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Reducing Unintended Pregnancy And Unsafe Abortion in Uganda

Although HIV/AIDS is probably Uganda's gravest public health issue, unintended pregnancy and unsafe abortion also rank high among serious health problems facing the country. Unplanned births are common and represent a growing proportion of all births— almost 40% in 2000, compared with 29% in 1995. With such high levels of unplanned childbearing, it is likely that abortion is becoming increasingly common in Uganda, even though national law permits abortion only to save a woman's life.[1] Evidence from small-scale studies suggests that abortion to end unwanted pregnancies is widespread, that it is usually performed clandestinely in unsafe conditions and that unsafe abortion is a leading cause of maternal death in Uganda.[2]

This report examines key changes since the late 1980s in the reproductive and contraceptive behavior and preferences of Ugandan women, assesses the extent to which births are unplanned and summarizes what is known about unsafe abortion in the country. To capture recent trends, the report provides information for 1988, 1995 and 2000—years for which comparable national survey data on these issues are available. To highlight the large differences across the country and the need for attention to variations in policies and programs, it includes measures for the four major regions of Uganda, and for urban and rural residents.

The purpose of the report is to increase awareness of, and attention to, Ugandan women's reproductive health care needs. We hope that policymakers, public health advocates and health care professionals will use the report's findings to develop informed policies and programs that could help reduce unintended pregnancies and lessen the negative impact of unplanned births and unsafe abortions on the health and lives of Ugandan women.

Uganda is characterized by change and uncertainty.

Uganda has a population of 26 million (as of 2003),[3] and its population is growing at a rate of 3.4% per year.[4] The population is predominantly rural (85%), and a substantial proportion of adults (32%) are illiterate.[5] Much of the population depends on agriculture.[6]

An estimated 5–6% of adults were infected with HIV/AIDS at the end of 2001, compared with 15% in 1991.[7]

The country's Northern region has been devastated by violent civil unrest since the late 1980s. About 1.2 million people in the region have been displaced from their homes.[8]

The per capita gross domestic product of $1,490 (in 2001) places Uganda between the poorer African countries, such as Malawi and Burundi, and the more industrialized ones, such as Zimbabwe and Ghana.[9] Uganda's economy grew at a rate of 6% per year in the period 1990–2003, and the annual rate of growth peaked at 10% between 1994 and 1995.[10] Economic development differs

Key Points

- **On average, women's ideal family size declined from 6.5 children in 1988 to 4.8 in 2000. However, the average woman has 6.9 children—two more than she wants.**
- **Rural women have substantially more children than urban women (7.4 vs. 4.0) but also prefer to have more children (5.1 vs. 3.8).**
- **In 2000, 39% of married women wanted no more children, and 40% wanted to postpone their next birth for at least two years.**
- **The proportion of recent births that were unintended (either not wanted at all or wanted at a later time) rose from 29% in 1995 to 38% in 2000.**
- **Unsafe abortion is a leading cause of maternal death in Uganda. One in five maternal deaths result from abortion-related complications, according to a three-hospital study in Kampala.**
- **Only 23% of married Ugandan women of childbearing age practice contraception, and only 14% use a modern method.**
- **In 2000, 33% of women aged 15–49 had an unmet need for contraceptives. The proportion was 36% in rural areas and 18% in urban areas.**
- **Lack of access to family planning services (especially in rural areas), misconceptions and myths about possible side effects of modern methods, and lack of partner support are among the major bar-riers to contraceptive use for Ugandan women, and thus contribute to a high level of unintended childbearing.**

