
PREVALENCE OF UNINTENDED PREGNANCY AND ASSOCIATED FACTORS IN PORT-SAID CITY

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ABSTRACT

Background: Unintended pregnancy is a key public health indicator. Estimating the prevalence of unintended pregnancy and identifying risk factors are crucial to the design of effective preventive interventions. **Aim:** The study was aimed to explore the prevalence of unintended pregnancy and associated factors in port-said city. **Subject and Methods:** The study was carried out at ante-natal clinics in all maternal and child health settings representing the six districts of Port-said using a cross-sectional descriptive design. The study subjects consisted of 600 women who attended the previous mentioned settings. A structured interviewed schedule sheet designed and utilized to collect the necessary data about unintended pregnancy, contraceptives and factors influencing them. **Results:** Results of study showed that about one third of the studied women were exposed to unintended pregnancy. Regarding reasons given by women for UP, almost half of them didn't use contraceptives and partially similar proportion were exposed to failure of the method used for contraception, and the rest reported that they discontinued using contraceptive method before the current pregnancy. A statistically significant relation was visible in the present study between deprived socio-economic backgrounds and the rate of unintended pregnancy.

Conclusion: Near to one third of women were exposed to unintended pregnancy. Age, age at first marriage, educational status of women, economy of the household, children ever born, contraceptive use, and spousal communication were significantly associated with unintended pregnancy in Port said. **Recommendations:** Mass media should be used more effectively as a powerful way to disseminate consistent knowledge to large number of the population about unintended pregnancy and contraceptives. Raising women awareness about contraceptive is imperative. Particular attention should be given about ECPs in case of unprotected intercourse to prevent unwanted pregnancy.

Key words: Unintended Pregnancy • Prevalence • Associated factors.

INTRODUCTION

Unintended pregnancy is an important public health issue in both high income and also in low and middle income countries because of its negative association with the social and health outcomes for both mothers and children (*WHO, 2013*). A key objective of global public health policy is the reduction of the number of unplanned conceptions. Available evidence shows that unplanned pregnancies can have a negative effect on women's lives and result in poorer outcomes than those that are planned (*Gipson et al , 2008*). Many pregnant women will need to end a pregnancy to avoid risks to their lives, psychological trauma, and socio economic turmoil (*IPAS, 2004*).

Estimating the prevalence of unplanned pregnancy and identifying risk factors are crucial to the design of effective preventive interventions. Yet attempts to do so have been beset by methodological challenges (*Krause , 2012*). A study was conducted in Egypt to estimate the prevalence and correlates of unintended pregnancy among ever-married women. The study revealed that near one fifth of women reported unintended pregnancy. The Egyptian rate of unintended pregnancy is closer to that found in the Islamic Republic of Iran, where the rate was 35% (*Shaheen et al , 2007*). This prevalence does not reflect the true magnitude of the problem, but can rather be considered as an underestimate since it was only calculated among ever-married women, and those whose pregnancies ended in birth (*Abbasi-Shavazi, 2004*).

Unmet need for contraception can lead to unintended pregnancies, with their harmful consequences such as unsafe abortions and unwanted births (*Population Action International Healthy , 2011*). Despite the widely available family planning effort to reduce UP, *Goto et al. (2002)* study in Japan revealed that 46.2% of the pregnancies were unintended and more than two fifths of them had repeated experience of UP, the rate of is still significantly large. Incorrect or inconsistent use of contraceptive contributed to the greater proportion of UP especially in developed countries however, in developing world lack of access to contraceptive is the underlying reason (*WHO, 2013*).

Numerous studies have shown that unmet need for family planning can have significant consequences for the health and well-being of women and children (*Seyfried, 2011*). Family planning (FP) began to be viewed as a way of making changes in women's lives, securing women's empowerment and ensuring their well-

being. Unmet need for FP is the number or percent of women currently married who are fecund and who desire to either terminate (or postpone childbearing, but who are not currently using a contraceptive method (*Cleland, 2006*). The decision to continue or discontinue use of a contraceptive involves a number of factors—the acceptability of contraceptive options, current and future circumstances, and fertility desires. Knowledge of the factors that may lead to contraceptive discontinuation remains incomplete, and a better understanding is hampered by the lack of a comprehensive framework that acknowledges the multiple and complex reasons that influence the decision to switch methods or stop using one altogether.

