Abortion Morbidity in Uganda: Evidence from Two Communities

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Executive Summary

The Community Abortion Morbidity Study was an exploratory qualitative study examining community perceptions of abortion morbidity experience among residents of Kampala and Mbarara districts in 2003. The data came from eight focus group discussions with women aged 18–60, 82 in-depth interviews with women aged 18–60 and men aged 20–50, and 33 in-depth interviews with health care providers (HCPs).

This report presents evidence on reasons for the occurrence of unwanted pregnancy, abortion practice, health problems women experience as a result of stopping a pregnancy, actions women take to obtain treatment, the barriers they face in obtaining treatment, and the social and economic consequences of abortion.

Unintended Pregnancy

Most respondents perceived unintended pregnancy to be a common occurrence in their community. The perception among the respondents was that unintended pregnancies occur most often among schoolgirls, maids, young women, unmarried women, widows and prostitutes. Unintended pregnancies are attributed to a breakdown in traditional paths of knowledge transmission because young girls no longer receive instruction on sexual matters as they did in the past; barriers to contraceptive use including men's perceptions of the serious side effects of modern contraceptive use and their unwillingness to use contraceptives; inconsistent family planning use out of ignorance or unwillingness perhaps fueled by the perception that women get pregnant even when they are using family planning methods; and the vulnerable position women are in, which compromises their ability to avoid unwanted intercourse.

The primary reasons given why women may not want a pregnancy are if the young woman is in school, the male denied paternity, the pregnancy is a product of adultery or the couple is poor. These reasons suggest that it is not just the groups specified above who are vulnerable to an unwanted pregnancy, but that many women are vulnerable.

Abortion: Spontaneous and Induced

All respondents perceived spontaneous abortions to happen relatively frequently in their community, and this phenomenon was primarily attributed to malaria, syphilis or previous use of contraceptives. The most common symptoms witnessed by HCPs among women who had had spontaneous abortions were severe abdominal pain and excessive bleeding, while complications from spontaneous abortions named by HCPs included serious fever, weakness, anemia and death. Self-treatment for spontaneous abortions was done first via herbs and if those were unsuccessful, they might be followed by drugs/tablets. Most HCPs said that women are usually unsuccessful or only sometimes successful at self-treating spontaneous abortions.

All HCPs reported that they prefer to refer a woman experiencing a miscarriage to a clinic or hospital. However, lack of money was given by all respondents as one of the reasons women do not get care from modern facilities. Even with modern medical care, traditional healers continue to play a role in the provision of health care because some community member respondents perceived traditional healers as able to address the causes of miscarriage. To the extent that respondents were reluctant to talk about induced abortion, these findings may be applicable to experiences of induced abortion.

Stopping a pregnancy is perceived to be a fairly common occurrence, primarily among schoolgirls, despite the difficulties and health consequences associated with obtaining an abortion. Traditional methods are perceived to be most commonly used to attempt to stop a pregnancy, but also tend to be less successful compared with modern methods. The perception held by the respondents was that more women are having abortions today than in the past because of the prevalence of HIV and because it's harder to look after children today.

The majority of men were not supportive of women's desire to stop a pregnancy and did not think that men in the community should be supportive. An

exception was made for schoolgirls, "helpless" women, women whose partner cannot support her and the future child, and house girls made pregnant by married men.

Abortion Complications and Treatment

The main causes of abortion complications were the use of herbs and delays in seeking care for minor complications which develop into serious complications. One of the primary reasons mentioned as to why women delay seeing care for abortion complications is because they did not have money to pay for the services. Fear of negative provider attitudes were also mentioned as a major reason why women delay seeking treatment for abortion complications. Most women are perceived to eventually seek treatment for abortion complications in a modern facility, primarily hospitals. Yet because many women wait until they have severe complications before they seek care, the majority of respondents stated that abortion complications frequently resulted in death.

The community members were divided on whether women need permission from the husband to seek health care. Those who felt that women do not need permission said that she did not because that could lead to a delay in seeking treatment with possible harmful health consequences. The most common reason given by both men and women for why the husband is told about seeking health care was to be able to secure financial assistance from him.

Social and Economic Consequences of Abortion Morbidity

Women are typically not able to keep their abortion a secret. Once their secret gets out, the community reaction, including that of the partner involved in the pregnancy, is strongly disapproving and may include ridicule and abuse.

Abortion complications were perceived to place a heavy burden not just on the individual, but also her family and her community. The greatest economic impacts of abortion morbidity cited by the respondents are the income lost while the woman is unable to work, the man's time off to care for the woman and/or the money spent on treatment. Women's daily activities, such as lifting and fetching water, are perceived to be greatly impacted by abortion complications and women may be unable to perform their usual daily activities for a few days up to half a year.

Policy and Program Implications

• *Improve contraceptive use through public education.* The widespread perception of the high prevalence of unintended pregnancies and abortion indicates a dearth of the proper use of family planning methods. Misconceptions about contraception are likely playing a part in depressing the country's low contraceptive use rate. Counseling and family planning services should be made available at postabortion care facilities, maternal-child health centers and family planning clinics. One strategy could be to stress to men the advantages of family planning for child spacing, as well as for the health of women. Educational efforts that provide accurate information on contraceptive effectiveness, including possible medically verifiable side-effects would help individuals make more informed contraceptive decisions. Mass media could also be used to disseminate information. Brothels, or any place that sex workers congregate, should be a distribution point for contraceptive education and services.

Since imperfect contraceptive use is a reality and more likely to occur when the sex is unplanned, including in coerced or forced sex situations, emergency contraception should be made available so as to be able to avert an unintended pregnancy.

Schoolgirls are perceived to be the group most at risk of experiencing an unwanted pregnancy and having an abortion. Comprehensive sex education that is developmentally appropriate, provides information on how to protect oneself from pregnancy and teaches skills to help girls negotiate contraceptive use would be a step toward providing young people with the tools necessary to help protect their sexual and reproductive health.

The provision of youth-friendly contraceptive services should be increased. These services could be provided via the existing network of public and private NGO health facilities and other places likely to be convenient for young people, including schools, discos, teenage/youth centers or any other places that young people congregate.

• *Promote better postabortion care*

Education to recognize the signs of spontaneous or induced abortion complications should be provided so that necessary health care can be sought promptly. The consequences which men and women should be taught about include the potential threat that these complications pose to the woman's future fertility and possibly to her life. Individuals should also receive information on the potential risks and consequences of seeking care

from untrained providers. Patients' perceptions of providers' negative treatment of women who present with abortion complications need to be dispelled—a step that would possibly help women with complications seek medical care faster and reduce barriers for women who might otherwise not seek care at all.

Efforts should be made to ensure provider skills in methods that they may employ to treat women with incomplete abortions (such as manual vacuum aspiration). Lower-level staff should be trained to provide treatment for less severe complications. Everything possible should be done to remove cost barriers for postabortion care.

• *Reduce demand for unsafe abortion*

In Uganda, abortion can legally only be performed to save the life of the mother; the enforcement of this prohibition drives women to resort to unsafe abortion. Until safe abortion is recognized as a public health priority, women and their families will continue to suffer the otherwise preventable health, social and economic consequences of abortion morbidity.

Chapter 1
Introduction

Overview

According to national law, abortion is illegal in Uganda except to save the life of the mother. Very few abortions are performed legally under this rule. Nevertheless, the practice is quite common: About 300,000 induced abortions occur annually among Ugandan women aged 15–49, a rate of 54 abortions per 1,000 women aged 15–49.[1] Since this procedure is highly restricted by the law, a large proportion of these abortions are carried out clandestinely and by unqualified providers. Therefore, complications including death are not infrequent. While the actual level of abortion morbidity and mortality in Uganda is unknown, a number of studies provide partial information. A 1993 study carried out in three Kampala hospitals found that one in five maternal deaths were a result of unsafe abortion, making unsafe abortion one of the leading causes of maternal mortality in Uganda.[2] In the mid-1990s, a study in Uganda with obstetrician-gynecologists who provided postabortion care in four major hospitals estimated that 2,000 incomplete abortions were treated annually in their facilities.[3] In 2000, the national maternal mortality ratio was estimated to be between 527 and 880 maternal deaths per 100,000 live births.[4] The most recent study available indicates that about 85,000 women (or 15 of every 1000 women of reproductive age) receive treatment for complications from induced abortions in Ugandan health facilities each year.[5]

Uganda is one of the poorest countries in the world with a per capita annual income of US$280.[6] More than 80% of the population lives in rural areas. There is a shortage of medical personnel in the country (one doctor for every 18,700 people[7]), due to a lack of educational opportunities and "brain drain" to first world countries.[8] This shortage is more pronounced in rural areas.[9] The limited accessibility to health services can make it difficult for Ugandan women to meet their reproductive health needs. The average family size is about seven children per woman; however, the ideal family size is lower (5.6 for men and 4.8 for women).[10] Although contraceptive use is still low (23% of currently married women were using a method in 2000–2001), more than half of married women and almost one-fifth of unmarried women do not want to have a child soon or do not want to have any (more) children.[11] The level of unmet need for effective contraceptive methods in the country is high (45%).[12]

Abortion in Sub-Saharan Africa

Reasons given for having an abortion are similar across studies conducted in Sub-Saharan Africa. Having too many children already, having already reached their desired number of children and poverty are the primary reasons given by women for having abortions.[13] Kinoti et al. (1995) and Kasolo (2000) found that in addition, being unmarried, having children who are too close in age, having conceived at the wrong time, being in poor health, or having become pregnant as a result of rape or incest were common reasons. Mirembe (1996) found women's desire to continue with their education a prevalent reason among her Ugandan study population.[14] In a district with a high level of HIV, Kinoti et al. (1995) found that women cited being HIV-positive as a reason to end the pregnancy.[15] The Sedgh et al. (2006) study mirrored some of the Ugandan studies' findings: Women had abortions to stop having children and because they were unmarried. The Sedgh et al. study also found that women often cited being in school, being too young, having a partner who did not want the pregnancy or no longer having a partner as other reasons for having an abortion.[16] The Oniang'o (1996) study respondents in Kenya gave as reasons for having abortions that they were not ready for marriage, did not want a baby, their father was too harsh, they wanted to continue their education, their boyfriend was not ready for marriage, and their boyfriend had left; this study focused exclusively on adolescents, which may be why her respondents' reasons are slightly different than the other studies' findings.

In one of the few studies done with men in Africa about abortion, Nyanzi et al. (2005) interviewed 40 *bodabodamen* (motorcycle taxi drivers) in Uganda about their experiences with and attitudes towards abortion. Almost half of their sample had partners who had experienced an abortion; the partners were mostly adolescent women who were students.[17] Although abortion was seen as a sin, it was also seen as a reprieve for the man, possibly allowing him to continue living where he is and continue to work at his current job (the implication being that if he were in danger of being convicted of defilement—sex with a minor—he could flee or go to jail); a way out for an unmarried female, especially one who has the possibility of continuing in school; a way to bring stability to a marriage for women who may have conceived with a lover; and a way for sex workers to continue to work.

Nyanzi et al. (2005) found that their respondents played an active role in facilitating the procurement of abortions (by identifying providers, providing transport and supplying money for the services or for postabortion care) when the social consequences of it becoming known that the male had been sexually active with that woman were potentially severe. When the woman was already known to be sexually active, was married, had a child or was seen as promiscuous, men's willingness to help carry out an abortion dropped off precipitously.

Where women seek abortions in Uganda is determined in part by place of residence and access to income which in turn determine, at least in part, the safety of the abortion. In a 2003 purposeful sample of health professionals with expertise in postabortion care (n=53), 96% stated that nonpoor women seek abortions from formally trained providers: physicians, clinical officers or nurses/midwives, while poor women attempt to self-induce or go to traditional healers.[18] Dilation and curettage (sharp curettage) is the most common method of abortion in urban areas while vacuum aspiration, "oral hormones"* and the insertion of objects into the uterus are thought to be used less frequently. Herbs and the introduction of objects into the uterus were perceived to be the most commonly used methods to induce abortion in rural areas. These same respondents believed that dilation and curettage was the most commonly used method among physicians to carry out an abortion in both urban and rural areas, while nonphysicians were perceived to rely mostly on hormonal drugs, herbs and sharp objects. The professionals thought that women were most likely to self-induce abortion with herbs.[19]

The health complications resulting from unsafe abortion are a serious health burden for women, their families, their communities, the health care system. A study of abortion cases in Mulago Hospital, Kampala, between 1983 and 1987 found that the most common problems presented by women who had had abortions were sepsis, hemorrhage and genital track trauma.[20] A 1994 study in four hospitals in Uganda found that the most commonly reported abortion complications were hemorrhage, infection (sepsis), uterine perforation and cervical injury—in that order.[21] Three-quarters of health providers surveyed in 2003 said that sepsis or septic shock and excessive blood loss are common abortion complications while half stated that uterine damage and infertility are common complications. One-third cited death.[22] A 2003 survey with key informants from a nationally representative sample of health facilities that treat postabortion complications estimated that 85,000 abortion complications from induced abortions are treated annually.[23]

Many factors may cause women not to seek treatment or delay seeking treatment for abortion complications.[24] The social stigma surrounding abortion in Uganda makes it very difficult for any woman to reveal that she has had an abortion. This need to maintain secrecy is a barrier to seeking assistance for women with abortion complications. Furthermore, traditional expectations which regard pregnancy as a test of endurance do not support women seeking care for pregnancy-related problems,[25] even though women may be more likely to seek health care for an illness (abortion complications) than for what is expected to be a healthy event (delivery). Lack of access to financial resources to pay for medical care or transportation to the health facility can also hinder women's ability to seek care.[26] Anticipation of abuse by medical personnel treating postabortion complications further discourages women from accessing medical care.[27]

Rationale and Objectives

Much remains unknown about the health-seeking behavior of women who abort: Do they, in fact, seek help to abort or do they try to self-induce? If they do seek care, from whom do they seek care? How long do they wait until they seek care if they are experiencing abortion complications? What are the socioeconomic and health consequences for those women who do not seek care for abortion complications or who delay in seek-

*While this is not an abortion method, it was named as such by the respondents.

ing care for their abortion complications? What is the extent and the impact of abortion-related morbidity on the lives of women and their families? In an attempt to gain purchase on these questions, the Guttmacher Institute, in collaboration with an in-country research consultant, Gabriel Jagwe-Wadda of the Faculty of Social Sciences, Department of Sociology, Makerere University, carried out the Community Abortion Morbidity Study (CAMS), an exploratory qualitative research project with the intention of gathering information on the morbidity experience of women who have had health complications resulting from unsafe abortions and who do not seek/obtain medical care in a modern health unit or hospital.

CAMS is one component of a larger research project titled, Documenting the Incidence and Impact of Unsafe Abortion: An Investigation for Uganda. The overall goal of the research project is to provide information to fill knowledge gaps and enable governments, international agencies, health professionals and nongovernmental organizations to deal more forthrightly with the abortion issue in Uganda. Other components of the project include (a) an examination of the conditions of abortion and of postabortion care and an estimation of the level of abortion incidence, based on two surveys, a Health Facilities Survey (HFS) and a Health Professionals Survey (HPS); and (b) an exploratory study of the pregnancy intentions of HIV-positive women.[28] The project began in 2002 and fieldwork for the CAMS, the HFS and the HPS was completed in 2003. The HIV study was fielded in 2005.