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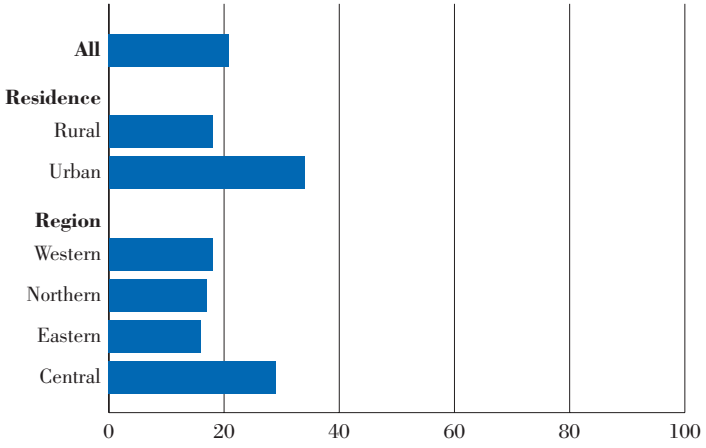
chart a
Sexual Experience

About one-fifth of young unmarried Ugandan women have had sexual intercourse.



Source: Uganda Demographic and Health Survey, 2000.

widely by region, however, and life in urban areas bears little resemblance to that in rural areas. Moreover, gaps between the urban and rural populations in economic and social conditions that often interact to shape women's and couples' reproductive preferences and behavior are increasing.

Ugandan women's educational attainment and employment status have improved somewhat.[11] By 2000, 32% of women aged 20–24 had obtained seven or more years of schooling, compared with 21% of women aged 40–44. Gains were even greater in the Central and Eastern regions. In addition, the proportion of women currently working grew from 61% to 74% between 1995 and 2000.* More important, the proportion currently working for pay in the form of cash rose from 51% to 62% during that period.

Advances in the educational attainment of women have not been as great in rural as in urban areas, and are not equally evident in all four regions of the country.[12] Among women aged 20–24 in 2000, 67% of urban residents and 24% of rural residents had had seven or more years of schooling. The proportion was 49% in the Central region, compared with only 16–26% in the country's three other regions.

Women's living conditions have also improved slightly.[13] Between 1988 and 2000, there were small gains in the proportion of women living in households with electricity (from 7% to 11%) and in households with a television set (from 2% to 8%). In addition, by 2000, 38% of women had weekly exposure to at least one form of media (radio, newspaper or television), compared with 30% in 1995.

*Part of this difference may be due to the different questions the Demographic and Health Surveys used to capture this information in the two years. In 2000, women were asked if they had worked in the past seven days, whereas in 1995, women were asked if they were currently working, which they may have interpreted to refer to a shorter time period (e.g., the current day or the last few days).

Some young unmarried women are sexually experienced.

Ugandan society generally does not condone premarital sexual activity. Most unmarried women, especially those still in their teens, face serious problems if they become pregnant.

Nationally, 21% of women aged 15–24 are unmarried and sexually experienced; that is, they have ever had sexual intercourse (Chart A). The proportion is above average in urban areas (34%), and it is higher in the Central region than in the other three regions (29% vs. 16–18%).

Ugandan women want smaller families than in the past.

The total fertility rate (TFR), which measures actual family size is high in Uganda by worldwide standards and has changed little in recent years. In 2000, the average woman had 6.9 children, not many fewer than the 7.4 children her counterpart had in 1988 (Table 1). In urban areas, average family size declined from almost six children to four during the same 12-year period, while in rural areas, it remained between seven and eight children.

However, Ugandan women today prefer to have nearly two fewer children than they did about a decade ago: Between 1988 and 2000, the ideal family size declined from 6.5 to 4.8 children. By 2000, urban women's desired family size was very close to their actual family size (3.8 and 4.0 children, respectively). In contrast, women in rural areas were having roughly two children more than their ideal number (7.4 vs. 5.1). These findings suggest high levels of unwanted childbearing in rural areas.

