

Investigate Women's Knowledge, Attitude and Their Immediate Intervention Regarding Habitual Abortion

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Abstract

Aim: to investigate women's knowledge, attitude and immediate intervention regarding their habitual abortion. **Setting:** The study was conducted at Ain Shams Habitual Abortion Outpatient Clinic. **Design:** A descriptive study design. **Sampling:** Sample size: 234 women. Sample type: A purposive sample **Tools:** 1) Structured interviewing questionnaire. 2) Likert scale. **Results:** The present study revealed that more than half among studied sample had incorrect knowledge concerning risk factors, complications, investigations, management as well as habitual abortion and future pregnancy. Nearly two-third among studied sample had positive attitude toward their habitual abortion. A significant relation between studied sample attitude and their age and No. of living births was observed. Three-quarter among studied sample had sought immediately maternity health services while few preferred to stay in bed for comfort and others consulted their relatives. **Conclusion:** the present study was concluded that more than half among studied sample had total incorrect knowledge regarding habitual abortion. Nearly two-third had positive attitude toward their habitual abortion. Age, area of residence, duration of marriage, No. of living births, and timing of abortion had significant impacts on positive attitude. The majority sought immediately maternity health services. **Recommendation:** Implementing post abortion counseling sessions using brochures and posters to increase women's knowledge regarding habitual abortion issues.

Key words: knowledge, attitude and habitual abortion.

Introduction

Habitual abortion (HA) is one area of reproductive medicine that is filled with controversy and confusion. With much ongoing research, new concepts are evolving and new treatment strategies are developed every now and then. Not only is the controversy restricted to management principles, even the definition has been

variably given by two different societies (*Mehta & Gupta, 2018*).

Habitual abortion is traditionally referred to as three or more consecutive pregnancy losses before 20 weeks of gestation (Ectopic, molar, and biochemical pregnancies are excluded.) *Singh et al. (2018)* while the European Society for Human Reproduction and Embryology and the Royal College of Obstetricians and

Gynaecologists, refer it to three consecutive pregnancy losses, including non visualized ones *Kolte et al.(2015)*. However, according to the American Society for Reproductive Medicine, it is defined as two or more clinical pregnancy losses that documented by ultrasonography or histopathologic examination, but not necessarily consecutive (*Practice Committee of the American Society for Reproductive Medicine, 2017*).

However, with significant developments in medicine with advanced laboratory testing, imaging and treatment modalities, it is now accepted to start clinical evaluation among couples following two consecutive losses particularly for anxious elderly couples with history of infertility following evidence-based investigations to rule out treatable causes regarding habitual abortion (*Kutteh, 2015*).

Approximately 10 to 25% among all clinically recognized pregnancies end in spontaneous abortion while HA affects 1-5% among reproductive-age couples since 5% experiences two consecutive abortion and only 1% experiences three or more consecutive abortion *Bashiri&Borick, (2018)*. More than 80% among all abortion take places before 12 weeks of gestation and less than 20 % occurs between the 12th and 20th weeks of gestation *Dugas & Slane, (2019)*.

Habitual abortion can also be classified into three categories. Primary category refers to two or more pregnancy losses with no pregnancy progressing beyond 20 weeks the age of viability and secondary one which refers to two or more losses after a pregnancy that has progressed beyond the age of viability and tertiary one that refers to multiple pregnancy losses between normal pregnancies (*Shetty et al., 2017*).

Habitual abortion is a negative experience among couples particular for primary category ones with no previous successful pregnancy outcomes since up to fifty percent among treating couples with unknown aetiologies and few evidence-based diagnostic and management strategies are available (*Craig et al., 2017*).

Moreover, abortion complications are emergency obstetrical life threatening condition need immediate timely obstetrical care services. As the World Health Organization (WHO) estimates that at least 80,000 women die annually as result of abortion complications, accounting for almost 13% of all maternal deaths worldwide (*World Health Organization, 2017*).