Bongaarts et al (2012) reported that many social determinants can influence the demand for and use of FP, either individually or in various combinations such as literacy status, spousal communication, religion, women's autonomy, age, total children ever born, age at first marriage, FP workers' visit and knowledge about FP are important to explain unintended pregnancy. In the multivariate analysis, these variables were found to have statistically significant influence on unintended pregnancy.

Significance of the Study:

In the literature review related to the factors associated with unintended pregnancy, it was observed that contraceptive failure was one of the most important factors. Contraceptive failure refers to incorrect or inconsistent use of a method or lack of use of any form of contraception. Despite the widely available family planning efforts to reduce unwanted pregnancy, the rate of unintended pregnancy is still significantly large. Incorrect or inconsistent use of contraceptive contribute to the greater proportion of unintended pregnancy especially in developed countries however, in developing world lack of access to contraceptive is the underlying reason (*WHO, 2013*). The main aims of this study are to find the associated factors, design and evaluate the efficiency of an evidence - based guideline on nurse's performance concerning family planning counseling to assist individuals and couples to space their children, prevent unintended pregnancies, and improve their overall reproductive health.

AIM OF STUDY:

The aim of this study was to explore the prevalence of unintended pregnancy and associated factors in port-said city.

SUBJECT AND METHODS:

Research design: a cross sectional descriptive design was utilized for women to collect data about unintended pregnancy, contraceptives and factors influencing them. **Study setting:** to ensure generalization of the study results on Port Said City, the study was carried out at antenatal clinics in all maternal and child health settings representing the six districts of Port-said, namely : primary health care centers (Port-fouad (1), Port-fouad (2), Bank elescan, El manakh (1), El manakh (2), El Kuwait, El arab(1), El arab(2), Fatma elzahraa, Omar Ebn Elkhatab, El abouty, Osman Ebn Afan, Mostafa kamel, and El gwhara) & hospitals (EL ameri hospital (out patient), El nasr hospital (out patient), Port- fouad hospital (out patient), and El tadamon hospital(out patient)). **Subjects:** a purposive sample of 600 women who attended the study setting and fulfilling the inclusion criteria were enrolled in this study during study period (8 months). Inclusion criteria included women had at least have one child or more, no medical or obstetric disorders, and no contraindications for using FP methods.

Tools for data collection:

A structured interviewed schedule sheet for women, this tool was designed mainly to collect data related to: -

- Socio-demographic data: which include; mothers name, age, address, education, family income, occupation, period of marriage, husband's age, husband's education , occupation, and housing condition.
- Obstetrical history: which include gravidity, parity, number of abortion, number of living children, and pregnancy interval.
- History of current pregnancy: as pregnancy intention, feeling after unintended pregnancy, and abortion's attempt.
- Determinants of unintended pregnancy, contraceptive use history, and sexual activity.

Content Validity:

After the tool had been designed, it was tested for its validity and reliability. Then the pilot study was carried out on 10% of the sample in the study setting that were

excluded from the study sample. The purposes of the pilot study were to test the applicability and clarify the feasibility of the study tools and it served to estimate the time needed to complete the tools. It also helped to find out any obstacles and problems that might interfere with data collection, based on findings of the pilot study, certain modification of the tools were done. Subjects included in the pilot study were excluded from the study subjects. Following this pilot study, the process of data collection was performed.

Methods of study

- An official letter from the dean of the faculty of nursing was sent to the director of the selected area of the study. The director of each clinic was contacted and informed in order to obtain permission to include women on the present research.
- The tools used in data collection. The tools were reviewed by a jury of 10 experts in the field of obstetrics and gynecological nursing and medicine to ascertain their content validity.
- Informed consent was obtained from each woman in the study after explaining its purpose and importance. Confidentiality of the information was assured by the researcher.
- A pilot study was carried out over a period of two months. It was conducted on 10% of total sample size involving women to evaluate the content validity, time required to fill each tool and feasibility of tools of the study. Necessary modifications were carried out as revealed from the pilot study.

Statistical analysis of data:

Up completion of data collection, variables included in the structured interview sheet, were coded prior to computerized data entry. The raw data were coded and transformed into coding sheets. The results were checked. Then, the data were entered using SPSS 20.0 statistical software package. Output drafts were checked against the revised coded data for typing and spelling mistakes. Finally, analysis and interpretation of data were conducted.