This report draws on data collected via in-depth interviews and focus group discussions with women and men who reside in the study communities and health care providers in the same districts. The interviews provide insight into

- the perceived prevalence and causes of unwanted pregnancy in the community;
- how women deal with an unwanted pregnancy;
- among those who choose to have an abortion, what they do, where they go and whom they see;
- the type of complications women commonly experience, and perceptions about how these vary according to the type of provider;
- how women deal with abortion complications;
- women's reasons for preferring particular providers;
- women's reasons for delaying seeking care;
- short- and long-term health and social consequences of abortion complications; and
- the social and economic costs of abortion complications.

Report Structure

Throughout the report we highlight differences and similarities among and within groups. After the study's methodology is presented, findings appear as follows: unwanted pregnancy, spontaneous and induced abortion practice, abortion complications and treatment and, finally, the social, economic and health consequences of abortion. A summary of the chapter's most critical findings are presented briefly at the end of each chapter. Recommendations for policymakers and program planners are included in the conclusion.

Chapter 2

Methodology

Collecting accurate information on abortion in Uganda is difficult as abortion is legally restricted. To identify reasons for having abortions, how women go about obtaining abortions, common complications which can result from unsafe abortion, how and if women obtain treatment for their complications, and the social, economic and health consequences of unsafe abortion, qualitative data were collected using instruments developed for the Community Abortion Morbidity Study (CAMS).

Study Areas

To provide representation from both urban and rural contexts, the study was conducted in two of Uganda's 56 districts: Kampala, an urban district and the capital city of Uganda, and Mbarara, a largely rural district. One subcounty/division was selected at random within each of the two selected districts. Within each subcounty, two parishes were selected. Efforts were made to recruit people from relatively well-populated areas to reduce fears associated with being identified as having participated in the study. In Kampala district, Rubaga division was selected and in that division, Kasubi and Namugoona parishes were selected. In Mbarara district, Birere subcounty, and Kikokwa and Kisulo parishes were selected. In both districts, the leadership of the community was cooperative and gave the research team all necessary assistance.

Study Design

To obtain information from a range of perspectives, the respondents were women of reproductive age (18–49), as well as women no longer of reproductive age (50–60), men aged 20–50, and health care providers who operate within the study communities (see Table 2.1). Respondents younger than 18 were not included in the study, since obtaining informed consent from the parents or guardians of minors was seen as a formidable barrier due to the extremely sensitive nature of the information being collected.

Focus group discussions (FGDs) were also carried out with women. The groups were formed to have age homogeny to increase the probability that the participants would feel comfortable participating in the discussion. The four focus groups consisted of women aged 18–25, 26–35, 36–49 and 50–60, and were conducted in both field sites, rendering a total of eight (see Table 2.2). Each FGD had between 8 and 12 participants.

Forty-two in-depth interviews (IDIs), 21 from each district, were carried out with women aged 18–49 because this group of women was currently at risk for experiencing unintended pregnancies and so they or their peers may have had abortions and experienced abortion complications themselves in the not-too-distant past. An additional 19 IDIs were carried out with women aged 50–60 to collect data on their daughters, other relatives or other women in their community who have had unsafe abortions and who may have suffered consequences from a lack of medical care or delays in obtaining care, and on whether abortion availability is at present different than it has been in the past. Because men can play an important role in women's decisions to have an abortion, as well as their access to abortion-related care,[29] and because the consequences of abortion may have far-reaching effects on the family, 21 IDIs were conducted with men aged 20–50 about the abortion experiences of their wives, female relatives and other women in their communities. Within this IDI sample, the men were better educated than the women, and most of the sample was married/in a union and Christian (see Table 2.3).

IDIs also were carried out with health care providers (HCPs) because they are knowledgeable about the kind of abortion complications that occur, the health consequences that result and the kind of care that is given. No HCPs were recruited on the basis of having performed abortions. The purpose of the HCP interviews was to get their opinions about and perceptions of abortion morbidity in the community. A total of 33 IDIs were held with health care providers (see Table 2.4).

Six of the respondents were midwives, seven were nurses and four each were in the following professions: medical doctors, dispensary personnel (staff of varying qualifications at a parish-level health center), drug shop pharmacists, traditional birth attendants and traditional healers. Only three HCPs interviewed were hospital-based providers. While many of the respondents treated different aspects of postabortion care, none of them specified this as part of their primary responsibilities. (For a list of their primary responsibilities, see Table 2.5.) Most of the health care providers were female. The majority were older than 25. By virtue of their profession, most had at least a secondary education.

Issues Addressed and Interview Guides

While the FGDs were designed to elicit perspectives on societal norms and expectations about abortion-related issues, the IDIs were designed to obtain detailed information by way of face-to-face, one-on-one conversations about abortion experiences with which the respondents were familiar. Altogether, the following five sets of guides were designed (available from the authors upon request):

- focus group discussion guides for women aged 18–49;
- focus group discussion guides for women aged 50–60;
- semi-structured in-depth interview guides for women aged 18–60;
- semi-structured in-depth interview guides for men aged 20–50; and
- semi-structured in-depth interview guides for community health care providers.

The FGDs focused on respondents' perceptions about the process of obtaining an abortion, the social and economic consequences of undergoing an abortion, and health complications due to unsafe abortions, including when women do not seek or obtain health care in a formal health facility. FGDs with 18–25-year-olds were intended to capture perceptions of abortion experiences among younger women who are generally believed to be more likely to have an abortion than older women. The FGDs with 50–60-years-olds discussed their opinions and experiences of abortion in the past compared with the present.

All of the IDI guides explored the following themes:

- the prevalence of unwanted pregnancy and abortion practice;
- health complications that women experience as a result of terminating pregnancies;
- actions women take when they experience abortion complications;
- health consequences women experience when they stop a pregnancy and do not obtain care or delay getting treatment for their complications; and
- economic and social consequences women experience for having an abortion.

The IDIs held with members of the community were designed with the expectation that in a non-purposeful community sample, only some respondents would have experienced abortion (or their partners would have experienced abortion) and even fewer would be willing to talk about it. Therefore, the interviews did not only ask about respondents' personal experiences with abortion but also about their friends' experiences and those of other community members. Women aged 50–60 were asked to compare abortion experiences during their own childbearing years with present abortion experiences with which they were familiar. Men were asked about men's reactions to women who want to have abortions, men's role in helping women have abortions, how men are affected by their partners' having an abortion, and what men could do to help women avoid unwanted pregnancies and health complications from unsafe abortion. The interviews with health care providers asked how they have handled being asked about abortion by their patients and how women are likely to be treated by health care professionals when seeking care for abortion complications. The health care providers were not asked if they personally had provided abortions.

Preparatory Activities

Pretesting

A pretest of the FGD and IDI guides was conducted in Katabi subcounty, Entebbe subdistrict, Wakiso district, between July and August 2003. A total of 12 IDIs with women aged 18–60, and two FGDs (one with young women aged 18–25, and one with adult women aged 26–49) were conducted.

Selection and training of field staff

For each district, the research team was comprised of a screener and two field interviewers (who were also the moderator and note-taker for the focus groups). The screener's job was to identify eligible respondents. Due to language diversity in the regions where the data were collected (Luganda being the primary language spoken in Kampala, and Runyankole the primary language

spoken in Mbarara), different screeners and field interviewers were recruited for each district. Six of the field team interviewers were female and one was male. The male interviewer only interviewed male HCPs, since female interviewers had greater facility in getting male community members to speak to them about abortion. All of the interviewers were graduates from the Department of Sociology, Makerere University, with backgrounds in social science research methods and field experience in qualitative data collection.

Fieldwork and Data Collection

Process for screening and selecting study participants

To enter the study sites, the Principal Investigator wrote a letter of introduction on behalf of the CAMS Coordinator, attaching copies of all relevant clearances from the Ministry of Health and the National Council of Science and Technology. These letters were presented to the resident district commissioners, who in turn gave permission to the research team to enter the area. The commissioners introduced the study teams to the subcounty parish chiefs and security officers at the local levels. In each study site, permission was obtained from the subcounty and parish chiefs or parish Local Council (LC) chairpersons or their representatives. The parish chiefs are LC chairpersons, who are the gatekeepers at the community level who guarantee the security of outsiders within the community. Once permission was obtained, the parish chief or the parish LC chairperson recommended women counselors to work with the research team as field guides. Given that the counselors were familiar with the LC zones and villages in the study parishes, they accompanied the research team to the LC zones to select and recruit respondents.

With assistance from the women counselors who knew the residents, the coordinator arbitrarily identified potential respondents. After identifying the potential respondent, the coordinator used the screener (see Appendix A) to determine eligibility, explained the purpose of the study, and reassured respondents that the study was aimed only at seeking their views, opinions, and perceptions regarding the topic, not incriminating anyone. Respondents were also assured of confidentiality, that their views, opinions or thoughts expressed in the interview would only be used for the intended purpose of the study. They were also told that their last names were not required and that their first names were only to be used until numbers were assigned to the tapes, which was done at the end of every day.

More health care providers refused to participate in the study than men and women community members. Providers in rural areas were more hesitant to participate than those in urban areas. The majority of HCPs who refused did so because they did not want to be associated with abortion.[30] When this occurred, the fieldworker explained more about the study to the potential respondent and reiterated how the respondent would be protected from any perceived social harms of participation. Most of the time, after learning more about the justification and intention of the study, the HCP would agree to participate. There was no difference in the refusal rate between Mbarara and Kampala among the HCPs. The research team went from one LC zone/village to another using the same selection procedure.

Among the women IDI respondents, fewer than one in 10 refused to participate. The refusals were from women who were engaged in an activity at the time they were approached, such as attending to a shop or farming. In addition, there were a smaller number who were wary of engaging in the topic of inquiry, possibly because of the stigma surrounding abortion. A number of other potential respondents who refused did so because of a lack of interest in the whole exercise, fear associated with being tape-recorded (see "Challenges During Data Collection" below) and fear of the legal implications that they perceived were associated with participating in a study on a mostly illegal practice.

Getting informed consent

Once a willing potential respondent had been identified, the coordinator registered the respondent. An interviewer was then charged with scheduling an interview with the respondent or inviting the woman to the FGD. The date of the focus group, venue and time were specified in a letter of invitation. The field interviewer obtained informed consent from each respondent before proceeding with the interview or begining the FGD. To ensure confidentiality, the coordinator and field interviewer made sure that the IDIs were conducted in a secure place convenient to the respondents. Similarly, the FGDs were conducted in safe, secure and quiet venues.

Data collection

In Kampala, the IDIs and FGDs were conducted in Luganda; in Mbarara, the IDIs and FGDs were held in Runyankole. All IDIs and FGDs were audio recorded and identification numbers were assigned to the recorded tapes by the coordinator. IDIs and FGDs were conducted in Kampala district in October 2003 and in

Mbarara district in November 2003. The tapes were transcribed by hand, first into the language in which they took place and then translated into English. The English translations were reviewed before they were entered into a word processing document.

On average, the IDIs took between 30 and 60 minutes. Generally, the FGDs for women of reproductive age (18–49) lasted about three hours (including breaks for having refreshments), while FGDs with older women (50–60 years of age) were a little bit longer than three hours, due to the additional questions on comparing today with past generations.

Challenges During Data Collection

The research team encountered some challenges during fieldwork.

- Locating enough respondents in two subgroups in particular—in-school and out-of-school young women for the FGDs—was difficult because potential respondents were often either at school or otherwise unavailable. It is also worth noting that fear due to perceived implications of participating in the study was more common among women of this age bracket than among older women. As a result, the research team had to ask women counselors of the respective parishes where the study team was recruiting to help identify the villages/zones which might have the potential respondents with the required characteristics.

- In a few cases in Mbarara, there were misconceptions about the purpose of the audio recorder, even after asking the respondent for permission to use the recorders and explaining the reasons for recording the interview. One misconception was suspicion that the recording was for a radio station to put the woman's voice on the air. Another misconception was that the recorder was a device that could detect whether the woman had had an abortion. Because of this misconception, the quality of the data obtained during the first day of fieldwork in Mbarara district was poor. After that experience, the field team put more emphasis on making sure that the presence and function of the tape recorder was explained.

Data Management and Analysis

Once fieldwork was completed, all tape-recorded interviews were transcribed and translated into English by the moderators and note-takers of the respective study sites. All translation was done by a project assistant under the strict supervision of the study coordinator. The study coordinator reviewed the translations before they were typed into a word processing document and the assistant reviewed them again after they had been typed up. Additional editing for clarification was also done before formatting and importing the documents into their respective project databases.

The text was coded using N6 qualitative software (QSR, Melbourne, Australia, 2001). The code structures of the analysis categories were created collaboratively between the in-country research team and the Guttmacher Institute research team. The codes were developed prior to beginning data analysis, based on the themes of the research instruments and the primary areas of interest of the study; however, the codes allowed for an etic process of analysis, as the themes that the codes encompassed were broad. The data analysis was strictly content analysis and did not include discourse analysis. All the coding of the data took place in Uganda and was reviewed and edited by Guttmacher staff until consensus was achieved within the research team.

The authors developed summary matrices of the themes present in the data based on the coding structure. In some cases, themes were examined by urban and rural residence, in other cases, they were examined by gender or health profession. Summary points were then written based on the themes arising from the matrices. Two authors reviewed each other's summary points to corroborate the analysis and interpretation of the results.

While we interviewed eight types of HCPs, for analysis purposes we categorized those eight types into three broader categories: traditional providers (including traditional birth attendants and traditional healers), drug shop pharmacists and modern providers (dispensary personnel, midwives, nurses, enrolled nurses and doctors). Differences according to subgroup are reported using these three primary groupings.

Within each chapter, results from the different groups of participants—women, men and healthcare professionals—and from both the FGDs and the IDIs are synthesized. The idea is not to compare the results from the two methodological approaches (FGDs and IDIs) but to blend them to enrich our understanding. When the responses are different according to subgroup (such as rural/urban residence or HCP type), these differences are pointed out. When no mention is made of subgroups, it is because no differences according to subgroup emerged from the data. Information on the experiences of individuals that a respondent knows and on

the respondent's own experiences is presented according to topic. It is specified in the data when the respondent is speaking about personal experience.

Data Quality and Limitations

Certain challenges which emerged during data analysis proved particularly problematic.

- It is difficult to obtain reliable information on abortion—even in qualitative studies, where the respondent is given more leeway than in quantitative studies—to discuss abortion the way s/he is comfortable or sees fit. Almost all of the respondents who discussed either having had an unwanted pregnancy or having a partner who had an unwanted pregnancy said that the pregnancy was carried to term. While all IDI respondents (not HCPs) were asked whether they or their partner had had an abortion, only three women talked about their own abortion experience and four men talked about the abortion experience of their partner. Yet based on the detailed information respondents provided on others' abortion experiences, there is reason to suspect that, in light of the widespread social stigma against abortion, some respondents may have been describing their own abortion experience but attributing it to someone else.

- While the IDI guides had been written to draw a distinction between the abortion experiences of members of the community and the abortion experiences of friends of the respondent, this distinction was not relevant for the respondents since the members of the community whose abortion experiences they were familiar with were their friends. Therefore, the information in these two sections was analyzed together.

