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Unintended Pregnancy And Induced Abortion In Uganda

CAUSES AND CONSEQUENCES

Unintended Pregnancy And Induced Abortion In Uganda: Causes and Consequences

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Table of Contents

Executive Summary 4

Chapter 1: The Troubling Reality of Unsafe Abortion 6

Chapter 2: The Prevalence and Practice of Induced Abortion 10

Chapter 3: The Health Consequences of Unsafe Abortion 14

Chapter 4: Unintended Pregnancy: The Root Cause of Abortion 19

Chapter 5: Key Findings, Obstacles and Recommendations 25

Appendix 29

Appendix Table 31

References 32

Executive Summary

Because abortion is banned in Uganda (except to save a woman's life) and because strong social stigma surrounds the issue, many women try to conceal their unplanned pregnancies and abortions. The clandestine nature of abortion makes it difficult to measure its incidence in Uganda and allows policymakers to avoid dealing with the problem. Yet the serious health consequences of abortions carried out in unsafe conditions by untrained or poorly trained practitioners impose a heavy burden on women, families and Uganda's already overburdened health care system. Studies of women hospitalized for the treatment of complications from unsafe abortion have documented the tragic burden of morbidity and death borne by many Ugandan women. New research findings now make it possible to fill in the many gaps in our understanding of the prevalence, causes and consequences of induced abortion in Uganda.

Induced abortion is common and available from a variety of providers

- An estimated 297,000 induced abortions are performed each year in Uganda, which translates to an annual abortion rate of 54 per 1,000 women aged 15–49.
- More than half of all abortions are believed to be carried out by medically trained providers (doctors, nurses, midwives). The remaining procedures are performed by nonprofessionals, including pharmacists, traditional providers and women themselves.
- Experts estimate that poor women are twice as likely as nonpoor women to induce their own abortions and only one-third as likely as nonpoor women to have their abortions performed by a physician.
- The methods used by medically trained professionals, especially in urban areas, are safer than those used by nonprofessionals. Trained professionals rely primarily on dilation and curettage (D&C) and manual vacuum aspiration; lay practitioners use a variety of often unsafe methods, including insertion of catheters or sharp objects into the uterus, a wide range of herbal remedies, medications (e.g., quinine, hormonal drugs, aspirin) and drinks made from detergents or other caustic substances.
- The more highly trained the practitioner, the more costly the procedure. Estimates suggest that, on average, physicians charge more for abortions (40,000–140,000 Ugandan shillings*) than do nurses and nurse-midwives (22,000–50,000 shillings), or traditional healers, herbalists and lay practitioners (19,000–54,000 shillings). Pharmacist fees range between 8,000 and 22,000 shillings.
- A woman is more likely to have a safe abortion if she can afford the services of a medically trained professional. However, not all abortions performed by these trained providers are safe.

Unsafe abortions and lack of postabortion care threaten women's health and lives

- The more highly trained the practitioner, the less likely an abortion will place a woman at risk. According to estimates, serious health consequences—including hemorrhage, infection or damage to the uterus—result from one in four abortions performed by doctors, four

*In 2003, the average exchange rate was 1,844 Ugandan shillings to the U.S. dollar (source: FXHistory: historical currency exchange rates, www.oanda.com/convert/fxhistory, accessed Aug. 22, 2006).

in 10 abortions performed by nurses or nurse-midwives, one-half of those provided by pharmacists or dispensers, two-thirds of those carried out by traditional practitioners and seven in 10 of those that are self-induced.

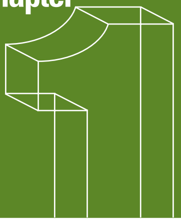
- Only six in 10 Ugandan women who experience complications from abortion are believed to receive treatment within the country's formal health care system. Each year, about 15 of every 1,000 women of childbearing age—a total of 85,000 women—are treated in medical facilities for abortion-related complications. Over the course of her lifetime, the average woman has a 50% chance of being treated for complications of induced abortion.
- The proportion of physician-performed abortions that lead to serious health consequences is many times higher in Uganda than in Western countries. This suggests that some Ugandan doctors have not been properly trained in the use of D&C or are working under unsafe conditions.
- Complications are most common among rural women, most of whom go to nonprofessional providers, and least common among urban women, most of whom go to medically trained providers.
- Of women with abortion complications who receive care, about one-third go to government and private hospitals, one-half go to government and private health centers, and the remainder are treated by private midwives. Almost six in 10 treated women receive their care in public health facilities, one-quarter in nongovernmental organization facilities and the remainder in private facilities run by midwives. Thus, the Ugandan government assumes the greatest responsibility for treating women with complications from unsafe abortion.
- Many level III and level IV health centers (the highest-level facilities below hospitals) do not have the medical supplies or sufficiently trained health professionals to provide proper postabortion care.
- An estimated 65,000 Ugandan women each year (or one-fifth of all women who obtain abortions) experience complications but receive no treatment. The chance of receiving treatment is believed to be lowest (five in 10) among poor women living in rural areas and highest (eight in 10) among nonpoor women in urban areas.
- Factors that explain why many Ugandan women with serious complications do not seek or receive treatment include the inability to pay for care, fear of revealing that they have had an abortion and concern that they will receive hostile or judgmental treatment from clinic and hospital staff.

Unintended pregnancy—the underlying cause of abortion—is common in Uganda

- Each year, an estimated 775,000 women in Uganda have unintended pregnancies. The proportion of Ugandan births that were unplanned rose from 29% in 1995 to 38% in 2000–2001, indicating high levels of unintended pregnancy.
- The gap between ideal and actual family size more than doubled in Uganda between 1988 and 2000, reflecting a growing desire for smaller families that has not been matched by an increase in the use of modern contraceptives. Many women in Uganda do not use modern contraceptives because they distrust them and because accurate information about the safety of these methods is not available.
- One-third of all Ugandan women of reproductive age want to stop or delay further childbearing but are not using a modern contraceptive method.
- An exploratory study of HIV-positive women in Kampala showed that almost all had at least one pregnancy since learning their HIV status. Most did not want the pregnancy, and half considered obtaining an abortion.

Action is needed on many fronts to reduce unintended pregnancy and unsafe abortion

- Policymakers and health planners need to consider and debate strategies to address the high levels of unsafe abortion and low levels of contraceptive use in Uganda.
- The political will exists to improve reproductive health care and to increase contraceptive use in Uganda, but the financial resources currently available are insufficient to achieve these goals.
- To reduce the grave health consequences and substantial long-term costs of unsafe abortion, resources should be directed at improving the availability and quality of postabortion care for women with complications.
- Wider training in the use of manual vacuum aspiration—a very safe method when used correctly—would reduce the frequency and severity of complications from abortions performed by medically trained professionals.
- Education in schools and other community settings, as well as through the mass media, is needed to emphasize the health and societal benefits of family planning.
- Improving knowledge about, access to and use of effective contraceptives would lead to lower rates of unwanted pregnancy and induced abortion.
- Men should be enlisted in efforts to improve reproductive health conditions among couples in Uganda.



The Troubling Reality Of Unsafe Abortion

In Uganda, as in many parts of the world, unsafe abortion is a serious reproductive health problem. It also constitutes a divisive moral and political issue—one that many policymakers choose to ignore. Because induced abortion is highly restricted by law in Uganda, it is often practiced in secret. As a result, many women who wish to end a pregnancy must rely on practitioners who use dangerous methods under unsanitary conditions. The consequences for women can be deadly.

Induced abortion is permitted in Uganda only when continuation of a pregnancy would endanger a woman's life.[1] However, the chances that a woman whose life is threatened by a pregnancy could obtain a legal abortion are very low. Because the practice is largely illegal, there are no official statistics on the number of abortions performed in Uganda each year. But there is abundant evidence that the practice is widespread. In a national study conducted between 1992 and 1994, 63% of women and men surveyed said that they knew someone who had had an abortion.[2] In addition, reports of abortion-related medical emergencies at Uganda's major teaching hospitals provide compelling evidence of the tragic—and sometimes fatal—health consequences of unsafe abortion.[3]

Unfortunately, there has been a lack of informed and open public discussion about unsafe abortion and the burden it places on women, families and Uganda's health care system. In fact, until recently, little was known about the magnitude of the problem or even the number of women in Uganda who have induced abortions. This report aims to fill that gap. It also tells the broader story behind the statistics: the high levels of unintended pregnancy* in Uganda; the many aspects of women's lives that create a high risk of unintended pregnancy; the wide range of providers—many of them lacking formal obstetrical training—who carry out abortions; and the widespread use of unsafe methods by many of these practitioners. To tell this story, we have drawn on data from a variety of sources, including health care facilities, public health experts, practitioners, and the men and women of Uganda (see Data Sources, page 9).

The purpose of this report is threefold: to make the new findings on abortion and unintended pregnancy available to policymakers, health planners, health care providers, advocates for women, educators and other concerned individuals; to increase awareness about the complex causes and far-reaching consequences of unintended pregnancy; and to encourage the development of programs and policies aimed at reducing both unintended pregnancy and unsafe abortion in Uganda.

Unsafe abortion is harmful to women, their families and society in general

Estimates suggest that the rate of maternal mortality (i.e., pregnancy-related death) in Uganda is among the highest in the world—between 505[4] and 880[5] maternal deaths for every 100,000 live births. In some parts of the country, the rate is believed to be as high as 1,200 deaths per 100,000 live births.[6] As in all countries where abortion is clandestine, unsafe abortion contributes to Uganda's high level of pregnancy-related deaths. For example, a study of women who were treated for pregnancy-related problems in three Kampala hospitals in 1992–1993 found that 21% of maternal deaths were due to complications of abortion.[7]

*An unintended pregnancy is defined as one that the woman would have preferred to have at another time (mistimed) or would not have wanted at any time (unwanted).

Chapter 1

Unfortunately, the situation in Uganda is typical of many parts of the developing world. Every year, according to the World Health Organization, some 67,000 women of childbearing age—including 30,000 in Sub-Saharan Africa—die from complications resulting from abortions performed by untrained and unskilled practitioners using dangerous methods.[8]

Mortality is not the only adverse outcome of pregnancy-related complications; some women are left with debilitating health problems. For every woman who dies as a result of pregnancy-related causes, including unsafe abortion, many more are left infertile or severely incapacitated by such conditions as vesico-vaginal fistulas, urinary incontinence, utero-vaginal prolapse and chronic pelvic inflammatory disease.[9]

Moreover, unsafe abortions may set in motion a damaging ripple effect that spreads from women themselves to their families and friends to the country's health care system. Many traditional abortion methods fail, so that women may end up visiting and making payments to a series of untrained providers; women who finally obtain an abortion might then face the prospect of having to find additional money to pay for treatment of medical complications they develop. Those who do not recover quickly from their complications—or who do not seek or receive any treatment—may subsequently be unable to take care of their children properly or to continue earning income that helps support their family. Additionally, many women who die from abortion complications leave husbands widowed, children orphaned and families suffering from the loss of emotional, spiritual, financial and day-to-day support.

The financial costs of unsafe abortion are borne not only by individual Ugandan women and their families but also by the nation as a whole, as hospitals are obliged to commit scarce medical resources (operating rooms, hospital beds, blood transfusions, antibiotics) and highly trained personnel to treat women for abortion complications. These requirements create a drain on Uganda's already overburdened and underfinanced health care infrastructure.[10]

Poor and uneducated women are most at risk

Of the 27 million people who live in Uganda,[11] 86% live in rural areas and depend for their livelihoods on subsistence farming or on agriculture-based industries that pay very low wages.[12] Although modernization and economic growth are occurring in some parts of Uganda, women have not benefited from these changes to the extent that men have, especially in rural areas, where the great majority of women live in poverty and have received little schooling. Overall, 45% of women in rural areas live in poor households,* compared with just 2% of women who live in urban areas.[13] Poverty is particularly widespread in Uganda's Northern region, where 71% of women are poor. This poverty is compounded by lack of educational opportunities: Rural women of childbearing age are much less likely than their urban counterparts to have had seven or more years of schooling (22% vs. 62%).

These statistics are important because unwanted pregnancy and unsafe abortion occur disproportionately among the most disadvantaged members of society, who are also the least likely to have access to high-quality postabortion services.[14] Poor women and those with little education (the two groups overlap significantly) often have little say in when they will marry, when they will first become mothers, the number of children they will have and when they will stop childbearing.[15] Moreover, contraceptive use is much lower

Abortion is highly stigmatized

Moderator: What is the general opinion in this community of women who have an abortion?

Respondent 1: It is a shameful act.

Respondent 2: They see it as an inhuman and criminal act.

Respondent 3: It is the same as if they saw a married woman having sex out of wedlock. They regard you as a prostitute.

Respondent 4: It is a shame. If they realize that you aborted, you don't fit in the community. You feel out of place because they gossip about you and curse you.

—Rural focus group, women aged 20–35

Interviewer: How would people from the community react if they found out that a woman interrupted her pregnancy?

Respondent: She becomes the laughing stock for the village. No one can sympathize with her when she gets complications.

—Rural woman, aged 60

If they find her, they arrest her and take her to the police. The community is against abortion. They talk about abortion, but people don't listen, mainly the prostitutes. If they found out that one aborted and they have evidence, they arrest her. If they have no evidence against her, they just backbite her.