RESULTS :

Table (1): illustrates the socio-demographic characteristics of the studied pregnant women. The table reveals that the ages of women ranged from 23 - 40 years; with a mean of 31.0 ± 3.6 . Meanwhile, two thirds of the studied sample (66.7%) were more than 30 years. Almost all of them (99.7%) were married and 89.8% had urban residence and 23.5% reported that they were employed at the time of the study. The same table denotes that more than two thirds of the studied women (67.2%) had secondary level of education and 20.2% could just read and write or had primary education. Meanwhile, more than one half (63.2%) reported that their monthly family income was not enough and their mean crowding index was 2.3 ± 0.3 .

Table (2): reveals that the ages of husbands ranged between 26-45 years; with a mean of 35.9 ± 3.8 . Almost three quarters of the husbands (73.0%) had secondary level of education. Meanwhile, 20.0% of them could just read and write or had primary education. As for husband's job status, only 3.2% were not employed at the time of study .

Figure (1): shows the distribution of the studied women according to their intention of pregnancy. The figure shows that about one third of the studied women (31.3%) were exposed to unintended pregnancy. .

As shown in **table: (3)**, women with unintended pregnancy were more likely to be older ($30 \leq 40$) and married at an age more than 20 compared to those who had intended pregnancy (77.7% vs. 61.7% and 88.8% vs. 74.8% respectively), differences observed are statistically significant ($P=0.03^*$). Meanwhile, they significantly more apt to be housewives, had low level of education, and insufficient income (88.8% vs. 70.9%, 38.9% vs. 11.6% and 83.5% vs. 53.9% respectively).

Table (4): reveals that husbands of the unintended pregnant women were more likely to be in the middle age groups ($30 < 40$), had low level of education and unemployed (83.0% vs. 76.2%, 36.7% vs. 12.3% and 5.3% vs. 2.2% respectively). Differences observed are statistically significant ($P < 0.0001^*$).

As shown in **table (5):** unintended pregnant women were more likely to use contraceptive pills, for short period (less than one year), and with improper counseling

compared to those with intended pregnancy (41.9% vs. 20.9%, 52.4% vs. 14.0% and 49.5% vs. 4.9% respectively). Meanwhile, they faced more side effects than the control group (54.3% vs. 12.9%). Differences observed are statistically significant $P < 0.0001^*$.

Table (1): Socio-demographic characteristics of the studied pregnant women (n=600)

Socio-demographic characteristics	Studied pregnant women (n=600)	
	No.	%
Age (years)		
20-	200	33.3
30-≤40	400	66.7
Min-Max	23.0-40.0	
Mean±SD	31.0±3.6	
Age at marriage		
<20	125	20.8
≥20	475	79.2
Min-Max	17.0-30.0	
Mean±SD	21.7±2.6	
Period of marriage		
< 10	311	51.8
≥10	289	48.2
Min-Max	3.0-18.0	
Mean±SD	9.2±2.9	
Marital status		
Married	598	99.7
Divorced	2	0.3
Residence		
Urban	539	89.8
Rural	61	10.2
Occupation		
Housewife	459	76.5
Working	141	23.5
Level of education		
can read and write	9	1.5
primary education	112	18.7
Secondary education	403	67.2
University education	76	12.7
Monthly family income		
Enough	221	36.8
Not enough	379	63.2
Crowding index		
Min-Max	1.3-3.0	
Mean±SD	2.3±0.3	

Table (2): Socio-demographic characteristics of the studied pregnant women's husbands
(n=600)

Socio-demographic characteristics of husbands	Studied pregnant women (n=600)	
	No.	%
Age (years)		
20-	22	3.7
30-	470	78.3
40-<50	108	18.0
Min-Max	26.0-45.0	
Mean±SD	35.9±3.8	
Level of education		
Read and write	37	6.2
primary education	83	13.8
Secondary education	438	73.0
University education	42	7.0
Occupation		
Work	581	96.8
Not work	19	3.2