- The interviews were all conducted in local languages (Luganda and Runyankole). This data analysis is based on the English translations of those transcripts. Nuances introduced in Luganda and Runyankole may have been lost during the translation, the translator may have introduced his or her own biases to the texts during the translation process, and such biases may have been carried though to the analysis. While every effort was made to make sure the translations adhered as closely as possible to the meaning in the original language, given the volume of pages that the study team was dealing with, some mistakes may have escaped unnoticed.

- One of the goals of the FGDs was to obtain detailed information on the process of women's health care seeking behavior to treat abortion complications. The FGD guides included questions about the first step women take to treat abortion complications, what happens if this first step fails, what is the next step and how long do they wait before taking the next step. The quality of the information collected was not as precise as we had hoped in part due to moderator variation and in part because there is variation within the population on how women choose to respond to abortion complications, making it difficult for respondents to answer what is "typical." This made it very difficult for us to be able to summarize any kind of typical process that women pursue when reacting to abortion complications.

Some respondents feared leagal repercussions if they were to admit to having had or performed abortions, especially in Mbarara district. Nurses in particular voiced the concern that the interviews were a ploy to implicate them in having performed abortions and refused to participate. Not surprisingly, no HCP said that s/he had personally assisted in an abortion. There is reason for HCPs to fear since abortion providers in Uganda are known to be prosecuted, sentenced to jail and can have their facilities shut down or their licenses suspended or revoked if they are found to be providing abortions.[31] HCPs were even reluctant to discuss treating abortion complications for fear that that would implicate them in the process. Providers who were known for treating abortion complications in the community denied treating abortion complications in the interview and stated that women with complications usually go elsewhere (such as Mulago Hospital). Midwives were the HCPs who most often admitted to treating abortion complications.

TABLE 2.1 IDI Respondents by residence and age, Community Abortion Morbitity Study, 2003

Category of target population	Kampala		Mbarara		Total
	Parish 1	Parish 2	Parish 1	Parish 2	
Community health providers	8	9	8	8	33
Women					
18–24 years	3	4	3	3	13
25–49 years	7	7	8	7	29
50–60 years	5	4	5	5	19
Men					
20–50 years	5	5	6	5	21
Total	28	29	30	28	115

TABLE 2.2 Focus group discussions by residence and age, Community Abortion Morbidity Study, 2003

Participants	Kampala	Mbarara	Total
Women			
18–25	1	1	2
26–35	1	1	2
36–49	1	1	2
50–60	1	1	2
Total	4	4	8

TABLE 2.3 Characteristics of women and men (IDIs), Community Abortion Morbidity Study, 2003

Characteristic	Women	Men
Total N	61	21
Age		
18–24	13	3
25–39	19	11
40–49	10	7
50–60	19	0
Residence		
Urban	31	10
Rural	30	11
Education*		
None	4	0
< Secondary	35	8
≥ Secondary	22	12
Marital status		
Married/in union	34	17
Not married/not in union	27	4
Religion		
Muslim	18	9
Christian	41	11
Other	2	1

*For one male respondent, education level not specified [Q not asked].

TABLE 2.4 Characteristics of health care providers (IDIs), Community Abortion Morbidity Study, 2003

Characteristic	Health Care Providers
Sex	
Female	25
Male	8
Age	
18–24	5
25–39	15
40+	13
Education	
< Secondary	7
≥ Secondary	26
Marital status	
Married/in union	20
Not married/not in union	13
Type of provider	
Medical doctor	4
Nurse	7
Midwife	6
Dispensary personnel	4
Drug shop pharmacist	4
Traditional birth attendant	4
Traditional healer	4
Has had 10 or more years of experience	16
Works in health facility	21
Does not work in health facility (Respondent's home, drug shop, self-employed)	12
Religion	
Muslim	5
Christian	22
Other	6
Total N	33

TABLE 2.5 Obstetric and gynecological services provided by the sample, Community Abortion Morbidity Study, 2003

Health care providers	Services
Traditional healers	Treatment for prolonged menstural periods, miscarriages, syphilis and AIDS
TBAs	Family planning and antenatal care, assisted in deliveries and gave infertility as well as sexual health advice
Drug shop/pharmacists	Sold drugs based on medical prescriptions and self-medication
Dispensary personnel	Maternal health care, family planning services and advised women on how to prepare for delivery by telling pregnant women to carry a razor blade, polythene paper and all the other supplies that are part of the basic safe delivery package
Nurses	Treatment for STIs, specifically syphilis
Midwives	Attended to women who experience miscarriages or feel stomach pains, provided antenatal care and delivered babies
Medical doctors	Provided maternal health care and family planning services (e.g., contraceptive pills and the injection)

Chapter 3

Unwanted Pregnancy

According to the 1995 Demographic and Health Survey, 29% of recent births to Ugandan women aged 15–49 in the five years preceding the survey were unplanned, i.e. they were not wanted or they were mistimed; by 2000–2001, that percentage had risen to 38%.[32] The reason for this increase in unwanted pregnancies was because desired fertility decreased rapidly during this time period, yet the increase in contraceptive use did not keep pace, rendering a greater proportion of the population vulnerable to experiencing an unwanted pregnancy. As of 2000–2001, contraceptive use was 23% among married women and 48% among unmarried women. Traditional methods, which are less effective at preventing pregnancy than modern methods, accounted for about 4.5% of use among all women for both groups. This chapter describes community perceptions regarding the frequency of unwanted pregnancies, reasons why unintended pregnancies occur, reasons for not wanting a pregnancy, who is consulted about what to do, the role providers play in helping women avoid unintended pregnancies and what women do when they are faced with an unwanted pregnancy.

Unwanted Pregnancies Occur Frequently

Most respondents perceived unwanted pregnancy to be a phenomenon occurring in their community. Women were much more likely to relate stories of unwanted pregnancies that were carried to term than were men, who exclusively related stories of unwanted pregnancies which women tried succesfully or unsuccesfully to abort or newborns they tried to kill through infanticide, indicating that men possibly are not aware of whether the pregnancy was unwanted unless there was an attempt to abort it or commit infanticide. Schoolgirls were the group most commonly perceived to experience an unwanted pregnancy. HCPs also named women working as maids, while women IDI respondents also named old women and male IDI respondents named unmarried women, widows and prostitutes.

Factors Contributing to Unwanted Pregnancies

The respondents felt that the most common reason unwanted pregnancies occur was because women do not consistently follow family planning directions, either out of ignorance or unwillingness.

It happens if the woman decided to take pills only on the days she has sex.
—Urban focus group, women aged 50–60

The perception is broadly held that women get pregnant on family planning, possibly because of incorrect use.

You see, there are family planning methods which are wrong. You see, she was swallowing pills but conceived.
—Rural male aged 30

This widespread perception most likely reinforces incorrect use, since there is a lower incentive to adhere to correct use if contraceptives are not believed to be effective.

Ignorance about how conception occurs was another prevalent reason given for why unwanted pregnancies happen.

Another problem with girls of 18 years and below is that they play sex in fear and so don't take time to prepare for sex. They have sex hurriedly. Some don't know that even when they play sex hurriedly they can get pregnant.
—Urban focus group, women aged 20–35

I. What other reasons can you think of [for why unwanted pregnancies occur]?
R. Ignorance is another reason. This is especially so among the youth. Usually the youth do things without assessing the end result. They only realize when it is too late and something has already hap-

pened. The boys impregnate the girls unknowingly and girls also get pregnant unknowingly. They lack sensitization and guidance on such matters.
—Rural male aged 37

Being deceived by men also came up frequently as another reason women experience unwanted pregnancies. Examples of deception included the male saying that he will use contraception and he does not, men intentionally rendering the contraception ineffective (i.e. perforating the condom) or by convincing his partner that s/he is not fecund.

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. After the game she cried that I had impregnated her. She even checked the calendar to note the date and time that I had impregnated her. And that is what happened exactly. That is the pregnancy she aborted.
—Rural male aged 36

Financial demands also compromise a female's ability to protect herself from an unwanted pregnancy.

At times you may be in a group of about four people. Three of them may have boyfriends and you, the fourth, don't. The three friends get money from their boyfriends and are able to buy pancakes at school. They reach a time and feel that they are tired of giving you their pancakes. So they suggest to you to get a boyfriend who can give you money to buy your own pancakes or to contribute some money and you buy pancakes as a group. The group influences you to get a boyfriend who at the end makes you pregnant.
—Urban focus group, women aged 18–25

While males commit deception and coercion (including giving the female money), which can lead to an unwanted pregnancy, forced sex experiences came up infrequently as an explanation of why unwanted pregnancies occur. The perpetrators of forced sex experiences were identified as teachers, male partners at discos and husbands.

Many of our husbands force us to have sex. He makes you to have sex whether you like it or not and you end up getting pregnant unexpectedly.
—Urban focus group, women aged 36–49

While these are all contemporary proximate determinants of unwanted fertility, older respondents were also asked to reflect on changes over time in causes of unwanted fertility. Among older respondents, there has been a perceived breakdown in traditional culture that has led to more unwanted pregnancies occurring. Respondents said that in the past, girls used to receive counselling from the *sengas* or parents but do not any more. *Sengas* are officially a father's sister, but can unofficially be any older woman in the community who educates young people about coming-of-age issues.

The dire warnings from parents were also perceived to have depressed sexual activity among adolescents in the past. A few respondents of a focus group of 50–60-year-olds said that in the past, parents told young people that if they had sex they would die. The respondents said that girls today do not listen to the advice given to them anymore. They said that girls nowadays say, "Those are old people/women, what can they tell me? Their ways are old-fashioned." These women also said that unwanted pregnancies are occurring at a higher rate today than in the past because now girls sleep in the same room as boys, resulting in heightened sexual awareness, since siblings may see each other nude or partially disrobed due to the lack of privacy. This response only came up in urban FGDs, so this phenomenon might be linked solely to urban overcrowding and not to a change in social values.

Men's Participation in Family Planning

When male respondents were asked about men's roles in avoiding unwanted pregnancies, men said that family planning, mainly the use of birth control pills, condoms and injections, was a way to help women prevent an unwanted pregnancy. It is noteworthy that only one

man mentioned vasectomy.

A few men suggested that husbands discuss family planning with their wives and that they reach an agreement on the type of method to use.

I. What do you think men can do to help women avoid getting unwanted pregnancies?
R. It requires sensitizing the people concerned, most especially girls and adolescents. They should be sensitized because at that age, they are ignorant of what can happen to them. The men should discuss with their wives and plan for their family. They could go to the doctor and adopt a suitable way of family planning.
—Rural male aged 37

Yet when men were asked whether women should use contraceptives, the majority described side effects they believed women experience from contraceptive use. The side effects believed to be related to pill use included cancer, stomach pains and deformed babies. Side effects believed to be related to injection use included infertility, continuous bleeding (once the method is stopped) and deformed babies. Other perceived side effects not clearly associated with any specific contraceptive method included weight loss, being at risk for miscarriages and future fertility problems. Only one man described medically recognized side effects: weight gain and amenorrhea.

When asked about their willingness to use a contraceptive method, the majority of men said they (themselves or their partner) would use a method, typically the condom. Those who expressed unwillingness to use a contraceptive method (mainly men in their mid-20s or 30s residing in rural areas) cited that "nothing is as good as having a child" and fear of side effects.

Reasons for Not Wanting a Pregnancy

Just under half of the women respondents said that they themselves had had an unwanted pregnancy. Women said pregnancies may be unwanted when the young woman is still in school because parents do not like their school children pregnant and girls want to continue their studies.

I. Have you ever been pregnant when you did not want to be or at a time you were not expecting it?
R. Yes.
I. How many times did this happen?
R. It happened to once, when I was still in school.
I. Why didn't you want the pregnancy you got?
R. I didn't want the pregnancy because it made me lose my educational opportunities.
I. Was your partner opposed to the pregnancy?
R. I don't think he wanted the pregnancy because he just raped me and made me pregnant.
I. How did you overcome this problem of an unexpected pregnancy?
R. I didn't get problems with the pregnancy because my father didn't chase me away from home. He gave me care until I gave birth.
I. Didn't you talk to anyone about your situation?
R. I didn't even know that I was pregnant. I got to know of it after the school took us for a medical check up and they wrote a letter I took to my parents. I got to know that I was pregnant when the pregnancy was six months old. I didn't even tell anyone about it. My father never told me that I was pregnant. He just told me to go to my grandparent's home for some time[…]after some time I gave birth.
—Urban female aged 48

In Uganda, a pregnancy carried to term always means ending, or at least temporarily halting, one's education, since schools expel pregnant students.[33] It is national policy that a pregnant teen cannot be in school, but a recent change in the national education policy now allows for students to come back to school after they are no longer pregnant.[34] Schooling is treated as a privilege and is seen as a key to a better life among Ugandan youth; therefore, being made to leave school is generally devastating.[35]

Other reasons for not wanting the pregnancy include when the man denies paternity, the woman did not want to have a child with that partner (including when women get pregnant through adultery), the previous child is still young and the couple/woman is poor. A few respondents gave being HIV-positive as a reason that the pregnancy could be unwanted. Older women (aged 35 and older) were more likely to say that women sometimes do not want to be pregnant because of inadequate resources, while younger women (younger than 35) were more likely to give reasons such as being in school, having enough children or having gotten pregnant with an extramarital lover.

A significant minority of the male respondents said that their partner had had a pregnancy that they or their partner deemed unwanted. Men said that a pregnancy would be unwanted if the woman does not know who fathered the pregnancy, the woman was having sex for money, the man denied paternity, the woman does not have enough resources to manage another child, the

woman does not want to have another child, the pregnancy is a result of not using family planning (because, men said, the man may have been reluctant to use contraceptives) or the woman is a prostitute and wants to keep moving freely.

I. What are some reasons why women may not want a pregnancy when they get pregnant?
R. There are two reasons. If one likes to have too much fun, such as discos and the like, those people can get unexpected pregnancies. The second reason is poverty. A woman could see a man and he persuades her that he is going to give her money. And because of too much love for money, she accepts to have sex, forgetting that she could get pregnant. Eventually she gets pregnant when she is not prepared for it.
—Rural male aged 37

Men's personal reasons for feeling that a pregnancy they were involved in was unwanted were that he was still studying, the woman was still a student and she did not have any money, she told him she was not ready to have a child with him, he got a girlfriend pregnant while married to someone else, he was in poverty, and he didn't want his co-wives to have so many children.

Sources of Advice on Unwanted Pregnancy

The most common people that that women talk to when faced with an unwanted pregnancy are friends and husbands/partners. Consulting friends was perceived to be more prevalent among the rural respondents. Friends were seen as being able to give advice on how to abort, as well as accompany their friends to abortions. Women who consulted their husbands/partners reported the following reactions: indifference ("he regarded it like all other pregnancies I ever had"), acceptance ("there was nothing we could do") and encouragement to stop childbearing after carrying this last pregnancy to term. Old women were sought out for advice on which herbs or drugs to use to end the pregnancy.

Men were asked hypothetically about couples' communication regarding unwanted pregnancies. A minority expressed the following views: that women do not tell their partners about unwanted pregnancies because telling the husband/partner that the pregnancy was unwanted could damage the relationship; that wives cannot say that they do not want the pregnancy, although prostitutes and concubines can; and that there can be poor communication between the partners so that this information is not shared. However, a minority of respondents assumed that women do tell husbands/partners if they are on good terms with them because they need their husband's/partner's assistance [possibly for an abortion]; and because men are equally responsible.