Thus, the best women's intervention to do if they experienced symptoms of abortion, go to maternity health hospital services seeking emergency care to control the situation and prevent further complications. In other words, the best course of action is going to the emergency room as delay for seeking medical help will put women in dangerous situations (*World Health Organization, 2019*).

So, nurses must integrate their multidisciplinary professional roles for dealing with women suffering from habitual abortion. As nurses as a direct care provider must provide evidence based practice for caring these women. Also, nurses must keep in mind psychological status of these women offering psychological support since evidence-based guidelines for HA recommend couple based psychological care where psychological support improves women's status, reduced two-to-four-fold miscarriage and improved live birth rates (*Patel et al., 2018*).

Justification of the Problem

Habitual abortion was a confusing multifactorial reproductive disorder causing a psychological emotional distress particular for childless women without successful pregnancy outcomes before since habitual abortion is usually referred to as a female problem (*Qublan, 2016*). As well as, abortion complications were one of the main causes of maternal mortality and morbidity causes where World Health Organization (WHO) reports that every day in 2017, approximately 810 women died from preventable causes related to pregnancy and childbirth (*World Health Organization, 2019*).

Additionally, habitual abortion was a nursing concern because the nurses would play multidisciplinary roles for women suffered from habitual abortion as a direct care provider, as a health educator and counsellor and as a manager who could design brochures and poster to enhance women's knowledge (*Gallagher et al., 2016*).

Moreover, there were rare studies assessing women's knowledge and attitudes and immediate intervention concerning their habitual abortion at faculty of nursing Ain Shams University. So, the present study was aimed to investigate women's knowledge and attitudes and immediate intervention concerning their habitual abortion.

Aim of this study

To investigate women's knowledge, attitude and immediate intervention concerning their habitual abortion

Research Questions

1. Did women have correct knowledge regarding habitual abortion?

2. What was women's attitude regarding their habitual abortion?

3. Were there significant relations between women's attitude and general characteristics & obstetric history?

4. What was women's immediate intervention at timing of abortion?

Subjects and methods

1. Technical design

Research design

Descriptive study design was utilized in this study.

Setting

The study was conducted at Ain Shams Habitual Abortion Outpatient Clinic.

Sampling

Sample Size

Two hundred thirty-four women were included based on sample size equation, a representative sample of total women from the Habitual Abortion Outpatient Clinic at Ain Shams University Maternity Hospital as in 2017, their total numbers are 600 women (*Chow et al., 2007*).

Sample Type

A Purposive sample was used in this study.

Inclusion Criteria

1. Women with a history of two or more habitual abortion.

2. Women's ages were between 20-45 years.

Tools of data collection:

A. Structured Interviewing Arabic questionnaire.

It was designed by the researcher included four parts:

Part I: assessed women's general characteristics regarding age, place of residence, educational level, working status and duration of marriage. **Part II:** assessed women's obstetric history as regard No. of abortions, No. of living births, timing of abortion and its cause. **Part III:** assessed women's knowledge regarding habitual abortion in form of multiple choices question (MCQ) regarding meaning, risk factors, symptoms, complications, specific investigations, management methods and effect of habitual abortion on subsequent pregnancy. **Part IV:** assessed women's immediate intervention at timing of abortion. **Scoring system for evaluating women's knowledge was developed as the following:**

Each question was scored as two for correct answer and one for incorrect answer.

While the total knowledge score was calculated as the following:

Women's knowledge was considered correct if the total score was equal or more than 60% and incorrect if it is less than 60%.

B. Likert Scale: It was adapted from The School-age Coping Strategy Inventory *Chen & Kennedy (2005) & Ryan-Wenger (1990)* and coping behavior checklist for Chinese children *Li, et al. (2010)*. It was translated into Arabic by the

researcher to assess women's attitudes concerning their habitual abortion including thirteen statements assessed three aspects of women's cognitive, behavioral and emotional attitudinal aspect. Where cognitive aspect was involved three positive statements and behavioral aspect was included six positive statements while emotional aspect was included four negative statements. Each statement was evaluated by likert attitude scale as Always, Sometimes, and Never.