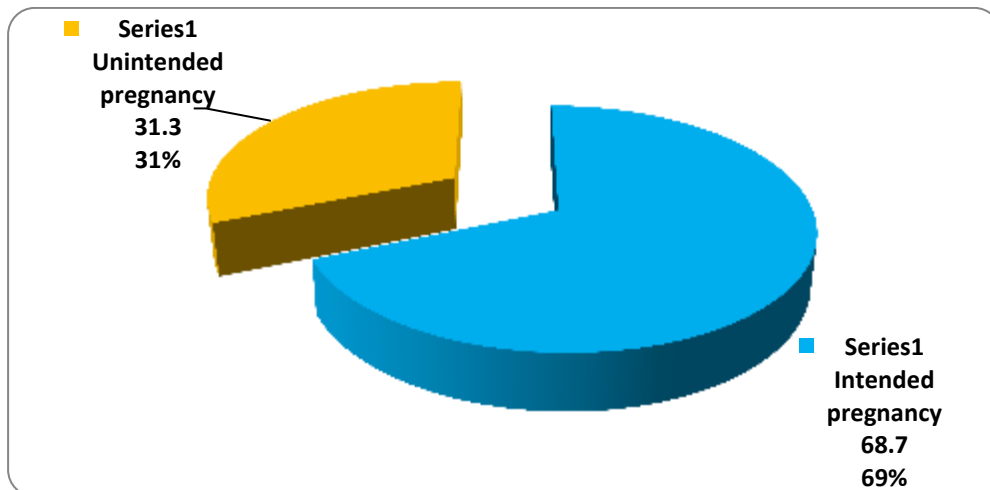


Figure (1): Distribution of the studied women according to their intention of pregnancy (n=600)

Table (3): Relation between the intention of the current pregnancy and socio-demographic characteristics of the studied pregnant women (n=600)

Socio-demographic characteristics	Groups				Significance
	Unintended (n=188)		Intended (n=412)		
	No.	%	No.	%	
Age (years)					
20-30-≤40	42	22.3	158	38.3	X ² =14.888 P<0.00001*
	146	77.7	254	61.7	
Age at marriage					
Less than 20	21	11.2	104	25.2	X ² =15.50 P<0.0001*
More than 20	167	88.8	308	74.8	
Period of marriage					
Less than 10	94	50.0	217	52.7	X ² =0.369 P=0.544
More than 10	94	50.0	195	47.3	
Residence					
Urban	164	87.2	375	91.0	X ² =2.025 P=0.155
Rural	24	12.8	37	9.0	
Marital status					
Married	186	98.9	412	100.0	FE P=0.03*
Divorced	2	1.1	0	0.0	
Occupation					
Housewife	167	88.8	292	70.9	X ² =23.152 P<0.0001*
Working	21	11.2	120	29.1	
Level of education					
can read and write	8	4.3	1	0.2	X ² =77.671 MCP=0.0001*
primary education	65	34.6	47	11.4	
Secondary education	111	59.0	292	70.9	
University education	4	2.1	72	17.5	
Crowding index					
Min-Max	1.7-3.0		1.3-3.0		Z=5.340 P<0.0001*
Mean±SD	2.4±0.3		2.2±0.3		
Monthly family income					
Enough	31	16.5	190	46.1	X ² =48.703 P<0.0001*
Not enough	157	83.5	222	53.9	

X²: Chi-Square test MCP: Monte Carlo corrected P-value FE P: Fisher's Exact test

Z: Mann Whitney test *significant at P≤0.05

Table (4): Relation between the intention of the current pregnancy and socio-demographic characteristics of the studied pregnant women's husbands (n=600)

Socio-demographic characteristics of husbands	Groups				Significance
	Unintended (n=188)		Intended (n=412)		
	No.	%	No.	%	
Age (years)					
20-	5	2.7	17	4.1	$X^2=3.525$ $P=0.178$
30-	156	83.0	314	76.2	
40-<50	27	14.3	81	19.7	
Level of education					
can read and write	20	10.6	17	4.1	$X^2=58.774$ $P<0.0001^*$
primary education	49	26.1	34	8.2	
Secondary education	118	62.8	320	77.7	
University education	1	0.5	41	10.0	
Occupation					
Work	178	94.7	403	97.8	$X^2=4.137$ $P=0.042^*$
Not work	10	5.3	9	2.2	

X^2 : Chi-Square test *significant at $P\leq 0.05$

Table (5): Relation between intention of the current pregnancy and use of contraceptives before recent pregnancy (n=600)

