whereas minority 1(3.3%) was not sure. This agrees with a study done by Appiah-Agyekum et al., (2015) in Ghana which showed

that women are at risk of unwanted pregnancies and septic abortion if their family planning needs are not met.

When asked whether the desire for a specific sex makes some women resort to the abortion assistance of herbalists, the majority (66.7%) of the women were not sure about this whereas a minority (13.3%) of them said yes it did so. This is in agreement with a study carried out by Valente, (2014) on access to abortion, investments in neonatal health, and sex selection; evidence from Nepal indicated that sex-selective abortion is also high in the region due to the preference for a male child

Furthermore, the majority (90%) of the women said that well-educated women were less likely to have more abortions than poor and illiterate women whereas the minority (3.3%) were not sure about it. Last but not least, the Majority (90%) of the women reported that adolescents mostly resorted to unskilled persons to perform abortions. This is so because of the love for adventure among adolescents which led to septic abortion. This is similar to a study by African Population and Health Research Centre (APHRC), (2017) reported that adolescents resort to unskilled persons performing it, using dangerous methods, and delay seeking care when complications arise. Adolescents are also more likely to experience complications, such as septicemia, internal organ damage, tetanus, sterility, severe virginal bleeding, incomplete abortion, septic abortion, ill health, infertility, and death of the woman, and even death or life-long conditions and disabilities such as obstetric fistula.

4.3. Socio-economic factors influencing Septic abortions among women.

The majority of the respondents (63.3%) had never been forced into a sexual relationship that led to pregnancy while the minority (36.7%) have never been forced. Consequently, the majority (72.7%)of the women aborted after being forced into a sexual relationship due to the pregnancy being unwanted. The majority of the respondents(36.7%) mentioned Monthly income level of their household was low. In addition, the majority of the respondents (86.7%) affirmed that household monthly

Income level could lead to septic abortion among women of childbearing age attending postnatal clinics. This was so because of the inability to meet the demanding medical fee at the health facility hence septic abortion. Similarly, Dankwah et al., (2018) indicated that low-income levels were associated with poor housing, nutrition, and healthcare access, as well as increasing the risk of septic abortion which later resulted in complications that were detrimental to the lives of the women.

Most (50%) of the participants disagreed that there is a link between septic abortion and lack of social support while the least (16.7%) of them agreed that there is a link between septic abortion and lack of social support. This implies that women had a positive attitude toward seeking social support, especially in instances of unwanted pregnancies to avoid septic abortion. In the same line, Bankole et al., (2015) revealed that poverty and lack of social support are one of the reasons women procure septic abortions despite the availability of safe abortion methods in Nigeria. It is therefore expected that clients who do not have enough money may end up in the hands of quack where they can receive cheap services

The majority (60%) of the respondents reported that the community beats a girl when she is found pregnant while a minority (6.7%) of them said that she is forced to get married. Due to the action from the community, the pregnant girl decides to carry out an abortion which may be septic due to such fear of beatings from the community. This is similar to a study done inAsiaby(Tamang et al.,2012) which indicated that societal norms that define the acceptability that rejection of abortion influences the outcomes of unwanted pregnancy. In some contexts, notably in Asia, sex-selective abortion is the result of societal values that favor male offspring

All (100%) affirmed that lack of money to pay for qualified health providers led to a septic abortion. This is because there are they could not afford the rightful measures of post-about care services. This contradicts with a study conducted

by Rocca et al.,(2013) on septic abortion after legalization which indicated that although it may be expensive and not readily available, some doctors provide services despite its illegality in private clinics with the same degree of safety as in resource-abundant environments forcing some women to resort to septic abortion which puts their life in danger. Since the majority of the women were financially stable, they ended up presorting this.

The majority (50%) of them said that fear of rejection by family members led to septic abortion. In addition, all (100%) of them reported that fear of sanction by the church led to septic abortion.

Concerning whether restrictive law led to septic abortion, the majority (53.3%) said yes while the minority (6.7%) of them weren't sure. This is so because in Uganda it is illegal to abort even though there are clinics and traditional birth attendants that practice it and in some cases, they are less knowledgeable hence leading to septic abortion. In agreement, Valley (2015) found out that in places where abortion laws are restrictive, different clandestine outlets exist for providing these services by doctors and another professional groups such as midwives and nurses.

Furthermore, half (50%) of the respondents reported that fear of not getting a husband led to septic abortion. In addition, the majority (73.3%) reported fear of stigmatization led to septic abortion. Furthermore, all (100%) of the respondents reported that fear of expulsion from school/institution led to a septic abortion. Similarly, a study done by Jelinska and Yanow (2017) revealed that some females of childbearing age resort to septic abortion because of the need to remain in school and fear of social reprisal arising from out-of-wedlock pregnancies which in most cases the abortion results in septic abortion.

Last but not least, study findings showed that the majority (80%) of the respondents reported that poor health education sensitization was not among the factors which led to septic abortion whereas the minority (20%) said it led to septic abortion. On the contrary, Tamang et al., (2012)reported that most women are unaware of the availability of various abortion services. The health workers didn't do enough to make the women know about the existence of various services related to abortion hence increasing the rates of septic abortion

4.4. Facility-related factors influencing septic abortion among women.

The majority 16(53.3%) of the respondents reported that the distance from their home to the nearest health facility was more than 5 km while the minority 4(13.3%) reported less than 1K. This means that the majority of the women could not manage transport fees to hence resort to septic abortion. This is similar to a study conducted by Sundaram et al., (2013) about individual and household level costs of septic abortion in which it was found that lack of income made most women of childbearing age unable to afford transportation costs to the health facility for safe abortion hence leading to septic abortion.