Validity

All tools of data collection were sent to three specialized University Professors, according to their comments, modifications in phrasing and sequencing of statements were considered.

Ethical Considerations

Letter of approval to conduct the study was obtained from the head of maternity and gynecological nursing department at Ain Shams University. Then an official approval was obtained from the Scientific Research Ethical Committee in Faculty of Nursing at Ain Shams University before implementing the study. An official permission was obtained from director of the Ain Shams University Maternity Hospitals at which the study was conducted. An oral Informed consent was obtained from each participant after explain the aim of the study. Anonymity and confidentiality would be guaranteed with no harm. Additionally, each woman had the right to withdraw from the study at any time. Tools of data collection did not touch women religious, dignity, culture and ethical issues.

Operational design

The study was conducted through two phases:

Phase 1: preparatory phase

The researcher had reviewed advanced national and international literature related to the study title then prepared and designed tools of data collection finally the pilot study was conducted.

Pilot Study:

The pilot study was carried out on 10% the total studied sample which was included 23 women who met the inclusion criteria to assess practicability and reliability of tools. No modification was done. So, the pilot study sample wasn't excluded from the study.

Phase 2: Field work

Through this phase, the researcher had attended the previously mentioned study setting six months from July to December/2018 two days/week (Sunday & Thursday) which was the date registered for habitual abortion clinic from 9 to 1 pm. Researcher had interviewed six women each day with previously mentioned sample criteria according to their sequences of attendance from clinic registration book. Each interview had consumed 20-25 min. Firstly, interviewing Arabic questionnaire was utilized followed by Likert scale to assess women's attitudes toward their habitual abortion until pre-determined number (234) was obtained.

Results

Analysis of Result

Table (1) revealed that (52 %) among the studied sample were aged from 20-30 years while few (6%) were aged from 40-45 years with mean 30.45 ± 6.294 . Table 1b illustrated that 83 % were from

urban area, table 1c revealed that 34 % had high level of education while 12 % was illiterate. Table 1d had pointed out that approximately 60 % was not working. Table 1e showed that 69% had enough income. Table 1f presented that 45% married since 1-5 years ago with mean 6.71 ± 4.01 .

Table (2) demonstrated that 76% among studied sample had 2-5 times of abortions while 11% had ten times and more abortions with mean 4.66 ± 3.36 . Table 2b revealed that 58% had living births. Table 2c illustrated that 76% had abortion during the first trimester of pregnancy while table 2d represented that 59% had unknown cause.

Table (3) showed that 59% among the studied sample had total incorrect knowledge regarding habitual abortion while 41% had total correct knowledge. As table 3 illustrated that 92%, 83%, 68%, 52% and 69% respectively among the studied sample had incorrect knowledge concerning risk factors, complications, investigations, management as well as habitual abortion and future pregnancy. However, 68% and 79% sequentially had correct knowledge regarding meaning and symptoms.

Table (4) indicated that 79% among studied sample always thought that habitual abortion has known causes that can be diagnosed by investigations. Similarly, 76% always thought that habitual abortion can be managed and 56% always thought that habitual abortion was better than having child with congenital anomalies. Regarding behavioral aspect, table 4b illustrated that 62% always talked and shared experiences with others, 68% relaxed through different media, 74% prayed and recited Quran, 71% sought emotional support from their spouse and family and 78% conducted follow up visits. As regard affective aspect, table 4c

pointed that 98% had always feeling of losing a child, 43% had feeling losing of femininity and motherhood role and 36% self-blamed and 58% had always fears to be divorced.

Table (5) pointed out that there were highly statistical significant relations between studied sample attitude and their age (**p value =.000**) and area of residence (**p value =.008**) while there was a statistical significant relation between studied sample attitude and duration of marriage (**p value =0.043**).

Table (6) represented that there were highly statistical significant relations between studied sample attitude and No. of living births (**p value =.000**) and timing of abortion (**p value =.018**) while there was a statistical significant relation between studied sample attitude and their No. of abortions (**p value =.025**).

Table (7): stated that 78% among the studied sample went to hospital maternity services seeking medical help while 16% and 6% preferred bed rest and consulted their relatives respectively.