I. Do women discuss with their husbands about their unwanted pregnancies?
R. They discuss with them because they are equally responsible. The woman tells the man that she is pregnant and what the man replies depends on what he thinks is good for him. It is the man who decides what to do and that is what the woman follows. In most cases, women discuss [the situation] with their husbands.
—Urban male aged 33

The Role of HCPs Regarding Contraceptive Use and Unwanted Pregnancy

The providers interviewed said that they give out information on contraceptives and advise women to use family planning. The contraceptive methods most frequently provided by HCPs are pills and injections. Other less frequently mentioned methods that HCPs advised women to use were condoms, foaming tablets (a kind of spermicide), IUDs, Norplant, breast feeding and abstinence for young girls. Herbal methods, which included tying herbs around the woman's waist, were mentioned by a few, mainly traditional, providers. A couple of dispensary personnel and traditional healers said that they do not promote modern family planning only natural methods because of their religion, but that they do refer women to other facilities for contraceptive services.

The majority of the HCPs said that they encourage women to carry unwanted pregnancies to term. A minority of HCPs said they encourage women with unwanted pregnancies to communicate with their husbands about possible solutions and to begin family planning. The ways that providers said they try to convince women to carry the pregnancy to term were by warning women of the dangers of abortion (stressing that the dangers are particularly high if the woman is HIV-positive) and threatening women with public humiliation.

I had actually gone to her to repair my clothes. She asked me if I could give her medicine to help her abort. The reason was that she is unable to look after the pregnancy. She did not tell me the reason why she was unable to look after the pregnancy. I told her to come to my place and find a solution. She came that very day. I told her that there is med-

icine to help abort but I told her not to do it because the child she was carrying could be an important person in the future such as a minister or some other important person. I encouraged her not to abort. I even scared her by telling her that if she aborts, I will put her name on the radio. She actually gave birth and the child is now big.
—Rural traditional healer, male aged 49

A few modern providers reported being willing to refer women to clinics or doctors who perform abortions. The conditions under which they said they referred women to abortion providers was when the woman did not want the HCP's advice on why she should not stop the pregnancy, if she could not look after the child or when the pregnancy would bring family conflict.

I. Do they [women seeking abortions] come to you for advice?
R. Yes, they do.
I. What advice do you usually give them?
R. […] When the pregnancy could bring family conflict, instability and even separation, I do refer the woman to [name deleted] clinic like I told you. If she wants to abort, she aborts from there. If she doesn't want to abort, she leaves it to grow. But they usually end up aborting.
I. So you usually advise them to go to [name deleted] clinic for abortion?
R. Yes.
I. Do you ever advise them to keep their pregnancies?
R. Sometimes I do.
I. Under what conditions/circumstances?
R. That issue of family stability is a special situation. If there is no way she can deceive the husband that the pregnancy belongs to him, she should abort because the family will break up. There are also those women who are not married but want to abort; I advise them and counsel them to keep their pregnancies.
—Rural doctor, male aged 28

How Women Handle Unwanted Pregnancies

Even when the pregnancy is unwanted, the majority of women are perceived to carry the pregnancy to term, in part because of the fear of possibly dying in the process of attempting to abort.

I. What do they do with the pregnancies?
R. Nothing. They just leave the pregnancies to grow and give birth.
I. Why don't they attempt to stop the pregnancies?
R. They 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 female aged 33

Other reasons given for not attempting abortion are because it is a sin/against their religion, women do not have money to pay an abortion provider, that abortion is not something a married woman can do and that women commit infanticide instead.

I. Let us talk about the second women you know who had an unwanted pregnancy.
R. The second woman I know did not abort due to lack of money. When she delivered the baby, she strangled/suffocated it to death. People did not realize that she did it intentionally; we buried the baby. She was not married and the man who impregnated her denied responsibility.
—Rural female aged 50

Comparing how unwanted pregnancies are handled today versus in the past, the participants said that in the past, people only had sex within marriage; that even if they didn't like their pregnancies, no one used to abort; and that infanticide used to occur (perhaps on a greater scale than today).

Conclusion

Not consistently following family planning directions out of ignorance or unwillingness, and poor family planning usage perhaps due, in part, to the perception that women get pregnant on family planning underscore the difficulty women have using contraceptives effectively. While females spoke about males deceptively rendering contraceptives ineffective, no male talked about doing this. Men spoke about their perceptions of the serious side effects of modern contraceptives. If they speak with their partners about these perceptions, it could very well discourage their partners from using contraceptives. Unwanted and consequently unplanned intercourse serves to further put females at risk of an unintended pregnancy, since the lack of control women have, exhibited by the fact that they cannot avoid unwanted intercourse, makes it difficult for them to introduce contraceptives. Another reason given by the respondents that unwanted pregnancies continue to occur at a very high rate in spite of the availability of modern methods of contraception is because of a breakdown in traditional paths of knowledge

transmission so that young girls are no longer receiving instruction on sexual matters the way that it was done in the past.

The perception among the respondents was that unwanted pregnancies occur frequently among school girls, maids, young women, unmarried women, widows and prostitutes. The primary reasons given for why women do not want the pregnancy are because the young woman is in school, the male denied paternity, the pregnancy is a product of adultery or the couple is poor. Based on those reasons, it is not just the specified groups who are vulnerable to an unwanted pregnancy but that many more women are vulnerable to experiencing an unwanted pregnancy. The personal experiences of the respondents belie the over-simplification of who is vulnerable to experience an unwanted pregnancy as the reasons for why the pregnancy would be unwanted apply to more than just those women. It is possible that these specific groups of women were named because it is assumed that, based on their social status, their pregnancies are unwanted because of the stigma associated with a pregnancy and that wantedness of a pregnancy is, in fact, a private matter.

While most health care providers encourage women to carry the pregnancy to term, a few modern providers were willing to refer women to other services to help then end an unwanted pregnancy, yet fear of death and lack of money hinder women's access to abortion.

Chapter 4

Spontaneous and Induced Abortion

Spontaneous abortion, the spontaneous loss of the fetus before the 20th week of pregnancy, represents one possible outcome of pregnancy. Drawing the line clearly between what is a spontaneous abortion and what is an induced abortion can be difficult when the stigma surrounding induced abortion can discourage women from acknowledging initiative they took to try to end a pregnancy. A study conducted in Bolivia, where abortion is also highly stigmatized, found that women intentionally performed contraindicated acts during pregnancy, such as falling down stairs or lifting and carrying heavy objects, with the intention of "giving nature a helping hand" and having a "natural miscarriage."[36] How a woman conceives of, as well as how she represents, the loss of the fetus may vary depending on her religious beliefs and whether she expects to have any control over her fertility, just to name a few possible factors.

Health care providers demonstrated in their answers a conflation of spontaneous and induced abortion. Some said that women who experience spontaneous abortions may be reluctant to seek health care for abortion complications for fear of being questioned by the medical professional treating them—implying that the abortion was not spontaneous. Other health care providers expressed skepticism that spontaneous abortions presented were actually spontaneous. Still others simply spoke of induced abortions when asked about spontaneous abortions and some named complications from spontaneous abortions that could most likely only come about as a result of induced abortion. One respondent used the phrase, "inducing a spontaneous abortion." Therefore, in highly stigmatized settings, spontaneous abortions may be representing an unknown proportion of induced abortions.

Spontaneous abortion was translated as *"okuvaamu olubuto"* which means "losing the pregnancy" as a result of unknown and unintended causes. The term induced abortion was translated in Luganda as *"okujjamu olubuto"* and in Runyankole as "*okwihamu enda"* which means "removing the pregnancy," meaning an intended loss of the pregnancy. These terms are the closest one can come in these languages to conveying these concepts and this should be kept in mind when interpreting the results. Since the term "spontaneous abortion" is not used in common parlance, when quoting a respondent, we translated *"okuvaamu olubuto"* as "miscarriage."

Spontaneous Abortion

This section discusses respondents' understandings of the causes of spontaneous abortion and the steps women take to seek treatment for possible complications that come about as a result of spontaneous abortion.

Causes of spontaneous abortion

The majority of respondents had knowledge of the causes of spontaneous abortion. Respondents recounted their personal experience of having a spontaneous abortion brought on by malaria, syphilis, previous contraceptive use, sickness, changes in the weather, spousal conflict, "too much heat in the stomach" and "overplaying sex"—some of which are recognized causes of spontaneous abortion while others are not.

> *We had a misunderstanding when we had just gotten married and fought, that's when she got a miscarriage. […] After fighting she got sick and threatened to miscarry. I took her to the clinic, but it did not help. She went ahead and miscarried.*
> *—Rural male aged 36*

> *Women say the miscarriages are caused by too much heat in the stomach [*nabbuguma*]. [Women with this affliction] can go to traditional providers and get herbs. If they get those herbs and get well, they don't get any more miscarriages.*
> *—Urban female aged 58*

Delays in seeking care

Self-treatment was usually the first step taken in addressing health complications from spontaneous abortions, but was often acknowledged as being unsuccessful. Drugs/tablets were the second step women are perceived to take. Traditional providers were the most likely to say that women are successful at self-treating spontaneous abortions. Health care from a trained professional was most likely to only to be pursued if the problems persisted. The primary reason given for this pattern of health care–seeking behavior was lack of money, which led women to try less expensive options first. Some of the men and women in-depth interview (IDI) respondents said that women sometimes get treatment from traditional healers in addition to treatment from a health facility. Monetary concerns are not the only reason women may choose traditional care over modern care since problems such as "too much heat in the stomach" are thought to be cured only by traditional care.

Congruent with the pattern described above, health care providers (HCPs) stated that, on average, women who experience a spontaneous abortion seek care from a trained provider no longer than one week after the event; only a few delay seeking treatment longer. Bleeding and watery discharge are perceived to spur some women to come soon, while lack of money, a dread of hospitals or general reluctance to obtain health care for unspecified reasons are reasons for delaying seeking care. HCPs said that women sometimes delay seeking care for spontaneous abortions for fear of being questioned by the provider. HCPs said that women turn up at health facilities claiming they have had a spontaneous abortion but with health complications that indicate possible induction.

The most commonly named conditions witnessed by HCPs among women who were experiencing or had experienced spontaneous abortions were severe abdominal pain and excessive bleeding followed by fever, weakness and anemia. Other symptoms named were pain in the fallopian tubes and a widening of the vagina, both of which are not medically-recognized conditions. When asked how they treat spontaneous abortions, most HCPs stated that they provide medicine to women experiencing spontaneous abortions—traditional providers offered herbs while all other HCPs provided painkillers and antibiotics. Most HCPs said they refer most women with spontaneous abortions to clinics, but send women who come to them in critical condition (i.e., those who have retained fetal parts or are bleeding) to hospitals.

Rural respondents said that women are more likely to seek care first from a health clinic, while urban respondents more often said that women go to hospitals immediately when the spontaneous abortion is not complete. While women may be attended to more quickly in a clinic, clinics charge fees; public hospitals provide (or at least are supposed to provide) free care. Avoiding fees by going to hospitals is a strategy more accessible to urban women.

Whether a woman has access to money is frequently determined by the relationship she has with the male involved in the pregnancy. According to the men interviewed, men are unlikely to assist a woman going to a modern provider if the relationship is a casual one, if he is not interested in the pregnancy outcome, if he denies paternity or if there is a lack of understanding within the couple.

Complications named by health care providers that can result from women not getting any treatment for a spontaneous abortion include death, serious fever, weakness, anemia, dehydration, stomach pain, continuous bleeding, a blood clot inside the womb, sepsis, damage of the uterus, unspecified pain and discharge. Yet it is unlikely that damage to the uterus would occur unless the abortion had been induced and death might only be a risk if there was spontaneous fetal death at a very late stage in the gestation that was not expelled. Therefore, this list of complications likely encompasses problems from induced as well as spontaneous abortion.

Induced Abortion

Attempting to stop a pregnancy was considered to be a fairly common occurrence. The following section presents results on abortion practice as perceived by the respondents—among women in their community, as well as respondent's own personal experiences. It discusses the characteristics of women who are perceived to be most likely to obtain an abortion; the types of abortion methods used; the steps women take to obtain an abortion; the barriers encountered while trying to obtain an abortion; male respondents' opinions of the conditions under which abortion is acceptable; and costs associated with obtaining an abortion. Finally, it presents changes that have occurred over time in abortion practices.

Who obtains abortions

Not surprisingly, the same segment of society that was perceived to be most likely to experience unwanted pregnancies is the segment that was perceived most likely to try to induce an abortion: schoolgirls.

Young girls are fond of playing around with young boys and end up getting pregnant unexpectedly. At the end, they decide to stop the pregnancies because they still need to go to school.
—Urban female aged 50

Respondents saw young girls between the ages of 8* and 23 as frequently interested in ending a pregnancy. Young girls were believed to seek abortions because the man may not be known or liked by her relatives, the man may be using her, the girl may want to still enjoy a social life, some have life aspirations after studying that could not be accomplished with a child and the girl may not be working or have any way of supporting herself and a child. But this perception held by the respondents may be a product of the fact that younger women may simply have a harder time keeping secrets.

I. You have said it is mostly the young girls who get the unwanted pregnancies and throw away the babies?
R. It is those young girls who still enjoy social life.
I. What about the old women?
R. The old women are wise and they do their things secretly. If I get pregnant, can you know that I even stopped the pregnancy? It is the young girls who can be known. When they get pregnant, they stop the pregnancies.
—Urban female aged 37

After schoolgirls and young girls, married women were the group most commonly named as seeking abortions for unwanted pregnancies. Some of the reasons given were because the married women may still want to enjoy themselves (meaning that they are involved in extramarital relationships and want to continue having extramarital relationships), they may have reached their desired number of children, they got pregnant out of wedlock, and they have husbands who do not support them or their children. Less frequently mentioned groups of women who are perceived to try to abort were prostitutes, unmarried women, old women (because it would be an embarrassment to be seen pregnant by their son-in-laws), girls from poor families, women who are not settled (i.e., women not at their father's homes who are not yet married but renting places on their own or living in lodges), and widows.

Of the respondents who spoke about their own or their partner's abortion attempts, the most common reason given for seeking the abortion was because the woman was still in school and/or the father was married to another woman and he denied responsibility for the pregnancy.

Abortion methods

The main method used by women to try to induce an abortion was herbs either self-administered or administered by a traditional provider. The most commonly mentioned herbs included *ennanda* (*Commelina,* also known as water grass)–an herb which is inserted into the vagina; *oluwoko* (*Phytolacca dodecandra,* also known as poke weed), which is pounded, dissolved and drunk; and a strong concoction made from tea leaves that is then drunk.

The woman had an herb which she inserted in her private parts. She then got contractions and delivered the fetus.
—Urban female aged 50

P1. I think if they go to traditional providers they give them an herb to drink and then after drinking, the pregnancy will be stopped.
[…]
P2. You can go to village old women who can use etiija [another traditional herb] or a sharpened stick which will pierce the uterus and it allows in air that causes the abortion.
[…]
P3. Usually the traditional providers give woman herbs to drink, say emuhoko *[oluwoko] or a* muranuga *[herb used in same way as oluwoko]. She drinks a cup; that day, the sun may not set without her aborting.*
M. What happens when you drink half a glass?
P4. With oluwoko, you can drink a glass. When you feel pain like some razor cutting your uterus; it means that the fetus will very soon come out.
—Rural focus group, females aged 36–49

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 the pregnancy.
—Urban traditional birth attendant, female aged 49

*While this seems extremely young to have experienced a pregnancy, this age was given by the respondents.