—Rural man, aged 28

Community Abortion Morbidity Study

*The wealth index used in this analysis was constructed using the approach developed by Rutstein and Johnson for the Demographic Health Surveys (DHS) (see Rutstein SO and Johnson K, *The DHS Wealth Index*, DHS Comparative Reports, Calverton, MD: ORC Macro, 2004, No. 6). The DHS collects extensive information on respondents' household assets; for Uganda, these assets included all items that reflect economic status, such as televisions, telephones, cars and donkeys; whether the respondent's house has electricity; and the types of material used for the walls and roof. Two additional items—whether respondents have a domestic servant and own agricultural land—were also included. This information was used to construct the wealth index, and respondents' households were classified into quintiles. In our analyses that are based on the DHS, households in the two lowest quintiles are classified as poor, households in the third and fourth quintiles are classified as middle class, and those in the fifth quintile are classified as rich.

among women with little schooling than among those with at least some secondary education;[16] this factor, too, puts less educated women at increased risk of unwanted pregnancy and, in turn, unsafe abortion.

Stigma and secrecy surround abortion in Uganda

In addition to being severely restricted, abortion is a highly controversial social issue in Uganda, particularly on religious grounds. The country's population is religiously diverse: Forty percent of Ugandans are Catholic, 41% are Protestant, 13% are Muslim and 6% practice other religions.[17] Many of these groups oppose abortion: For example, the growing fundamentalist evangelical movement in Uganda condemns the procedure,[18] and the official policy of the Catholic church in Uganda is that abortion is a "fundamental evil."[19]

More generally, there is widespread social stigma surrounding abortion, even among highly educated individuals. A 1997 survey of adult men (students and employees) at institutions of higher learning in Kampala found that six in 10 believed that the women most likely to have abortions are prostitutes, and seven in 10 stated that abortion is always wrong.[20] In addition, many health providers who are aware of the consequences of unsafe abortion, or who object to abortion on moral or religious grounds, often discourage women from seeking abortions—thus driving the procedure underground.[21]

Because the practice is both largely illegal and widely condemned, most women do all they can to conceal their abortions. This is a major reason why women often delay seeking medical care if they experience complications. It also explains why induced abortion is hard to measure and often underreported.

A guide to this report

Chapter 2 provides an estimate of the current level of abortion in Uganda. It then describes the kinds of abortion providers that women go to, the methods commonly used and the associated costs. Chapter 3 provides estimates of the risk of complications from abortions performed by various types of providers. It also describes the facilities in Uganda's health care system that are most likely to treat women with abortion-related complications, and discusses the likelihood that women in need of such services will obtain them. Chapter 4 examines the phenomenon of unintended pregnancy—the root cause of most abortions. It looks at the proportion of pregnancies that are unintended and discusses the major reasons that rates of unintended pregnancy are high in Uganda. Finally, Chapter 5 summarizes the report's findings and discusses the policy and program implications for government, nongovernmental organizations, medical professionals, educators and the media.

Data Sources

STUDIES INCLUDED IN THIS REPORT

To obtain a broad perspective on the issue of abortion in Uganda, this report draws on data from five different sources—health care professionals, hospitals and other health facilities, focus groups and in-depth interviews with community residents, and national surveys of men and women. All of the studies, except for the Demographic and Health Surveys, were conducted by researchers at the Guttmacher Institute and colleagues in Uganda.

- **Health Facilities Survey.** In 2003, researchers surveyed a nationally representative sample of facilities within Uganda's formal health care system that treat women with abortion-related complications.[1] The 359 facilities included government, private and nongovernmental organization hospitals; the two highest levels (III and IV) of health centers, again including government, private and nongovernmental facilities; and clinics operated by private midwives, an important group of postabortion care providers. The selected facilities accounted for 100% of hospitals, 40% of level IV health centers, 17% of level III health centers and 13% of private midwives in Uganda. The investigators obtained estimates of the number of women who received postabortion care at each facility in 2003; these numbers were weighted to provide regional and national estimates.

- **Health Professionals Survey.** Researchers also conducted in-depth interviews with 53 Ugandan health professionals in 2003.[2] Factors considered in selecting participants included their affiliation, their expertise in and experience with abortion issues, and their reputation in the field of reproductive health. The survey team made a particular effort to include experts familiar with the context of abortion in rural areas; 52% of participants had worked in rural areas for at least six months, and almost three in 10 had worked primarily in rural areas. Respondents came from eight of Uganda's 56 districts (Kampala, Mukono, Mpigi, Wakison, Iganga, Jinja, Sembabule and Rakai) and included nurse-midwives, medical officers, clinical officers, gynecologists, policy advisers, researchers and public health specialists. These experts were interviewed in person about their perceptions concerning abortion providers, the abortion techniques most likely to be used by poor and nonpoor women living in urban and rural areas, women's risk of experiencing health complications from an abortion and their likelihood of obtaining medical treatment if complications occur.

- **Community Abortion Morbidity Study.** This qualitative study on the consequences of unsafe abortion was conducted in 2004 in one urban area and one rural area of Uganda.[3] The participants, who were interviewed individually or in focus groups, included women aged 18–60, men aged 20–50 and health care providers who worked within the same communities. The providers included midwives, nurses, doctors, dispensary personnel, drug shop pharmacists, traditional birth attendants and traditional healers. Issues covered during the interviews included participants' knowledge of and experiences with unwanted pregnancy, induced abortion and the social and economic consequences of abortion, particularly for women who delay seeking or do not obtain abortion-related care.

- **Exploratory study of HIV-positive women's pregnancy experiences and preferences.** An exploratory study of 38 HIV-positive Ugandan women aged 18–35, and 15 health care providers who serve HIV-positive women, was carried out in 2005.[4] In personal interviews, the women discussed the fertility-related experiences they had had since diagnosis, including such topics as their childbearing desires, contraceptive use and discussions with sexual partners and health care providers about contraceptive use and pregnancy. The interviews with health care providers focused on their attitudes, preferences and practices regarding their provision of reproductive health care to HIV-positive women.

- **Demographic and Health Surveys.** Nationally representative surveys of women in Uganda aged 15–49 were conducted in 1988, 1995 and 2000–2001.[5] These surveys included numerous questions about issues of fertility, contraceptive use, sexual behavior and reproductive health.

DATA LIMITATIONS

The Health Facilities Survey obtained an approximate count of the number of postabortion patients treated at each sampled facility, based on senior staff members' knowledge of the facility's patient load. This survey was retrospective (it asked about the number of patients treated in the average month and in the past month) and did not prospectively collect data on patients, either from medical records or directly from patients themselves.

The Health Professionals Survey examined the perceptions and opinions of a cross-section of knowledgeable health professionals regarding conditions of abortion service provision, the probability that women would experience serious medical complications and the likelihood that women would obtain care in a hospital or health facility if they did have complications. These probabilities are not based on empirical data from women themselves regarding their health-seeking behaviors.

The Community Abortion Morbidity Study, which used qualitative research techniques, provides insights regarding the process by which women decide to have an abortion and about behaviors and consequences related to abortion complications. However, because the study was implemented in only one rural area and one urban area, the findings may not be representative of or generalizable to Uganda as a whole. In addition, the study was exploratory in some respects, as it addressed topics (the social and economic consequences of unsafe abortion) that have not been well studied.

The study of HIV-positive women was exploratory as well. Given the lack of prior studies, the qualitative design and protocols were newly developed. The study was conducted in Kampala and thus did not involve a nationally representative sample, and it included only women who knew that they were HIV-positive and who were utilizing services at two sites that provided health care and support for HIV-positive women.

Despite the above limitations, the information from these sources gives an approximate picture of the circumstances and conditions surrounding abortion in Uganda and allows us to make a reasonable estimate of the incidence of the practice. Such indirect estimates, based on a number of assumptions, are necessary given that national statistics on abortion and abortion-related complications do not exist.

Chapter 2

The Prevalence And Practice Of Induced Abortion

In attempting to address the issue of induced abortion in Uganda, health planners have been hampered by not knowing how widespread the practice is. New research findings on the number of women treated each year for abortion-related complications now make it possible to estimate the incidence of abortion in Uganda.

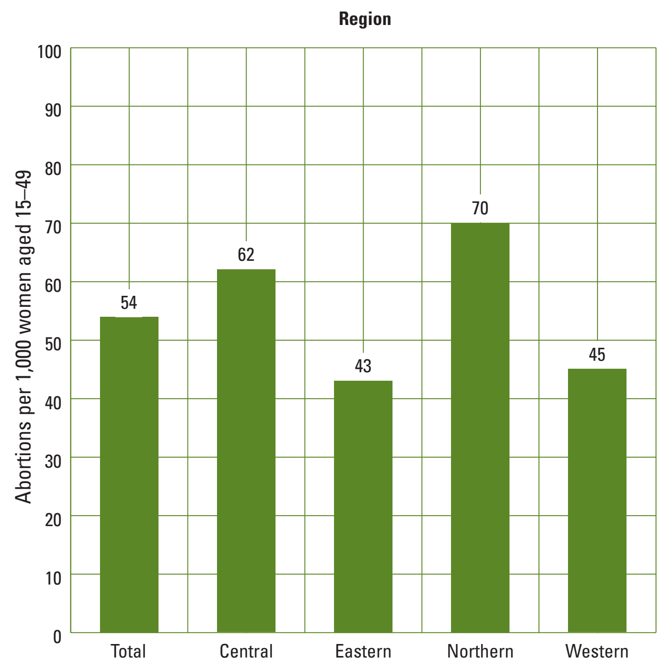
The findings reveal that health care providers treated about 85,000 Ugandan women for complications of induced abortion in 2003.[1] However, women who obtain treatment for abortion-related complications represent only the visible tip of the iceberg. For every woman who receives treatment at hospitals and health centers, an additional but unknown number have an abortion but experience minimal or no complications; have serious medical complications but do not obtain treatment for them or die before receiving treatment; or have complications that are treated outside the formal health care system. Therefore, if we want to estimate the overall number of abortions, the number of women who receive treatment for abortion-related complications in health care facilities must be adjusted to account for these "invisible" women.

We estimate that for each of the 85,000 Ugandan woman known to receive care for abortion complications in 2003, an additional 2.5 women either had abortions free of complications, had complicated or incomplete abortions for which they did not receive care, or received care outside of the formal health care system. (See Appendix, page 29, for an explanation of the methodology used to make this calculation.) The actual number of women who had abortions in Uganda in 2003 is estimated to be 297,000.[2]

These 297,000 abortions translate to an annual rate of 54 abortions for every 1,000 Ugandan women aged 15–49—or approximately one for every 19 women in this age-group. The estimated abortion rate varies in different parts of Uganda (Figure 2.1)[3] and is highest (70 per 1,000) in the country's Northern region—the area with the highest proportion of women living in poverty (71%), the lowest level of modern contraceptive use (6%) and the smallest proportion of women with seven or more years of schooling (12%).[4]

FIGURE 2.1

The estimated abortion rate in Uganda is highest in the Northern and Central regions.



Source Reference 3.

Poor women are often unable to afford a doctor's services for an abortion

Those who go to doctors find it easy to stop the pregnancies because the pregnancies are stopped well. It's those who do not have money to go to doctors that find stopping pregnancies difficult because they use traditional methods. They use traditional methods, get problems and end up going to health facilities.

—Urban woman, aged 32

Community Abortion Morbidity Study

A woman's ability to pay influences her choice of provider

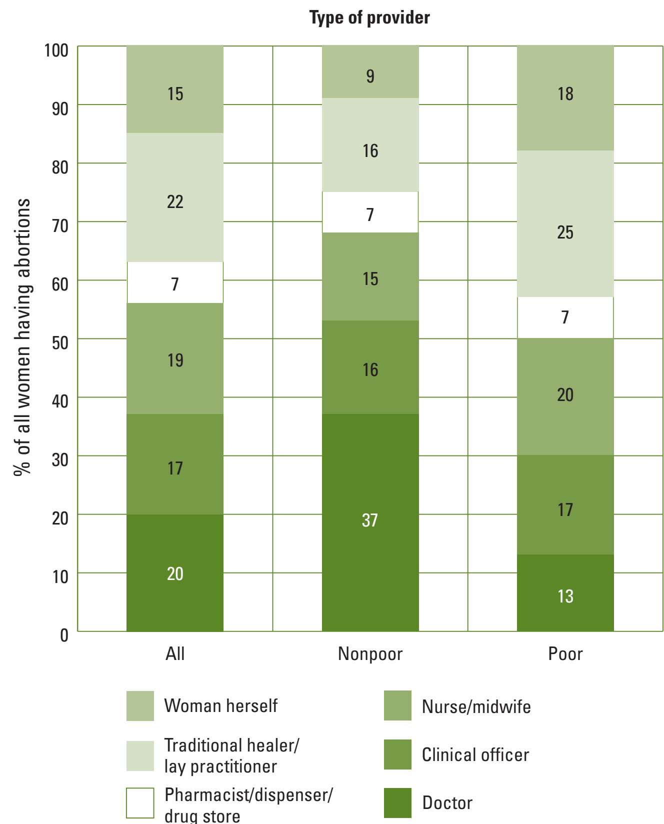
Where and how a Ugandan woman ends an unplanned pregnancy often depends on her financial situation. Wealthier women can obtain the services of trained health professionals—including some doctors, clinical officers,* nurses and nurse-midwives—who are willing to perform abortions using such modern surgical methods as dilation and curettage (D&C) or manual vacuum aspiration. Women who cannot find or cannot afford the services of a doctor or nurse turn to less costly providers: pharmacists (who might provide hormonal drugs or other abortifacients), traditional healers, traditional birth attendants, herbalists or other kinds of lay practitioners. Some pregnant women also attempt to induce an abortion on their own.[5]

Regardless of her financial situation, a woman seeking an abortion often begins with the least expensive option: herbal or other home remedies. If this doesn't work, she may next go to a traditional healer or to a pharmacist. If these steps are ineffective as well, women who can afford the cost may then go to a doctor or nurse for a surgical procedure. At each of these stages, some women who have been unsuccessful in obtaining an abortion give up and opt to continue their pregnancy to term.[6]

In a recent study conducted in southwestern Uganda, commercial motorcycle drivers ("bodabodamen")—a group familiar with the workings of local popular culture—confirmed that a diverse network of professional and lay reproductive health providers facilitate and maintain the practice of abortion in Uganda. These providers include "professionally trained health personnel at all levels, pharmaceutical dealers ranging from [pharmacists with graduate degrees] to mere drug store attendants, traditional birth attendants, faith healers, elderly relatives, knowledgeable peers and concerned family members." The authors of the study conclude that a "meshing of diverse abortion services" in Uganda's Southwest region "provides a range of available options at a range of negotiable prices."[7]

FIGURE 2.2

Poor women are considered to be less likely than nonpoor women to go to medically trained providers for an abortion.