A number of social and economic factors are shaping Ugandan women's desire for smaller families. Such factors include:

- improvements in education among women living in urban areas (a development that has been shown worldwide to be associated with a preference for fewer children[14]);
- increases in the number of women who work outside the home and thus have less time to care for their children;
- a growing understanding among many parents that children need more than primary schooling to function in modernizing and urban societies, but also that keeping children in school requires

Data Sources

Data presented in this report are derived largely from the 1988, 1995 and 2000 Uganda Demographic and Health Surveys (DHS). These surveys are part of a worldwide project conducted by ORC Macro, in collaboration with national governments, to collect and disseminate data on fertility, family planning, maternal and child health, and HIV/AIDS. The samples surveyed are nationally representative and are large enough to permit estimates for Uganda's four regions. (For 1988, six regions were consolidated into the four regions used for 1995 and 2000.) The 1988 survey interviewed 4,730 women aged 15–49, the 1995 survey interviewed 7,070 and the 2000 survey interviewed 7,246.

table 1
Family Size

Actual and ideal family size among all women aged 15–49, by region and residence, Uganda, 1988 and 2000

	All	Region				Residence	
		Central	Eastern	Northern	Western	Urban	Rural
Actual family size*							
1988	7.4	na	na	na	na	5.7	7.6
2000	6.9	5.7	7.4	7.9	6.9	4.0	7.4
Ideal family size							
1988	6.5	6.1	6.3	6.7	6.9	5.5	6.6
2000	4.8	4.4	4.8	5.6	5.1	3.8	5.1

*Total fertility rate. *Notes:* na=not available. Values are average numbers of children. *Sources:* Uganda Demographic and Health Surveys, 1988 and 2000.

resources, which, in turn, increases the motivation to have fewer children;

• widespread poverty in both urban and rural areas; and

• uncertainty about the society's stability in the north.

Four in ten births are unwanted or mistimed.

In 1995, 29% of recent births to Ugandan women aged 15–49 were unintended; that is, they were not wanted at all or were mistimed (wanted later). By 2000, this proportion had risen to 38%; more specifically, 14% were unwanted and 24% were mistimed (Chart B, page 4). Unintended childbearing increased in all regions except the Central region, where the level was already high in 1995 (42%). Particularly rapid increases during the five-year period occurred in the Eastern region and Northern region, where insurgency has led to the breakdown of systems for providing health services.

Because women often seek to end unintended pregnancies by abortion, Uganda's level of unintended pregnancy is higher than its level of unintended births. Also, abortion levels are likely to be above average in urban areas and in the Eastern region, because unintended births, and probably also unintended pregnancies, are more common there than in other parts of Uganda.

Most women do not want another child soon or ever.

As family-size goals decline, an increasing proportion of women do not want to have any more children. In addition, as women face growing demands to become educated or to find paying jobs, some may wish to postpone a pregnancy, even if they eventually want large families.

Between 1988 and 2000, the proportion of married women aged 15–49 who did not want to have any more children increased from 19% to 39%; comparable increases occurred in both urban areas and rural areas (Chart C, page 5). Trends with respect to women's desire to delay the next birth are quite different from those regarding the wish to have no more children. The proportion of married women who wished to delay the next birth by two or more years changed relatively little between 1988 and 2000, hovering around 40%. This pattern suggests that most married women have a need for birthspacing at some time, regardless of their family-size goals.

Overall, 79% of married women 15–49 want to stop or delay childbearing. In 2000, the proportions of married women in the Central, Eastern and Western regions who wanted to stop childbearing were close to the national average (39–42%; not shown). The proportion in the Northern region was somewhat below average (33%), but even this level represents a tripling of the proportion since 1988.

In addition, in 2000, 44% of sexually experienced unmarried women did not want any more children.

The balance between the desire to stop childbearing and the desire to space pregnancies shifts dramatically as women grow older.[15] In the teenage years, women's overwhelming need is to postpone pregnancy by at least two years, and as may be expected, very few want no more children. But by their early 30s, 53% of women do not want to become pregnant again, and 28% want to delay their next pregnancy. In their 40s, most women (70–75%) do not want to become pregnant again.

Whether a woman is more likely to end an unwanted than a mistimed pregnancy clearly depends on her individual situation. The implications of a mistimed pregnancy for an unmarried teenager could be as serious as, if not more serious than, the consequences of an unwanted pregnancy for a married woman in her late 30s who already has more children than she wanted.

Many Ugandan women resort to unsafe abortion.