Among the respondents who had been involved in an abortion attempt, herbs were the most frequently mentioned method used to try to stop the pregnancy. A woman described how she obtained local herbs from an old woman in her home village:

I. What herbs did she give you?
R. I don't know. She boiled the herbs and gave me a bottle to drink, and the pregnancy stopped. The pregnancy was still young and so the drug given was not so strong to cause me any harm.
—Urban female aged 20

Less frequently mentioned traditional methods included steam (herbs are put on food which is cooked and the steam coming from the herbs is meant to stop the pregnancy), wearing herbs, drinking detergent such as Omo, using piercing objects (other than ennanda), as well as combinations of the above, for example Omo and tea leaf concentrate. According to the respondents, traditional methods sometimes work when trying to stop a pregnancy at an early gestation. Generally, though, they are ineffective.

P1. Sometimes one can take herbs and the fetus refuses to come out.
M. Does the fetus stay alive or does it die?
P2. The fetus dies and fails to come out, so she keeps feeling pain in the lower abdomen.
M. Which methods usually cause the fetus to die and not come out?
All. When they use local herbs.
P3. They prefer to use local herbs because they have no money. So afterwards she goes to hospital so that she is given an injection and the fetus comes out.
—Rural focus group, women aged 18–25

The use of modern providers to induce an abortion was less frequently mentioned. Modern providers most frequently named were doctors and nurses. Abortions performed by these personnel are typically carried out in clinics which provide safe abortions or in hospitals. In these facilities, injections* (unspecified), drugs† (unspecified) or machines‡ (type of machine not specified) are used to stop the pregnancy.

While HCPs said that most women who consult modern providers are successful in stopping a pregnancy, other respondents said that modern methods sometimes fail to stop a pregnancy because methods can fail and doctors can be deceptive.

P8. If you insist on a doctor […] to help you to stop a pregnancy, he can deceive you. […] He can give you an injection for malaria and deceive you [telling you] that it was meant for stopping the pregnancy.
P7. Doctors do so if they don't want you to stop a pregnancy.
P8. The doctor can take your money, say 100,000 Ugandan shillings [UGS; equal to US$54], and deceive you. He tells you to go home and wait for about a month for the pregnancy to stop. If you go to him after a month he tells you that it is not possible to stop it then because the child is fully grown.
—Urban focus group, women aged 20–35

When the first attempt at stopping a pregnancy fails, participants said that women seek further help to try to stop the pregnancy.

Tablets and drugs (self-administered or provided by HCPs) were also described as another commonly used method to stop the pregnancy. Some of the drugs women use are selected because they are contraindicated for pregnant women, for example, chloroquine or quinine. Large doses of aspirin and sleep aids were also named as methods used to induce abortion.

P1. You can also buy yourself 20 aspirin, swallow them and the pregnancy is stopped.
P2. Some can take an extra dose of Piltons [medication that induces sleep].
M. What other medicine do the modern health care providers use to aid an abortion?
P3. Quinine. They give you an overdose of quinine. You just go to the clinic and tell them that you have malaria and would like to buy quinine. You go home and get someone to inject you.
—Rural focus group, women aged 20–35

There were some differences in the types of abortion methods reported by residents in urban and rural areas.

*Pitocin might be used to induce contractions to expel the fetus if the pregnancy is in the second and third trimesters.

†Some drugs that might be being used that would effectively induce abortion are Cytotec (misoprostol) and RU-486 (mifepristone). Due to confusion over the proper use of the morning after pill regime, there is evidence that large doses of birth control pills might also be administered to woman which would not be effective at inducing abortion. Quinine might be being used as well.

‡Vacuum aspiration machines would be the only machines that would sensibly be used to carry out an abortion.

As expected, respondents in Kampala (women and HCPs) were much more likely to say that women could consult modern health providers than respondents in Mbarara. However, respondents from Mbarara were much more likely to report the use of hospitals to obtain an abortion than respondents in Kampala. Men from Mbarara were more likely to mention the use of herbs than were men residing in Kampala.

Respondents were evenly divided on whether women get abortions alone or go with a friend. Those who said she goes with a friend said the friend can deal with any abortion-related problems and can get help if needed. Those who said that women are more likely to go alone said it is because women want to keep the abortion a secret.

If you are going to commit a crime of murder, can you tell another person?
—Rural focus group, women aged 50–60

One woman whose abortion attempt failed describes how no one knew that she had attempted to stop her pregnancy:

R. No one got to know, even the aunties I stayed with when I was sick never knew about it.
I. What about the husband?
R. He, too, did not know about it. After the three months, I got well and by the time I gave birth I was already healthy again.
—Urban female aged 30

Participants said that young women are likely either to go with their mothers or with their boyfriends, especially if the boyfriend is supportive of the abortion. Some urban participants felt that women were more likely to be accompanied when they go to a modern provider because there is a need for a witness to sign for the woman (although abortion is almost always illegal, this signing is a formal legal practice that some trained providers do to take extra precaution to do should the woman suffer complications and need someone to act on her behalf). An equally prevalent perception was that women are not likely to be escorted to modern providers because these providers want to work in secrecy.

Barriers to obtaining abortions

The majority of men and women IDI respondents said that the primary barrier to inducing abortion was fear of death, followed by concern about health complications.

It's difficult. You could die in the process. It even puts your people in problems. If you get sick, they have to look for money to nurse you and get you back to health. And, again, you can die in the process. Some do die when aborting.
—Rural female aged 18

Not having money was also identified by the majority of respondents as a barrier to getting a safe 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 [to get their complications treated].
—Urban female aged 32

Males said doctors' desire to earn money lures them into performing abortions so that, with money, it is possible to obtain a safe abortion.

Yes, it is easy, because we have many providers of all categories in this community and most of these providers are looking for money. So they are willing to attend to women who are in such a situation.
—Urban male aged 50

A shortage of providers was not perceived by the respondents to be a major barrier to obtaining an abortion.

Men's attitudes toward abortion

Male respondents stated that men, in general, are not supportive of women having abortions: They do not agree with the practice; they believe that the aborted child could be an important member of society; they believe that the woman could die undergoing the abortion, and in such situations fear that they themselves might be arrested. Other reasons that came up less frequently were that poor men fear the costs of abortion and treatment for abortion complications; it may be the woman's only opportunity to have a child; and men who have AIDS would like to have three or four children before they die.

I. Do you think men in this community are supportive of a woman's desire to stop a pregnancy?
R. No, they are not supportive because one who aborts could die and more so, the aborted baby is

also a human being.
—Rural male aged 28

Some men want children and getting a child is not something easy. Some men die without producing a single child. Some men want babies and if a woman gives birth, he feels proud to get someone to call him father.
—Urban male aged 32

The general consensus among men was that married people do not decide to stop a pregnancy together.

If a man really loves a woman, it is rare for such a man to encourage his wife to stop a pregnancy.
—Urban male aged 40

Being an unmarried woman was not a sufficient reason to have an abortion.

R. Every woman should not really abort. I think if she conceives, even if by accident, she should go ahead and give birth.
I. What if a woman is not married?
R. She should still give birth because I know she can gamble and look after a child even in the absence of a man. Women these days know how to work. She can work and support herself.
—Rural male aged 44

Men said that women who are HIV-positive should not abort because they can give birth to a healthy baby, given the availability of drugs that prevent mother-to-child transmission.

Yet an exception was made for a young woman who is in school: The majority of men believed it to be acceptable in this situation for the girl to get an abortion.

[If] a schoolgirl […] becomes pregnant, she fears people at home will beat her up or her studies will be ruined. That one should stop the pregnancy and go back to school.
—Rural male aged 33

There was a sense among the men that if they get a schoolgirl pregnant, they must do everything they can to help facilitate the abortion—even spend UGS500,000, a phenomenal sum in Uganda, to help the schoolgirl obtain an abortion. This desperation seemed to be largely motivated by self-interest. The reason males gave for being in support of a schoolgirl's abortion was that the male could be brought up on defilement (rape) charges if the schoolgirl is found to be pregnant. Other situations in which men said they are supportive of women having abortions are when the man perceives the woman to be helpless, if the man cannot support the woman and future child or when a married man gets a housegirl/maid pregnant.

The cost of abortion

It is very difficult to obtain information on the cost of abortion because many people did not seem to know the cost and there was also a great deal of variability in what people reported. Nevertheless, since cost is the primary barrier to obtaining a safe abortion, we have presented the respondents' perceptions of how much abortions cost.

Nonproviders' estimates of the cost of obtaining an abortion from a professional sources ranged from UGS10,000 to more than UGS100,000 (equal to about US$6–58), while cost estimates of an abortion from a traditional source were UGS10,000–30,000 (US$6–18). These prices are similar to prices given by HCPs in the country.[37]

Respondents said if women have the means to access resources without having to tell the partner, women pay for the procedure themselves. If a husband does not want his wife to reproduce or the couple has arranged to stop the pregnancy, the woman can get financial assistance from her husband.

Women's ability to seek health care

In Uganda, women have traditionally needed to be accompanied by a man when they are moving about in public, as it has historically been considered unseemly for a woman to be seen moving alone. This expectation was seen as outdated by many respondents, considering the agency women have in contemporary Ugandan society:

I. Do women need permission to seek medical care?
R. From whom? I am renting a house myself, feeding myself. When I get a problem, who should I seek permission from, then? I even don't know the man who impregnated me; maybe he left or he was just a passerby. Now whom do I ask for permission?
—Rural female aged 48

It's not like long ago when women had to seek permission for everything. If you tell a man these days

that you are in pain, he can ask you what you are waiting for to go to the health center.
—Rural female aged 30

A minority of both men and women did say that women have to get permission from their husbands to seek care. The reasons women gave were to avoid offending the husband; to get money from him to cover the medical costs; and because if you don't and you tell him that you had a spontaneous abortion, he could suspect that you stopped the pregnancy yourself (suggesting that there is frequently the suspicion that women misrepresent how the abortion came about). As one urban 35-year-old explained, "He is the head of the home. Your life as a woman is in his hands, and if you get any problem, he is answerable."

Changes over time in abortion practice

Focus group discussion (FGD) participants aged 50–60 said that abortion is more common now than it was in the past.

P.1. These days, even some men ask their wives to stop the pregnancies. It never happened like this in the past.
P.12. It is too common these days because people enjoy themselves a lot [have more sex], unlike in the past.
P10. Diseases such as HIV/AIDS that exist these days make women stop pregnancies. A woman fears to give birth to an HIV-infected baby and so decides to stop the pregnancy. HIV/AIDS did not exist in the past.
P.9. Women of the past took a pregnancy to be very important unlike women these days.
P.3. Looking after children these days is so hard, unlike in the past. That is why many people these days stop pregnancies so as to limit the number of children.
—Urban focus group, women aged 50–60

Women also mentioned a lack of resources (less land and food), that life is now more expensive and the detrimental effect of modern education, which teaches young people about sexual intercourse.

M. Are you saying that generally people of long ago used not to have unwanted pregnancies?
All: Yes
P.6 It is only in these modern Western days where children have gone to school that we have also seen new things. They are in schools and learn about lovemaking and all that comes with it. Didn't we tell you that if you became pregnant long ago you would be digging your own grave?
P.2 Education has caused very many children to die when actually they would not be dying. Children used to fear God and their parents, but now, education has brought many problems among children. The white man brought us many problems and we shall never overcome them.
—rural focus group, women age 50–60

Conclusion

Respondents perceived spontaneous abortions to happen frequently with the primary causes being malaria, syphilis or previous contraceptive use. The perception that contraceptive use leads to future spontaneous abortions is a dangerous misperception since it may serve to further decrease modern contraceptive use in a country that already has a low rate of contraceptive use.

The data show that respondents, including HCPs, conflate spontaneous abortion with induced abortion, and report similar potential complications for both. The lack of a clear distinction between the two types of abortion may be because of intentional mislabelling of an induced abortion as spontaneous by women, but it may also be a result of the social framing of abortion (i.e., that it is possible to induce a spontaneous abortion). Furthermore, to the extent that health care providers and other witnesses believe the woman that she is suffering from spontaneous abortion complications when she really induced, these other people may believe they are truly witnessing complications from spontaneous abortion. Therefore, to an unknown extent, the findings on spontaneous abortion may be applicable to experiences of induced abortion.

The respondents perceived most women with an unwanted pregnancy to carry the pregnancy to term, but they also perceived abortion to be common. One possible explanation for this is that the respondents may not be counting abortions as unwanted pregnancies. An alternative explanation is that the respondents' responses are inherently inconsistent since if abortion is common for unwanted pregnancies it is not possible for the majority of unwanted pregnancies to be carried to term.

Stopping a pregnancy is perceived to be a fairly common occurrence among schoolgirls in particular, despite the difficulties and health consequences associated with obtaining an abortion. Money is the primary determinant of where a woman obtains an abortion and consequently the safety of that abortion. The majority of men were not supportive of women's de-

sire to stop a pregnancy and did not think that men in the community should be supportive, yet they made an exception for schoolgirls. Abortion among married women remains largely invisible to men. Men have a general lack of comprehension of what an unwanted pregnancy means for married women: Males said that women who are married should not abort because they are not in school and thus do not have much to lose by being pregnant, which ignores the personal circumstances of many married women's lives. There was an absence of any discussion by men about the possible need for therapeutic abortion. This lack of empathy generally characterized men's attitudes towards women's private experiences with abortion. The few respondents who provided detailed information about their or their partner's personal experience with abortion substantiated community perceptions about who gets abortions and the methods women use.

Chapter 5

Abortion Complications and Treatment

This chapter presents the most common abortion complications women experience, the proximate determinants of those causes, the extent of women's access to hospitals or other modern health facilities to treat abortion complications, and the experiences of women with abortion complications who do not reach a formal health facility. Little is know about whether this last group of women receives no care, receives care from traditional healers or whether they die before getting access to modern health care.

We report findings on abortion complications based on the literal translation from the local languages in which the interviews were conducted but some of the concepts which were discussed in these local languages do not translate easily. One of these concepts which came up frequently in the interviews is the term *"nabaana avunze,"* meaning "rotting uterus." A rotting uterus in Luganda means a uterus that has been damaged or is necrotizing as a result of injury, in this case, caused by an abortion. It can be a short-term medical complication if addressed quickly. If untreated, it can lead to long-term complications including permanent damage of the uterus, damage to other organs, and removal of the uterus. Therefore, this is the interpretation of that term as it appears in the text.