Note Poor women are defined as those whose income is below the national average.

Source Reference 8.

Medically trained personnel perform more than half of all abortions

According to knowledgeable health professionals, about one-fifth of abortions in Uganda are performed by doctors. Similar proportions are performed by clinical officers, by nurses or nurse-midwives, and by traditional providers (healers, herbalists and traditional birth attendants). In the remaining one-fifth of cases, women induce their own abortions or obtain abortion-inducing products from a pharmacist. These figures suggest that 56% of abortions are carried out by medically trained providers and 44% by untrained or traditional providers. However, the proportion of abortions performed by medically trained professionals is estimated to be lower for poor† women (50%) than for nonpoor women (68%; Figure 2.2).[8]

*Clinical officers are professionals who have completed their basic medical training and are licensed to practice medicine, but have not yet chosen a medical specialty.

†For the purposes of the Health Professionals Survey, poor women were defined as those whose income was below the national average; nonpoor women were defined as those whose income was above the national average.

In rural areas, familiarity with traditional abortion methods is widespread

Respondent 1: I think if [women] go to traditional providers, they give them an herb to drink and then after drinking, the pregnancy will be stopped.

Respondent 2: You can go to village old women who can use . . . a sharpened stick which will pierce the uterus and it allows in air that causes the abortion.

Respondent 3: Usually the traditional providers give a woman herbs to drink, [such as] a muhoko or a muranunga. She drinks a cup, that day may not set without aborting.

Respondent 4: With oluwoko, you can drink a glass and when you do, you feel pain like some razor cutting your uterus. It means that the fetus will very soon come out.

—Rural focus group, women aged 36–49

Community Abortion Morbidity Study

TABLE 2.1

Estimated cost of an abortion, in Ugandan shillings, by type of provider, according to women's poverty status and place of residence

Provider	Nonpoor		Poor	
	Urban	Rural	Urban	Rural
Doctor (private health clinic)	140,000	59,000	102,000	43,000
Doctor (government health facility)	85,000	48,000	67,000	40,000
Clinical officer	66,000	38,000	43,000	30,000
Nurse/midwife	50,000	30,000	32,000	22,000
Traditional practitioner	54,000	30,000	27,000	19,000
Pharmacist	22,000	13,000	11,000	8,000
Self	14,000	10,000	6,000	6,000

Note Poor women are defined as those whose income is below the national average.
Source Reference 15.

It may seem surprising that as many as half of poor women obtain abortions from medically trained providers. However, many of these women go to nurses and midwives, who charge less than doctors do for their services. Also, it appears that some doctors and nurses voluntarily charge fees low enough to be affordable even to poor women.

It may also be somewhat surprising that so many women who are not constrained by poverty go to lay practitioners, such as traditional healers, or induce their own abortions.[9] Because of the stigma attached to abortion, even women who can afford the services of doctors or nurses may prefer the relative anonymity that comes from using traditional providers or from ending their own pregnancy.

Most doctors and nurses use safer methods than those used by untrained providers

As might be expected, the methods used by physicians to induce abortion are perceived to be safer than those used by lay practitioners or by pregnant women themselves. Health experts estimate that three-quarters of physicians in urban areas and two-thirds of those in rural areas use D&C as their primary method. Manual vacuum aspiration is the primary method for only one in five urban physicians and one in 12 rural physicians, even though this is the medically recommended method for first-trimester abortion.[10]

Practitioners who are not physicians (that is, the full range of other provider types, from formally trained midwives to traditional providers) are likely to use a variety of methods, including hormonal drugs of the kind used to precipitate contractions of the uterus (the primary method of three in 10 nonphysicians in urban areas and two in 10 in rural areas) and even D&C or manual vacuum aspiration (one in five urban nonphysician providers and one in seven rural nonphysician providers rely on one of these surgical techniques). However, some use more dangerous techniques, such as the insertion of rubber catheters or sharp objects into the uterus, or the consumption or vaginal application of caustic substances or powerful herbal remedies.[11] The use of traditional methods is confirmed by community residents, who mention such practices as inhaling steam from cooked herbs, wearing dried herbs, drinking detergents or applying combinations of these techniques (see box, p. 13).[12]

Ugandan health professionals believe that women who induce their own abortions are most likely to use traditional herbal remedies, particularly if they live in rural areas.[13] Among those who self-induce, one in four women in rural areas and one in five women in urban areas use either ennanda or oluwoko,* the most commonly used herbs for this purpose. Urban dwellers frequently use hormonal drugs. A very small proportion of women who end their own pregnancies are believed to resort to the kinds of dangerous methods used by traditional healers, including sticks inserted into the uterus or excessive doses of chloroquine.[14]

Doctors charge the highest fees

In general, the more training a practitioner has, the higher the cost of an abortion, especially in urban areas. The most expensive abortions are those performed by urban doctors who work in private health clinics (Table 2.1).[15] Health care professionals estimate that poor women pay about 102,000 Ugandan shillings (about US$55)† for such an abortion and nonpoor women pay 140,000 shillings (about

*Ennanda (or *Commelina*) is also known as water grass. It is an herb that is inserted into the vagina to induce abortion. Oluwoko (*Phytolacca dodecandra*) is commonly known as pokeweed. Juice is squeezed from fresh leaves, mixed with water and then drunk.

†At an exchange rate of 1,844 Ugandan shillings to the U.S. dollar.

US$76). Doctors in rural areas who practice in private health centers charge less than half these rates. Never-the-less, even these lower fees represent a substantial burden in a country where income is very low (in 2003, gross domestic product per capita was US$249, or US$1,457 when adjusted for purchasing power parity).[16]

Depending on their clients' financial status and whether they work in a rural or urban community, traditional healers, herbalists and lay practitioners are estimated to charge roughly the same range of fees (19,000–54,000 shillings, or US$10–29) as those asked by nurses and nurse-midwives (22,000–50,000 shillings, or US$12–27). This is surprising, given that nurses are formally trained and are likely to use safer methods. Traditional practitioners also charge more than pharmacists, whose costs range between 8,000 and 22,000 shillings (US$4–12) and who, again, offer methods that are probably safer than those used by traditional providers.[17] Traditional health providers probably have an advantage in terms of fee-setting because they are the most easily available practitioners and play an important role in community belief systems. In addition, even wealthier women may fear going to a doctor or nurse for an illegal procedure.

Understandably, given the everyday nature of the products women use on themselves, self-induced abortions are the least expensive way of attempting to end a pregnancy: They are thought to cost between 6,000 and 14,000 Ugandan shillings (US$3–8).[18]

Interestingly, all providers seem to adjust their fees according to their clients' ability to pay. Charges are lower for poor women than for nonpoor women, and higher in urban areas than in rural areas. This finding echoes the results of a study of abortion practice in Kenya, which found the existence of "similar fee ranges" for "physicians, herbalists and quacks" and concluded that "most physicians are willing to use a sliding scale."[19] The comparable finding in Uganda may help explain how an estimated three in 10 poor women can afford to seek abortions from doctors or clinical officers.

Abortion Methods Used in Uganda

This list of abortion methods is based on interviews with health professionals (the Health Professionals Survey) and community members (the Community Abortion Morbidity Study). Although all methods cited by respondents are listed, they are not necessarily effective. Phrases in brackets are author explanations. Local names for some herbs are given in two languages: Luganda and Runyankole.

SURGICAL AND MEDICAL METHODS

Dilation and curettage
Manual vacuum aspiration
Saline instillation

HERBS*

Akaiha bukuru
Amaduudu
Ejirikiti
Ejobyo
Ekiko [*Erythrina*/fireman's cap or coral bean]
Ennanda/nanda/eteija [*Commelina*/water grass]
Etiija
Etwata
Kamunye
Karitus
Muranunga
Nyarwefora
Oluwoko/omuhoko/emuhoko [*Phytolacca dodecandra*/pokeweed]
Omujaaja
Omuravunga
Orunyenje [*Euphorbia tirucalli*/milk bush or petroleum plant]
Tea leaves

OTHER METHODS

Drinking laundry detergent, bleach or gasoline
Sodium chloride
Inhaling steam from foods cooked with certain herbs
Insertion of catheter into vagina
Insertion of object into vagina (stick, reed, cassava, clothes hanger, metal)
Medications (e.g., aspirin, sleeping pills, quinine, chloroquine), often in large doses
Oral hormonal drugs
Smoking cow dung
Tying the stomach
Washing the womb
Wearing herbs

*Most herbs are consumed in liquid form (squeezing fresh leaves and mixing with water, or boiled and drunk as tea) or inserted into the vagina (as leaves or herbal solutions). In some cases, the plant's stem is inserted into the uterus.

Source Reference 12.

The Health Consequences Of Unsafe Abortion

When abortion is clandestine, as it generally is in Uganda, it is often unsafe and can entail serious physical risk for women. According to the World Health Organization, unsafe abortions are characterized by the provider's inadequate skills, unsanitary facilities and use of hazardous techniques.[1] Health risks at the time of an unsafe abortion include infection, hemorrhage, septic shock and abdominal injury. In the long run, chronic problems such as pelvic infection, ectopic pregnancy and infertility can occur.

Factors that are largely beyond a woman's control—whether she lives in an urban or rural area, her financial situation, her age and her health status—also influence her risk of abortion-related health complications. Compared with urban residents, women who live in rural areas have access to fewer trained medical professionals who offer safe services and to fewer properly equipped hospitals that provide postabortion care. Poor women may delay seeking an abortion until they can raise the necessary funds—a potentially hazardous situation, because abortions performed later in pregnancy pose greater health risks than early abortions. Similarly, due to financial concerns, poor women are more likely than wealthier women to delay obtaining treatment for any complications that arise. Young women and those with little education may be less aware than older and better educated women that delaying an abortion and waiting before seeking treatment for complications can exacerbate health risks.

Women with certain pre-existing health problems are also especially vulnerable to the hazards of unsafe abortion. If a woman with abortion-related complications was anemic before the procedure, excessive bleeding afterward could pose a severe threat to her health. And women with chlamydia or gonorrhea are at high risk of upper genital tract infection after an unsafe abortion.[2]

Women know that many abortion methods are dangerous

[Women considering an abortion] are afraid of dying because they see other women who end their pregnancies and die. We have a daughter who died in this way.

—Urban woman, aged 33

It's difficult. You could die in the process. It puts your people in problems. If you get sick, they have to look for money to nurse you and get you back to health. Again, you can die in the process. Some do die when aborting.

—Rural woman, aged 18

Others drink herbs and come to me saying that "I drank oluwoko," but I tell them that oluwoko is a poisonous plant and it kills. Of course oluwoko stops pregnancies, but it kills. My young sister almost died when she used oluwoko to stop her pregnancy.

—Urban traditional birth attendant, woman aged 49

Community Abortion Morbidity Study

New evidence from personal interviews and focus group discussions suggests that many Ugandan women understand at least some of the health risks associated with clandestine abortion.[3] Given this awareness, the decision by thousands of Ugandan women each year to have an abortion is all the more striking. One can only conclude that many women are so desperate not to have a child that they knowingly risk their health and survival in order to end a pregnancy.

Abortions performed by doctors are not necessarily safe

Understandably, the less skilled the abortion practitioner, the greater the likelihood that a woman will have complications. In Uganda, the risk of complications requiring medical

Not all abortions carried out by medically trained professionals are safe

Respondent 1: It is not only traditional providers. I believe even modern providers face the same problem. They may know what to do, but because abortion in Uganda is illegal, the doctors can easily make mistakes because they stop pregnancies in hiding and hurriedly. They fear to be caught in the act because [abortion] is illegal.

Moderator: Do all modern providers know what to do?