The actual level of abortion in Uganda is unknown, but a small number of studies carried out in the past decade provide some insight. In a 1992–1994 national-level study, 63% of women and men surveyed said that they knew someone who had had an abortion, and respondents with more than a secondary education were the most likely to say so.[16] A 1994 study in four major Ugandan hospitals estimated that 2,000 women were treated for complications of incomplete abortions in these hospitals each year.[17] However, women treated for complications in hospitals represent only a fraction of those obtaining clandestine abortions: Some women may not have any complications, and some who do may not seek, or may fail to obtain, hospital treatment for various reasons, such as fear of alerting the authorities to their involvement in an illegal activity or the lack of a hospital nearby that provides treatment for abortion complications.

Based on existing studies, it appears that high proportions of abortions in Uganda are

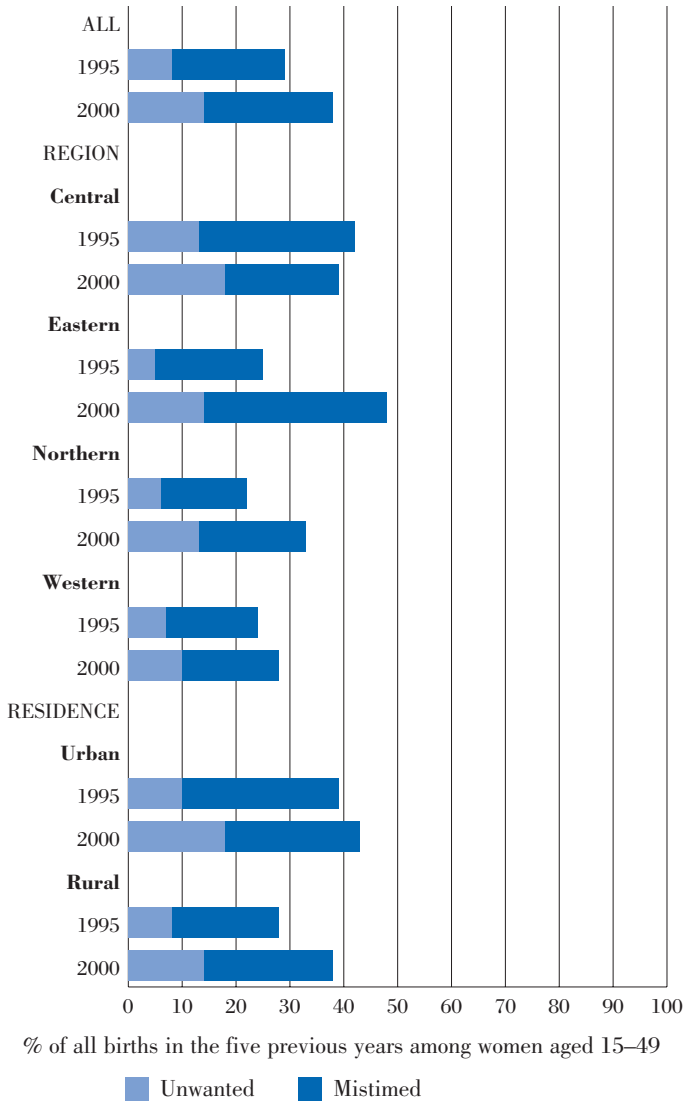
performed in secrecy and with unsafe techniques that can lead to serious health consequences for women, including death. In fact, unsafe abortion is believed to be a leading cause of maternal death in the country. A 1992–1993 study in three Kampala hospitals found that 21% of maternal deaths were due to abortion-related complications.[18] In the 1994 study at four hospitals, the most common complications reported were hemorrhage, infection (sepsis), uterine perforation and cervical injury.[19] Longer-term consequences can include infertility, a particularly serious condition for young women who may not yet have had any children.