Family planning methods used	Groups				Significance
	Unintended (n=105)		intended (n=364)		
	No.	%	No.	%	
Type of family planning used					
Condoms	8	7.6	16	4.4	$Z=2.036$ $P=0.042^*$
Pills (combined or progesterone only)	44	41.9	76	20.9	
Hormonal injection	2	1.9	74	20.3	
IUD	35	33.3	184	50.5	
Period safety	2	1.9	5	1.4	
Lactational amenorrhea	14	13.3	9	2.5	
Use based on counseling					
Yes	53	50.5	346	95.1	$X^2=57.594$ $P<0.0001^*$
Not	52	49.5	18	4.9	
Duration of use					
One month	2	1.9	1	0.3	$t=2.167$ $P=0.037^*$
Less than a year	55	52.4	51	14.0	
More than a year	48	45.7	312	85.7	
Decision to use					
Husband only	2	1.9	14	3.8	$Z=6.856$ $P<0.0001^*$
Wife only	76	72.4	111	30.5	
A joint decision between the spouse	27	25.7	239	65.7	

Occurrence of side effects after use the method					
Yes	57	54.3	47	12.9	$^{MC}P=0.001^*$
No	48	45.7	317	87.1	
#Side effects	(n=57)		(n=47)		$^{FE}P=0.024^*$
Bleeding between period	34	50.0	24	51.1	
Increase in weight	10	14.7	16	34.0	
Nausea	4	5.9	0	0.0	
Chest pain	7	10.3	4	8.5	
Headache	3	4.4	3	6.4	
Mood swings	5	7.4	0	0.0	
Severe pelvic pain	5	7.4	3	6.4	

Z: Mann Whitney test X²:Chi-Square test ^{MC}P : Monte Carlo test ^{FE}P : Fisher's Exact test t: t-test *significant at $P \leq 0.05$

Categories are not mutually exclusive

DISCUSSION:

Births that were unintended by the mother are at elevated risk of adverse social, economic, and health outcomes for the mother and the child. In less developed regions, about one-fourth of pregnancies are unintended (unwanted or mistimed) and 18 million undergo unsafe abortions each year, contributing to high rates of maternal death (*Haub and Herstad, 2002*). According to the present study findings, about one third of the studied women were exposed to unintended pregnancy. This is in coherence with *El zanaty et al (1995)* in Egypt, and *Johnson et al (2004)* in Jordan, *Shaheen et al. (2007)* in Islamic Republic of Iran and *Hamadela and Tizta (2012)* in Ethiopia, where the rate was 35.0%. Unlikely, a lower proportion "one fifth of all the births" were reported by *Jaeni et al (2009)* in Indonesia, *Faye et al (2013)* in Senegal "14.3%" and *Sedgh et al. (2014)* in Nigeria "28.0%". Moreover, a higher proportion of women experiencing unintended pregnancy was reported by nearly half of women *Goto et al (2002)* in Japan, *Adhikari et al (2009)* in Nepal and 54.1 % in Tanzania (*Exavery et al.,2014*). Additionally, most of the research on the prevalence of unintended pregnancies is based on data from the United States. Studies report that the prevalence of unintended pregnancies ranges from one third upwards to one half of all births (*Finer and Zolna, 2014*). The discrepancies among the various studies addressing the above mentioned prevalence and the present one has been attributed to diverse tradition, cultural and religious denominations between various countries.

The present finding investigates the factors influencing the occurrence of unintended pregnancy. These include socioeconomic, socio-cultural, demographic and access to health information/services. The bivariate analysis showed that the variables such as literacy status, spousal communication, religion, women's autonomy, age, total children ever born, age at first marriage, FP workers' visit and knowledge about FP are important to explain unintended pregnancy. In the multivariate analysis, these variables were found to have statistically significant influence on unintended pregnancy. These findings are partially in congruence with *Bongaarts et al (2012)*. They reported that many social determinants can influence the demand for and use of FP, either individually or in various combinations.