Types of Short- and Long-Term Abortion Complications

A short-term health problem was defined as lasting less than three months. The most commonly mentioned short-term abortion complications were bleeding, abdominal/stomach pain, infection (sepsis)/"rotting uterus" and retained fetal parts in the womb. Other types of complications less frequently identified were weakness, general pain, being sick, unspecified pain, vomiting, becoming thin, dehydration, weight loss, headaches, dizziness, nausea and fever. Of the respondents who said they had attempted abortion, most described short-term complications such as stomach pains, bleeding and fever. A woman who had a failed abortion attempt recounted the following experience:

R. I used emuhoko. *I drank it and vomited to death.*
I. I thought emuhoko itself can kill a person?
R. It may be because, personally, I was about to die. I vomited so much almost to death and I stopped. But after vomiting I got better. I vomited like for five hours, but not consecutively.
I. What did you do or what did you use to treat yourself?
R. I didn't do anything because I never wanted anybody to see me.
I. But didn't you do anything since you were feeling weak?
R. I didn't know anything to use.
I. How long did it take you to feel the stomach pains?
R. It [the vomiting] stopped on that very day. I didn't even go to any health unit.
—Rural female aged 40

A long-term health problem was defined as lasting longer than three months. Damage to the uterus, including uterine removal, anemia and infertility, were the most frequently mentioned long-term complications.

If she had her uterus injured in the process of stopping the pregnancy, the injured uterus can be removed and the woman fails to get pregnant again. If the uterus got injured in the process of stopping the pregnancy, one may not survive.
—Urban focus group, women aged 18–25

If some [fetal] particles remained in the uterus, the uterus gets rotten and it can be removed. If one went early and the uterus was cleaned she can be okay but if she delayed, the uterus can get rotten and be removed. Such a woman whose uterus is removed cannot be able to produce again.
—Urban woman aged 32

Other long-term problems were believed to include urination problems described as a continuous leaking of urine and associated with having a bad smell (clinically known as fistula), spontaneous abortions and cancer.* In some instances, respondents provided information on the duration of the complication, which resulted in some short-term complications actually being long-term complications. For example, one respondent mentioned that someone experienced bleeding related to abortion complications for a year.

Reasons for infertility as a consequence of abortion complications other than the ones above included if the woman had stopped several pregnancies, if her ovaries had been burned by health providers† who might purposefully harm the woman and if "the babies women kill as they stop the pregnancies curse them and they fail to get pregnant again" (urban focus group, women aged 36–49). Other perceived causes of infertility were that the abortion was badly done, the woman had complications, the woman did not seek treatment or the woman had had several or "too many" abortions. Having trouble in the future getting pregnant because "God only gave her one egg" and infertility being a punishment from God were brought up by a few people.

I think it can affect her ability to get pregnant again because you might find that God had given her only five eggs which she aborted and became infertile.
—Rural male aged 36

Reasons given by health care providers (HCPs) for women not being able to get pregnant after stopping a pregnancy included if drugs or herbs were used improperly to stop the pregnancy (by the woman or by a provider), the abortion procedure having been done poorly or the woman having delayed getting care and thus contracting an infection.

Other long-term complications that were not equated directly with infertility were damage to the woman's reproductive organs, a problem in her fallopian tubes, chronic inflammatory diseases, bad health, being sick and weak, cancer and psychological problems. Psychological problems included feeling tortured because of having had an abortion or experiencing regret and guilt. One respondent who had used local herbs to abort identified pain in her lower abdomen during sex as a long-term health consequence resulting from her abortion.

Having a bad smell, chronic illness, stomach pain, anemia and weakness were mentioned by some women as health consequences women suffer even if they receive immediate care for complications. Death was the most frequently cited consequence of delaying care, not receiving care at all or being attended to by an untrained provider. Two of the four focus groups in Kampala discussed how women may think about committing suicide because they do not have money to seek treatment or because having complications make women feel helpless.

Causes of Complications

Traditional methods, typically herbal methods, were seen as the main cause of short-term complications (e.g., vomiting, diarrhea, heavy bleeding) and long-term health consequences (e.g., uterine cancer, death). The complications can be a result of the incorrect use of herbs, overdoses, uterine damage caused by being pierced with *ennanda* or a sharp instrument, and incomplete abortion, in which the woman retains placenta or fetal parts which can decompose inside her and lead to death from septic shock.

P1. I have heard many cases of women who die in the process of stopping pregnancies, especially those who use herbs.
P2. There is a girl I saw when I was young. She was given herbs by the traditional healer but she died.
—Urban focus group, women aged 20–35

M. What methods of abortion do you think cause the most serious complications?
P. Using traditional herbs may cause bigger problems because the fetus comes out in parts. Some parts are retained and they rot in the uterus. There

Case study: Herbs are a frequent cause of complications

A 35-year-old woman from Kampala recounted how her sister attempted to stop a pregnancy by using the herb *oluwoko*. Her sister experienced diarrhea and vomiting as a result and nearly died. Her friends took her to the health unit for treatment. The abortion attempt had failed and so she later ended up giving birth.

*There is no evidence linking abortion or abortion complications of any sort to cancer.

†Women explained that certain health workers use chemicals (drugs) which might cause damage to the uterus to cause the abortion and that these drugs had the potential of burning women's ovaries and causing infertility.

is a person who I know, it happened to her, and she was taken to the hospital for evacuation. Since then she has never gotten pregnant again.
—Rural focus group, women aged 20–35

I. Do these self-induced methods succeed in stopping the pregnancy?
R. [The women] end up dying. Some use ennanda and pierce the fetus in the uterus. They bleed until they die. They pierce the uterus because they want the pregnancy to just bleed out. They bleed nonstop until they go into a coma.
—Urban nurse, female aged 23

Even women who go to modern providers are perceived to be at risk of experiencing complications. In two focus group discussions (FGDs), participants said that going to a trained provider can result in the same complications as going to an untrained provider. Participants referred to modern providers making mistakes, accidentally perforating the uterus and generally being inexperienced in conducting abortions. Machines modern providers use were perceived to have the potential to result in a perforated uterus, a damaged bladder, heavy bleeding and death.

P1. 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 it is illegal.
M. Do all modern providers know what to do?
P2. 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

A medical doctor explained that since the abortion procedure is not legal, there are no guides on how it should be done and therefore providers are apt to carry out the procedure incorrectly, injuring the woman in the process.

Treatment Options

Most respondents reported that women who seek care for abortion complications tend to seek modern services, primarily in hospitals (typically for more severe complications) or clinics (typically for minor complications). Women were described as either going for services immediately when they experienced serious complications or when self-treatment or traditional methods failed.

A minority of the respondents thought women were more likely to rely first—and possibly only—on herbs and traditional providers to treat abortion complications. While lack of money is one factor that restricts women's access to modern providers, women's belief in traditional medicine is one of the reasons why women go to a traditional healer.

I think the traditional herbs work. Sometimes you ask yourself, "If the herbs worked for people of long ago, why not for me?" So most women trust it. For example, our mothers and grandmothers would tell us that the local herbs work well and that all the tablets and modern drugs are made out of the local herbs.
—Rural female aged 30

Other less frequently named sources of treatment for complications were drugs (type of drug not specified) bought from shops or clinics; injections from hospitals, clinics, or dispensaries; and massages.

Social Support for Treating Abortion Complications

Participants reported that women may seek treatment alone, may be accompanied by the male involved in the pregnancy (if he was informed of the abortion and if he agreed to the abortion), or may be accompanied by a family member who is close to the woman, most frequently mothers. The main reason why women go alone is to keep the abortion a secret.

M. What are some reasons that some women want to go alone?
P1. She could fear to tell the mother because the mother will kill her. She decides, "Let me go alone, if I am to die, I die." She goes alone and seeks treatment.
P2. Others fear gossip. She could go with a friend and the friend spreads the rumors, yet she wants it kept a secret. So she decides to go alone. When things go bad, she ends up telling the parents and it brings her problems.
P3. The mother/father could be too harsh and could refuse to pay her school fees if she discloses that she did such a thing.
P4. There are some nurses who are harsh and could tell you not to tell anyone that she helped you abort. So if you get problems later, it becomes hard

for you to go to her with someone because she told you at first that "I am going to treat you but I don't want you to tell any one."
—Rural focus group, women aged 18–25

The illegality of and stigma surrounding abortion in Uganda encourage women to deal with abortion complications alone out of the need to protect the identity of the provider, as well as the fear of the social shame of being identified as having had an abortion. These constraints, of course, increase the health risks to the woman.

When men do provide support, they provide financial support such as buy the woman medicine, arrange for transportation or take the woman to a facility for treatment.

For me, if I agree with my partner to abort,…I go to the clinic/hospital and buy her medicine. If it requires taking her to the hospital I take her. If it requires buying her energy building foods, I can buy them.
—Rural male aged 40

As a man, if you really love your wife, especially those who are married, the man has that duty to support the women in this matter. You have to seek treatment for her. You don't just leave her to seek treatment herself. You don't just leave her like that! This is one of the responsibilities of the husband in the home.
—Urban male aged 40

I. What do men do when their wives or partners experience health problems after stopping or attempting to stop a pregnancy?
R. The man and woman face this problem alone in their house. But if these two people, man and woman, have a common understanding, the man cares and makes sure the woman gets treatment. But if a woman stopped a pregnancy without the knowledge of the man because the woman no longer loves man, the man does not care. The woman suffers alone.
—Urban male aged 46

Not having money was mentioned by a couple of men as a reason why males may not provide support for abortion complications.

The Cost of Treatment for Postabortion Complications

A delay of 2–7 days was perceived to be the amount of time women generally wait before seeking care. The consensus among the respondents was that women are more likely to seek care immediately if they have money or experience more serious and immediate health complications, although even with serious complications, women who reside in rural areas are perceived to have a harder time accessing care.

Obtaining a cost estimate from the respondents for treating abortion complications was difficult, since most respondents said it depended on the severity of the complication. The cost estimates from the men and women IDI respondents ranged from UGS3,000 to UGS200,000 (equal to about US$1.50–110), while the cost estimates from the HCPs were lower, ranging from UGS2,000 to UGS100,000 (equal to about US$1–55). One reason that the estimates from the men and women might be higher is that they may have been including in their estimate more than one step in obtaining care (e.g., first from a traditional provider, perhaps then from a pharmacy, and then from a medical facility). They may also have included costs of medication and transportation to the source of care in their estimates. HCPs are likely reporting the direct costs charged to a patient for the single step in treatment in which they are involved.

The barrier of not having money to pay for treatment constitutes one of the primary reasons women delay obtaining care.

M. Do they go for treatment immediately?
P1. Some do and others delay and wait until the health situation worsens.
P2. They are usually forced by other people to go for treatment.
M. Hw long do they usually wait before seeking any treatment?
P3. A woman can spend a month without going for treatment. You can find her when she is already rotten. She is in the house and it is up to you, the sympathizers, to take her for treatment.
P4. 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

Overall, respondents indicated that health facilities are available in the community but that money alone guarantees access to safe treatment. A number of re-

spondents said that providers attend first to patients who have money and that patients with money are treated well. While having money was specified as a prerequisite to getting treated at clinics (private health units), it also speeds up the treatment one receives at the hospital (public health unit).

There are clinics in this area but they require money. The nurses can treat you/care for you very well. If someone needs treatment for abortion complications she can get it as long as she has the money.
—Rural female aged 50

I. How easy or difficult is it to get treatment for abortion complications in a hospital?
R. If one has enough money, then treatment becomes easy. But if there is no money, the victim is forced to seek treatment from the public hospital, which is congested—where people push each other for services, etc. It is not easy, anyway.
I. Does this cost anything?
R. Well some are treated free of charge but those ones are treated last. They first treat those with money.
—Urban male aged 22

Most HCPs reported that women will have to pay a fee for treatment, except perhaps in hospitals, although, echoing what the men and women IDI respondents said, money gets one faster treatment.

I. Is it easy for women to access health services?
R. To some, it is easy but to some it is not easy because of their low income and in these [private] health facilities, they require them to pay money and that means that some of them cannot access these health services, so they have to resort to coming only to these government health centers where they can get cheaper services.
—Urban dispensary personnel, male aged 28

I. Do women need to pay for the treatment?
R. In most of the health units, women have to pay for the treatment. Those who go to clinics have to pay. Those who go to health units such as Namuggoona clinic have to pay. Even those who go to Mulago Hospital [a public hospital] pay in order to be attended to quickly.
—Urban traditional birth attendant, female aged 49

A few men and women IDI respondents said some providers do not give preferential treatment to women with money but rather do their job by attending to those in need. The majority of HCPs reported that wherever women go for care, those who experience severe complications are treated immediately and their cases are handled as an emergency, irrespective of financial need.

When respondents were asked why they think that women seek treatment from traditional providers, the most frequent response given was the cheaper cost of getting treatment from traditional providers.

I. In your opinion why do you think certain women prefer to seek treatment from traditional providers?
R. I think these traditional people are near to them; they may not demand money up front. I think they have more personal attachments to those people than people in the clinics.
I. What about the payments?
R. Even payments are negotiable. You may be allowed to pay in kind or you may be allowed to pay later.
—Rural medical doctor, male aged 43

If a woman had money, she would try the modern medical providers and would resort to traditional providers only when the modern providers have failed. It is because of lack of money someone begins with traditional providers.
—Rural male aged 37

Attitudes of Providers

Modern providers were described by men and women IDI respondents as displaying negative attitudes towards patients who come in for treatment of abortion complications: They are perceived to question women about their decisions to stop a pregnancy, they can call for the woman's arrest and imprisonment; they can "abuse" women (one way of doing this is by making them wait for treatment); and they can question them about how they attempted to induce an abortion before providing treatment. Fear of being questioned by providers constitutes one of the primary reasons identified by the respondents for why women delay seeking treatment for abortion complications.

What I know is they abuse the women because stopping a pregnancy is killing a human being. They first accuse her and after that . . . refer her to Mulago Hospital.
—Urban female aged 42

A minority of HCPs said that either they treat abortion complication patients badly or that other HCPs treat these women badly. Some HCPs specified that providers in government facilities were sometimes rude.

The health workers in the government hospitals are sometimes rude; I don't know why. The reason why we the 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. But those in government health centers don't give a damn; you either come if you want or you don't. They don't stand to lose by your not coming.
—Rural dispensary personnel, female aged 25

They [women with abortion complications] are not at all discriminated [against]. They are given the treatment required, as long as they go there with the money to pay for their treatment. Discrimination may be in Mulago where treatment is free, but in private hospitals, patients are treated equally.
—Urban traditional birth attendant, female aged 39

While these providers perceive HCPs in government facilities not to work for money, evidence presented earlier indicates that even in government facilities, which are supposed to provide free care, money influences the kind of treatment women receive.

For those HCPs who thought that such patients were badly treated by health workers, the main reason cited for why this happened was that health workers did not approve of the woman having stopped a pregnancy. Aware of this prejudice, men and women IDI respondents stated that some women do not inform the provider of the real cause of abortion complications (for example, a woman may say she did it unintentionally or that she had a spontaneous abortion) for fear of provider prejudice and in order to avoid "bad treatment" (see description of abortion practice in Chapter 4).

Yet most of HCP respondents said that HCPs treat women seeking treatment for abortion complications professionally and without prejudice.

R. They [other HCPs] don't rebuke the women. They treat them well and even give them counseling.
I. Why do the providers treat the women in that way?
R. They do so so that they make the women feel free to contact them whenever they get health problems.
—Urban nurse, female aged 25

I think the treatment is not bad. They [other HCPs] treat them professionally. We are not supposed to mistreat patients. We care for women [with abortion complications] well, like any other patients. Even if you kill a person and get injured and you come for treatment, we treat you as a patient and don't discriminate against you. Those are our professional ethics.
—Rural medical doctor, male aged 28

Respondents perceived traditional providers to provide friendlier services.