Respondent 2: Not all. Some of them do it for the sake of getting money. They don't have experience in stopping pregnancies.

—Urban focus group, women aged 20–35
Community Abortion Morbidity Study

treatment (such as excessive bleeding, infection or injury to the reproductive organs) is estimated to be one in four among women who obtain their abortions from doctors; more than four in 10 among those who go to nurses, clinical officers or pharmacists; two out of three among those using traditional healers or lay practitioners (including traditional birth attendants); and three out of four among women who induce their own abortions (Figure 3.1).[4]

In industrialized countries, abortions carried out by doctors are generally safe. For example, when D&C is properly performed, the rate of medical complications is no more than one in 100,[5] and the complications are generally far less serious than those that occur when poorly trained personnel perform the procedure. For this reason, the estimate that one in four abortions performed by doctors in Uganda result in complications is troubling. Moreover, the risk of complications is even higher—one in three—among poor women in rural areas who obtain abortions from doctors.[6]

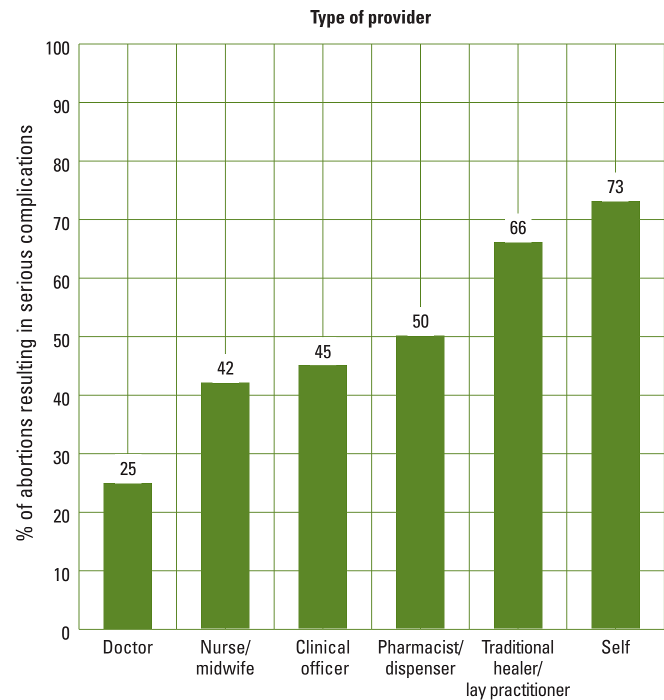
There are several possible explanations for the reportedly high level of complications among women who go to doctors for an abortion. Because of financial constraints, poor women might seek the services of doctors who charge low fees; these providers may be less skilled or less experienced in performing abortions than physicians who charge high fees, and they may be more likely to use D&C (rather than the less invasive method of manual vacuum aspiration). Another reason for the high rate of complications may be that doctors, especially those in rural areas, often have to work under relatively unsanitary conditions, particularly when providing clandestine services. It is also possible that some providers who claim to be doctors are not.

When the abortion provider is a doctor, nurse, clinical officer or pharmacist, the risk of complications is highest for poor rural women and lowest for nonpoor urban women.[7] Risks for nonpoor rural women and for poor urban women fall between those for the other two groups.

For women who seek abortions from traditional practitioners, the risks are estimated to be similar for poor and nonpoor women in urban areas (about six in 10) and for poor and nonpoor women in rural areas (about seven in 10).[8]

FIGURE 3.1

Women who induce their own abortions or go to traditional practitioners are estimated to be most likely to have abortion complications.



Source Reference 4.

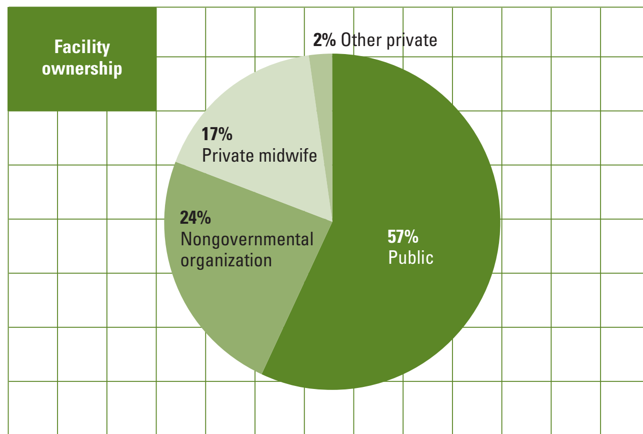
Women mainly seek postabortion treatment from hospitals and health centers

The primary sources of postabortion care in Uganda are the hospitals and local health centers that make up Uganda's formal health care system. Uganda has 96 hospitals, most of them located in urban areas. Fifty-three of them are run by the government, 38 are administered by not-for-profit nongovernmental organizations (NGOs) and five are for-profit private institutions. Almost all hospitals in Uganda provide postabortion care.

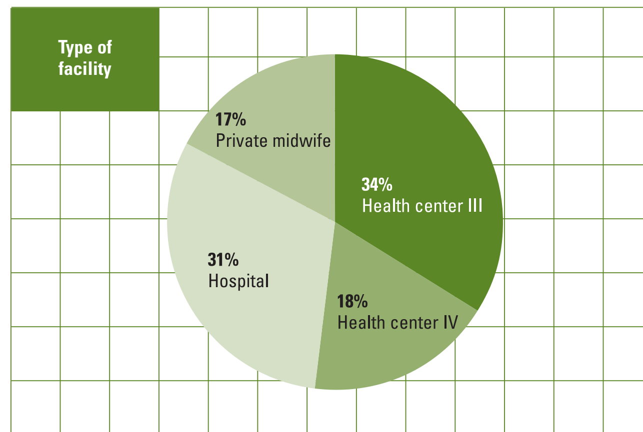
Health centers, which can be administered by the government or by private organizations, are graded into four levels. Those in the lower two levels (I and II) do not provide abortion-related care; instead, they refer patients to higher-level facilities. About nine in 10 level III and level IV centers offer postabortion care, although the latter have better medical equipment and more highly trained staffs.[9] Uganda's network of trained midwives, who generally work out of their own homes, also make important contributions to postabortion care.[10]

FIGURE 3.2

Government facilities treat the majority of women with abortion complications . . .



. . . and just over half of postabortion patients are treated in health centers.



Note Proportions are among women treated in the formal health system.
Source Reference 11.

Almost six in 10 women treated for complications within Uganda's formal health system receive care in publicly owned facilities. Thus, the Ugandan government provides the majority of postabortion care. About one-fourth of women are treated in hospitals and health centers run by NGOs, one in six are treated by private midwives, and a very small proportion receive care in privately owned health centers (Figure 3.2).[11]

Although health centers vary widely in the quality of care they are able to provide, these facilities treat an estimated 52% of all postabortion patients who receive care within the formal health system. Hospitals treat an estimated 31% of cases, and private midwives care for the remaining 17%.[12] However, the average annual caseload per facility is almost four times greater for hospitals (360) than for level IV health centers (95). Level III health centers that offer postabortion care treat, on average, about 50 cases a year, as do private midwives.[13]

Traditional healers are seen as more sympathetic

The traditional provider may be the one more accessible to her. She finds it easier to approach the traditional provider than to approach a modern provider. The [traditional] provider may be welcoming, greets people well and attends to them in a friendly way. If you go to a modern provider, even if you have [brought] money, first they neglect you and then abuse you, and you regret [having gone] to them.

—Urban woman, aged 49

Community Abortion Morbidity Study

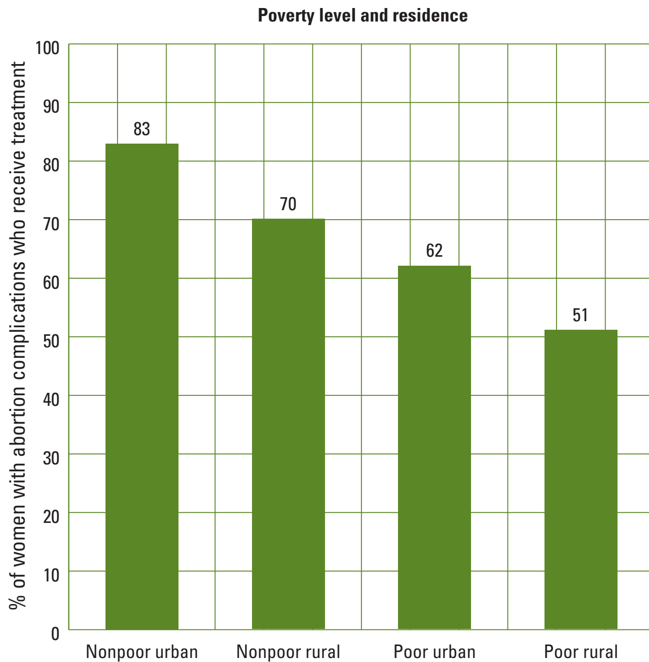
Doctors in government health facilities and nurse-midwives are viewed as the major providers of postabortion care for poor women in both urban and rural areas, as well as for nonpoor rural women, whereas private doctors are considered the main source for this type of medical care for better-off women in urban areas. However, some women, especially those in rural areas, go to traditional providers for the treatment of abortion complications.[14] Women do this, community residents explain, because local healers may charge less than trained doctors and nurses, and because traditional providers are viewed as treating women more discreetly and compassionately.[15] However, the postabortion care that women receive from traditional providers is often far less than optimal; for example, traditional healers would not be in a position to give blood transfusions or to perform safe uterine evacuations for incomplete abortions. Moreover, when women go to traditional providers, they are delayed from getting the medical care they need, which may allow their condition to worsen.

Public hospitals are responsible for most treatment of severe complications

Although nearly 70% of postabortion care is provided by health centers or private midwives, skilled and complex postabortion care is largely available only in hospitals.[16] Almost all hospitals and health centers that treat complications of abortion can provide antibiotics for women with infections, and most can also prescribe oxytocics (drugs that stimulate contractions of the uterus to complete the expulsion of the fetus). Nearly all surveyed hospitals—as well as seven in 10 level IV health centers, four in 10 level III health centers and two in 10 midwives—report that they treat women with incomplete abortions using at least one of the following methods: D&C, manual or electric vacuum aspiration, evacuation with a curette, sponge forceps or digital evacuation.[17] Only 2% of level III and level IV health centers have the ability to perform blood transfusions, compared with 88% of government hospitals and 73% of private hospitals.[18]

FIGURE 3.3

Women who are poor and live in rural areas are less likely than other women to receive treatment if they have abortion complications.



Note Poor women are defined as those whose income is below the national average.
Source Reference 21.

Ugandan women have a 50% lifetime chance of being treated for abortion complications

As noted earlier, about 85,000 Ugandan women each year are estimated to receive treatment for abortion complications in hospitals or health centers or from private midwives. This number translates to 15 women per 1,000 women of childbearing age being treated for abortion-related complications each year.[19] If this rate stays unchanged during the typical Ugandan woman's childbearing years, over her lifetime she will have a 50% chance* of receiving care for health complications following an induced abortion.[20]

However, not all women with complications seek or obtain treatment. In general, a woman's chances of obtaining the postabortion care she needs are a function of her ability to pay and where she lives. Better-off women and those who live in urban areas are more likely than poor women and those living in rural areas to obtain treatment if they experience abortion-related complications. Experts estimate that eight in 10 nonpoor women in urban areas, seven in 10 nonpoor women in rural areas, six in 10 poor women in urban areas and only half of poor women in rural areas would receive treatment if they suffered serious abortion complications such as excessive bleeding, fever or injury (Figure 3.3).[21]

Because the majority of women in Uganda live in rural areas, where access to health care is poor, only an estimated six in 10 of all women with abortion-related complications receive treatment from the formal health care system.[22] Looked at another way, roughly one in five of the estimated 297,000 women who have an abortion each year—a total of 65,000 women—suffer complications that require medical care but do not get treatment in a medical facility (Figure 3.4, page18).[23]

Inability to pay is the main reason women do not seek or obtain postabortion care

According to community respondents, the inability to pay is the primary reason that women do not seek postabortion care or delay obtaining treatment. Even if a woman reaches a hospital or health center, the facility may turn her away if she lacks the money to pay for treatment.[24] Another potential barrier is that some health centers are not able to treat abortion complications properly, so some women may be referred to another site, which could involve further outlays of money for lengthy travel and additional treatment.[25]

Fear of health care staff is another barrier

Some community members claim that hospital and clinic staff are sometimes hostile toward patients seeking treatment for abortion complications. These residents express the fear that health care workers might challenge women about their decision to end a pregnancy, or call for the women's arrest and imprisonment. Some practitioners are

*A woman is fertile for about 35 years (roughly from age 15 to 50) and the annual rate of treatment for abortion complications is 15 per 1,000 women aged 15–49. Therefore, if all other factors remain the same, and if relatively few women have more than one unsafe abortion for which they require treatment of complications, approximately 525 of every 1,000 women would be treated for complications of induced abortion during their lifetime (15 x 35 = 525).

Inability to pay is a major deterrent to obtaining treatment for abortion complications

In most of the health units, women have to pay for treatment.

—Urban traditional birth attendant, woman aged 49

There are clinics in this area but they require money. The nurses can treat you and care for you very well. If someone needs treatment for abortion complications, she can get it as long as she has the money.