In addition, according to the respondents, the highest number 28(93.3%) of them reported that the distance from home to the nearest health facility contributed to septic abortion since they found it hard to pay the fares for transport. In the same line, Prada et al., (2016) found out that distance to the health care facility was associated with associated with septic abortion. Long distance traveled to the health care facility makes most of the women resort to septic abortion which in most cases leads to septic abortion.

The majority of respondents (66.7%) reported the Unavailability of health-care services being part of the factors leading to septic abortion. This demoralized the women from seeking improved health care services for abortion hence ending up practicing septic abortion without anymore better choices. This is in line with a study carried out by Tunde and State, (2013) found that poor standards of facilities and non-availabilities of drugs were significant predictors of illegal abortion among adolescents leading to septic abortion.

With regard High cost of safe abortion services in the hospital leading to septic abortion, the majority(56.7%)of the women said yes. In addition, all (100%) who reported said that be-

cause they could not afford proper treatment of post-abortion care since they were to be charged money to access those services. On the contrary, Yogi and Neupane, (2018) indicated that septic abortions were carried out by non-registered and non-trained practitioners and health workers who are not listed or certified in safe abortion care according to the reformed abortion law of the Government of Nepal 2003.

According to the respondents, the majority (70%) reported that the Poor attitude of health workers led to septic abortion while the minority (30%) did not. Furthermore, when it came to Long waiting times before accessing services in healthcare facilities majority (86.7%) reported that it forced them to resort to septic abortion because they became tired of waiting for healthcare providers. Similarly, Mulumba et al.,(2017) revealed that long waiting hours discouraged women from going for safe abortions in medical facilities. Waiting for long hours is stressful and sometimes it can be worsened by poor interpersonal communication between patients and health care providers, where patients were sometimes asked to sit down on the floor when benches were all occupied.

Furthermore, the majority (66.7%) of the women reported that unnecessary requirements like parents' or spouses' consent before providing abortion services led to a septic abortion. This is so because the women regarded such as irrelevant and not connected to their health needs. This disagreed with a study done by Rocca et al., (2013)which indicated that some doctors provide services despite its illegality in private clinics with the same degree of safety as in resource-abundant environments forcing some women to resort to septic abortion which puts their life in danger.

The majority 25(83.3%) of the respondents reported that Negative attitudes against women adolescents in the hospital ground that they are underage to receive abortion services led to a septic abortion. This led to septic abortions among adolescents due to fear of being embarrassed by the health workers. This agrees with a report by the Uganda Ministry of Health(2018) on the mid-term review report for the health sector development plan 2015/16 - 2019/20 which indicated that adolescents face unique barriers to obtaining safe abortion due to negatives the of health workers. They are slower to recognize and accept the pregnancy and are less likely than older and more experienced women to know where to seek advice and help. They are also more likely to avoid the physician's fee, thus exposing themselves to ineffective methods hence septic abortion.

5. Conclusion.

The study results and discussion revealed that demographic factors that influenced septic abortion among women were age, education level attained, religion marital status, and employment status. The personal factors that were identified included a positive history of abortion and fear of being expelled from school. Socio-economic factors were poor social support, fear of rejection by family members, low monthly income, high cost of health care services as well the fear of being sanctioned by the church. Healthy facility factors that were identified consisted of the Unavailability of healthcare services, Poor attitude of health workers, Long waiting times before accessing services in the healthcare facilities, and unnecessary requirements like parents' or spouses' consent before providing abortion services.

6. Recommandations.

6.1.

6.1.1. To the Ministry of Health.

It is recommended that mass sensitization through the use of the media should bed one to certain women on the effects of septic abortion.

Advocating for young girls who have become pregnant for them to continue with their academics.

Government should ensure that enough health workers are recruited in all hospitals across Uganda.

6.1.2. To Kampala district.

The district should establish a policy against forced sexual relationships to minimize the incidences of unintended pregnancies.

6.2. To IRAN-Uganda Hospital

It is recommended that septic abortion among women can be reduced and managed by considering and maintaining a balance between the following variables: regular health education talks about the dangers of septic abortion and all categories of abortions, and mass sensitization of the community against practices of septic abortion.

6.3. To nurses and midwives.

Nurses and midwives should come on board to speak out on matters concerning septic abortion.

7. Implications of the study.

The study findings have implications for nursing practice and nursing research and are as follows.

7.1. The implication to nursing practice.

The study revealed that all women are prone to stress, hence it should be one of the things they should avoid in their day-to-day lives.

7.2. Implications to nursing research.

The study provided health workers with a clearer picture of septic abortion and health are linked, and hence what specific choices can be made to better manage as well as prevent septic abortion and create greater health.

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9. List of Abbreviations .

APHRC: AfricanPopulationandHealthResearchCentre

FP: family planning

HCPs: HealthCareProfessionals

IPAS: InternationalProject AssistanceServices

IPD: InpatientDepartment

MHS: MaternalHealthServices

MOH: Ministry of Health

NGOs: Non-GovernmentOrganizations

PAC: PregnancyAssessmentCentre

RHS: ReproductiveHealthSurvey

UNMEB: UgandaNursesandMidwivesExaminationsBoard

USA: UnitedStates of America

Ushs: Ugandan shillings

WHO: WorldHealthOrganization

WoRA: Women of reproductive age

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