Unsafe abortions not only threaten the health and lives of Ugandan women, but also drain limited resources from the country's health care system. Women who have abortion complications may require several days of hospitalization, treatment with expensive antibiotics, or blood transfusions.[20]

Women in Uganda express many reasons for seeking to end a pregnancy: having too many children already, living in poverty, having children who are too close in age, being unmarried, having conceived at the wrong time, being in poor health, or having become pregnant as a result of rape or incest.[21] In one of the districts hardest hit by HIV/AIDS, women also cite being HIV-positive as a reason for ending a pregnancy.[22] Thus, younger and older women in Uganda, unmarried as well as married, take the step of ending an unwanted pregnancy by unsafe abortion. At the national level, however, we do not yet have a clear picture of the age or marital profile of women who obtain unsafe abortions, or of their reasons for doing so.

chart b
Unintended Births

The proportion of births that are unwanted or mistimed is increasing in nearly all parts of the country.



Sources: Uganda Demographic and Health Survey, 1995 and 2000.

Most sexually active women do not use any contraceptive method.

Levels of contraceptive use, which were extremely low at the end of the 1980s, are on the rise in Uganda (Table 2, page 6). Between 1988 and 2000, the proportion using any method of family planning increased from 5% to 23% among married women, and from 14% to 44% among unmarried women who are sexually active (i.e., they had intercourse in the last three months). Among married women in urban areas, the proportion more than doubled (from 18% to 46%), and it climbed even more dramatically in relative terms in rural areas (from 4% to 19%). But despite these gains, the widening gap between actual and wanted family size suggests that women's preferred number of children is falling faster than contraceptive use is increasing.

Most current contraceptive use in Uganda involves a modern method—the pill, IUDs, injectables, implants, the male condom, spermicide, or female or male sterilization. Six in 10 married women who use contraceptives—or 14% of all married women—depend on one of these methods. In 2000, the proportion of all married women using a modern method was highest in the Central region (26%) and lowest in the Northern region (6%). Nationally, among married contraceptive users, the most commonly used contraceptives are injectables and the pill (used by 28% and 14%, respectively—not shown).

Between 1988 and 2000, the Central region had the largest absolute increase in the proportion of married women using modern methods (from 5% to 26%). The smallest such increase occurred in the mostly rural Northern region (from zero to 6%), which suggests that much of the increase in the rate of overall contraceptive use in this region (from 1% to 21%) was due to married women's growing reliance on traditional methods (from 1% to 15%). Given this region's extreme poverty and civil unrest, women living there—particularly those residing in internal displacement camps—are likely to have poor access to modern methods of family planning, including condoms.

Thirty-eight percent of sexually active unmarried women

rely on modern methods; that is, almost nine in 10 contraceptive users in this group. In addition, the rate of condom use is much higher among sexually active unmarried women than among married women (24% vs. 2%—not shown). Unmarried women's greater reliance on modern methods in general and on the condom in particular is due to several factors: Their strong motivation to prevent unplanned pregnancy, the ease of access to a method that does not require going to a provider, their perceptions about the side effects of modern methods other than the condom and their understanding that they are likely at higher risk of sexually transmitted infections, particularly HIV, than married women.

Overall, four in 10 married women using contraceptives in 2000 chose traditional methods—18% lactational amenorrhea, 11% periodic abstinence, 5% withdrawal and 4% other, local methods (not shown). Among married women, reliance on these methods was highest in the Northern region, where these methods accounted for almost three-quarters of all contraceptive use. At the national level, reliance on traditional methods was substantially lower among unmarried women, accounting for only one-seventh of all use.

The level of contraceptive use differs widely between married women in urban and rural areas (46% vs. 19%); the disparity is entirely the result of differences in the rate of use of modern methods (38% vs. 10%) rather than of traditional methods (8–9% in both areas). Similarly, among sexually active unmarried women, urban residents are much more likely than rural residents to practice contraception (61% vs. 36%), and this gap also is due mainly to differences in levels of use of modern methods. For both married and unmarried women, these differences likely reflect higher levels of education, employment and disposable income among urban women, as well as better access to family planning services in towns and cities.

Married women living in the Eastern, Northern and Western regions are the most likely not to practice any form of contraception (79–85%), although the proportion is high in the Central region as well (63%). Among sexually active unmarried women, those living in the Northern and Western regions are the most likely not to use any contraceptives (74–78%).