The traditional provider may be the one more accessible to her. She finds it easier to approach the traditional provider than approaching 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 taken money, first they neglect you and then abuse you, and you regret why you went to them.
—Urban female aged 49

I. In your opinion, why do you think certain women prefer to seek treatment from traditional providers?
R. Lack of money to go to modern health providers and, again, traditional providers are accessible. They also handle women well compared to the modern health workers. The modern health workers can also spread the rumor about her. But the traditional providers keep it a secret. More so the traditional providers are cheap.
—Rural traditional birth attendant, female aged 50

Provider's personal experiences providing treatment for abortion complications

HCPs said that they treat women who experience minor abortion complications with drugs, antibiotics or herbs (mentioned by a traditional provider). Midwives said they used squeezing/pressing on the stomach as a treatment to get out retained fetal products and/or blood clots. For women who present more severe complications (for example, bleeding, retained placentas, incomplete abortions or severe abdominal pain), HCPs primarily from Kampala said they refer women to hos-

pitals, since hospitals are able to handle these more severe cases.

If they don't come with severe complications, I give them antibiotics. If one comes with severe complications such as severe abdominal pain, I refer her to the hospital. But if one comes without heavy bleeding, and does not have a bad smell, I give her antibiotics.
—Urban nurse, female aged 23

In most cases I don't provide it [health care for women who experience complications]. In that situation I refer them to Mulago or other bigger hospitals because I can't tell what is inside their bodies or what complication they have in particular. So I send them to bigger hospitals. I feel I can't manage such cases.
—Urban drug shop pharmacist, female aged 23

HCPs say they also refer women to doctors, more experienced providers, clinics (private) and health centers (public).

Other factors which influence access to health care

Most of respondents said that health facilities that could treat abortion complications are near (less than three miles away) and accessible, and that distance to health facilities was not a barrier to accessing services. A few providers, mainly those residing in Mbarara said, however, that facilities were far and one drug shop pharmacist specified that some women die because of long distances to health centers. In spite of the fact that health facilities are generally accessible, there was an awareness that many health care providers are not able to handle abortion complications and so a woman appearing with abortion complications is frequently referred somewhere else and that place may be inaccessible to her because of distance, the time it takes to travel there, the time it takes to receive treatment there or the price of receiving treatment there.

Only a few of the HCPs said that women were required to meet certain prerequisites before obtaining the needed health care such as providing supplies: gloves, drugs and a polythene paper (how this is used is not specified) or providing background information including where the patient ended the pregnancy, who attended to her, and what method was used. Another less frequently mentioned criteria for seeking care was that women prefer to go to locations that are outside of their community because it means they are less likely to encounter people they know there.

Other than logistical concerns, the main reasons for delaying seeking treatment were fear of telling someone, fear of being questioned (by nonmedical personnel) and fear of being arrested. Other reasons for delay that were mentioned less frequently were ignorance of the symptoms of abortion complications or of the need to seek care, waiting for complications to disappear in the hopes of getting better, first trying local herbs and only seeking treatment when badly off or when the woman feared death.

I. You have said some delay [obtaining postabortion care] and are taken to a health facility when in a sorry state.
R. Because there are some who stop pregnancies and fear to be known, they decide to keep at home and treat themselves, hoping it is easy to recover but end up having their health situation worsen and are later taken to health facilities.
—Urban female aged 49

I. Do women seek health care as soon as they notice they have a problem?
R. It takes them time. Some feel shy and keep quiet, hoping to get fine. But when they worsen and fear they are going to die, when they cannot even walk or stand by themselves without support, they talk and they are taken to a health center.
—Rural dispensary personnel, female aged 25

Comparing getting treatment for complications today versus in the past, participants between the ages of 50–60 said that today it is easier to get treatment due

Case study: Women not seeking care on their own when needed

A 50–year-old woman from Mbarara related the story of a woman she knew who had gotten pregnant with a lover while she was married and she feared being abused by her husband, so she had an abortion. Her uterus was damaged during the abortion procedure and, as a result, the woman fell ill and experienced heavy bleeding. The woman "kept quiet over it" but eventually her health condition worsened to the point that she was taken to the hospital in critical condition and was not able to recover. Prior to dying, she confessed that she had aborted and named the person who helped her. That person was subsequently arrested.

to the abundance of health care facilities and the availability of modern methods to treat complications.

P.11. These days, people go to modern providers, get injections and tablets to treat complications. Within a few days, the woman gets better. In the past, women used herbs to treat complications and it could take a woman many days to get better.
M. How?
P.9. In the past, when a woman stopped a pregnancy, she could not go to health care providers to get the womb cleaned. She could just use herbs.
P.5. In the past, women mainly used herbs to treat the complications, but today, they go to modern providers to get injections and tablets.
—Urban focus group, women aged 50–60

Reasons for and Consequences of Not Seeking Care

Reasons why some women do not seek care at all echo the findings on why women delay seeking treatment. The main reasons given for not seeking care were lack of money and fear, including fears that people will know the woman stopped the pregnancy, fear of being questioned by the provider, fear of rumors and fear of being arrested. Fear was more likely to have been mentioned by residents from Kampala than residents from Mbarara.

I. What are the reasons some women do not seek care?
R. Those are women who stopped pregnancies secretly and don't want their husbands to know about it. […] Others just fear to go to the health providers thinking the providers will abuse them for stopping the pregnancy.
—Urban female aged 20

They [women who do not seek care] 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. Most of the pregnancies are stopped using the help of the traditional providers or people who know the drugs. Women fear that if they go to a hospital for treatment they can be arrested and asked to reveal the people who helped them stop the pregnancies.
—Urban female aged 44

Ignorance was also named as a reason women do not seek care—women do not know that they are supposed to seek care.

I. Why do some women not seek care when they have abortion complications?
R. It is because of ignorance. When the fetus comes out, they do not get to know what remains inside. The daughter of a friend of mine died under similar circumstances. She fell very sick after stopping a pregnancy and she never sought treatment. By the time the father realized it, and decided to take her for treatment, it was too late and she died.
—Urban male aged 40

As the narratives above illustrate, death due to heavy bleeding, sepsis or infection of one's reproductive organs is perceived to be the most common consequence for women who do not seek care.

I. What happens to these women who do not seek health care to treat their abortion complications?
R. The infection becomes severe and she is brought to hospital at the verge of death. The end result is death for those who do not seek care at all.
—Rural midwife, female aged 38

There is a woman I know who was a widow and remained in her home looking after her children. Then she got pregnant. She went somewhere to abort. She was given the herbs and she went back to her home to wait for the fetus to come out but she did not get a complete abortion. The fetus did not come out completely. It ended up rotting inside the uterus and would come out in pieces. After some time she said she was weak. She only revealed her secret at the point of death and without going for treatment.
—Rural male aged 40

Other less frequently mentioned complications from not seeking care were infertility, anemia and uterine removal. Resistance to seeking treatment, while not only grounded in fear and shame, may also be related to the traditional treatment of pregnancy as a test of endurance which does not support women seeking care for pregnancy-related problems (see Introduction for a further explanation of this idea).[38]

Conclusion

The main causes of abortion complications were identified as resulting from the use of herbs, lack of care and inadequate care. There were a few noteworthy differences regarding the types of abortion complications identified, according to residence. Women from Kam-

pala were more likely to cite bleeding and damage to the uterus than their counterparts in Mbarara. Death, damage to the uterus, infertility and anemia were mentioned more frequently as complications by HCPs residing in Kampala than those in Mbarara. Psychological problems were only mentioned in the Kampala FGDs. Therefore, what are perceived to be abortion complications may be influenced by region-specific health understandings.

A number of barriers were described to obtaining treatment, including fear, lack of money and perceived negative provider attitudes toward patients seeking treatment for abortion complications. Money was seen as improving access to treatment even from public facilities, even though this treatment should be free. While it seems that there remain primarily price barriers that hinder women's access to modern providers, the respondents perceived modern providers to be more commonly used to treat abortion complications than traditional providers. Men stated that they would be supportive and help their girlfriend/wife if she experienced abortion complications under the condition that they had agreed to the abortion together. Otherwise, women were largely left without social support. The primary reasons for not seeking care were the same as the reasons why women delay seeking care. Consequences mentioned for not seeking care were death due to heavy bleeding or sepsis.

There is incongruence between how individuals outside of the health sector perceive providers to treat patients seeking treatment for abortion complications and how HCPs view how they and their colleagues treat these women, with the former being quite negative and the later being overall positive. Some reasons why this might be the case are that health care providers might be unwilling to disclose discriminatory practices, it may be that this used to be much more common than it is today, and that it may only be a minority of providers who engage in discriminatory behavior but that their reputations outside of the health community might go far beyond their sphere of influence.

Another source of disagreement between these two groups of individuals is whether money is necessary to be treated well. While individuals outside of the health sector stated that money was necessary to be treated even in a public facility, providers stated that they are trained to treat individuals equally and that all who come to a public facility deserve to be treated. This discrepancy could be accounted for by the fact that HCPs wanted to present the most socially approved of responses to the interviewers and therefore did not want to admit to any unethical behavior that they had committed. Additionally or alternatively, rumors about the need to pay medical bribes may be more common than the practice itself.

It was common for HCPs to say they referred women with abortion complications elsewhere. This may have been a result of a mistrust of the interviewers by the HCPs and/or the respondents' desire to distance themselves from anything related to abortion. Not being able to get to the provider to which they were referred was seen as a barrier to obtaining appropriate medical care by respondents, so if women are being referred at the rate that they seem to be getting referred by HCPs, this may constitute a significant barrier to getting appropriate care.

Chapter 6

Social and Economic Consequences of Abortion Morbidity

This chapter highlights the social and economic consequences of abortion morbidity within the Uganda cultural context. Very little information has existed to date on the social and economic costs of abortion morbidity. Respondents identified social and personal consequences of abortion complications, including the community reaction towards women who have had an abortion; the main economic consequence of abortion; and the ways in which abortion complications impact women's daily lives.

Social and Personal Consequences

Respondents stated that it is generally not possible for women to keep their abortions a secret, especially if they experiences complications.

I. How did they get to know [that she had had an abortion]?
R. They have to know because a bad act can't fail to be known. She went to the health unit without any sickness and then they found her dead body in a clinic….Some can tell a neighbor that a person has died….The neighbor will tell another and the news will spread.
—Rural female aged 48

Women from Mbarara were much more likely than those from Kampala to say that women who have an abortion are not able to keep it a secret. A few respondents said that women are able to keep their abortions secret if they go alone to get the abortion, if they do not tell anyone about it and if they do not experience complications.

When participants in the focus group discussions (FGDs) were asked how women manage when people find out they stopped a pregnancy, they said that women tend to feel uneasy, uncomfortable, ashamed and not free to relate with other people. The community reaction towards women who have stopped a pregnancy was overwhelmingly negative, with the community reaction in Mbarara stronger than the community reaction in Kampala. Women who have had abortions are viewed as murderers, criminals and/or prostitutes, and are abused, ridiculed, gossiped about and disrespected.

M. What is the general opinion in this community of women who have an abortion?
P1. It is a shameful act.
P2. They see it as an inhuman and criminal act. […]
P3. It is the same as if they saw a married woman having sex out of wedlock. They regard you as a prostitute.
P4.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

I. How would people from the community react if they found out that a woman interrupted her pregnancy?
R. She becomes the laughing stock for the village. No one can sympathize with her when she gets complications.
—Rural female aged 60

If they find her, they arrest her and take her to the police. The community is against abortion. They talk about this thing, 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 male aged 28

Respondents agreed that most men react negatively when they find out that a woman stopped a pregnancy. Respondents from Mbarara said men are likely to chase the wife away from home, men may abuse the woman and/or the abortion can lead to family conflict which

can lead to the couple getting divorced/separated, especially if the husband/partner had not been part of the decision to stop the pregnancy.

R. It is very bad. The man can chase her away from home.
I. Are there some men who are supportive when their wives have abortion complications?
R. […] If the woman aborted, the man cannot support her.
—Rural male aged 37

Some men said that the man would have to get another lover or wife if his wife had an abortion because his wife would be weak, because she would no longer please him or because he would like to produce children.

I. Are men able to work when women experience abortion complications?
R. A man continues doing his daily activities only that he may be forced to cheat on his wife and produce children outside marriage because the one who aborts proves that she does not want to produce.
—Rural male aged 34

Other social repercussions that were identified were not having marriage prospects, pain during intercourse, not being able to carry out normal activities and having to drop out of school. A few men and women said that women are unable to have sex as a consequence of abortion complications guaranteeing that her husband divorce her or take another wife.

Economic Consequences

The main economic consequence of abortion complications (mentioned in general or as a result of delaying treatment or going to an untrained provider) was income reduction due to the woman's inability to work or because of the loss of her job or the man having to take time off to help the woman.

P1. She spends a lot of money on treatment and some days without working. By the time she resumes work, she can even fail to get more capital to invest in her business.
P2. When she stops a pregnancy, her income reduces because she cannot work.
—Urban focus group, women aged 50–60

Most respondents mentioned that the woman or the family experiences a significant loss of wages due to women being unable to work. Only a few respondents were able to quantify an amount. Their estimates ranged from UGS10,000 to 60,000 (US$6–33).

In addition to the loss of wages, spending money on the treatment of abortion complications also presented the woman and sometimes her family with an economic burden.

I. How do women's complications affect their husbands or partners personally?
R. The man? Seeing a woman sick and unable to work affects the man. The man has to spend money on treating the women and so he gets financially affected. Most of his money is spent on treating the women's complications.
—Urban male aged 23

In the FGDs, delaying treatment or going first to an untrained provider were described as increasing the overall costs related to the abortion complication. Participants mentioned that money used for treatment may come out of the children's school fees, which may prevent children from continuing their schooling.

According to the respondents, women who experience abortion complications are most likely unable to engage in daily activities. The main activities women cannot do are what the respondents called "hard jobs" such as digging, lifting or carrying heavy things. Washing clothes (and bending over), fetching water and cooking were also identified as daily activities which women could potentially no longer perform if they suffered from abortion complications. Cooking, however, was identified by other respondents as a light task that women could perform along with other tasks such as washing utensils, looking after children, and doing simple tasks even after they suffered from abortion complications. The main reason identified as to why women cannot perform certain responsibilities is because they are experiencing pain or feeling weak. When women are not able to do their daily activities, neighbors, friends, relatives or the husband can take over some of her daily responsibilities. If the family has money, housemaids must be hired to help out.

The range of time respondents estimated that women's daily activities are affected when they experience abortion complications was 4–5 days to six months. One respondent said that it would take a year and another said "all life." Men, in general, estimated a longer period of disability than females.

Respondents who had personal experiences dealing

with abortion complications described women's daily activities as being affected by the short-term complications of the abortion. Some of the activities women could no longer engage in were cooking, washing, fetching water and working.