Table 1: Frequency distribution regarding general characteristics among studied sample (N =234).

General characteristics		Frequency	
a. Age group	No.		%
20-30 yrs.	121		51.7
- 40	99		42.3
- 45	14		6.0
b. Area of residence			
Rural	39		16.7
Urban	195		83.3
c. Education			
Illiterate	29		12.4
Read and write	52		22.2
Secondary education	74		31.6
High level of education	79		33.8
e. Working status			
Working	94		40.2
Not working	140		59.8
f. Duration of marriage			
1-5 yrs	106		45.3
-10	89		38
>10	39		16.7

Table 2: Frequency distribution concerning obstetric history among studied sample (N =234).

Obstetric history		Frequency	
a.	No. of abortions	No.	%
	2-5	177	75.6
	6-9	31	13.2
	≥10	26	11.1
b.	No. of living births		
	None	98	41.9
	1	82	35
	≥2	54	23.1
c.	Timing of abortion		
	≤3 months	178	76.1
	>3 months	56	23.9
d.	Cause of habitual abortion		
	Known	96	41
	Unknown	138	59

Table (3): Frequency distribution concerning studied sample correct & incorrect knowledge related to habitual abortion (N =234).

	Knowledge items	Correct		Incorrect	
		No.	%	No.	%
1.	Meaning of habitual abortion.	160	68.4	74	31.6
2.	Risk factors leading to habitual abortion.	18	7.7	216	92.3
3.	Symptoms of habitual abortion	185	79.1	49	20.9
4.	Complications of habitual abortion	40	17.1	194	82.9
5.	Investigations of habitual abortion.	76	32.5	158	67.5
6.	Management of habitual abortion	113	48.3	121	51.7
7.	Habitual abortion and future pregnancy.	72	30.8	162	69.2
	Total knowledge score	96	41	138	59

Table (4): Frequency distribution according to studied sample attitude toward their habitual abortion (N=234).

Items	Always		Sometimes		Never	
	No.	%	No.	%	No.	%
a. Cognitive aspect						
1. Habitual abortion has known causes that can be diagnosed by investigations	185	79.1	11	4.7	38	16.2
2. Habitual abortion can be managed	177	75.6	5	2.1	52	22.2
3. Habitual abortion is better than having child with congenital anomalies	130	55.6	5	2.1	99	42.3
b. Behavioral aspect						
4. Talk and share experiences with others	146	62.4	5	2.1	83	35.5
5. Relax through different media	158	67.5	19	8.1	57	24.4
6. Pray and recite Quran	172	73.5	15	6.4	47	20.1
7. Take adequate rest and nutrition	84	35.9	17	7.3	133	56.8
8. Seek emotional support from spouse and family	165	70.5	54	23.1	15	6.4
9. conduct follow up visit	183	78.2	4	1.7	47	20.1
c. Affective aspect						
10. Losing of a child	229	97.9	0	0.0%	5	2.1
11. Losing of femininity and motherhood role	100	42.7	74	31.6%	60	25.6
12. Self-blame	85	36.3	112	47.9	37	15.8
13. Fear to be divorced	136	58.1	16	6.8	82	35

Table (5): Relation between studied sample general characteristics and their attitudes (N=234).

General Characteristics	Attitude				Chi-Square Test	
	Positive (N= 146)		Negative (N= 88)		X2	P- Value
	No.	%	No.	%		
Age						
20-30 yrs.	65	44.5	56	63.6	26.894	.000**
- 40	74	50.7	25	28.4		
- 45	7	4.8	7	8		
Area of residence						
Urban	124	84.9	71	80.7	9.612	.008**
Rural	22	15.1	17	19.3		
Educational level						
Illiterate	16	11	13	14.8	8.556	.200
Read and write	38	26	14	16		
Secondary education	47	32.2	27	30.7		
High level of education	45	30.8	34	38.6		
Working status						
Working	57	39	37	42	.610	.737
Not working	89	61	51	58		
Duration of marriage						
1-5 yrs	73	50	33	37.5	6.291	0.043*
-10	55	37.7	34	38.6		
>10	18	12.3	21	23.9		

Table (6): Relation between studied sample obstetric history and their attitudes (N=234).