One-third of all women have unmet need for contraceptives.

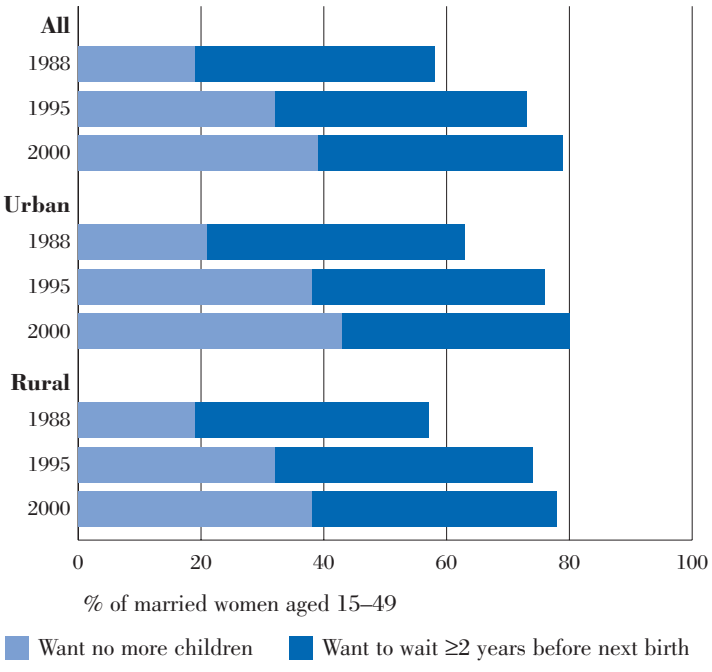
Unmet need for contraceptives is high in every region of the country: In 2000, 33% of all women aged 15–49 did not want a child soon or ever, but were not using any method of contraception (Chart D, page 7). The proportion of women with unmet need was twice as high in rural areas as in urban areas (36% vs. 18%). And across regions, it was highest in the Eastern and Western regions (37–39%).

While modern methods provide effective contraception, traditional methods have high failure rates. Therefore, looking only at the use of modern methods provides insight into the level of unmet need for effective contraceptives. The proportion of married women aged 15–49 with an unmet need for an effective method grew somewhat during the years 1995–2000 in the Eastern, Northern and Western regions. The largest increase occurred in the Northern region (from 45% to 52%). Thus, the increased desire of women in the Northern region to stop childbearing appears not to have been matched by a rise in use of effective birth control. This situation is likely to result in high levels of unwanted pregnancy and, perhaps, of unsafe abortion.

chart c

Childbearing Preferences

The majority of married women do not want another child soon or ever.



Sources: Uganda Demographic and Health Surveys, 1988, 1995 and 2000.

Policies are in place to improve women's lives.

During the 1990s, the Ugandan government adopted a series of policies aimed at improving the status of women. The National Population Policy, enacted in 1995, had the goals of reducing high fertility rates and high levels of maternal mortality by encouraging contraceptive use, improving access to family planning services, raising the minimum age at marriage to 18 years, and promoting educational and employment opportunities for women.[23] In that same year, Uganda revised its constitution, setting aside 30% of all electoral seats for women. Today, women hold 25% of seats in the lower house of parliament (elected in 2001).[24]

In 1997, the National Gender Policy recognized gender as a salient factor in the planning and funding of development programs.[25] In response to high rates of illiteracy, the Universal Primary Education Policy, established that same year, guar-

table 2

Contraceptive Use

Percentage distribution of married women and sexually active unmarried women aged 15–49, by current contraceptive method, according to region and residence, Uganda, 1988, 1995 and 2000