—Rural woman, aged 50

She could have stopped a pregnancy and the provider told her to buy certain drugs to treat the complication. If she does not have any money to seek treatment, she delays to go for treatment.

—Urban focus group, women aged 36–49

Community Abortion Morbidity Study

said to mistreat patients with complications (by making them wait a long time for treatment, for example) or to question them harshly about what they have done before providing treatment.[26] However, having money improves a woman's chances of being treated well. In fact, a small proportion of clinic staff cite the ability to pay for care as a reason for treating patients well.[27]

The perception that certain health care workers treat postabortion patients badly is shared by some providers themselves. Although most community-based health care workers who were interviewed said that hospital and clinic staff treat women professionally and without prejudice, a minority said that either they themselves or other health care workers treat patients with abortion complications rudely, primarily because they do not approve of terminating a pregnancy.[28]

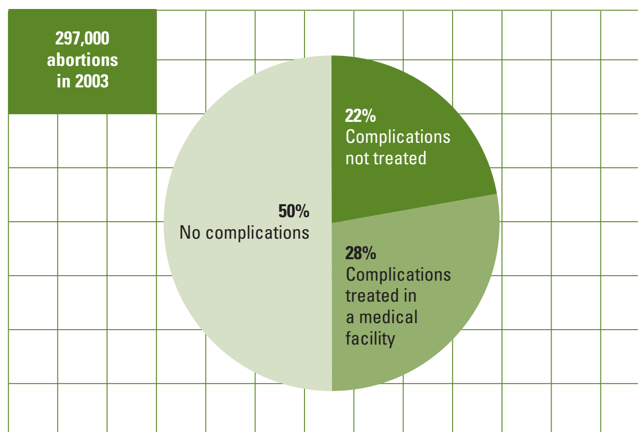
It should be noted, however, that it is likely that the constraints under which postabortion care is provided contribute to women's negative perceptions of providers. Overcrowding, understaffing and shortages of medical supplies make it hard for health care providers in most government facilities to give women with abortion-related complications the attention they need. It is also understandable that clients who may be in pain, bleeding or feverish would have difficulty understanding that poor conditions in health facilities, not just staff attitudes, affect the way they are treated.

Some of women's beliefs regarding the care they are likely to receive in health clinics echo the major theme of a recent study that examined why so many poor rural women in Western Uganda do not seek professional medical care when they give birth. Pregnancy in this part of the country is considered a test of endurance, and maternal mortality is generally viewed as a sad but not unusual event. Accordingly, many women consider going to a primary health unit or referral hospital only as a last resort. The study's authors concluded that the lack of skilled staff at the primary health care level, patient's complaints of abuse, neglect and poor treatment by health professionals, and women's poor understanding of the risks of home delivery all help explain the unwillingness of most rural residents to give birth in health facilities.[29]

Rural women are not alone in having difficulties negotiating Uganda's health care system. Another study, based on interviews with women who had almost died from pregnancy-related causes and were treated at Kampala's major teaching hospital, suggests that women's unfamiliarity with urban hospital systems and their social powerlessness may contribute to the high level of maternal mortality in urban Uganda.[30] If one considers the problems that these women had—even though pregnancy and childbirth have none of the stigma of induced abortion—it is hardly surprising that our own study found that many women with abortion-related complications do not seek care.

FIGURE 3.4

One in five Ugandan women who have an abortion experience complications that go untreated by medical professionals.



Source Reference 23.

Women often anticipate hostility from clinic and hospital staff

They abuse the women because stopping a pregnancy is killing a human being. They first accuse her and after that treat her.

—Urban woman, aged 42

Others just fear to go to the health care providers, thinking the providers will abuse them for stopping the pregnancy.

—Urban woman, aged 20

They have the problem of fearing to tell the providers what happened to them. They fear that they and the people who advised them to stop the pregnancy can be arrested. Women fear that if they go to hospital for treatment, they can be arrested and asked to reveal the people who helped them stop the pregnancies.

—Urban woman, aged 44

The health workers in the government hospitals are sometimes rude. I don't know why. The reason why we health providers in private clinics treat our patients well is because the customer is king. We have to handle them well because we need their money.

—Rural dispensary staff member, woman aged 25

Community Abortion Morbidity Study

Poor understanding of the health risks of unsafe abortion is also a factor

Community-based health care workers suggest that some women delay seeking care for abortion complications because they do not understand the importance of early treatment. Other women decide to try traditional remedies first or just hope that their symptoms will go away. Some women seek modern treatment only when other remedies have failed, when they are severely ill or when they are afraid they might die.[31]

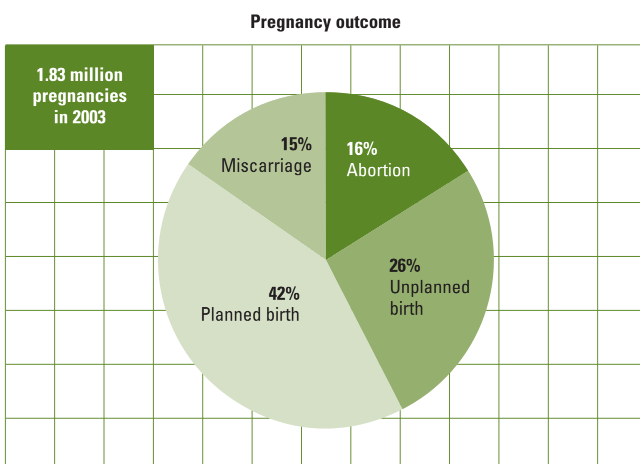
Unintended Pregnancy: The Root Cause of Abortion

Unintended pregnancy is the primary immediate reason that women throughout the world obtain abortions. A very small proportion of pregnancy terminations are carried out for health or other reasons. More often than not, however, induced abortion reflects a pregnant woman's decision that she is in no position to bear and raise a child at this point in her life.[1]

In Uganda, there are many reasons why a pregnancy may be unwanted. The woman and her partner may believe that they already have too many children[2] or that they are too poor to support a new child.[3] The woman may be in school,[4] unmarried, in poor health, or pregnant as a result of rape or incest.[5] She may have simply conceived at the wrong time.[6] In yet other cases, poor marital relationships,[7] sometimes involving physical or psychological abuse by partners,[8] are a factor.

FIGURE 4.1

Four in 10 pregnancies in Uganda are unintended.



Notes Percentages do not total 100 because of rounding. Unplanned births include births that were not wanted at all and those that were not wanted at the time of conception.
Source Reference 9.

Four in 10 pregnancies in Uganda are unintended

Now that we have a new estimate of the number of abortions that are performed each year in Uganda, it is possible to use this information to measure the frequency of unintended pregnancy. The 2000–2001 Demographic and Health Survey tells us the proportion of births in Uganda that women reported as unplanned—either mistimed or not wanted at all. Our assumption is that these unplanned births, and all of the abortions in our estimate, represent unintended pregnancies.

Overall, about 1.83 million pregnancies occur in Uganda each year.* An estimated 16% of these pregnancies end in induced abortions, 26% in unplanned births, 42% in planned births,

*Calculation of pregnancy intentions, numbers and rates involved several steps. We estimated the annual number of births by applying age-specific fertility rates from the 2000–2001 Uganda Demographic and Health Survey to the number of Ugandan women in each five-year age-group (within the age range 15–49) in 2003. (Population data come from the United Nations Population Division publication *World Population Prospects: The 2002 Revision, Vol. II*, New York: United Nations, 2003). We obtained the proportion of births that were unplanned—mistimed or unwanted at the time they were conceived—from the 2000–2001 Uganda Demographic Health Survey, and applied these to the estimate of the total number of births in 2003. To calculate the rate of unintended pregnancy for 2003, we combined the number of unplanned births and the number of abortions. The number of spontaneous abortions is estimated to be 20% of live births plus 10% of induced abortions, based on biological patterns identified in clinical studies (source: Bongaarts J and Potter R, *Fertility, Biology and Behavior*, New York: Academic Press, 1983). Information on whether pregnancies ending in spontaneous abortions were wanted is lacking, but a certain proportion would have been unintended. Because this proportion is unknown, our estimates of unintended pregnancy do not include any spontaneous abortions and are therefore underestimates.

A variety of factors contribute to unintended pregnancy

PROBLEMS WOMEN HAVE USING FAMILY PLANNING CORRECTLY

[Unintended pregnancy] happens if the woman decided to take pills only on the days she has sex [with a man].

—Urban focus group, women aged 50–60

MALE DECEPTION

A man can engage you in a serious relationship and you accept. But because you fear him, he can make you do whatever he wants. He tells you that he has already got a family planning injection that prevents him from impregnating women. Men usually deceive girls like that. You can tell him to use a condom and he refuses, claiming that he got a family planning injection, and you end up getting pregnant.

—Urban focus group, women aged 20–35

When I impregnated her, I knew I had. Because I went to her place and asked her for sex. She refused, claiming that she was in her unsafe period. I was burning with passion, so I convinced her that I was going to time [my ejaculation] and withdraw before ejaculation so that I don't impregnate her. When the time came for ejaculation, I failed to withdraw because I was enjoying myself.

—Rural male, aged 36

TRADITIONAL SEX EDUCATION INSTITUTIONS HAVE ERODED

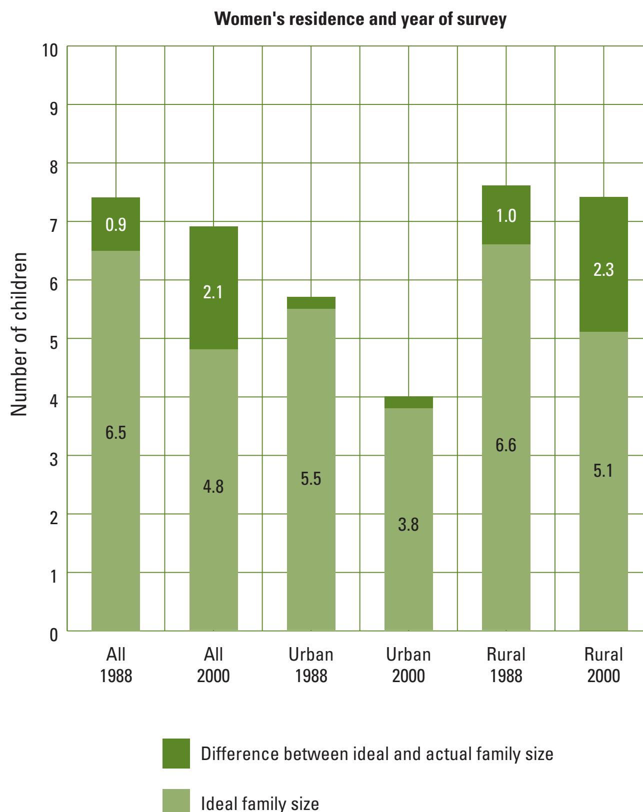
Those past days when we were in school, we used to have senior women who would help to counsel the girls. Even the *sengas* used to do their work of counseling girls, but these days it's worse. The girls are left to make their own decisions and end up getting accidental pregnancies.

—Urban focus group, women aged 36–49

Community Abortion Morbidity Study

FIGURE 4.2

Ugandans want smaller families, but the gap between ideal and actual family size more than doubled between 1988 and 2000.



Source Reference 17.

and 15% in spontaneous abortions (Figure 4.1, page 19).[9] This means that 42% of pregnancies in Uganda (the 16% that resulted in abortions plus the 26% that resulted in unintended births)—a minimum of 775,000 each year—can be classified as unintended). This analysis points to the fact that not all unintended pregnancies end in abortion: About 38% do,* and the remainder lead to unintended births.

Many circumstances in women's lives can lead to accidental pregnancies

The fact that four in 10 pregnancies in Uganda are unplanned can be partially understood in terms of the complexity and difficulty of many women's lives, interviews with community residents reveal.[10] First, many women appear to have difficulty using modern methods of contraception correctly, which increases their risk of contraceptive failure. In addition, a substantial proportion of Ugandan women do not use contraceptives at all because they believe that contraceptives are detrimental to women's health. Other themes also emerge from these interviews: the untrustworthiness of men, who sometimes sweet-talk young girls into having sex by falsely promising that they will protect them against pregnancy; the breakdown of traditional community- and family-centered methods of teaching young people about sexual matters (particularly the institution of *sengas*, or paternal aunts), leaving adolescents with fewer knowledgeable and supportive sources to guide them through their sexual lives; and, of course, poverty.[11]

Moreover, some Ugandan men have sexual partners other than their wives. In 2000–2001, one in five sexually active unmarried men aged 15–24 and one in seven married men aged 25–39 reported that they had had two or more sexual partners in the previous year.[12] It is likely that the true percentages are even higher, given that sexual activity is generally underreported in surveys. Women who become pregnant by men who are not their husbands may well consider these pregnancies unwanted.

In addition, some community respondents suggested that women and families affected by HIV/AIDS might consider pregnancies unwanted because they fear transmitting the infection to a newborn.[13] According to the 2004–2005 National Sero-Behavioral Survey, an estimated 7.5% of Ugandan women aged 15–49 are HIV-positive, and 440,000 women of reproductive age were living with HIV in 2005.

*The 297,000 abortions represent 38% of the 775,000 unintended pregnancies.