A number of studies have shown that a relationship exists between age of the woman and increased risk of unintended pregnancy. The results of this study show that women with unintended pregnancy were more likely to be older (30-≤40). This is partially in agreement with *Adhikari et al (2009)* from Nepal, *Jaeni et al (2009)* study from Indonesia, *Najafian, et al (2010)* from Iran and *Geda and Lako (2012)* from Nigeria. These findings matched with those of studies conducted in Ecuador, Vietnam, China, and Bangladesh among married pregnant women, who were in reproductive age group, showed that as women's age advances, the likelihood of unintended pregnancy increases (*Calverton, 2014*). Conversely, *Sriprasert et al (2014)* study in United States indicated that women less than 20 years of age at the time of their pregnancy were more likely to experience their pregnancy as unintended, compared to those who were over 40 years of age.

The present study shows that women with unintended pregnancy married at an age more than 20 compared to those who had intended pregnancy. This is due to the delayed age of marriage in Egypt. Similarly, *Kost and Forrest (1988)* study in USA reported that women married at an age of 35 years and more were more likely to experience an unintended pregnancy. Unlikely, *Nasab et al (2010)* in Iran found that women married before the age of 18 were 4.6 times more likely to experience unintended pregnancy compared to those who married at age of 18 and above. Also *Nasab et al (2010)* study found that the rate of unintended pregnancy significantly increase in the age group less than 18 as compared to those married between 19-24 years. Additionally, *Goto et al (2002)* in Japan found that there is significant negative

relationship between age at first marriage and unintended pregnancy which could be related to the earlier initiation of sexual intercourse which exposes women to becoming pregnant several times.

Regarding to literacy status, the finding of the present study shows that almost half of the unintended pregnant women had low level of education. This is supported by *Finer and Zolna (2014)* study in United States who found that women without a high school degree had the highest unintended pregnancy rate among all educational levels (73 per 1,000 women aged 15–44), and rates were lower for women with more years of education. Meanwhile, *Crosby et al (2003)* study revealed that women with less education were more likely to experience unintended pregnancy. In contrast, the study of *Abbasi-Shavazi (2004) & Stephenson et al (2008)* noticed that women with primary, secondary and higher education were more likely to report unintended pregnancy compared to un-educated women whereas those women whom partner has higher education were less likely to report unintended pregnancy. Moreover, *Goto et al (2002)* in Kenya, Japan and Nepal reported that there was no significant association between the experience of unintended pregnancy and women's education.

Such dissimilarities among the results of the above-mentioned studies and the present one could be attributed to the difference in the sample size and its criteria of selection. Moreover, the state of being well did not mainly depend on the educational level, but mostly on woman attitude toward seeking healthy and preventive behavior. In this regard, the maternity nurse should recognize that health education leads to a better-combined input that increases the person's ability and willingness to change preventive health behaviors.

More than three quarters of the unintended pregnant women in this study were housewives and had an insufficient income. This is partially in accordance with *Finer and Zolna (2014)* who reported that the rate of unintended pregnancy among higher-income women was less than half the national rate (18 vs. 45 per 1,000), while it was 112 per 1,000 women aged 15–44 in 2011 among poor women. This is possibly explained by the fact that women in formal employment tend to earn more, have higher levels of reproductive health knowledge and participate in social networks that support family planning and reduced fertility. Conversely, *Abbasi-Shavazi (2004)* in Iran and *Exavery et al (2014)* in Tanzania found that women occupation was not

significantly related with unintended pregnancy. This dissimilarity between the various studies may be related to the difference in the setting or the difference in the measurement of the socioeconomic variable. Most of the studies calculate this variable after analyzing the proxy variables of socioeconomic status, and few studies measure this variable by asking the income of the household categories of this variable (poor, middle and rich) arbitrary; therefore, the results need to be interpreted cautiously (*Exavery, et al.,2014&Mukaba et al.,2015*).

The place of residence has mixed effects on unintended pregnancy. Some studies found that women from urban areas are at higher risk of unintended pregnancy, while others found that women from rural area are more at risk of unintended pregnancy. Similarly the present study finds no significant relation between the residence and unintended pregnancy. *Braun et al., (2013)* explained this by women preferences for contraceptive use in rural or urban areas that predict the risk of unintended pregnancy.

A statistically significant relation was visible in the present study between deprived socio-economic backgrounds and the rate of unintended pregnancy. This is matching with *Bongaarts et al., (2012)* in United States who showed that husband level of education is an important predictor of unintended pregnancy. Increasing level of education will help in improving the husband's awareness regarding the effective use of contraceptives which in turn helps his wife in the choice of contraceptives.