MARRIED WOMEN

Method	All	Region				Residence	
		Central	Eastern	Northern	Western	Urban	Rural
Any							
1988	5	8	4	1	4	18	4
1995	15	25	11	14	10	34	12
2000	23	37	15	21	18	46	19
Modern*							
1988	3	5	2	0	1	12	2
1995	8	16	6	3	7	28	5
2000	14	26	9	6	11	38	10
Traditional†							
1988	2	3	2	1	3	6	2
1995	7	9	6	11	3	6	7
2000	9	11	5	15	7	8	9
No method							
1988	95	92	96	99	96	82	96
1995	85	75	89	86	90	66	88
2000	77	63	85	79	82	54	81
Total							
1988	100	100	100	100	100	100	100
1995	100	100	100	100	100	100	100
2000	100	100	100	100	100	100	100

SEXUALLY ACTIVE UNMARRIED WOMEN‡

Method	All	Region				Residence	
		Central	Eastern	Northern	Western	Urban	Rural
Any							
1988	14	14	12	0	15	25	11
1995	36	46	31	14	24	53	29
2000	44	57	41	21	26	61	36
Modern*							
1988	7	7	6	0	7	16	4
1995	26	38	17	7	18	47	18
2000	38	52	34	16	19	57	30
Traditional†							
1988	7	7	6	0	8	9	7
1995	10	8	14	7	6	6	11
2000	6	5	7	5	7	4	6
No method							
1988	86	86	88	100	85	75	89
1995	64	54	69	86	76	47	71
2000	56	43	59	78	74	39	64
Total							
1988	100	100	100	100	100	100	100
1995	100	100	100	100	100	100	100
2000	100	100	100	100	100	100	100

*The pill, IUD, injectables, implant, spermicide, condom, and male and female sterilization. †Periodic abstinence, lactational amenorrhea, withdrawal and other, local methods. ‡Sexually active is defined as having had sexual intercourse in the three previous months. *Sources:* Uganda Demographic and Health Surveys, 1988, 1995 and 2000.

anteed free primary education for at least four children per family and, with the goal of ensuring education for girls, reserved half of all school places for them.[26] In addition, affirmative action policies have been implemented for women at the university level to ensure that an increasing proportion of women obtain higher education.

In 1999, the National Health Policy aimed to reduce mortality, morbidity and fertility through organizational and management reform of the national health care system and of the Ministry of Health, strengthening the management of district-level health services and building capacity for improved health care delivery at the subdistrict level.[27] In the same year, the National Action Plan for Women for the period 1999–2004 provided a framework to advance the position of women in the areas of poverty reduction, income generation and economic empowerment; reproductive health and rights; legal framework and decision-making; and education.[28]

Services to protect women's reproductive health are lagging.

The Ministry of Health of Uganda has made a concerted effort to establish policies and programs aimed at promoting safe motherhood, family planning and reproductive health advocacy. However, many Ugandan women are still unable to achieve their family-size goals, particularly in less affluent areas of the country. One reason is that these policies and programs have not been fully implemented, especially at the local level, and therefore the services they call for have not

been sufficiently developed.

In the mid-1990s, the Ugandan government was decentralized, and district-level administrators became responsible for planning, budgeting and implementing all government programs in their districts, including family planning services. Yet a lack of community awareness of national reproductive health policies, a lack of skilled labor, insufficient supplies in health facilities and a strained budget have all been identified as major barriers to providing family planning services that adequately address the needs of Ugandan women. A 1998 survey in Kampala, Jinja, Lira and Kabarole—districts representing the country's four regions—showed that many district administrators were not even aware of the reproductive health recommendations endorsed by the Ministry of Health.[29]

The same study also revealed that many health centers did not have an adequate supply of modern contraceptives and were often forced to refer women to hospitals for care; such referrals could be a major deterrent, considering the high costs of travel. The authors concluded that to bridge the gap between national policy and individual behavior, the central government must better articulate national policies to district officials and properly evaluate district-level management and programs.

Lack of access to health and family planning services is a leading barrier to contraceptive use in Uganda, particularly in rural areas.[30] The estimated median distance from a woman's home to the nearest health facility offering family planning services is 12 miles, too great a distance for women whose primary mode of transportation is walking.[31] In rural areas, only 39% of the population live within three miles of a health facility offering family planning services, compared with 99% in urban areas.[32]

Many Ugandan women, particularly in rural areas, rely on community-based distribution (CBD) programs as a source of family planning education and methods. However, focus group discussions have revealed that the volunteers who staff these programs are dissatisfied with the lack of compensation and incentives for their efforts.[33] Therefore, CBD programs in Uganda may not be sustainable unless a viable remuneration strategy is developed.[34] The loss of these programs would have adverse consequences for women living in remote rural areas.