I. What specific things was she unable to do during the time she was feeling pain?
R. She could not do anything. Not even washing the utensils or lighting the charcoal stove. It is her friend who did the work for her.
I. For how long?
R. For about four days only.
—Rural male aged 36

Conclusion

The social and economic consequences of abortion described in this chapter show that these abortion complications place a heavy burden not just on women, but also her family and her community. Women are typically not able to keep their abortion a secret. Once their secret gets out, the community reaction, including that of the partner involved in the pregnancy, towards a woman who has experienced an abortion is strongly disapproving, ridiculing and abusive and it may have a long-term impact on her social status.

The greatest economic impact of abortion morbidity cited by the respondents comes from the income loss which is due to a woman's inability to work, the man's time off of work to care for the woman and/or the money spent on treatment. Women's daily activities such as lifting and fetching water are believed to be greatly impacted by abortion complications and women may be unable to perform their usual daily activities for anywhere from a few days to half a year, further stressing her social relations. Due to the incomplete and conditional information presented on estimates of the impact of abortion complications on women's daily activities, it was not possible to calculate from the data disability adjusted life years. Abortion complications due to unsafe abortion not only present health consequences for women but the impact of the complications can be felt across the social and economic spectra of her life, impacting her marriage, possibly resulting in her children dropping out of school, and straining her social ties to others in the community.

Chapter 7

Program and Policy Implications

This report, based on qualitative data collected in Kampala and Mbarara from community members and health care providers, presents new evidence on the reasons for unwanted pregnancy, abortion practice, health problems women experience as a result of stopping a pregnancy, actions women take to obtain treatment, barriers they face in obtaining treatment and the social and economic consequences of abortion. These findings have programmatic and policy implications for improving the lives of women, their families and community members who are impacted by the morbidity and mortality associated with unsafe abortion.

The abortion law in Uganda is the result of laws promulgated by English colonizers in the nineteenth century. At that time, abortion was illegal in Europe and so the laws in the territories were a natural extension of the laws at home. Since then, abortion has been legalized in Europe, but the old laws have not been revised in this former colony.[39] The abortion law is currently being discussed in Uganda and there is support within some factions of the government to revise the current restrictions on abortion to make it more accessible. While the current restrictions are being debated, steps can be taken to help women avoid unwanted pregnancies and reduce the probability that they will suffer from untreated abortion complications and social stigma regarding abortion.

Prevent Unwanted Pregnancy and Unsafe Abortion Through Contraceptive Use

The widespread perception of the high prevalence of unwanted pregnancies and abortion in the respondents' communities, a perception that is supported by recent quantitative evidence[40], indicates a dearth of use of family planning methods. To address the burden of unwanted pregnancy and thus reduce unsafe abortions, there are two major avenues of appropriate intervention: public education about pregnancy prevention, including abstinence and contraceptive use, and contraceptive services.

Many respondents expressed negative attitudes towards contraceptive use, including the perception that women get pregnant while using family planning methods and that family planning use leads to future spontaneous abortions. Misconceptions such as these are likely playing a part in depressing the country's already low contraceptive use rate. Ignorance about family planning methods was named as another reason for unwanted pregnancies occurring. Educational efforts targeted at improving individuals' understanding of how contraceptives prevent pregnancy and providing accurate information on contraceptive effectiveness, including possible medically verifiable side-effects, would help individuals make more informed contraceptive decisions. Information about the high failure rate of withdrawal and other traditional methods of contraception should be included in the same education efforts to justify the promotion of modern methods as the preferred methods.

The majority of respondents saw youths, particularly girls in school, as the group most at risk of experiencing an unwanted pregnancy and having an abortion. Currently, 38% of sexually active* 15–19-year-old unmarried women are using a contraceptive method.[41] There is a need, therefore, for sexuality education to begin early, preferably at the beginning of adolescence. The most effective place for this information to be disseminated is through schools. The current provision of sexuality education is unequal, and the qualifications of the educators are generally inadequate.[42] Comprehensive sex education that is developmentally appropriate and provides information on relationships, decision-making and skill building on how to resist peer pressure, how to postpone sexual involvement and how to protect oneself when sexually active would provide young people with tools to help protect their sexual and reproductive health. As teachers are respected community members, with adequate training, they could be

*Defined as having had sex in the three months prior to the survey.

effective conduits of this information.

To reach the population at large, including youth who are no longer in school, the mass media could be used to disseminate information about contraception. Approaches such as the Enter-Educate approach could also be used to disseminate information via avenues such as popular soap operas. Uganda has undertaken an aggressive information campaign to address HIV, involving government programs, nonprofit agencies and the mass media, and they have initiated outreach programs which include free hotlines, phone-in radio programs, Internet outreach and print media resources. These same networks could be used to distribute contraceptive information. Health care providers could also provide education about contraception when women receive counseling at maternal/child health centers or other health clinics. Another point of entry would be at postabortion care facilities.

Another reason given for unwanted pregnancies occurring was that women have difficulty using contraceptive methods correctly and consistently. This can be because appropriate/preferred methods are unavailable or inaccessible. Therefore, a wide range of contraceptive methods that meet the specific needs of all women should be made available and affordable, possibly with the assistance of government or donor subsidies. When appropriate, long-term contraceptive methods should be more widely available, as methods such as injections or IUDs are highly effective and reduce the possibility of user error. Personal and community mechanisms for improving adherence to family planning directions should also be encouraged.

Men's reluctance was also named as a barrier to contraceptive use. Very little has been done to encourage couples' communication regarding contraceptive use in Uganda. One strategy that could be used for encouraging dialogue between couples could be to stress to men the advantages of family planning use for child spacing, as well as for the health of women. In Uganda, as in most places of the world, reproductive health services have typically not targeted males.[43] Therefore, extra effort must go in to making facilities available and receptive to educating and treating men of all ages. Men should also be educated about the safety of vasectomy.

Access to contraceptive methods, primarily condoms but possibly emergency contraception as well, could be provided via the existing network of public and private NGO health facilities and other places likely to be convenient for young people, including schools, discos, teenage/youth centers and any other places that young people congregate. Commercial sex workers are seen as another group likely to experience an unwanted pregnancy. Therefore, brothels, or any place that sex workers congregate, should also be a distribution point for contraceptive services. Given the additional risk of HIV for all sexually active persons, the provision of condoms and information on correct use and the importance of consistent use, will serve to not only protect against unwanted pregnancies but STIs, including HIV, as well.

Since imperfect contraceptive use is a reality and more likely to occur when sex is unplanned (including in coerced or unwanted sex situations), emergency contraception should be promoted so as to be able to avert an unwanted pregnancy in situations when no contraceptives were used or contraceptives were used incorrectly. Contraceptive distribution points, such as the ones mentioned above, as well as postabortion care facilities would be logical places to educate women about emergency contraception and distribute it.

It is important to keep in mind that any outreach efforts of information or services are more difficult because more than 80% of the population of Uganda resides in rural areas. Community-based distribution programs, which were successful in reaching rural populations with family planning information and services in Latin America, could be a fruitful model to follow. Efforts should be made to decentralize information and service provision in order to reach more women in rural areas.

Aside from their physical location, those services that do exist are not necessarily user-friendly. The service delivery hours do not suit some population groups; the services are frequently of low quality due to inadequate technical and communication skills among providers; the attitudes of providers can be alienating to groups whose sexual activity is not socially accepted, such as unmarried adolescents; the physical structures are inadequately maintained, including frequently being out of stock of various medicines including contraceptives, especially at the more rural sites; and sometimes the structures do not allow for privacy or confidentiality between the doctor and patient.[44] Thought must be given to how to make contraceptives services more accessible to individuals in need.

Provide Better Postabortion Care

When an unwanted pregnancy does occur and the woman seeks an abortion that results in complications—or when an incomplete spontaneous abortion occurs—prompt health care is necessary to secure that woman's future health. Respondents said that one of

the primary reasons that women delay seeking care for abortion complications was because they did not have money to pay for the services. Therefore, access to appropriate care would be improved through reducing official cost barriers and reducing doctors' preferential treatment of patients with money.

The majority of respondents in this study stated that spontaneous and induced abortion complications were a frequent cause of death. Therefore, education to recognize the signs of spontaneous or induced abortion complications should be provided so that necessary health care can be sought promptly. Because women tend to delay treatment for abortion complications as they wait and observe their health status and hope to get better, women and men should be educated about the consequences of not seeking timely treatment or treatment at all. The consequences which men and women should be taught about include the potential threat that these complications pose to the woman's future fertility and possibly to her life. Individuals should also receive information on the potential risks and consequences of seeking care from untrained providers. Yet because there is a shortage of health care services in Uganda[45] which in part drive women to continue to seek services from untrained providers, traditional providers should be encouraged to refer cases of abortion complications to more highly trained modern medical providers. This would increase the probability that women suffering from these health complications would receive appropriate care as soon as possible.

The treatment of abortion complications drains financial and human resources and places a burden on the already overtaxed health care system. When women do access modern health care for abortion complications, respondents spoke about how problems can arise when providers are untrained or undertrained in treating abortion complications. Efforts should be made to ensure provider skills in methods that they may employ in these types of situations (such as manual vacuum aspiration (MVA)) and to train lower-level staff to provide treatment for less severe complications. Because fear and negative provider attitudes were mentioned by many respondents as reasons why women delay seeking treatment for abortion complications, it is crucial to improve the quality of care offered by modern providers, as well as the abortion patients' perceptions of providers' treatment of women who present with abortion complications.

There have been efforts to improve the training of postabortion care providers in Uganda. Beginning in 1996, Ipas, in conjunction with the Ministry of Health and other stakeholders have provided training in postabortion care services for doctors and midwives. As a result of this collaboration, the Ministry of Health has stated their intention to provide postabortion care in Health Center Level III facilities where midwives will be able to use MVA to treat incomplete abortions of gestational lengths of up to 12 weeks.[46] Ipas has suggested that Uganda undertake a national postabortion care expansion strategy to coordinate improved geographic coverage (one way of doing this would be by involving the private sector in providing postabortion care) and maintain MVA equipment.[47] These steps could reduce the frequency and severity of abortion complications that extract such a high toll on the health and well-being of women and their families in Uganda. Yet the further education of medical staff and improved access to postabortion services can only go so far in a culture where men are most likely the ones controlling the money and therefore, for many, the access to health care. These important social factors must be taken into account in the design of any strategy to improve postabortion care.

Destigmatize Abortion

This study included questions on the social cost of abortion–a topic which has been previously understudied in Uganda. Respondents described strongly disapproving and negative community reactions towards women who have had an abortion. Similarly, the majority of men described not being supportive of women's desire to stop a pregnancy, generally only specifying a few conditions under which abortion is acceptable. When a woman experiences abortion complications, it makes it harder for her to keep her abortion a secret, opening her up to social stigma associated with abortion. Some of the stigma appears to be grounded in the perception that not only are women who have abortions choosing not to reproduce in this pronatalist society, they are going a step further by having an abortion, which is largely seen as being murder and embodying a hatred towards children. Abortion culturally challenges women's predominant identity of the mother. Therefore, since it is not socially desirable to be seen as challenging the role of the good mother, there is a need to keep secret the act and the need for treatment for and resulting complications.[48] Reducing stigma would promote a safer environment for women in which to obtain treatment for abortion complications and would possibly help women with complications seek medical care faster, as well as reduce barriers for women who might not otherwise seek care at all.

The fear of being mistreated by health care professions when seeking care for abortion complications represented another significant barrier and source of delay for women with abortion complications. There must be a strong social message conveyed to women—and also to health care providers—that women have the right to postabortion care. If health providers can be further educated about this, it would hopefully reduce their abusive treatment of women with postabortion complications.

In December 2003, Uganda signed the African Charter on Human and People's Rights on the Rights of Women in Africa. That charter specifies that women have the right to control their fertility; to decide whether to have children; to decide on the number and spacing of their children; to obtain adequate, affordable and accessible health services; and to access medical abortion in cases of sexual assault, rape, incest, danger to the mental and physical health of the mother, and danger to the life of the mother or the fetus.[49] Yet there has been opposition from the Catholic Church to Uganda's signing of this charter, likening Uganda's support of it to condoning murder, since the Catholic Church in Uganda continues to take a very conservative stance towards abortion.[50] While this stance has been perceived by some as out of step with the direction that the country is headed, in a country where 40% of the population is Catholic, the Catholic Church remains a major political force.

Official law remains much more conservative than what is stated in the African Charter on Human and People's Rights on the Rights of Women in Africa. The current legal status of abortion—that it can only be performed to save the life of the mother—and the fact that the prohibition on abortion is enforced[51] is the reason why so many women resort to unsafe abortions in the first place. Yet the popular understanding of the law is not uniform and contradictory public statements have been made about the actual meaning of Uganda's abortion law on the books. An official Ugandan representative speaking at the Committee on the Elimination of Discrimination Against Women on May 31, 1995, was called upon to discuss the provision of abortion in Uganda. The representative stated at that time that the legal provision of abortion was possible if two medical doctors independently agreed that it was necessary for the woman's health, a more liberal interpretation than that frequently enforced within Uganda.[52] Therefore, more liberal public interpretations such as these of Uganda's abortion law, in addition to Uganda's endorsement of the African Charter and the new evidence of the extent of unsafe abortion in Uganda,[53] suggest that the law may be out of step with prevailing public will and that the time may be ripe to revisit the legal provision of abortion in Uganda. Until safe abortion is recognized as a public health priority, women and their families will continue to suffer the health, social and economic consequences of this preventable epidemic.

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Appendix A: Screening Form

SCREENING QUESTIONNAIRE FOR WOMEN AGE 18–49, WOMEN 50–60 AND MEN 20–50 (FGDs AND IDIs)

1. Date of elaboration of list: ___ (Month) ____ (Day) _____ (Year)

2. Name of District: _____

3. Name of Subcounty: _____

4. Name of Village: _____

5. Household number: _____

6. First Name (for the purpose of this study) _____

7. Sex (interviewer tick accordingly):
   - Male ____
   - Female ____

8. What is your age? (interviewer tick accordingly). If age is unknown, estimate based on historical event at birth event.
   - 18–25 ____
   - 26–35 ____
   - 36–49 ____
   - 50–60 ____

9. FOR WOMEN 18–25: Are you currently enrolled in a school? Yes__ No__

10. Have you ever had/ever fathered a child?
    - Yes: ___
    - No: ___

11. FOR WOMEN ONLY. Have you ever had a miscarriage?
    - Yes: ___
    - No: ___

12. FOR MEN ONLY. Have you ever been involved in a pregnancy situation?
    - Yes: ___
    - No: ___

13. Person willing to participate:
    - Yes: ___
    - No: __

14. Person selected for:
    - FGD ____
    - IDI ___

15. Person not selected for the study:
    - Did not meet the criteria ___
    - Did not want to participate ____

SELECTED PERSON FROM THE SCREENER PAGE

Household Number: _____

First Name: _____

Address:

_____

_____

_____

Selection criteria:

For FGD with Women 18 to 49 years old: selection criteria will be age and residence. That means, it doesn't matter if women ever had a child and/or ever had a miscarriage.

For IDIs with women 18–60 the selection criteria will be: age, residence and abortion experience. That means women who ever had a child and/or ever had a miscarriage (YES in either one or both Q. 9 and Q. 10 of Screening Questionnaire).

For IDIs with men 20–50, the selection criteria will be: age, residence and ever fathered a child or ever been in a pregnancy situation (YES in either one or both Q. 9 and Q. 11 of Screening questionnaire)