Unintended pregnant women were more likely to use contraceptive pills before the current pregnancy, for a short period (less than one year), and with improper counseling compared to those with intended pregnancy. Meanwhile, they faced more side effects than the control group. This is also corroborated with *Geda and Lako, (2011)* who mentioned that mother visited by family planning worker before pregnancy were less likely to experience unintended pregnancy as compared to not visited. The possible reason may be family planning outreach workers provide information and service and mobilize the community on family planning matter. They increase women knowledge about contraceptives, counsel them about various options available and how to cope with side effects and the consequences of unintended pregnancy

The present result revealed that less than one third of unintended pregnant women used contraceptives based on a joint decision between spouses before recent

pregnancy. This is in agreement with *Kaye (2006) & Nwokocha (2006)* who reported that current use of family planning methods based on a joint decision is very low among Uganda women. They explained this by the fact that in patriarchal society; women are often given less opportunity to be self-supportive.

CONCLUSION:

Based on study findings, it can be concluded that:

Near to one third of women were exposed to unintended pregnancy. Age, age at first marriage, educational status of women, economy of the household, children ever born, contraceptive use, and spousal communication were significantly associated with unintended pregnancy in Port said. Overall, there is a substantial demand among women for effective contraceptive methods. This can be done by focusing on information and education to the newly wed couples and pregnant mothers during antenatal check-ups.

RECOMMENDATIONS:

Based on the results of the present study, the following recommendations were suggested:

Mass media should be used more effectively as a powerful way to disseminate consistent knowledge to large number of the population about unintended pregnancy and contraceptives. Husband involvement in family planning, particularly in areas with deep-rooted patriarchal culture is recommended. Raising women awareness about contraceptive is imperative. Particular attention should be given about ECPs in case of unprotected intercourse to prevent unwanted pregnancy. Simple illustrative booklets and pamphlets in Arabic language should be prepared and made available in family planning centers addressing practical issues related to the unintended pregnancy and contraceptives to reduce the unmet need with particular attention in the country. Replication of the present study at different setting and among various subjects is recommended. Meanwhile, further research is recommended about other pre determinants of unintended pregnancy and its consequences on both mother and baby.

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معدل انتشار الحمل غير المقصود و الأسباب المتعلقة به في مدينة بورسعيد

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الخلاصة

الحمل غير المقصود هو مشكلة صحية عامة مهمة في كلا من البلدان أصحاب الدخل المرتفع و أيضا في البلدان متوسطة أو منخفضة الدخل نتيجة لارتباطها السلبي مع النتائج الاجتماعية والصحية لكل من الأمهات والأطفال. تهدف هذه الدراسة إلي معرفة معدل انتشار و محددات الحمل غير المقصود في مدينة بورسعيد. أجريت هذه الدراسة في عيادات ما قبل الولادة في جميع المراكز الصحية و العيادات الخارجية بالمستشفيات في مدينة بورسعيد. تم استخدام أداة اعتمادا على المراجع التمريضية الحديثة حيث تم استخدام دراسة وصفية مقطعية لجمع البيانات حول الحمل غير المقصود والعوامل المرتبطة به للأمهات. و قد أوضحت الدراسة بأن ما يقرب من ثلث النساء تعرضن إلى الحمل غير المقصود. وخلصت الدراسة إلى أهمية تفعيل حملات عن تنظيم الأسرة بشكل مكثف من خلال التركيز على تعليم المتزوجين حديثا والأمهات الحوامل أثناء فحوصات ما قبل الولادة، و يجب تحديد النساء من ذوي الاحتياجات و توفير سهولة الوصول من وسائل منع الحمل والمعلومات المتعلقة باستخدام وسائل منع الحمل لهم. وبهذه الطريقة تقل نسبة وفيات الرضع و الأمهات وكذلك انخفاض الحاجة إلى الإجهاض و الحفاظ على الأسرة. و أوصت الدراسة بتكرار هذا البحث في أماكن أخرى، فمن المستحسن إجراء مزيد من البحوث حول أسباب و محددات الحمل غير المقصود وعواقبه لكلا من الأم والطفل. أيضا وُصي بعمل برامج تدريبية للممرضات من أجل تعزيز المعرفة و الممارسة فيما يتعلق بالحمل غير المقصود، و وسائل تنظيم الأسرة المختلفة و الوسائل الطارئة.