The prevalence of HIV among Ugandan women aged 15–34 is higher than that among their male counterparts, which underscores the higher risk of this infection among women in their prime child-bearing years (see box, p. 23).[14]

Undoubtedly, though, the fundamental reason for the high rate of unintended pregnancy in Uganda is the low level of effective contraceptive use by women who want to space their pregnancies or who do not want to have any more children.

Ugandan couples want smaller families than in the past

In 2000, Ugandan women averaged 6.9 children over the course of their childbearing lives, the same number as in 1995 and only slightly fewer than the 7.4 they averaged in 1988. However, their average ideal (i.e., preferred) family size declined substantially, from 6.5 children in 1988[15] to 5.6 children in 1995[16] and 4.8 children in 2000. This means that women are now having two more children, on average, than their ideal number—and that the gap between ideal and actual family size has more than doubled (Figure 4.2).[17] In Uganda's Eastern region, where almost half (47%) of all recent births are reported as mistimed or unwanted, the gap between the number of children women want and the number they have is even wider—2.6 children.[18]

The desire for smaller families reflects a number of trends in Ugandan society. First, it is becoming increasingly difficult for parents to support a large number of children, especially in urban areas and in families broken apart by the sickness or death of one or both parents (most often from AIDS, but in some cases from other illnesses or violence).

In addition, as women in Uganda are becoming more educated, their goals and values are changing. Not only do they want fewer children, but they are striving to give the children they do have better opportunities in life by providing them with more extensive schooling; a primary education is no longer sufficient for success in an increasingly modern world. The high cost of raising and educating children puts pressure on families to try to reduce the number of children they have.[19]

TABLE 4.1

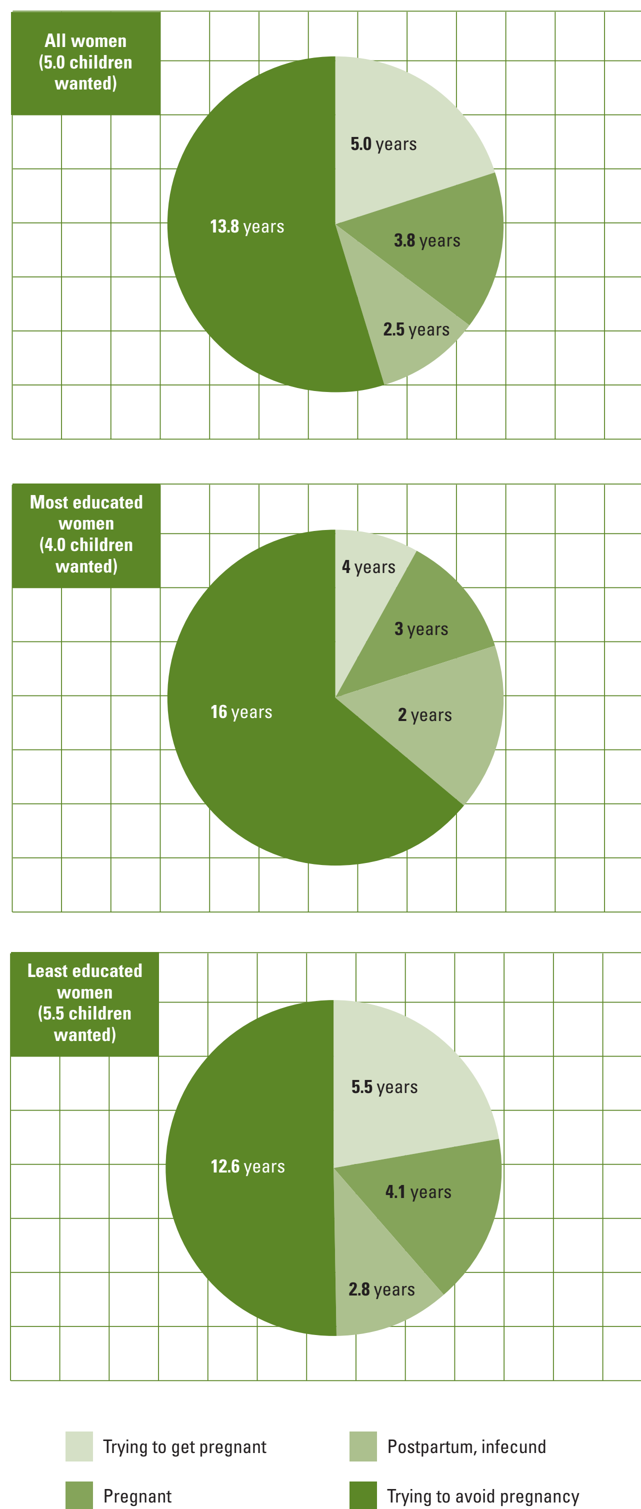
Percentage distribution of births, by wantedness, according to year

Intendedness of birth	% 1995	% 2000–2001
Wanted at this time	71	62
Not wanted at this time	21	24
Unwanted at any time	8	14
Total	**100**	**100**

Note Percentages are of births in the five years prior to the survey.
Sources **1995 data**—Reference 20. **2000–2001 data**—Reference 21.

FIGURE 4.3

The average Ugandan woman must spend almost 14 years using effective contraceptives if she is to avoid unintended pregnancies



Note Numbers may not total to 25 years because of rounding.
Sources Reference 22 and first footnote, page 22.

In 1995, women characterized 29% of their recent births as unintended—that is, not wanted now or at any time.[20] By 2000–2001, this proportion had risen to 38%, and the proportion of births that were unwanted ever had risen from 8% to 14%—a relative increase of 75% (Table 4.1).[21] The fact that a growing proportion of Ugandan women say that their recent births were unintended is striking evidence of their difficulty in planning the timing of their births and having the smaller families they now want.

Most women must spend many years trying to prevent pregnancy

Ugandan women say they want about five children. To achieve this goal, if women remain fertile and sexually active during the 25 years between the ages of 20 and 45, they will spend, on average, five years trying to get pregnant, almost four actually being pregnant and more than two years unable to become pregnant after a recent birth—for a total of about 11 years.* However, that leaves nearly 14 years during which they must try not to become pregnant (Figure 4.3, page 21).[22]

Highly educated women, who want an average of just four children, must spend even more time trying to avoid an unintended pregnancy—about 16 years. Even Uganda's least educated women, who want the largest families, have to spend almost 13 years successfully avoiding pregnancy if they are to have, on average, only the 5.5 children they say they want.[23]

Very few Ugandan women use modern contraceptives

To protect herself from unintended pregnancy over so many years, a woman must practice contraception. However, the use of effective contraceptive methods in Uganda is very low. In 2001, only 23% of married women of childbearing age were using contraceptives—14% a modern method and 9% a traditional method.† Among those who were unmarried but sexually active, 38% used a modern method and 6% a traditional method.[24]

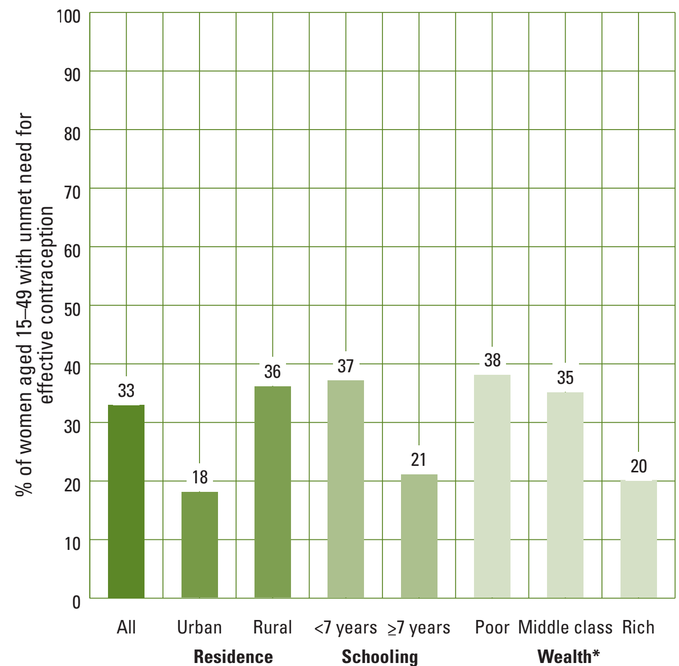
Levels of modern contraceptive use vary widely by region and residence. In urban areas, 38% of married women aged 15–49 used a modern method, compared with only 10% in rural areas. And in Northern Uganda, the country's poorest region, only 6% of married women of childbearing age were using a modern contraceptive method, compared with 26% in the relatively more developed Central region.[25]

*The concept underlying this analysis was suggested by Jane Menken, now at the University of Colorado. These are hypothetical estimates based on the assumption that it takes a woman one year to become pregnant (see Bongaarts J and Potter RG, *Fertility and Biology and Behavior*, New York: Academic Press, 1983), that each pregnancy lasts nine months and that in the absence of lengthy breast-feeding or postpartum abstinence, a woman is unable to conceive for six months following each birth.

†Traditional methods are withdrawal and all types of periodic abstinence. Modern methods, which are considered to be more effective than traditional methods, include the pill, sterilization, emergency contraceptive, injectable, IUD, condom and other barrier methods.

FIGURE 4.4

One in three Ugandan women of childbearing age have an unmet need for effective contraception.



*According to criteria outlined in footnote, page 7.
Source Reference 26.

Unmet need for contraception in Uganda is very high

Many Ugandan women of childbearing age who do not want to become pregnant are not using a modern contraceptive method. Data show that the unmet need for contraception—the proportion of Ugandan women of childbearing age who are fertile and sexually active, do not want a child soon or ever and are not using modern contraceptives—is now 33% (Figure 4.4).[26] Among women who live in rural areas, have little schooling or are poor, this unmet need is even higher (36–38%).

Distrust of modern methods of contraception is an important reason why levels of use are so low. When Ugandan women who say they want no more children were asked why they were not using a contraceptive method, 25% said that they were afraid of side effects or that contraceptives were inconvenient to use. A further 14% said that their partners were opposed to the use of contraceptives, and 13% said that they did not know where they could obtain family planning methods or that they could not get to a site that provides contraceptives. Five percent said their religion forbids the use of contraceptives.[27]

Several of these barriers to use reflect the inadequate availability of accurate contraceptive information and reliable services and the poor quality in general of Uganda's family planning programs. In addition, there are reports of shortages of contraceptive supplies in many health centers, a factor certain to discourage women from practicing family planning.[28]

Some aspects of the status of women may also help explain low levels of contraceptive use in Uganda. Gender inequity, sexual abuse and domestic violence are common,[29] and women often must defer to their husbands in decisions regarding the family.[30] Ugandan men tend to want larger families than their wives, which could influence women's contraceptive use.[31] In addition, many women lack the power to negotiate condom use with their husbands[32] and, to some extent, contraceptive use in general.[33]

Pregnant HIV-Infected Women in Kampala Are Ambivalent About Having Children

In the early 1990s, when Uganda's HIV/AIDS epidemic was at its height, an estimated 29% of pregnant women were HIV-positive. Since then, the proportion of pregnant women who are infected with HIV has fallen dramatically—to just 7% in 2004.[1] However, because an estimated 440,000 Ugandan women aged 15–49 are HIV-positive,[2] the reproductive and sexual health of HIV-infected women, including their access to and use of contraceptives and induced abortion, is of great importance. To examine these issues, an exploratory study was carried out in Kampala in 2004. The researchers conducted in-depth interviews with 38 HIV-positive women aged 18–35 who were enrolled in a health care and support program, as well as with 15 health workers who provided care to HIV-positive women.[3]

During these interviews, the HIV-positive women expressed a great deal of ambivalence about whether to have a child and a great many fears about abortion. Their health workers generally advised the women not to become pregnant. But once the women did become pregnant, the providers overwhelmingly discouraged them from seeking an abortion:

> One mother who really didn't want to be pregnant was surprised and shocked when . . . she was discovered to be pregnant. . . . I told her I could not do much about it. She was five months pregnant. . . . I told her that I am trained to preserve life and thus cannot authorize an abortion.
>
> *—35-year-old doctor*

> Many of them end up accepting the situation, because when options of abortion and the risks involved are discussed with them, they choose to maintain the pregnancy.
>
> *—51-year-old nurse-counselor*

> [T]he . . . mother said . . . that this man had got many women and that they were about seven women. So she was regretting [having a relationship with him], saying that "I don't think he will help me with this baby." But . . . I really counseled her and then took her back to her personal counselor and . . . made her . . . join the "mama club."
>
> *—35-year-old nurse-midwife*

The interviews also revealed how the HIV-positive women contracted and coped with their infection, and how the illness affected their reproductive health decisions:

- The majority of women said that sexual intercourse with their husband was the source of their infection.
- More than half did not know that they were HIV-positive until they were tested for the virus as part of prenatal care.
- All but six of the women had told their husband that they were infected. Those who had not done so attributed their reluctance primarily to fear of losing their husband; they knew of men who separated from their wives after learning that she was HIV-positive.
- The women said they were fearful and anxious about such matters as losing their job; not being able to find a job; physical illness and mental stress; marital problems; becoming a widow once their sick husband died; being unable to take care of their children; and the care and schooling of their children after they die.
- Nine out of 10 women had used a contraceptive method since learning of their diagnosis. The condom was the most commonly used method. Some women engaged in dual method use: condoms plus another type of contraceptive.
- Almost all of the respondents had had at least one pregnancy since finding out that they were HIV-positive. Most reacted negatively upon learning that they were pregnant, and half considered abortion, claims that were corroborated by the women's health care providers. The women's greatest concerns about being pregnant were how the pregnancy might affect their health and whether their future child would be infected with the disease.
- All of the respondents who considered abortion either were dissuaded from this action by their health care workers or decided on their own that abortion would put their health or life at risk.