Obstetric history	Attitude				Chi-Square Test	
	Positive (N= 146)		Negative (N= 88)		X ²	P- Value
No. of abortions	No.	%	No.	%		
2-5	111	76	66	75	11.178	.025*
6-9	21	14.4	10	11.4		
≥10	14	9.6	12	13.6		
No. of living births						
None	48	32.9	50	56.8	26.717	.000**
1	52	35.6	30	34.1		
≥ 2	46	31.5	8	9.1		
Timing of abortion						
≤3 months	103	70.5	75	85.2	8.057	.018**
> 3 months	43	29.5	13	14.8		
Causes of habitual abortion						
Known	57	39	39	44.3	1.937	.380
Unknown	89	61	49	55.7		

Table (7): Frequency distribution regarding studied sample's intervention at timing of abortion.

Studied sample intervention	Frequency	
	No.	%
a. Go to maternity health services seeking medical help	182	77.8
b. Prefer Bed rest	38	16.2
c. Consult relatives	14	6

Discussion

The present study aimed to investigate women's knowledge, attitude and their immediate intervention regarding habitual abortion. This aim significantly approved within the frame work through the present study research questions since the first research question was "**Did women have correct knowledge regarding habitual abortion**"? This question was significantly answered through the present study research findings as it was observed that more than half the

studied sample had total incorrect knowledge regarding habitual abortion since the majority had incorrect knowledge as regard risk factors, complications, investigations, and management of habitual abortion as well as habitual abortion and future pregnancy. However, most of the studied sample had correct knowledge regarding meaning and symptoms.

This finding may be due to from **researcher's point view** into a lack of health education sessions during the post-abortion period regarding habitual abortion

issues. Additionally, Egyptian culture society ignores reproductive health and sexuality issues because it is immoral to discuss issues related to reproductive system among young Egyptian female that consequently reflected upon incorrect knowledge among these married women. This explanation was supported by *Munakampe et al. (2018)* who stated that there was a limited knowledge about sexual and reproductive health among young females (adolescents) in low and middle-income countries.

The present study finding was agreed with *Campillo, et al. (2018)* who found that misunderstanding of causes and risk factors of abortion was a public health issue since it was reported that there was a limited knowledge among University College Cork students regarding most important causes and risk factors of abortion despite their educational level.

Also, this study finding was agreed with *McGee (2015)* who found that there was a lack of knowledge regarding nursing care and management after abortion among the participant Sweden women.

Moreover, the present study research findings had revealed that nearly one-third among studied sample had correct knowledge regarding effect of habitual abortion on future subsequent pregnancy. However, almost of them expected further occurrence of habitual abortion.

This finding was agreed with *Bailey, et al. (2019)* who demonstrated that American women in United Kingdom with a history of recurrent abortion hoped for the best but expected the worst where a further miscarriage would occur describing it as being back on the "roller coaster" of pregnancy.

On the other side, the present study finding was disagreed with *Lake et al. (2014)* regarding symptoms because it was found that there was incorrect knowledge among the participant Malawian women regarding symptoms as more than half among Malawian women incorrectly believed that pain and bleeding they experienced were typical pregnancy signs, not obstetric danger signs pointing to abortion.

As regards the second research question which was "**what was women's attitude regarding habitual abortion**"? The present study research findings had represented that nearly two-third among the studied sample had positive attitude while few among them had negative attitude regarding habitual abortion.

The finding may be justified from **researcher's point view** that the majority among the studied sample from an urban area, and their ages were ranged from 20 to 30 years old and more than half had live births that may have significant impacts on positive attitude. Also, this could be justified by that the Islamic religion as a common religious requires total acceptance and satisfaction with God's decision while it is undoubtedly great wisdom in this respect. This explanation can be supported by *Van and Meleis (2012)* who showed that many African American women connected to spiritual or religious beliefs and activities as a vital source of strength and guidance to help in recovery from involuntary pregnancy losses' emotions in their lives.