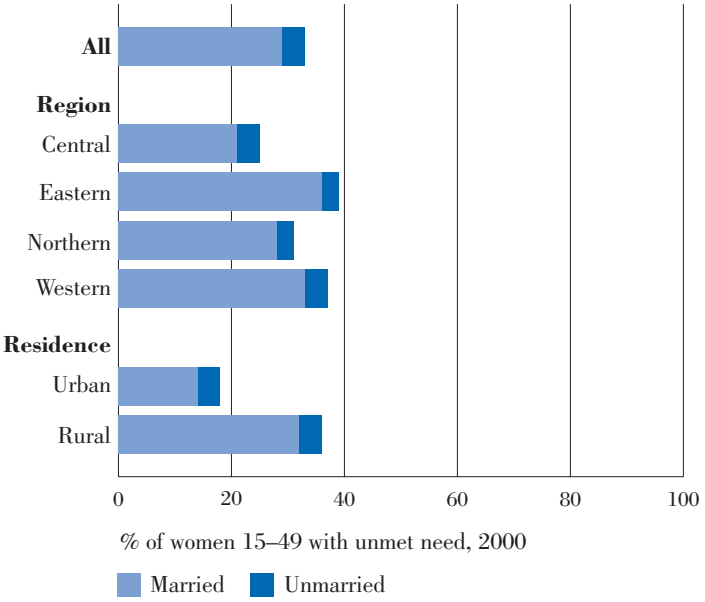
Women face other barriers to contraceptive use as well.

Misconceptions and myths about possible side effects of modern methods, particularly the pill and IUD, are obstacles to their use, suggesting the need to improve education about family planning methods in Uganda.[35]

Lack of support by a spouse or partner also contributes to low levels of contraceptive use among Ugandan women.[36] In qualitative studies, many women report that their partners are not supportive of contraception.[37] Evidence also suggests that couples rarely discuss family planning.[38] Focus group discussions with Ugandan men and women reveal that men believe that responsibility for family planning lies with women, while women say that their husbands prevent them from using contraception.[39]

chart d
Unmet Need

One-third of all women in Uganda need but are not using contraceptives.



Source: Uganda Demographic and Health Survey, 2000.

Over the years, family planning efforts in Uganda have focused primarily on women. However, many Ugandan men share their wives' desire to have smaller families. In 2000, Ugandan men said that their ideal family size was 5.6 children—more than the average number that women wanted (4.8 children) but 1.3 fewer than the number they already had.[40] Because women's use of family planning methods often depends on their partner's approval and support, programs must involve men and encourage them to support women in their use of modern contraception—for example, by setting up services that are male-friendly and that encourage men to accompany their partners.[41]

Immediate action is needed on many fronts.

The increase in contraceptive use among Ugandan women during the 1990s is encouraging. However, the level of use remains low, and unmet need for effective methods of family planning is extremely high, particularly in rural areas—where 85% of the population live. Women's motivation to limit and space births has risen faster than their use of contraceptives; the result is that increasing proportions of births are mistimed or unwanted. Sexually active unmarried women, who are mostly adolescents or women in their 20s and who are particularly affected by an unplanned pregnancy, have a great need for better education on sexual and reproductive health and prevention of unplanned pregnancy, as well as improved access to contraceptive ser-

vices and supplies. Without comprehensive steps to improve the current situation, many Ugandan women will continue to risk their health and lives to end unwanted pregnancies by unsafe abortion. The quality and accessibility of family planning services in Uganda, including postabortion services and contraceptive counseling, must be substantially improved by the public sector (at the national, district and local levels), assisted by the private sector and nongovernmental organizations, if current levels of unintended pregnancy and unsafe abortion are to be reduced.

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Credits

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