> *Interviewer:* Did you think about abortion?
> *Respondent:* Yes, I thought about it but then changed my mind because I could easily have died in the process.
>
> *—32-year-old woman with four children*

> *Interviewer:* How did you feel after getting pregnant?
> *Respondent:* At first it was too much for me and I wanted to terminate it. But when I went to the counselor, she advised against it [and] instead told me about the Prevention of Mother-to-Child Transmission program. I joined when the pregnancy was one month.
>
> *—32-year-old woman with one child*

Continued

Although none of the HIV-positive women in the study terminated their most recent pregnancies, health care workers reported that some women with HIV do choose to have abortions, despite the workers' recommendations against the procedure.

> They come to you, their counselor, saying, "You see, I am pregnant and the only option I have is abortion." We talk about its dangers, but still they come back and tell you, "You see, counselor, I aborted and I am fine."
>
> *—27-year-old counselor*

Women related that almost all of the men who reacted negatively to their partner's pregnancy wanted her to have an abortion. Some tried to force her to do this by mistreating her or by denying responsibility for the pregnancy.

The majority of the HIV-infected women said that after learning of their diagnosis, they had reassessed the number of children they wanted. In some cases, they decided to have fewer children than they had planned; in other instances, learning their HIV status had strengthened their desire to have no more children. Most women, regardless of how many children they had, said that they would be very upset if they became pregnant again. Nevertheless, almost all reported that if they did conceive again, they would not have an abortion, citing reasons such as health concerns (including fears that abortion could lead to death or damage their uterus or bladder), religious convictions, the procedure's illegality, the lack of support they would receive and the hope that the child might not be infected with HIV.

The few HIV-infected women who did want more children said that this was because of pressure from their male partner, or that a newly married woman would have to have a child to satisfy her husband. The health care providers were aware of this pressure:

> I . . . talked to mothers . . . to find out why people who know [that they are HIV positive] decide to become pregnant. I . . . found out that mainly it was social and psychological issues. Social, in that at a certain age, like in our African setting, parents and everybody else is expecting someone to get married and get children, and even those who do not get married, they still ask them why they do not have a baby. So many of them get children to fit in the society.
>
> *—41-year-old nurse-counselor*

This exploratory study illustrates both the pressures that HIV-positive women in Kampala face if they become pregnant and their difficulties in making decisions about pregnancy and future childbearing.

Although many women with HIV do not want to have another child, almost all of the respondents in this study had had at least one pregnancy since their diagnosis. When these HIV-positive women became pregnant, most reacted negatively, and about half considered having an abortion. In some cases, pressure to have an abortion came from male partners. These thoughts of ending the pregnancy were counterbalanced by women's fear of health risks from unsafe abortion and the reluctance of their health care providers to help them obtain an abortion.

The study shows that to protect women from HIV and for HIV-positive women to have further control over their fertility and be able to avoid unintended pregnancy, men's expectations and demands must be addressed. Couples should be encouraged to communicate their childbearing preferences with each other to minimize discordance, and access to contraceptives should be improved to minimize inconsistent use and reduce women's vulnerability to unintended pregnancy. Although nine out of 10 women had used contraceptives since their diagnosis, the fact that so many of them had an unintended pregnancy suggests that providers need to spend more time counseling their clients on how to use contraceptives consistently and correctly. Given the relevance of these issues to the public debate on abortion, more research is needed on HIV-positive women's motivations and attempts to obtain abortions.

Key Findings, Obstacles And Recommendations

Levels of unintended pregnancy and unsafe abortion are extremely high in Uganda. Although many observers suspected that this was the case, based on research conducted over the past decade, findings from new national studies confirm that Ugandan women and couples are experiencing great difficulty in achieving their reproductive goals. Given the major impact that unsafe abortion has on women's health and survival, and its far-reaching consequences on children, families and the community, it is clear that these findings challenge policymakers to find solutions. The research results presented in this report are fundamental to the design of policies and programs that are necessary to reduce the incidence of unintended pregnancy, unplanned births and unsafe abortion, and to improve the reproductive health of women in Uganda.

Key findings

- An estimated four in 10 pregnancies in Uganda are unintended. This means that about three-quarters of a million Ugandan women become pregnant every year without wanting to have a child. And each year, an estimated 297,000 women end pregnancies by means of induced abortion—many using techniques that threaten their health and sometimes their life. The rate of maternal mortality in Uganda is among the highest in the world—and unsafe abortion may be responsible for a fifth of these deaths.

- Although induced abortion is largely illegal, services appear to be widely available throughout the country. Abortions are performed by members of the medical profession, including doctors, midwives and nurses, as well as by pharmacists, dispensers, traditional birth attendants and traditional healers. More than half (56%) of Ugandan women who have abortions go to doctors or nurses to end their pregnancy, one-fifth use any of a wide range of traditional providers, one in seven induce their own abortions, and a small proportion obtain abortifacient drugs from pharmacists or dispensers.

- Poor women are more likely than wealthier women to go to nonmedical providers for an abortion, although about half go to doctors and nurses. Conversely, about a third of wealthier women use pharmacists, traditional healers and other lay practitioners, or end their own pregnancies. The apparently wide availability of abortions performed by medically trained providers, the need for secrecy and the small difference in cost between abortions performed by nurse-midwives and those induced by traditional and unskilled providers are some of the factors that might explain these patterns.

- Women who end their own pregnancies or go to traditional providers are more likely than those who go to doctors, nurses or nurse-midwives to experience health complications. But some complications are believed to result from procedures performed by formally trained medical professionals. Inadequate training and experience, and unhygienic conditions, are among the reasons why the rate of complications is much higher for abortions performed by trained professionals in Uganda than for abortions performed by physicians in industrialized countries.

- In a given year, Uganda's hospitals, health centers and private midwives treat approximately 85,000 women for abortion-related complications. This number translates to a rate of 15 per 1,000 women of childbearing age being treated for complications each year. Much of this care has become the responsibility of Uganda's public sector hospitals and health centers, placing a substantial burden on the country's health care facilities—particularly

on government-owned hospitals, which already suffer from shortages of trained medical staff and supplies.

- Many women who experience complications do not or are unable to obtain treatment. Overall, only about six in 10 women with complications are likely to obtain postabortion care. This treatment is frequently not free, and many women cannot afford to pay for it. Other reasons that women may not obtain treatment include the fact that the medical facilities that offer postabortion care are often hard to reach; also, some women fear that seeking care in health facilities will expose them to legal prosecution; and health workers are often distrusted or considered unsympathetic or judgmental.

In summary, the conditions surrounding the practice of induced abortion in Uganda today are complex. Abortion is not legal except on the narrowest grounds, and there is strong social and religious stigma attached to it, yet the procedure is very common and health professionals as well as traditional providers are involved in its practice.

Obstacles to improving reproductive health care

There are a number of obstacles to improving reproductive health conditions in Uganda. From a policy standpoint, these barriers should be surmountable, because Uganda is a signatory to all of the significant international agreements of recent decades related to the improvement of reproductive health conditions and the status of women. These agreements include the 1980 Convention on the Elimination of All Forms of Discrimination Against Women, the 1994 International Conference on Population and Development Programme of Action and the 1995 African Charter on People's and Human Rights. As a signatory to the last document's Article 14 on Health and Reproductive Rights, Uganda pledged to "provide adequate, affordable and accessible [reproductive] health services, including information, education and communication programmes to women, especially those in rural areas."[1]

However, translating policy agreements into programs requires resources and commitment, and by and large Uganda's resources are woefully insufficient. The shortcomings in Uganda's reproductive health care system have already received a great deal of attention from health experts within the country, and the major problem—though by no means the only one—appears to a severe shortage of funding.[2] A recent analysis concluded that "inadequate funding, shortage of trained health personnel, an inadequate network of functional health infrastructure, and serious shortages in drug supplies are the biggest challenges in the health sector."[3]

In 2002, total per capita spending on health care in Uganda was estimated to be US$15 annually, and 60% of that total was accounted for by private, out-of-pocket expenditures rather than by government spending.[4] In the 1990s, a government decentralization program gave local districts the responsibility for providing all government services. However, observers believe that the consequences of this step have been troubling. These consequences include a reduction in the funding for health care relative to other government programs[5] and a drop in the proportion of health spending that goes to primary care (which would include family planning) as opposed to curative services.[6] It should also be noted that current reports on total government health care spending include the Ministry of Health's expenditures on HIV/AIDS programs.[7] Because HIV/AIDS programs receive a substantial proportion of the overall amount spent on health care, this accounting approach distorts and misrepresents the size of the budget for other areas of health care.[8]

Analysts have noted that inadequate funding for reproductive health care in Uganda contributes to a variety of problems: women's lack of access to proper medical care during the postabortion period;[9] poorly functioning health systems with weak referral mechanisms (especially during obstetric emergencies), inadequate capacity for the provision and maintenance of medical equipment, and poor management of drugs and contraceptives; and weak development and management of human resources.[10] In fact, government assessments show that 47% of health centers do not have any trained medical staff.[11]

More indirectly, some adverse reproductive health conditions in Uganda are exacerbated by such factors as the sense of stigma surrounding abortion;[12] cultural norms that support the entitlement of men to have multiple sexual partners;[13] inadequate male involvement in reproductive health programs;[14] the low status and limited decision-making power of women, especially with respect to contraceptive use;[15] and the widespread prevalence of myths pertaining to contraception.[16]

Recommendations

A broader public discussion about unsafe abortion is essential. More public attention to the issues of unintended pregnancy and unsafe abortion is greatly needed. The new evidence presented in this report provides, for the first time, a sense of the magnitude of the burden that unsafe abortion places on Ugandan society and also puts a human face on the statistics. It gives policymakers, health professionals, health advocates and all those concerned about the consequences of unsafe abortion the information they need to debate the issue openly, at the national, regional and district levels. It also reinforces the need for these same professionals to review the legal and medical grounds under which abortion may be allowed and, at a minimum, to establish mechanisms for implementing the criteria that currently exist.

Standards of postabortion care must be raised and coverage expanded. The limited resources available for reproductive health care in Uganda are a serious obstacle to reform. However, policymakers should be helped to understand the importance of providing postabortion care services, including family planning counseling,[17] that

follow established worldwide standards.[18] In addition to protecting the dignity, well-being and rights of women, justification for these services can also be made in terms of the savings that would accrue from reducing the need to treat the immediate as well as the long-term health problems associated with unsafe abortion.

The World Health Organization guidelines for postabortion care emphasize the importance of using manual vacuum aspiration, rather than D&C, to treat incomplete abortion during the first trimester. Improved and expanded training in manual vacuum aspiration is greatly needed in Uganda. Training in this technique should be made part of the curriculum for every medical practitioner who is likely to deal with women's obstetric needs. Midlevel medical personnel—private midwives and nurse-midwives—should also be provided with training and with the appropriate equipment for this purpose.

Some women seek postabortion care only when they are at risk of dying; others die because they did not receive the proper care even though it was sought early enough. A number of obstacles—financial, logistical and cultural—stand between women with life-threatening complications and the care they need. This is particularly true for poor women and those in rural areas. Most of the health facilities that offer high-quality postabortion care are hospitals, almost all of them located in urban areas. The expansion of comprehensive postabortion services to rural areas, where most Ugandans live, must become a priority.

Consideration should also be given to eliminating requirements that women have to pay for treatment of abortion complications in public hospitals and health centers. This will probably happen only when adequate public resources for the provision of postabortion care are made available.

Moreover, research shows that many women who need postabortion care are apprehensive about the disapproval and abuse they fear they will receive from health care workers in hospitals and health centers. Judgmental attitudes and behavior from professional staff have no place at health institutions, especially in circumstances in which women are particularly vulnerable and in need of compassionate care. For changes to occur in staff attitudes, there must be more training and greater community monitoring of health care services.

Improve access to family planning services. Uganda's Ministry of Health lists among its priority activities the provision of care during pregnancy, childbirth and the postpartum period; emergency obstetric care; contraceptive services; adolescent-friendly health services; and the encouragement of male involvement in reproductive health. These programs have been undertaken with the goal of reducing maternal mortality by 30% and increasing the prevalence of modern contraceptive use to 30%.[19] The country still has a long way to go to realize these goals.

Although many types of action are needed, reducing the number of unplanned pregnancies can best be achieved by addressing the lack and poor quality of contraceptive services in Uganda.[20] Despite government efforts to improve coverage, the availability of family planning services remains deficient: Many government health clinics do not stock a wide range of methods, contraceptive supply mechanisms are inadequate and there are not enough trained health workers to provide comprehensive family planning services.[21]

But family planning is not only a woman's responsibility. National information campaigns should be designed to reach community members—particularly men—in order to improve knowledge and understanding of contraception, increase men's willingness to use a method and foster their support for their female partners' contraceptive decisions. Couples should be encouraged to use effective contraceptive methods, offered guidance to help them choose the method most appropriate for them and counseled on its correct use and possible side effects. Further campaigns should be aimed at improving public knowledge about the consequences of unintended pregnancy and unsafe abortion.