The present study finding was agreed with *Ibrahim et al. (2019)* who reported that Emirati Arabian women experienced recurrent abortion reacted in a positive way utilized religious beliefs and activities to reduce their problems and discomfort stated that "Thanks to God that I had children in Paradise that would

intercede for us on the Day of Judgment" since satisfaction with divine destiny is one of the causes affecting participant's sympathy, adaptability, and accepting this phenomenon in their lives.

On the contrary, this study finding was disagreed with *Tavoli et al. (2018)* who found that Iranian women responded in a negative way expressed more psychological distress toward their recurrent abortion. Also, *Harvey et al. (2012)* stated that experience of early abortion among Australian women was a significant event in their lives with three major themes of losing such as loss of a baby, loss of motherhood role and loss of hopes and dreams the women possessed for their baby accompanied by guilt and self-blaming feelings believing they had done something or there was something wrong physically with them caused it.

Concerning the third research question, which was **"were there relations between women's attitude regarding habitual abortion and their general characteristics and obstetric history?"** In the light of the present study, the research findings had revealed that there was a highly statistical significant relation between studied sample attitude and their age (**p-value =.000**), area of residence (**p-value =.008**) while there was a statistical significant relation between studied sample attitude and duration of marriage (**p-value =0.043**). Additionally, there was a highly statistical significant relation between studied sample attitude and No. of living births (**p-value =.000**) and timing of abortion (**p-value =.018**) while there was a statistical significant relation between studied sample attitude and No. of abortions (**p-value =.025**).

The finding can come back into from **researcher's point view** that women's responses and attitudes can be differed from woman to another depending

on variable factors such as general factors like age, place of residence, and educational level as well as obstetrical factors like presence of living births and other related factors. This explanation can be supported by *Shreffler et al. (2012)* who showed that there are crucial factors shape women's psychological response and attitude to pregnancy loss such as pregnancy commitment and attachment (e.g., gestation length, feeling fetal movement), experiences since the loss (e.g., recency of loss, giving birth after the loss, and having experienced multiple losses) and background characteristics (e.g., education level, age, marital stability relationship).

This present study finding was agreed with *Mulvihill & Walsh, 2014* who found that women's responses regarding pregnancy loss in urban Ireland were significantly different from rural Ireland women since less known about the needs and experiences of those women. Moreover, *Shreffler et al. (2012)* illustrated that there were significant relations between American women responses toward pregnancy loss and their ages, women with multiple losses having no living birth as well as time of gestational age as they responded in more negative way than others since they felt being punished with feeling of inadequacy and failure of being as a woman.

Finally, concerning the fourth question which was **"What was women's immediate intervention at timing of abortion?"** the present study findings showed that three-quarter among studied sample went to hospital maternity health services seeking medical help while few among studied sample preferred bed rest and consulted their relatives.

The finding may due to from **researcher's point view** that the majority among studied sample went to hospital

maternity health services seeking medical help once symptoms of abortion appeared either for reassurance or for confirming diagnosis of the abortion.

This finding was in similar with *Lake et al. (2014)* who showed that some Malawian women sought medical help believing that maternal death was an inevitable consequence after abortion as well as all the women interviewed believing it was important to come to the hospital in a case of abortion.

Conclusion

It was found that more than half among the studied sample had total incorrect knowledge regarding habitual abortion. Nearly two-third among studied sample had positive attitude toward their habitual abortion. Age, area of residence, duration of marriage, No. of abortions, living births, and timing of abortion had significant impacts on positive attitude. Majority among the studied sample sought immediately maternity health services for medical help.

Recommendations

1.Design and implement post-abortion counseling sessions for women suffered from habitual abortion.

2.Hospital administrators must pay attention to designing brochures and posters at Ain shams habitual abortion outpatient clinic.

3.Conduct health educational campaigns regarding habitual abortion in the rural area.

Further study:

Investigate effect of habitual abortion on women's quality of life

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