Accurate information about contraception must be widely and effectively provided. Informational efforts should involve traditional and modern sources of communication and utilize all possible stakeholders, including community leaders and teachers, as well as those responsible for producing television programs, newspapers, magazines and popular songs. Some of these efforts could be tied in with existing HIV/AIDS prevention initiatives, an approach that might strengthen public awareness of the dangers of unsafe abortion and attract further support from policymakers and international donors.

Uganda already provides family life education in schools. However, a recent survey found that only 44% of boys and 50% of girls aged 15–19 had ever attended a sex education class or talk, and of these, one-third and one-sixth, respectively, said they had not done so before their first sexual experience.[22] To address this problem, policymakers at both the national and local level need to pursue a number of solutions, which may include increased training for teachers, providing sex education classes at earlier ages and ensuring that students are taught self-efficacy skills (an approach that is especially important for young adolescents). In addition, information programs that attract out-of-school youth must be strengthened.

It is hardly surprising that the annual abortion rate in Northern Uganda is estimated to be the highest in the country (70 per 1,000 women aged 15–49).[23] Since 1980, the Lord's Resistance Army, a rebel group, has imposed its presence in this region through violence, terror, rape and

Policies That Support Women's Education Are Key

Improving women's education is an important indirect strategy to reduce the prevalence of unintended pregnancy and unsafe abortion in Uganda. Experience from other countries has shown that improvements in women's education are associated with declines in the prevalence of early marriage, early childbearing and the desire for large families, and with increased levels of contraceptive use. In Uganda, this process is already under way. Four in 10 married women with seven or more years of schooling are using modern contraceptive methods, compared with one in six of those with only a primary education.[1] And the desired family size of these more highly educated women is smaller by two children.[2]

Very few girls in rural areas stay in school beyond the first six years, and the typical life course for young women—one that serves to perpetuate their disadvantage—is shaped largely by the belief that a woman's primary role in society is to marry and bear children. Fulfilling these expectations, half of all Ugandan women marry before they are 18 years old,[3] [0]and about one in four adolescent women have already had a child.

If a girl in Uganda is still in school when she becomes pregnant, she is, in most cases, automatically expelled. This national policy is currently being reviewed, and this reassessment may eventually lead to the development of ways to help girls remain in school, whether or not they continue the pregnancy to term.

Women's lack of schooling and power are not only linked to the lack of choice and dearth of alternatives to very early marriage and motherhood. They can also be seen in women's susceptibility to adverse rumors about modern contraceptives, to being easily intimidated by officious or judgmental health workers, to being subordinated to their male partners, and to being unable to find the few shillings they might need to travel to a nearby town that has a properly equipped hospital or to buy the antibiotics necessary to prevent or treat postabortion infection. Moreover, our research in the community found that health care providers often blame lack of education for women's inadequate or delayed use of health clinics to treat abortion complications.

intimidation. As a result, thousands of families have been displaced or broken up by deaths or kidnappings, many husbands have died or disappeared, rape is widespread and traditional sources of social and economic support for families are extremely fragile. In addition, most private midwives have left the region. Given the very high levels of induced abortion and abortion morbidity in the North, the need for improved reproductive health information and care is especially great in this part of the country.

The energetic public promotion of family planning services is just a beginning. Resistance to contraception among both women and men is deep-seated in Uganda. In many cases, distrust is based on incorrect information about the safety of modern methods or their long-term side effects, and on the absence or poor quality of information from health providers. However, Ugandan couples increasingly want smaller families and also want to space their children at healthy intervals. Thus, providers need to emphasize the importance of contraceptive use to achieving the childbearing goals of women and couples, with special attention to those who are HIV-positive.

Action is urgently needed on a number of fronts

The breadth of recommendations made here poses a daunting yet surmountable challenge for Uganda. It also allows for the involvement of a wide spectrum of concerned Ugandans. Policymakers, educators, religious leaders, journalists, health professionals, health planners, humanitarian aid workers, women's advocates and the donor community all have a role to play in efforts to reduce unintended pregnancy and the unsafe abortions that often follow. In an encouraging precedent, the prevalence of HIV in Uganda was reduced during the 1990s through just such a concerted effort by a broad-based cross-section of governmental and nongovernmental institutions and groups.[24]

Efforts should be made to improve Uganda's family planning information and service programs, increase financing for emergency obstetric services (including postabortion care), inform public discussion of the issue of unsafe abortion, improve sex education for adolescents in and out of school, and advance the education of women (see box), especially in rural areas. Education can help women understand the dangers of unsafe abortion, improve their status in the community and empower them to play a more active role in their own reproductive health—especially by adopting and effectively practicing family planning. In addition, initiatives to strengthen women's contraceptive decision-making must include strategies to improve men's attitudes toward family planning. Each of these approaches will help reduce the incidence of unintended pregnancy. Taken together, their impact could be decisive in reducing the scourge of unsafe abortion in Uganda.

Appendix

Methodology for estimating the incidence of induced abortion

To estimate the incidence of induced abortion in Uganda, we adopted a method devised for other country-level studies.[1] Briefly, we calculated the number of women treated for abortion-related complications each year in Uganda's formal health system, subtracted probable cases of spontaneous abortion (i.e., miscarriages) and then estimated the proportion of induced abortions that the remaining hospitalizations represent. This approach involved the following steps:

Estimating the number of women hospitalized for abortion complications

We used data from the Health Facilities Survey to estimate the number of women treated for abortion complications. For each hospital, health center and clinic in the study, an informant was asked whether the facility provided inpatient or outpatient treatment for complications of spontaneous and induced abortion. If it did, the informant was asked to estimate the number of women treated at the facility for complications of abortion (both spontaneous and induced) in a typical month and in the past month. These two numbers were averaged and the result was multiplied by 12 to produce an estimate of the number of women treated for any abortion complication at the facility in 2003. Our nationwide weighted estimate of women treated for any abortion complication was 109,926 cases.*

The next step was to estimate the proportion of these cases that involved treatment of complications from spontaneous abortions (using assumptions outlined in an earlier publication[2]) and to remove these cases from the total. This is necessary because the complications of spontaneous abortion are often similar to those of induced abortion and because the legal restrictions on abortion lead many women to report induced abortions as spontaneous ones.

Based on clinical studies on the biological patterns of spontaneous abortion,[3] we made the assumption that women who have spontaneous abortions relatively late in pregnancy—that is, at 13–22 weeks' gestation—probably require care at a health facility. (Although some women who have spontaneous abortions earlier in pregnancy seek medical care, relatively few are hospitalized. Pregnancy losses at 23 or more weeks are usually classified as fetal deaths, rather than as spontaneous abortions.) Spontaneous pregnancy losses occurring at 13–22 weeks' gestation (whether treated or not) account for 2.9% of all recognized pregnancies, and live births account for 84.8%; therefore, such spontaneous abortions are equal to 3.4% of all live births. We estimated the number of women in each five-year age-group (based on United Nations Population Division data for 2000 and 2005 for Uganda). We interpolated to obtain estimates for 2003, and then applied age- and region-specific percentage distributions of women (from the 2000–2001 Demographic Health Survey) to estimate the number of women in each age-group for each region. Applying age-specific fertility rates from the 2000–2001 Demographic Health Survey to the population numbers, we estimate that there were 1,254,812 live births and 42,789 late spontaneous abortions in Uganda in 2003.

Estimating the proportion of spontaneous abortion patients who received treatment

Further adjustment is needed, however, because not all women who have spontaneous abortions will receive treatment from a health facility. Hence, the number of women treated for spontaneous abortion in Uganda is actually less than our estimate of 42,789. One approach to dealing with this issue is to assume that the proportion of women with spontaneous abortions at 13–22 weeks who obtain treatment is similar to the proportion of women giving birth who deliver in a hospital (39%). However, because women in a high-fertility setting such as Uganda are probably more likely to seek medical care for a pregnancy complication (symptoms of spontaneous abortion) than for a normal event (delivering a baby), we assumed that women would be 50% more likely to obtain medical care for a spontaneous abortion than they would be to deliver in a medical facility. After taking into account regional differences in the proportion of births that take place in hospitals, we estimated that 25,168 women are treated each year in Ugandan health facilities for complications of spontaneous abortion. Subtracting this figure from the total number of women treated annually for induced or spontaneous abortion (109,926) yields an estimate of 84,758 women treated for complications of induced abortion.

Estimating the total number of induced abortions in Uganda

Women who receive treatment for complications of induced abortion represent only a fraction of the number of women who obtain abortions. This is because some women who have abortions do not experience complications, some experience complications but do not obtain medical treatment, some obtain care from an informal or private source rather than from a health facility, and some

*The number of women treated for complications of induced or spontaneous abortion includes 33,986 women treated in hospitals, 19,449 in level IV health centers, 37,414 in level III health centers and 19,077 in clinics run by private midwives, for a total of 109,926.

die before obtaining care. To account for these "invisible" abortions, we calculated a multiplier—the number by which the 84,758 cases of treated abortion complications must be multiplied to yield the total number of induced abortions performed in Uganda.

The multiplier was derived from information obtained from the Health Professionals Survey. Respondents to this survey were asked to estimate the proportion of abortions in Uganda performed by each type of provider. They also estimated, for each provider category, the proportion of abortion patients who were likely to experience complications and the proportion of women with complications who were likely to obtain care in an official health facility.

Because the conditions in which abortions are performed vary greatly according to a woman's socioeconomic status and place of residence, the above questions were asked separately for each of four subgroups of women: urban poor, urban nonpoor, rural poor and rural nonpoor. It is generally believed that better-off women, who are able to afford the services of trained medical professionals, are much less likely than other women develop complications serious enough to warrant hospitalization. On the other hand, poor rural women, who often rely on untrained practitioners using unsafe methods, have a much higher risk of developing complications that require treatment. Similarly, socioeconomic status and place of residence influence the likelihood that a woman who has complications will be able to obtain treatment.

After calculating the proportion of women in each subgroup who are likely to be hospitalized for complications, these percentages were weighted by the relative sizes of the four groups nationally to arrive at a multiplier for Uganda as a whole. From these computations, we estimate that 28% of women undergoing an induced abortion are likely to receive treatment for complications. The national multiplier is the inverse of this proportion: 3.5 (rounded from 3.54). Applying the multiplier to the 84,758 Ugandan women thought to be treated for abortion complications results in an estimate of 296,653 induced abortions performed each year.[4]

APPENDIX TABLE

Social, demographic and reproductive characteristics of women in Uganda, by region and residence, 2000–2001

Characteristic*	Total	Region				Residence	
		Central	Eastern	Northern	Western	Urban	Rural
SOCIAL AND DEMOGRAPHIC							
Religion							
Catholic (%)	40.4	40.5	32.3	58.5	37.3	39.8	40.5
Protestant (%)	40.5	36.2	42.9	29.6	50.4	34.0	41.8
Muslim (%)	13.1	19.9	17.0	9.5	2.2	21.5	11.4
Other (%)	6.1	3.5	7.7	2.3	10.1	4.7	6.4
Lives in urban area (%)	16.7	36.0	10.3	6.7	4.7	na	na
Has ≥7 years education (%)	28.4	46.0	23.8	12.1	21.1	61.8	21.7
Has any exposure to media (%)	54.6	76.4	50.0	26.0	49.7	85.7	48.4
Lives in poor household (%)†	38.0	17.4	41.7	70.7	39.9	1.8	45.3
REPRODUCTIVE							
Wants a child later (%)‡	39.8	39.5	37.6	42.0	41.4	37.3	40.1
Wants no more children (%)‡	38.5	41.5	39.1	32.5	38.6	42.7	37.9
Uses modern contraceptive (%)‡§	14.0	26.2	9.3	6.0	11.3	38.2	10.4
Among women aged 15–19, % who have begun childbearing	25.6	25.8	29.7	30.4	17.5	18.8	27.2
Means							
No. of births**	6.9	5.7	7.4	7.9	6.9	4.0	7.4
No. of children desired	4.8	4.4	4.8	5.6	5.1	3.8	5.1
Medians							
Age at first sex††	16.7	16.7	16.1	16.5	17.5	17.0	16.6
Age at first marriage††	17.7	18.2	16.9	17.1	18.0	19.7	17.3
Age at first birth††	18.5	18.7	18.1	17.9	19.1	19.9	18.3

*Among women aged 15–49 unless otherwise indicated.
†Poor is defined as having a household income in the lowest two quintiles nationally.
‡Among currently married women aged 15–49.
§Includes the pill, IUD, injectable, emergency contraceptive, sterilization, condom and other barrier methods.
**Total fertility rate.
††Among women aged 20–24.
Note na=not applicable.
Source Special tabulations of Uganda Bureau of Statistics and ORC Macro, *Uganda Demographic and Health Survey 2000–2001*, Kampala, Uganda: Uganda Bureau of Statistics and Calverton, MD, USA: ORC Macro, 2001.

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Box: Policies That Support Women's Education Are Key

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